Chapter-1

Introduction and Expanding Horizons of ART

Almighty gave a capacity to every living being to give birth to a similar species thus every living being is desirous to have a child. Family gives an aspiration to anybody to do something for the betterment of the family. Any married couple is incomplete unless they don’t have third one in between, i.e. the child. In Indian mythology, a person is incomplete without having a son. He can’t go to heaven and will move in various “Yonies”, unless his son gave water to his departed sole after his death.

Unfortunately everybody is not that much fateful to have child for various reasons. It may be psychological or physiological disorder or else. Adoption is well adopted and established procedure of having child for such persons. Mythology and history both are full of examples of adoption. Even religious laws provide methodology, Procedures and legitimacy to such child with all rights.

Now the time has been changed and technological development gave new avenues and provided new opportunities to child seekers. Assisted reproductive technology is the technology, enable such peoples having their own child, in spite of almost every disability to have, physiological or other.

A thorough Discussion with the Doctors of 3 ART Hospitals at Hyderabad and going through their brochures, and collection of information from various web sites enabled the candidate to deeply understand the complications in the procedure of ART. Since he has been previously associated with Hindustan Latex Limited and Dealt with Training part of Reproductive Technology, so, is well aware of the Technical terminologies, Human Reproduction and advances in Artificial Insemination.

Since Assisted reproductive technology is a complicated technology and uses in various ways, so to ascertain and analyze the legal issue behind it, first we should understand the human reproduction, intervention of technology in human reproduction and complex relationship of genetic mother/father and biological mother father and even otherwise also legal mother father of a child born out of this Assisted Reproductive Technology.
The Technical Information is largely based upon the Folder published by
Patients”. The information has been modified after consultation with ART
Expert as per Indian Conditions.

UNASSISTED REPRODUCTION

In order to understand assisted reproduction and how it can help
infertile couples, it is important to understand how conception takes place
naturally. For traditional conception to occur, the man must ejaculate his
semen, the fluid containing the sperm, into the woman’s vagina around the
time of ovulation, when her ovary releases an egg. Ovulation is a complex event
controlled by the pituitary gland, which is located at the base of the brain. The
pituitary gland releases follicle-stimulating hormone (FSH), which stimulates
follicles in one of the ovaries to begin growing. The follicle produces the
hormone estrogen and contains a maturing egg. When an egg is mature, the
pituitary gland sends a surge of luteinizing hormone (LH) that causes the follicle
to rupture and release (ovulate) a mature egg.

Following ovulation, the egg is picked up by one of the fallopian tubes.
Since fertilization usually takes place inside the fallopian tube, the man’s sperm
must be capable of swimming through the vagina and cervical mucus, up the
cervical canal into the uterus, and up into the fallopian tube, where it must
penetrate the egg in order to fertilize it. The fertilized egg continues traveling to
the uterus and implants in the uterine lining, where it continues to develop.

Intrauterine Insemination (IUI)

Intrauterine insemination (IUI) is the placement of a man’s sperm into a
woman’s uterus using a long, narrow tube.

More information on IUI includes the following:

- IUI is most effective for treating:
  - women who have scarring or defects of the cervix
  - men who have low sperm counts

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from http://www.reproductivefacts.org/intrauterine_insemination_IUI_FactSheet
men who have sperm with low mobility

- men who cannot get erections

- men who have retrograde ejaculation, a condition in which sperm are ejaculated into the bladder instead of out of the penis

- IUI can be used in combination with medications that stimulate ovulation; this combination can increase the chance of pregnancy in some cases.

- The success of IUI depends on the cause of the couple's infertility. If inseminations are performed monthly with fresh or frozen sperm, success rates can be as high as 20% per cycle depending on whether fertility medications are used, the age of the female partner, and the infertility diagnosis, as well as on other factors that could affect the success of the cycle.

**IN VITRO FERTILIZATION (IVF)**

There are many factors that can prevent the union of sperm and egg. Fortunately, assisted reproductive technologies such as IVF can help. IVF is a method of assisted reproduction in which a man’s sperm and a woman’s eggs are combined outside of the body in a laboratory dish. One or more fertilized eggs (embryos) may be transferred into the woman’s uterus, where they may implant in the uterine lining and develop. Excess embryos may be cry preserved (frozen) for future use. Initially, IVF was used to treat women with blocked, damaged, or absent fallopian tubes. Today, IVF is used to treat many causes of infertility, such as endometriosis and male factor, or when a couple’s infertility is unexplained. The basic steps in an IVF treatment cycle are ovarian stimulation, egg retrieval, fertilization, embryo culture, and embryo transfer. These are discussed in the following sections.

**Ovarian Stimulation**

During ovarian stimulation, also known as ovulation induction, medications or “fertility drugs,” are used to stimulate multiple eggs to grow in the ovaries rather than the single egg that normally develops each month.

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Multiple eggs are stimulated because some eggs will not fertilize or develop normally after fertilization.

Timing is crucial in an IVF cycle. The ovaries are evaluated during treatment with vaginal ultrasound examinations to monitor the development of ovarian follicles. Blood samples are drawn to measure the response to ovarian stimulation medications. Normally, estrogen levels increase as the follicles develop, and progesterone levels are low until after ovulation.

Using ultrasound examinations and blood testing, the physician can determine when the follicles are ready for egg retrieval. Generally, eight to 14 days of stimulation is required. When the follicles are ready, HCG or other medications are given. The HCG replaces the woman’s natural LH surge and causes the final stage of egg maturation so the eggs are capable of being fertilized. The eggs are retrieved before ovulation occurs, usually 34 to 36 hours after the HCG injection is given.

Up to 20% of cycles may be cancelled prior to egg retrieval. IVF cycles may be cancelled for a variety of reasons, usually due to an inadequate number of follicles developing. Cancellation rates due to low response to the ovulation drugs increase with a woman’s age, especially after age 35. When cycles are cancelled due to a poor response, alternate drug strategies may be helpful to promote a better response in a future attempt. Occasionally, a cycle may be cancelled to reduce the risk of ovarian hyper-stimulation syndrome (OHSS). Treatment with a GNRH agonist or antagonist reduces the possibility of premature LH surges from the pituitary gland, and thereby reduces the risk of premature ovulation. However, LH surges and ovulation occur prematurely in a small percentage of ART cycles despite the use of these drugs. When this occurs, since it is unknown when the LH surges began and eggs will mature, the cycle is usually cancelled. Collection of eggs from the peritoneal cavity after ovulation is not efficient.

**Egg Retrieval**

Egg retrieval is usually accomplished by trans-vaginal ultrasound aspiration, a minor surgical procedure that can be performed in the physician’s office or an outpatient center. Some form of pain medication is generally administered. An ultrasound probe is inserted into the vagina to identify the follicles, and a needle is guided through the vagina and into the follicles. The eggs are aspirated (removed) from the follicles through the needle connected
to a suction device. Removal of multiple eggs can usually be completed in less than 30 minutes. Some women experience cramping on the day of the retrieval, but this sensation usually subsides by the next day. Feelings of fullness and/or pressure may last for several weeks following the procedure because the ovaries remain enlarged. In some circumstances, one or both ovaries may not be accessible by trans-vaginal ultrasound. *Laparoscopy* may then be used to retrieve the eggs using a small telescope placed in the umbilicus.

**Fertilization and Embryo Culture**

After the eggs are retrieved, they are examined in the laboratory for maturity and quality. Mature eggs are placed in an *IVF culture medium* and transferred to an incubator to await fertilization by the sperm.

Sperm is separated from *semen* usually obtained by masturbation or in a special condom used during intercourse. Alternatively, sperm may be obtained from the testicle, *epididymis*, or *vas deferens* from men whose semen is void of sperm either due to an obstruction or lack of production.

Fertilization may be accomplished by *insemination*, where *motile* sperm are placed together with the oocytes and incubated overnight or by *intracytoplasmic sperm injection (ICSI)*, where a single sperm is directly injected into each mature egg. ICSI is usually performed when there is a likelihood of reduced fertilization, e.g., poor semen quality, history of failed fertilization in a prior IVF cycle. Overall, pregnancy and delivery rates with ICSI are similar to the rates seen with traditional IVF.

**Sperm Injection.**

Visualization of two *pronuclei* the following day confirms fertilization of the egg. One pronucleus is derived from the egg and one from the sperm. Usually 65% to 75% of mature eggs will fertilize after insemination or ICSI. Lower rates may occur if the sperm and/or egg quality are poor. Occasionally, fertilization does not occur at all, even if ICSI was used. Two days after the egg retrieval, the fertilized egg has divided to become a 2- to 4-cell embryo.

By the third day, a normally developing embryo will contain approximately 6 to 10 cells. By the fifth day, a fluid cavity forms in the embryo, and the placenta and fetal tissues begin to separate. An embryo at this stage is called a *blastocyst*. Embryos may be transferred to the uterus at any time
between one and six days after the egg retrieval. If successful development continues in the uterus, the embryo hatches from the surrounding zona pellucida and implants into the lining of the uterus approximately 6 to 10 days after the egg retrieval.

**Assisted hatching (AH)** is a *micromanipulation* procedure in which a hole is made in the zona pellucida just prior to embryo transfer to facilitate hatching of the embryo. Although AH has not been demonstrated definitively to improve live birth rates, AH may be used for older women or couples who have had unsuccessful prior IVF attempts. There is no clear benefit of AH to improve pregnancy or live birth rates in other groups of IVF patients.

**Preimplantation genetic diagnosis (PGD)** is performed at some centers to screen for inherited diseases. In PGD, one or two cells are removed from the developing embryo and tested for a specific genetic disease. Embryos that do not have the gene associated with the disease are selected for transfer to the uterus.

These procedures require specialized equipment and experience together with IVF (in a couple who may otherwise not need IVF to conceive). Some couples, especially those who are carriers of genetic diseases, consider embryo screening beneficial in reducing the risk of having an affected child. While PGD can reduce the likelihood of conceiving a pregnancy with an affected child, it cannot eliminate the risk. Confirmation with *chorionic villus sampling (CVS)*, *amniocentesis* or other testing is still necessary.

**Embryo Transfer**

The next step in the IVF process is the embryo transfer. No anesthesia is necessary, although some women may wish to have a mild sedative. The physician identifies the cervix using a vaginal speculum. One or more embryos suspended in a drop of culture medium are drawn into a transfer catheter, a long, thin sterile tube with a syringe on one end. The physician gently guides the tip of the transfer catheter through the cervix and places the fluid containing the embryos into the uterine cavity. The procedure is usually painless, although some women experience mild cramping.

The maximum number of embryos transferred is based on the patient’s age and other individual patient and embryo characteristics. Since each embryo has a fair probability of implantation and development, the number of embryos
to be transferred should be determined for each patient, taking into account
the odds of achieving a pregnancy based on the number of embryos transferred
weighed against the risk of *multiple gestation*. These guidelines have been
effective in helping U.S. ART programs maintain their high success rates while
significantly decreasing the number of high-order multiple pregnancies (triplets
and higher). The reproductive endocrinologist or embryologist will discuss this
with the patient prior to the transfer.

*Cryopreservation*

Extra embryos remaining after the embryo transfer may be
cryopreserved (frozen) for future transfer. Cryopreservation makes future ART
cycles simpler, less expensive, and less invasive than the initial IVF cycle, since
the woman does not require ovarian stimulation or egg retrieval. Once frozen,
embryos may be stored for prolonged periods, and live births have been
reported using embryos that have been frozen for almost 20 years. However,
not all embryos survive the freezing and thawing process, and the live birth rate
is lower with cryopreserved embryo transfer. Couples should decide if they are
going to cryopreserve extra embryos before undergoing IVF. There are two
methods used to cryopreserve embryos: conventional (slow) freezing and
“*vitrification*” or fast freezing. Doctors determine which method is best to use
based on their experience and the developmental stage at which the embryos
are frozen. Although some reports claim that vitrification may have higher
success rates after thawing/warming.

It should also be noted that more and more ART centers are
cryopreserving oocytes (eggs) prior to fertilization. This is done most commonly
in young women who are about to undergo treatments or procedures that may
affect their future fertility, such as chemotherapy for cancer. However, it is also
used for couples who do not wish to freeze embryos because of concerns over
their survival during freezing and thawing or the dilemma of what to do with
remaining embryos after they have completed their families.

Finally, it should be noted that although there are theoretical risks,
freezing of sperm, eggs, and embryos is very safe. There have been no
documented cases of infectious disease transmission, nor do the risks or birth
defects, chromosomal anomalies, or pregnancy complications appear to be
increased compared with using fresh sperm, eggs, or embryos.
VARIATIONS OF IVF

*Gamete intrafallopian transfer (GIFT)* is similar to IVF, but the gametes (egg and sperm) are transferred to the woman’s fallopian tubes rather than her uterus, and fertilization takes place in the tubes rather than in the lab. Another difference is that laparoscopy, a surgical procedure, is necessary to transfer the sperm and egg to the tubes. GIFT is an option only for women who have normal fallopian tubes. Some couples may consider GIFT for religious reasons because eggs are not fertilized outside the body. One limitation of GIFT is that fertilization cannot be confirmed as with IVF. Today, very few couples are adopting GIFT.

Another ART procedure is *zygote intrafallopian transfer (ZIFT)*. This technique differs from GIFT in that fertilization takes place in the lab rather than the fallopian tube, but is similar in that the fertilized egg is transferred to the tube rather than the uterus. This procedure also requires a laparoscopy. Today, ZIFT comprises less than 1% of ART procedures performed in the United States. Similar to GIFT very few couples are adopting ZIFT.

SUCCESS RATES

The success rates of an IVF center depends upon a number of factors, and a comparison of clinic success rates is not meaningful because patient characteristics and treatment approaches vary from clinic to clinic. For example, the type of patients accepted into the program and the numbers of embryos transferred per cycle affect the program’s statistics. Statistics calculated on small numbers of cycles may not be accurate. An IVF center’s rates may change dramatically over time, and the compiled statistics may not represent a program’s current success.

This difference also appears in the definitions of pregnancy rates and live birth rates. For example, a pregnancy rate of 40% does not mean that 40% pregnancy will be resulted in live birth. A *biochemical pregnancy* is a pregnancy confirmed by blood or urine tests but not visible on ultrasound, because the pregnancy stops developing before it is far enough along to be seen on ultrasound. A *clinical pregnancy* is one in which the pregnancy is seen with ultrasound, but stops developing sometime afterwards. Ultimately some of them convert into live birth. Therefore, when comparing the “pregnancy” rates of different clinics, it is important to know which type of pregnancy is being compared. Though Pregnancy rate is of only scientific uses, because most couples are more concerned with a clinic’s live birth rate, which is the probability of delivering a live baby per IVF cycle.
Pregnancy rates, and more importantly live birth rates, are influenced by a number of factors, especially the woman’s age.

**Third Party Assisted ART**

When couples do not achieve pregnancy from infertility treatments or traditional ART, they may choose to use a third party assisted ART method to have a child. Assistance can consist of:

- Sperm Egg and Embryo Donation
- Surrogates and Gestational Carriers

**DONOR SPERM, EGGS, AND EMBRYOS**

IVF may be performed with a couple’s own eggs and sperm or with donor eggs, sperm, or both. A couple may choose to use a donor if there is a problem with their own sperm or eggs, or if they have a genetic disease that could be passed on to a child. Donors may be known or anonymous. In most cases, donor sperm is obtained from a sperm bank. Both sperm and egg donors undergo extensive medical and genetic screening, as well as testing for infectious diseases. Sexually transmitted disease screening and testing for both sperm and egg donation must be highly regulated.

Donor sperm is frozen and quarantined for six months, the donor is re-tested for infectious diseases including the AIDS virus, and sperm are only released for use if all tests are negative. Donor sperm may be used for *insemination* or in an ART cycle. Unlike intrauterine insemination (IUI) cycles, the use of frozen sperm in IVF cycles does not lower the chance of pregnancy.

Donor eggs are an option for women with a uterus who are unlikely or unable to conceive with their own eggs. Egg donors undergo much the same medical and genetic screening as sperm donors. Until recently, it has not been possible to freeze and quarantine eggs like sperm. Recent advances in oocyte freezing, though, have made this a possibility, and there are a few companies and clinics that are using such an approach. The egg donor may be chosen by the infertile couple or the ART program. Egg donors assume more risk and inconvenience than sperm donors. Egg donors selected by ART programs generally receive monetary compensation for their participation. Egg donation

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is more complex than sperm donation and is done as part of an IVF procedure. The egg donor must undergo ovarian stimulation and egg retrieval. During this time, the recipient (the woman who will receive the eggs after they are fertilized) receives hormonal medications to prepare her uterus for implantation. After the retrieval, the donor’s eggs are fertilized by sperm from the recipient’s partner and transferred to the recipient’s uterus. The recipient will not be genetically related to the child, but she is a biologic parent in the sense that she will carry the pregnancy and give birth. Egg donation is expensive because donor selection, screening, and treatment add additional costs to the IVF procedure. However, the relatively high live birth rate for egg donation provides many couples with their best chance for success.

In some cases, when both the man and woman are infertile, both donor sperm and eggs have been used. Donor embryos may also be used in these cases. Some IVF programs allow couples to donate their unused frozen embryos to other infertile couples. Appropriate screening of the individuals whose genetic embryos are used should adhere to federal and state guidelines. The use of donor sperm, eggs, or embryos is a complicated issue that has lifelong implications. Talking with a trained counselor who understands donor issues can be very helpful in the decision-making process. Many programs have a mental health professional on staff or the physician may recommend one. If a couple knows the donor, their physician may suggest that both the couple and the donor speak with a counselor and an attorney. Some states require and most IVF centers recommend an attorney to file paperwork for the couple with the court when donor gametes or embryos are used.

SURROGACY/GESTATIONAL CARRIER

The word ‘surrogate’ has its origin in Latin ‘surrogatus’, past participle of ‘surrogare’, meaning a substitute\(^4\), that is, a person appointed to act in the place of another. The word ‘surrogate' literally means 'substitute' or 'replacement'. A 'surrogate mother' is therefore a 'substitute mother': she is a woman who, for financial and/or compassionate reasons, agrees to bear a child for another woman who is incapable or, less often, unwilling to do so herself. In other words, she is a substitute or 'tentative' mother in that she conceives, gestates and delivers a baby on behalf of another woman who is subsequently to be seen as the 'real' (social and legal) mother of the child. Thus a surrogate mother is a woman who bears a child on behalf of another woman, either from

her own egg or from the implantation in her womb of a fertilized egg from other woman. The Report of the Committee of Inquiry into Human Fertilization and Embryology or the Warnock Report (1984)\(^5\) defines surrogacy as the practice whereby one woman carries a child for another with the intention that the child should be handed over after birth.

The Black’s Law Dictionary categorizes surrogacy into two classes: **Gestational surrogacy** and **Traditional surrogacy**. They are defined as follows:

**Gestational surrogacy** - A pregnancy in which one woman (the genetic mother) provides the egg, which is fertilized, and another woman (the surrogate mother) carries the foetus and gives birth to the child.

**Traditional surrogacy** - A pregnancy in which a woman provides her own egg, which is fertilized by artificial insemination, and carries the foetus and gives birth to a child for another person. Gestational surrogacy can be considered total in the sense that an embryo created by the process of IVF is implanted into the surrogate mother. Traditional surrogacy may be called partial or genetically contracted motherhood because the surrogate mother is impregnated with the sperm of the intended father making her both the genetic and the gestational mother; the child shares make-up of the commissioning father and mother\(^6\).

**TECHNOLOGY OF SURROGACY**

Surrogacy became possible with the advent of two distinctly different reproductive technologies: artificial insemination and in vitro fertilization. Artificial insemination (AI) was the first method of non-coital conception (that is, without sexual intercourse) to be developed\(^7\).

It is a simple procedure in which sperm is injected into the vagina of a woman, who carries the resulting child until birth. Donated semen has mainly been used to impregnate the fertile wife of an infertile husband\(^8\). In this way, the couple can raise a child who is genetically related to one of the partners. In vitro fertilization (IVF), known as the test-tube baby

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\(^5\) The Assisted Reproductive Technologies (Regulation) Bill-2010, Indian Council of Medical Research (ICMR), Ministry of Health &Family Welfare, Govt. of India, pg. 4 (aa).


method\(^9\), involves removing the eggs from a woman's ovaries through a surgical procedure generally through laparoscopy. The eggs are then placed in a laboratory dish together with a man's sperm. If all goes well, one of the sperm will fertilize an egg and the resulting embryo will be inserted into the woman's womb through her vagina. In vitro fertilization is primarily used by childless couples who, for some reason, are unable to conceive in the conventional way. Surrogacy emerged in conjunction with these two methods of reproduction. In some surrogacy arrangements, the surrogate is inseminated with the sperm from the husband of the infertile couple.

The resulting child is genetically related to the surrogate mother and to the husband of the infertile couple. Another type of surrogacy arrangement involves removing the infertile wife's egg by laparoscopy, placing it in a laboratory dish with her husband's sperm, and inserting the resulting fertilized embryo into the surrogate's womb. The resulting child, who is genetically related to both the infertile woman and the fertile male, is then carried by the surrogate until birth. Thus, depending on the infertility problem involved, either AI or IVF may be used in a surrogacy situation.

The most common kind of surrogacy is where a woman's egg, either through artificial insemination or, less often, natural intercourse, is fertilized by the sperm of the male partner of the couple desiring a child (the commissioning father). Here the surrogate is the genetic mother of the child that she promises to give up, while the role of social and legal mother is taken over by another woman (the commissioning mother). To denote the genetic link between the surrogate and the child she bears, we shall call this type of surrogacy 'genetic surrogacy', although it is more often referred to as 'partial surrogacy'. It is also possible, if the commissioning father is infertile or wishes not to pass on a defective gene, to fertilize the surrogate's egg with the sperm of a donor or with that of her husband, which is referred to as 'total surrogacy'.

Another form of surrogacy utilizes the process of in vitro fertilization where the egg and semen are obtained from the commissioning couple (or from anonymous donors), the resultant embryo subsequently being implanted into the surrogate or carrying mother. We shall refer to this as 'gestatory surrogacy', since the surrogate only performs the function of gestation for the

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9 Jyotsna A. Gupta, Women's Bodies: The Site for the Ongoing Conquest by Reproductive Technology 93, 103 (1991) http://repository.library.georgetown.ebooks.11203942
commissioning couple, without having a genetic link with the child. This type of surrogacy is sometimes called ‘full surrogacy’.

**RISKS OF ART**

The medical risks of ART depend upon each specific step of the procedure. The following are some of the primary risks of ART procedures:

1. Ovarian stimulation carries a risk of hyper stimulation, where the ovaries become swollen and painful. Fluid may accumulate in the abdominal cavity and chest, and the woman may feel bloated, nauseated, and experience vomiting or lack of appetite.

2. Up to 30% of women undergoing ovarian stimulation have a mild case of Ovarian Hyper Stimulation Syndrome (OHSS) that can be managed with over-the-counter painkillers and a reduction in activity.

3. In moderate OHSS, women develop or accumulate fluid within the abdominal cavity, and gastrointestinal symptoms may occur. These women are monitored closely, but generally do very well with simple outpatient management. The condition tends to resolve without intervention unless pregnancy occurs, in which case recovery may be delayed for several weeks.

4. Up to 2% of women develop severe OHSS characterized by excessive weight gain, fluid accumulation in the abdomen and chest, electrolyte abnormalities, over-concentration of the blood and, in rare cases, the development of blood clots, kidney failure, or death. It may be medically necessary to drain fluid from the abdomen with a needle if breathing becomes difficult. Women with severe OHSS require hospitalization until the symptoms improve. If pregnancy occurs, OHSS can worsen. Occasionally, termination of pregnancy must be considered in the most severe cases.

5. Although initial reports suggested that women who use fertility drugs have an increased risk for ovarian cancer, numerous recent studies support the conclusion that fertility drugs are not linked to ovarian cancer. Nevertheless, there is still uncertainty whether a risk exists, and research continues to address this question. An annual gynecologic visit
is recommended for all women with examination of the ovaries, regardless of prior use of ovulation medications.

6. There are risks related to the egg retrieval procedure. Laparoscopy carries the risks of any surgery that requires anesthesia. Removing eggs through an aspirating needle entails a slight risk of bleeding, infection, and damage to the bowel, bladder, or a blood vessel. This is true whether the physician uses laparoscopy or ultrasound to guide the needle. Less than one patient in 1,000 will require major surgery to repair damage from complications of the egg retrieval procedure. In rare cases, infection may occur from the retrieval or embryo transfer.

7. The chance of multiple pregnancy is increased in all assisted reproductive technologies when more than one embryo is transferred. Although some would consider twins a happy result, there are many problems associated with multiple births, and problems become progressively more severe and common with triplets and each additional fetus thereafter. Women carrying a multiple pregnancy may need to spend weeks or even months in bed or in the hospital in an attempt to delay preterm delivery. The risk of preterm delivery in multiple pregnancies is high, and babies may be born too early to survive. Premature babies require prolonged and intensive care and risk lifelong handicaps due to premature birth. Some couples may consider multifetal pregnancy reduction to decrease the risks due to multiple pregnancy, but this is likely to be a difficult decision.

8. Data also suggest that IVF conceptions, even singletons, have a slightly increased risk of preterm delivery or low birth weight.

9. First trimester bleeding may signal a possible miscarriage or ectopic pregnancy. If bleeding or pain (before 13 weeks) occurs, a medical evaluation is needed to determine the cause. Some evidence suggests that early bleeding is more common in women who undergo IVF and GIFT and is not associated with the same poor prognosis as it is in women who conceive spontaneously.

10. Miscarriage may occur after ART, even after ultrasound identifies a pregnancy in the uterus. Miscarriage occurs after ultrasound in nearly 15% of women younger than age 35, in 25% at age 40, and in 35% at age 42 following ART procedures.
11. There is approximately a 5% chance of ectopic pregnancy with ART. It is not clear whether the risk of birth defects is increased with IVF. Most studies do not show an increased risk, but several studies do. Research is ongoing to determine the magnitude, if any, of this risk. Furthermore, when ICSI is used in cases of severe male factor infertility, a genetic cause of male infertility may be passed on to the offspring.

Assisted reproductive technologies involve significant physical, financial, and emotional commitments on the part of the couple. Psychological stress is common, and some couples describe the experience as an emotional roller coaster. The treatments are involved and costly. Patients have high expectations, yet failure is common in any given cycle. Couples may feel frustrated, angry, isolated, and resentful. At times, frustration can lead to depression and feelings of low self-esteem, especially in the immediate period following a failed ART attempt. The support of friends and family members is very important at this time. Couples are encouraged to consider psychological counseling as an additional means of support and stress management. Many ART programs have a mental health professional on staff to help couples deal with the grief, tension, or anxieties associated with infertility and its treatment.

PREPARATION FOR ART

Preliminary preparation for an ART procedure may be as important as the procedure itself. Testing for ovarian reserve may be recommended in order to predict how the ovaries will respond to fertility medication. The chance of success may be poor, for example, if tests demonstrate diminished ovarian reserve or fertility potential. Ovarian reserve may be determined by any of these methods: measuring FSH and estradiol levels on the second or third day of a menstrual cycle, measuring the level of AMH (anti-müllerian hormone), performing a clomiphene citrate challenge test, or counting the number of small follicles in the ovary (antral follicle count). An elevated FSH and/or estradiol level, a low antral follicle count, or a low AMH level is associated with reduced pregnancy rates, especially in women over the age of 35 years. However, age itself is the single most important factor in determining the chances for success with IVF.

Uterine cavity abnormalities such as fibroids, polyps, or a septum may need to be corrected before IVF or GIFT. A hydrosalpinx, a fluid filled, blocked
fallopian tube, reduces IVF success. Some physicians advise clipping or removing the affected tube prior to IVF.

Semen is tested before ART. If semen abnormalities are identified, consultation with a specialist in male infertility should determine if there are correctable problems or underlying health concerns. For example, genetic abnormalities in the Y chromosome have been linked to some cases of male infertility; and men born without a vas deferens, the tube that transports sperm from the testicle, are often carriers of a gene that causes cystic fibrosis. In these circumstances, genetic testing may be advisable. Major advances have been made in the treatment of male infertility, and IVF may help some men who were previously considered sterile. Detailed consultation with a specialist in male infertility is essential.

When sperm cannot be collected by masturbation, other forms of sperm retrieval are available. For example, for men who cannot ejaculate, such as those with spinal cord injuries, medical procedures to assist ejaculation are recommended. These procedures include penile vibratory stimulation (PVS) and electroejaculation (EEJ). During PVS, a strong vibrator is placed on the head of the penis to deliver stimulation resulting in ejaculation. During EEJ, electrical impulses from a probe placed in the rectum near the prostate often stimulate ejaculation. For men who are able to ejaculate, but who do not produce sperm in their semen, medical procedures are available to retrieve sperm from reproductive tissues. These procedures include microepididymal sperm aspiration (MESA), percutaneous epididymal sperm aspiration (PESA), or testicular sperm extraction (TESE). MESA can be performed to recover sperm after vasectomy or after failed vasectomy reversal, and in some men with absence of the vas deferens. TESE involves testicular biopsy and recovery of sperm directly from testicular tissue, and may be performed in an office setting with local anesthesia. Sperm obtained by these methods may be frozen, stored, and thawed for later ART.

Lifestyle issues should be addressed before ART. Smoking, for example, may lower a woman’s chance of success by as much as 50%. Live birth rates after ART decrease significantly with obesity, due to a combination of lower pregnancy rates and higher miscarriage rates. Achieving a more optimal weight prior to undergoing IVF appears to be appropriate. All medications, including over-the-counter supplements, should be reviewed since some may have detrimental effects. Alcohol and recreational drugs may be harmful, and
excessive caffeine consumption should be avoided. Because folic acid taken prior to pregnancy reduces the risk of neural tube defects such as spina bifida, women should take prenatal vitamins containing at least 400 micrograms of folic acid before beginning an ART cycle. A complete exam and Pap smear may identify problems that should be treated before pregnancy. A detailed examination of ART insurance benefits is helpful. Even if ART is excluded from a policy, coverage may be available for some aspects of these procedures. Couples should consult their company’s benefits director in advance, since options such as a medical savings account may be available. It is also important to determine the costs for the ART treatment cycle. Keep in mind that fees for initial consultation, screening tests, medications, and special procedures such as ICSI and cryopreservation may not be included in the estimate. Other expenses to consider include travel, lodging, and time missed from work.

**SELECTING AN ART PROGRAM**

When selecting an ART program, information is crucial. Important points for consideration include the qualifications and experience of personnel, types of patients being treated, support services available, cost, convenience, live birth rates per ART cycle started, and multiple pregnancy rates. Older programs have established live birth rates based on years of experience. Small and new programs may still be determining their live birth rates, although their personnel may be equally well qualified. Every couple wants to use the most successful ART program, but many factors contribute to the overall success of a program. For example, some clinics may be willing to accept patients with a low chance of success. A clinic may specialize in certain types of infertility treatment. Costs may vary among programs. A couple may prefer a program based on interpersonal interactions with the ART team, or may feel more confident in the recommended treatment plan. Consequently, it is not appropriate to compare programs based only on the published pregnancy rates.

Cloning is the most recent technology in ART, but human cloning is not permissible being considered immoral by the world community.
GLOSSARY OF ART

**Amniocentesis.** A procedure in which a small amount of amniotic fluid is removed through a needle from the fetal sac at about 16 weeks into a pregnancy. The fluid is studied for chromosomal or other abnormalities which may affect fetal development.

**Anti-müllerian Hormone (AMH).** A hormone which is often measured in a woman to help determine her egg supply, or "ovarian reserve". It is secreted by small, growing follicles.

**Antral follicle count.** The number of follicles noted by ultrasound at the beginning of the menstrual cycle, usually day 2 or 3.

**Assisted hatching (AH).** A procedure in which the zona pellucida (outer covering) of the embryo is partially opened, usually by application of an acid or laser, to facilitate embryo implantation and pregnancy.

**Assisted reproductive technologies (ART).** All treatments which include the handling of eggs and/or embryos. Some examples of ART are in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), pronuclear stage tubal transfer (PROST), tubal embryo transfer (TET), and zygote intrafallopian transfer (ZIFT).

**Biochemical pregnancy.** When a woman's pregnancy test is initially positive but becomes negative before a gestational sac is visible on ultrasound.

**Blastocyst.** An embryo that has formed a fluid-filled cavity and the cells have begun to form the early placenta and embryo, usually 5 days after ovulation or egg retrieval.

**Cervical canal.** The passageway leading from the vagina into the uterus.

**Cervical mucus.** The substance in the cervix through which sperm must swim to enter the uterus.

**Cervix.** The narrow, lower end of the uterus.

**Clinical pregnancy.** A pregnancy confirmed by an increasing level of hCG and the presence of a gestational sac detected by ultrasound.

**Clomiphene citrate challenge test (CCCT).** A test of ovarian reserve in which serum FSH is checked on days three and ten of the menstrual cycle and clomiphene citrate is taken on days five through nine.

**Clomiphene citrate.** An oral antiestrogen medication used to induce ovulation.
**Cryopreservation.** Freezing at a very low temperature, such as in liquid nitrogen (-196°C) to keep embryos, eggs, or sperm viable.

**Cryopreserved.** Frozen.

**Ectopic pregnancy.** A pregnancy in the fallopian tube or elsewhere outside the lining of the uterus.

**Egg (oocyte).** The female sex cell (ovum) produced by the ovary, which, when fertilized by a male's sperm, produces an embryo.

**Egg retrieval.** The procedure in which eggs are obtained by inserting a needle into the ovarian follicle and removing the fluid and the egg by suction. Also called oocyte aspiration.

**Electroejaculation (EEJ).** Procedure to cause ejaculation of sperm, performed by electrical stimulation of tissue in the region of the prostate.

**Embryo.** A fertilized egg that has begun cell division.

**Embryo culture.** Growth of the embryo in a laboratory (culture) dish.

**Embryo transfer.** Placement of an embryo into the uterus or, in the case of ZIFT and TET, into the fallopian tube.

**Endometriosis.** A disease in which tissue resembling endometrium (the lining of the uterus) grows outside the uterus. It is often associated with infertility.

**Epididymis.** The duct between testes and vas deferens where sperm are stored and mature.

**Estradiol.** The predominant estrogen (hormone) produced by the follicular cells of the ovary.

**Estrogen.** The female hormone largely responsible for thickening the uterine lining during the first half of the menstrual cycle in preparation for ovulation and possible pregnancy. Estradiol is the main estrogen.

**Fallopian tubes.** A pair of tubes attached to the uterus, one on each side, where sperm and egg meet in normal conception.

**Fertilization.** The fusion of sperm and egg.

**Fibroids.** Benign (non-cancerous) tumors of the uterine muscle wall that can cause abnormal uterine bleeding and pain.

**Follicle.** A fluid-filled structure in the ovary containing an egg and the surrounding cells that produce hormones. As the follicle matures, the fluid can be visualized by ultrasound.
**Follicle-stimulating hormone (FSH).** The pituitary hormone responsible for stimulating the growth of the follicle that surrounds the egg. In addition, it is the hormone in injectable ovulation medications that promotes growth of the follicles.

**Gamete intrafallopian transfer (GIFT).** The direct transfer of sperm and eggs into the fallopian tube. Fertilization takes place inside the tube.

**Gestational carrier.** A woman who carries a pregnancy for another couple. The pregnancy is derived from the egg and sperm of the couple. Although she carries the pregnancy to term, she does not have a genetic relationship to the resulting child.

**Gonadotropin releasing hormone (GnRH).** Hormone secreted by the hypothalamus, a control center in the brain, which prompts the pituitary gland to release FSH and LH into the bloodstream.

**GnRH agonists.** A GnRH analog that initially stimulates the pituitary gland to release LH and FSH, followed by a delayed suppressive effect. GnRH agonists are also used to help stimulate follicle growth when started at the beginning of an IVF cycle.

**GnRH analogs.** Synthetic hormones similar to the naturally occurring gonadotropin releasing hormone used to prevent premature ovulation. There are two types of GnRH analogs: GnRH agonists and GnRH antagonists.

**GnRH antagonists.** Synthetic hormones similar to the naturally occurring gonadotropin releasing hormone used to prevent premature ovulation. These medications have an immediate suppressive effect on the pituitary gland.

**Human chorionic gonadotropin (hCG).** A hormone produced by the placenta; its detection is the basis for most pregnancy tests. Also refers to the medication used to induce ovulation and during the final stages of egg maturation.

**Human menopausal gonadotropin (hMG).** An ovulation drug that contains follicle stimulating hormone (FSH) and luteinizing hormone (LH) derived from the urine of postmenopausal women. hMG is used to stimulate the growth of multiple follicles.

**Hydrosalpinx.** A blocked, dilated, fluid-filled fallopian tube.

**Intracytoplasmic sperm injection (ICSI).** A micromanipulation procedure in which a single sperm is injected directly into an egg to attempt fertilization, used with male infertility or couples with prior IVF fertilization failure.
**Insemination.** Placement of sperm into the uterus or cervix for producing a pregnancy, or adding sperm to eggs in IVF procedures.

**In vitro fertilization (IVF).** A process in which an egg and sperm are combined in a laboratory dish to facilitate fertilization. If fertilized, the resulting embryo is transferred to the uterus.

**IVF culture medium.** A special fluid into which sperm, eggs, and embryos are placed when outside the human body.

**Laparoscopy.** A surgical procedure that allows viewing of the internal pelvic organs. During the procedure, a long, narrow, fiber optic instrument, called a laparoscope, is usually inserted through an incision in or below the woman's navel. One or more additional incisions may be made for inserting additional instruments.

**Luteinizing hormone (LH).** The pituitary hormone that normally causes ovulation and maturation of the egg.

**Male factor.** Infertility caused by a problem in the male; for example the inability to ejaculate or insufficient number of sperm.

**Microepididymal sperm aspiration (MESA).** Outpatient microsurgical procedure used to collect sperm in men with blockage of the male reproductive ducts such as prior vasectomy or absence of the vas deferens. Used in IVF-ICSI procedures.

**Micromanipulation.** The IVF laboratory process whereby the egg or embryo is held with special instruments and surgically altered by procedures such as intracytoplasmic sperm injection (ICSI), assisted hatching, or embryo biopsy.

**Motile.** Moving.

**Multifetal pregnancy reduction.** Also known as selective reduction. A procedure to reduce the number of fetuses in the uterus. This procedure is sometimes performed on women who are pregnant with multiple fetuses who are at an increased risk of late miscarriage or premature labor. These risks increase with the number of fetuses.

**Oocyte.** Medical term for egg, the female gamete. Also called ovum (singular) or ova (plural).

**Ovarian hyperstimulation syndrome (OHSS).** A condition that may result from ovulation induction characterized by enlargement of the ovaries, fluid retention, and weight gain.
**Ovarian reserve.** A woman's fertility potential in the absence of specific pathophysiologic changes in her reproductive system. Diminished ovarian reserve is associated with depletion in the number of eggs and worsening of oocyte quality.

**Ovarian stimulation.** See Ovulation induction.

**Ovary (Ovaries).** The two female sex glands in the pelvis, located one on each side of the uterus. The ovaries produce eggs and hormones including estrogen, progesterone, and androgens.

**Ovulation.** Release of an egg from the ovary.

**Ovulation induction.** The administration of hormone medications (ovulation drugs) that stimulate the ovaries to produce multiple eggs. Sometimes called enhanced follicular recruitment or controlled ovarian hyperstimulation.

**Penile vibratory stimulation (PVS).** A procedure to cause ejaculation of sperm, performed by vibratory stimulation of the penis.

**Percutaneous epididymal sperm aspiration (PESA).** A sperm aspiration procedure in which a needle is inserted into the epididymis (gland that carries sperm from testicle to vas deferens) in order to retrieve sperm for use in an IVF procedure.

**Pituitary gland.** A small gland just beneath the hypothalamus in the brain that secretes follicle stimulating hormone (FSH) and luteinizing hormone (LH).

**Polyps.** A general term that describes any mass of tissue which bulges or projects out or upward from the normal surface level.

**Preimplantation genetic diagnosis (PGD).** A test performed by an embryologist in which one or two cells are removed from an embryo. The removed cells are then screened for genetic abnormalities. PGD may be performed in conjunction with IVF.

**Progesterone.** A female hormone secreted during the second half of the menstrual cycle. It prepares the lining of the uterus for implantation of a fertilized egg.

**Pronuclei.** The nuclei of the male and female gametes (sperm and egg) seen in the one-cell embryo (zygote).

**Septum, uterine.** A band of fibrous tissue present from birth that forms a wall within the uterine cavity. A septum may increase the risk of miscarriage and other pregnancy complications.
**Semen.** The fluid ejaculated by the male.

**Sperm.** The male reproductive cells that fertilize a woman's egg. The sperm head carries genetic material (chromosomes), the midpiece produces energy for movement, and the long, thin tail wiggles to propel the sperm.

**Sperm preparation.** A method of treating semen to remove the seminal fluid and isolate the sperm cells.

**Spina bifida.** A birth defect of the spinal column. Spina bifida is the failure of the spine to close properly during development.

**Testicular sperm extraction (TESE).** Operative removal of testicular tissue in an attempt to collect living sperm for use in an IVF-ICSI procedure.

**Traditional surrogate.** A woman who carries a pregnancy intended for an infertile couple. The surrogate's egg is fertilized with sperm from the male partner of the infertile couple.

**Transvaginal ultrasound aspiration.** An ultrasound-guided technique for egg retrieval whereby a long, thin needle is passed through the vagina into the ovarian follicle and suction is applied to accomplish retrieval.

**Ultrasound.** A technology that uses high-frequency sound waves to form an image of internal organs on a monitor screen; used by fertility specialists to monitor the growth of ovarian follicles and to retrieve the eggs from the follicles and evaluate a pregnancy.

**Uterus (womb).** The hollow, muscular female reproductive organ in the pelvis in which an embryo implants and grows during pregnancy. The lining of the uterus, called the endometrium, produces the monthly menstrual blood flow when there is no pregnancy.

**Vagina.** The canal in the female that leads to the cervix, which leads to the uterus.

**Vas deferens.** The two muscular tubes that carry sperm from the epididymis to the urethra.

**Vitrification.** An ultra-rapid method of freezing eggs and embryos that may offer certain advantages compared to traditional types of cryopreservation.

**Zona pellucida.** The egg’s outer layer that a sperm must penetrate in order to fertilize the egg.

**Zygote.** A fertilized egg before cell division (cleavage) begins.
**Zygote intrafallopian tube transfer (ZIFT).** An egg is fertilized in the laboratory and the zygote is transferred to the fallopian tube before cell division takes place. Eggs are retrieved and fertilized on one day and the embryo is transferred the following day.

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Chapter 2

SOCIAL RECOGNITION OF ART IN INDIA

With the growing technical possibilities of assisted reproduction, the once monolithic idea of parenthood falls into pieces. Motherhood in particular splits up into genetic, gestational, and social motherhood – three roles that, once bound together, can now be taken over by two or even three different women. An increasingly popular and socially somewhat accepted model involving multiple mothers for one child is surrogacy: A surrogate mother commits herself to carry an embryo for another woman who for reasons of reluctance, age, or medical conditions cannot or does not want to do so. Usually, \(^1\) one of the intended parents gives his sperm for the fertilization of an egg that may stem either from the surrogate mother herself (traditional surrogacy) or from the intended mother or an egg donor (gestational surrogacy).

Whereas surrogacy has been technically feasible for decades, it has only recently become a thriving business and thereby created various socio-legal complications. Between 2006 and 2010, figures have increased nearly tenfold, \(^2\) meanwhile amounting to some small 4-digit number of surrogacy cases involving intended parents from European countries every year. \(^3\) Most surrogacies take place in India, Ukraine, California, and Central America. The direct costs of a surrogacy range between about US$ 15,000 and US$ 100,000, depending on the price level of the respective country. \(^4\) New markets like Thailand emerge and promise better service at low cost. \(^5\)

India became most popular surrogacy destination whereas Indian society is conservative. Study into this growing industry has remained on

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\(^1\) As only in rare cases are both intended parents lacking in fertility, it is only once in a blue moon that the sperm comes from a donor.


\(^3\) Ibid, fn. 3, p. 119..


the journalistic level up until now. Some literary study were also conducted, but the same have certain limitations, thus actual status in India for two reasons, first the study conducted are focused on Anand in Gujrat and the second is the study conducted were limited on social aspects only. Very little empirical evidence exists around the effects of surrogacy on the woman’s health, family, and other social contexts and at the same time issue concerned with the legal complication arising out of this. Similarly, very little research has examined Indian women’s decision-making process to become surrogates.

Issues are more or less same around the globe as conservative peoples have similar thoughts across the world. In India literature on this aspect is not enough, so humble researcher adopted the sample survey method. First he interviewed the actual players, who may also victim of social stigma associated with this process, i.e. the surrogates and the persons reside in the vicinity of those surrogate women. But before interacting with them, it is found appropriate to discuss the issues raised throughout the world associated with the ART and surrogacy arrangements.

Since ART procedure is very personal and even in case of sperm donation the privacy of couple remains safe and society has no objection on the same, but this issue becomes of wide importance, when it associates with the Surrogacy arrangement or commonly said “Womb on rent”, Whereas public opinion is split as to whether surrogacy should be supported, though, intended parents and their children hardly face discrimination or any other lack of acceptance.\(^6\)

The word 'surrogate' literally means 'substitute' or 'replacement'. A 'surrogate mother' is therefore a' substitute mother': she is a woman who, for financial and/or compassionate reasons, agrees to bear a child for another woman who is incapable or, less often, unwilling to do so herself. In other words, she is a substitute or 'tentative' mother in that she conceives, gestates and delivers a baby on behalf of another woman who is subsequently to be seen as the 'real' (social and legal) mother of the child.

The most common kind of surrogacy is where a woman's egg, either through artificial insemination or, less often, natural intercourse, is fertilized by the sperm of the male partner of the couple desiring a child (the commissioning father). Here the surrogate is the genetic mother of the child that she promises to give up, while the role of social and legal mother is taken over by another woman (the commissioning mother). To denote the genetic link between the surrogate and the child she bears, we shall call this type of surrogacy 'genetic surrogacy', although it is more often referred to as 'partial surrogacy'. It is also possible, if the commissioning father is infertile or wishes not to pass on a defective gene, to fertilise the surrogate's egg with the sperm of a donor or with that of her husband, which is referred to as 'total surrogacy'. Another form of surrogacy utilises the process of in vitro fertilisation where the egg and semen are obtained from the commissioning couple (or from anonymous donors), the resultant embryo subsequently being implanted into the surrogate or carrying mother. We shall refer to this as 'gestatory surrogacy', since the surrogate only performs the function of gestation for the commissioning couple, without having a genetic link with the child. This type of surrogacy is sometimes called 'full surrogacy'. Researcher tried to analyse the perception of the society in this chapter, whether there is anything intrinsically immoral about surrogacy arrangements from the perspective of the surrogate mother herself. Specific attention is paid to the claim that surrogacy is similar to prostitution in that it reduces women's reproductive labour to a form of alienated and/or dehumanised labour. He deals elsewhere with the question surrounding the moral acceptability of surrogacy from the perspective of the child, where more attention is paid to the issue of commodification of children and the morality of surrogacy contracts.

**Surrogacy and prostitution**

Opponents of surrogacy are fond of pointing out that an analogy exists between commercial surrogacy and prostitution. Mary Warnock cites a similar objection, supposedly expressed by a doctor: surrogacy is described as 'a form of exploitation similar to prostitution'. Andrea Dworkin, the well-known American feminist, states that: '[m]otherhood is

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becoming a new branch of female prostitution with the help of scientists who want access to the womb for experimentation and power. Women can sell reproductive capacities the same way old-time prostitutes sold sexual ones but without the stigma of whoring because there is no penile intrusion. It is the womb, not the vagina, that is being bought.\(^8\)

It is not difficult to detect certain similarities between prostitution and surrogacy. Prokopijevic referred as: 'In both cases one's physical service is being offered, in both instances a deep personal or emotional relationship is not required for the transaction to be completed, in both cases material compensation is offered for the physical services provided'.\(^9\) These similarities are, as Prokopijevic rightly points out, superficial and relatively unimportant compared to the differences between the two cases. They are also characteristic features of most transactions where physical labour is traded for material compensation. It happens every day that we trade money for services without forming a 'deep personal or emotional relationship' with each other. Those who claim that surrogacy is similar to prostitution on these grounds (and that it is therefore immoral), must be living in a society of 'prostitutes', and feeling very unhappy about the situation.\(^10\)

However, Study conducted by the researcher reveals entirely different notion about surrogacy. General perception about the surrogacy is more or less based upon misconceived information or on impression that the Surrogate conceives through actual physical contact.

While discussing with the people of the vicinity of surrogates, Researcher explained them the procedure of Surrogacy, once, they could not believe, but on explaining through graphics that she does not even touch the intended father, most of them realized their wrong perception. Most of them considered it as highest sacrifice. Even some of them told that even it is for money, still the sacrifice for the contentment of being mother/father of their own child for others is a Noble Cause.

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\(^10\) Anton van Niekerk and Liezl van Zyl The ethics of surrogacy: women's reproductive labour, Journal of medical ethics, 1995; 21: 345-349, Downloaded from jme.bmj.com on March 16, 2014 - Published by group.bmj.com
Otherwise also in Hindu culture “The Kanyadan” considers as the highest sacrifice and in Islam the sacrifice of the Son.

Undoubtedly, all the surrogates participated in the study, entered into the arrangement only for the money, but their sacrifice cannot be devalued and it should be regarded as a “Noble Cause”.

**Alienated labour**

Drawing an analogy between surrogacy and prostitution is hardly adequate to show that surrogacy is immoral. Anderson makes an attempt at a more in-depth discussion of the objection that surrogacy is wrong because it commodifies women's reproductive labour. She writes that the application of economic norms to the sphere of women's labour violates their claim to respect and consideration.

First, 'by requiring the surrogate mother to repress whatever parental love she feels for the child, these norms convert women's labour into a form of alienated labor'. ('Alienated labour' here is understood in the twofold Hegelian sense, i.e., as 1. The situation when the product of labour is separated from its producer, but where it is separated from the producer precisely because the producer surrendered it to someone else and, more generally, to the market). Secondly, Anderson continues, 'by manipulating and denying legitimacy to the surrogate mother's evolving perspective on her own pregnancy, the norms of the market degrade her'. Arneson's reply to the first objection is simply that the contract 'does not require the surrogate mother to feel in certain ways, but rather to act in certain ways'. He acknowledges that the contract may require her to act against her feelings to fulfil its terms, and that to this extent her labour might turn out to be alienated labour. 'But in a liberal society', Arneson continues, 'alienated labor is not forbidden'.

His reply to the second objection (that the contract denies legitimacy to the surrogate's own evolving perspective on her pregnancy) can be summarized as follows. Any contract determines one's future behaviour to some extent. Signing a contract does not deny that one's views and feelings might change in the interim. But undergoing a change of one's perspective, of one's views or feelings, does not change the terms

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of the contract, for this would defy the purpose of the contract, ie, to provide mutual assurances of how the parties to the contract would act in future. In short, Arneson's point is again that the contract does not require the surrogate to deny or suppress her feelings and changing perspective, but only to act in the way specified by the contract.\textsuperscript{12}

With these remarks Ameson completely misses the point that Anderson tries to make. Everybody knows that 'alienated labor is not forbidden in a liberal society', and that it would be inappropriate (or at least unasked for) for me to develop a personal and emotional relationship with every baker before I buy his bread, or with every electrician before I employ his services. I use these people as nothing more than means to an end, and no one complains that my treatment of them is similar to prostitution.

But Anderson's point is not that surrogacy is immoral because it is a form of alienated labour, but because pregnancy should not become an act of alienated labour. Being denied the legitimacy of one's perspective on one's labour, being alienated from your feelings and having to act against one's emotions is not wrong per se, but only wrong if the labour in question is women's reproductive labour (or another special form of labour). It is in this sense that surrogacy is similar to prostitution: not that both are forms of alienated labour, but that in both cases a physical capacity (sexual intercourse and gestation) that should be afforded special respect, is degraded to a form of alienated labour. What lies at the heart of the objection that surrogacy is similar to prostitution, is that women's reproductive labour, like their sexuality, should not be compared to and treated in the same way as other forms of physical labour.

Anderson says that 'pregnancy is not simply a biological process but also a social practice. Many social expectations and considerations surround women's gestational labor, marking it off as an occasion for the parents to prepare themselves to welcome a new life into their family'.\textsuperscript{13} We shall call the thesis that women's reproductive labour is intrinsically different from other forms of labour the 'asymmetry thesis', following


\textsuperscript{13} Anderson E S, Supra note 5
Debra Satz. But is this thesis true? Is there anything intrinsic to women's reproductive labour that should keep us from commodifying it or turning it into a form of 'alienated labour'?

Satz cites a few versions of the 'essentialist thesis' that focus on the biological or naturalistic features of women's reproductive labour, for instance that many of the phases of the reproductive process are involuntary, while other forms of labour are voluntary at virtually every step; that reproductive labour extends over a period of approximately nine months, while other forms of labour do not typically necessitate a long-term commitment, and that reproductive labour involves significant restrictions of a woman's behaviour during pregnancy, while other forms of labour are less invasive with respect to the worker's body.

Satz is right to reject the argument that these characteristics of reproductive labour can be used to establish the asymmetry thesis. It is not difficult to name other forms of labour that have the same characteristics as those pointed out by the essentialist thesis as the distinguishing features of reproductive labour. Satz is also right to reject Pateman's claim that a woman's reproductive labour is more 'integral' to her identity than her other productive capacities, and that therefore it should not be treated as an alienable commodity. We shall not attempt to criticize Pateman's view - we leave that to those feminists who decided not to have children, to infertile women and to postmenopausal women (all of whom should, in Pateman's view, be suffering from a serious identity crisis). Instead, we shall focus on an aspect of reproductive labour that is overlooked by the essentialist thesis and that of Pateman: the obvious fact that a pregnant woman is carrying a fetus to which she will eventually give birth.

The essentialist thesis analyses the characteristics of reproductive labour independently from, and without ever mentioning, the resultant child(ren). Similarly, Pateman finds reproductive labour to be an integral part of a woman's identity, without referring to the resulting child, which certainly is the most important part of pregnancy. And this is exactly what


15 Ibid

distinguishes women's reproductive labour from other forms of labour, namely that the product of their labour is not something but someone. The relationship between a pregnant woman and her unborn fetus is essentially different from that between a worker and his or her material product. This could be explained in many ways. We rest with the Barbarian remark that a person's relationship to material things is instrumentalist; things are means to an end, but not ends in themselves. People's relationships to other people, and mothers' relationships to their infants in particular, are manifestly different.

Children are not means, but ends in the relationships with their mothers; mothers regard the relationship as a meaningful end in itself, and not (if the relationship is authentic) as a means to some other end. Thus, instead of saying that reproductive labour is the most integral part of the female identity (as Pateman does), one can rather claim that the bond between a pregnant woman and her child is usually (or should be) an integral part of her pregnancy.

Certainly, psychological attachment of a mother with her infant, cannot be distinguished on the basis of Genetic or Biological relationship and any theory or words have no capacity to explain them, but perception of common man is not that much simple.

Saritha, a Surrogate in Hyderabad, bluntly said, “We Indians are giving births, without looking the future of resultant children, on sacrifice of one of them, we may ensure better life for others”. On alienation of her body, she assertively asks “What unusual we are doing, which a normal lady doesn’t...? She further adds that “beside money, exhilaration of intended parents is our real reward”.

Now a days, India is becoming more practical. P. Narsingh Reddy, a peon in a Private Company in Hyderabad explains “Devaki given up her child to Yashoda for his betterment, India has long tradition of such sacrifice”.

Beyond above theoretical analysis and opinion of western ideologist the surrogates are in high spirit being an instrument of exultant to others, specifically with whom they don’t have any previous contact.

17 Changed name
Researcher met certain intended parents and one of the genetic mothers from USA Lilly Jafferson while discussing with, expressed her feelings:

"Surrogacy advocates in the United States will tell you not to get involved with poor surrogates under any circumstances because it can lead to exploitation, "she said" I initially disagreed with this line of thinking. Charges of "renting a womb" and exploitation have long tarnished the practice of surrogacy. But in my mind, a woman going through the risks of labor for another family clearly deserves to be paid. To her, this was not exploitation. This was a win-win, allowing the surrogate to have a brighter future and the couple to have a child. If my money was going to benefit an Indian woman financially for a service she willingly provided, I preferred that it be a poor woman who really needed help because the money that a surrogate earns in India is, to be blunt, life-changing."

Socio-Psychological Phenomenon

To illustrate this point one can analyze the term 'pregnancy' in more detail. On one level 'pregnancy' refers to the biological and physiological process of 'having developing child(ren) in the womb'. In this sense female animals can be said to be pregnant, while no male can ever be pregnant. But the word can also be taken to mean 'expecting a child', i.e., the conscious knowledge that one is going to have a child. Female animals cannot be said to be pregnant in this sense, while it is not uncommon to say that the male partner of a pregnant woman is expecting a child. (It is not uncommon for the male partner of a pregnant woman to experience morning sickness or even labour pains.) Thus human reproductive labour is not only physical labour or a biochemical state, but may also be a social and psychological process in which a bond is established with the fetus in expectation of its birth.

This is the phenomenon, which develops an intimacy with the child in womb. During the pregnancy mother falls in love with the baby so also her family members waiting for the birth. It is common perception that intended parents are away from this feeling.
The researcher, humbly state that he is not agree with this perception as he met a number of intending mothers and observed their involvement in the process like Dadi or Nani (Paternal or Maternal Grand Mother). Lilly Jafferson expressed these moments in following words:-

I just wanted everything to be OK because I didn't think it was going to work. I was so sad from the chaos and loss I'd already experienced in trying to have children so I was very cautious with expectations. I knew I would only want the best for her (The Surrogate) and to feel some kind of bond with her for carrying to term, but I ended up feeling like her elder sister. I wanted her to be comfortable, happy and safe. I just wanted to take care of her and make her feel as safe and comfort as possible. Maybe that's friendship but it felt like sisterhood.

On asking of her relationship with the Surrogate she told:

when I first met her it felt like a business transaction. She needed some money for her family, it was the equivalent of 10 to 15 years of salary and She had fertility challenges so it was win-win, but initially it felt like more business transaction. It's surrogacy, it's not ideal but they came up with a business agreement for both parties. I saw her for the first time in the beginning.

After she left, they'd exchange e-mails through a translator and Clinic would send photos during the course of the pregnancy. One of the most challenging things was the distance.

When your surrogate's in the U.S. you're able to talk to her every day and you're free to be engaged in her life so I didn't have that option, which was really sad and unfortunate because I really wanted to feel connected to the pregnancy. I had been pregnant before, once until very far in, so it was hard for me. If I could do it all over again I would stay in India the whole time. I think it's such a big part of the process and that was definitely a huge challenge for her.

When I couldn't do it any longer I got on a plane, and I was so happy that I did. They'd do things like braid each other's hair, do each other's makeup.
They don't speak the same language so the relationship was based on these basic human principles and exchanges.

*We'd take short walks, watch movies, some Indian films. I got this drum set, and she played that a couple of times. Music, we really bonded on music and had fun making fools ourselves. There were lots of iPhone films and looking at films together and sitting around doing nothing. She'd look at magazines I'd brought. I think her favorite was when I bought Toblerone chocolate.*

Certainly this feeling places entirely different picture of an intended mother then perceived. The same Socio-Psychological Phenomenon appears from the experience of Lilly, beyond any barricade of culture, religion or even the language.

In this situation biological mother is secure about the future of intended child and also ensure the better life for rest of her family.

*Change of perspective*

This also explains the 'change of perspective' that many surrogates experience as their pregnancy develops: whereas at first they might feel that pregnancy is simply a form of physical labour, that they will have no difficulty giving up the child, and that they are simply performing a service for an infertile couple, these women often realize as the time of delivery nears, that they are expecting a child, in the full social and psychological sense of knowing that they are going to give birth to a human being that is closely tied to themselves. The problem with surrogacy arrangements is therefore that it causes a woman to be pregnant while expecting her not to acknowledge the fact that she is expecting her child. It tries to divorce pregnancy from the conscious knowledge that you are going to give birth to your child. In this way the surrogate becomes a mere 'environment' or 'human incubator' for someone else's child. Satz tries to bypass this criticism by saying that we are not really sure which emotions pregnancy 'normally' involves. She points at the fact that many women fail to bond with their fetuses (some abort them), and that some even fail to bond with their babies after they deliver them.\(^\text{18}\)

\(^{18}\) Satz D.Supra note 8
The implication of this seems to be that we should not object to the institution of surrogacy as such, but only to those cases in which the surrogate does bond with the fetus but is nevertheless forced to give up the child against her will. In these cases the objection that the surrogate is performing alienated labour does hold, since she is forced to act against her feelings. But this problem could perhaps be overcome by not legally forcing surrogates to hand over the babies to whom they gave birth. The surrogate would thereby not be compelled to act against her feelings, and the legitimacy of her changing perspective on her pregnancy would not be denied. She would be free to fulfil the terms of the contract by handing over the child, or, if she felt unable to do that, to keep the child.

Prokopijevic gives a similar solution to this problem, which he describes as a 'repercussion of a non-moral nature'. He states that 'the surrogate mother might be allotted a certain period of time in which she could change her mind and keep the newly-born child, with corresponding compensation being paid to the other party, including the expenses arising as a result of hospital care and the breaking of the contract'. But to this the defenders of the rights of the commissioning couple would object that, although the female partner was not physically pregnant, they were both 'pregnant' in the social and psychological sense of 'expecting a child', preparing for its birth as any expectant couple might do. The child may even be their genetic child. To deny their desire to raise the child would thus be to deny the legitimacy of their perspective on 'their' pregnancy, to alienate them from their evolving emotions concerning the child that they have come to accept as their child. And this is anything but a 'repercussion of a non-moral nature'!

Prokopijevic completely fails to take this into consideration when he says that, if one supposes that the number of surrogate mothers who change their minds is about ten per cent, this does not mean that the institution of surrogacy would be seriously endangered, for '[a]s far as the persons who order the baby in those ten per cent of cases are concerned, it is unlikely that they will have such bad luck the next time'. He calculates the chances 'to have such bad luck the next time' as 1/100, and says that 'we should neglect such a slight probability'19. Prokopijevic's attitude towards the commissioning parents' feelings and their desire to have a

child is similar to the attitude of some defenders of surrogacy arrangements towards the surrogate's feelings. It is for the very reason that pregnancy is much more than a mere biological and physical process that we should not neglect the commissioning parents' growing perspective on their pregnancy.

Just as adoptive parents may come to love a child as they would love their 'own' (read 'genetic') child, the commissioning parents may come to view the surrogate's pregnancy as 'their' pregnancy, as their expectation of a child. One cannot expect them to be satisfied simply to 'try again later' if the first attempt turns out to be unsuccessful. Those cases in which a dispute arises about who the social parents of the child should be, could be sorted out by considering the well-being of the child itself. Instead of asking who the 'real' parents of the child are one should rather consider who would be best able to care for the child. From the perspective of those who compete for the status of legal parents, however, there is no easy solution. For, if the surrogate is forced to hand over the child against her will, her labour would turn out to be alienated labour, since she is asked to separate herself from the fruit of her womb and to surrender that fruit to someone else. If, on the other hand, it is decided that the surrogate (and her husband, if she has one) should be the legal parent(s), the commissioning parents would be denied the legitimacy of their evolving perspective on their pregnancy and their child (which is usually also genetically related to at least one of them). In cases where the surrogate decided to keep the child, surrogacy could therefore be said to be immoral, since whatever happens, some moral and psychological harm (or at least disappointment) may come to one of the parties. But what if the surrogate does not change her mind about handing over the child?

Some surrogacy agencies have reported a high percentage of successful transactions. It is said that in these cases all the parties to the contract are better off than before: the commissioning parents are somewhat poorer financially, but with their much desired child, while the surrogate is well compensated materially for her labour, without feeling that she has performed alienated labour. Does any moral harm result from these instances of surrogacy?
Dehumanising labour

The most one can object to in these cases are that the surrogate's labour is 'dehumanising'. As we have indicated above, the distinguishing feature of human pregnancies is that they may also entail a conscious knowledge of the significance of this physiological state and an active expectation of, and preparation for, the birth of a child. Although it is hardly 'natural' or 'normal' for a person to develop this kind of perspective on her pregnancy, we can all recognize that it is good. Yet contract pregnancies are geared towards keeping the surrogate from experiencing pregnancy and childbirth in this way. Instead, it asks the surrogate to relinquish her ability to interpret and control the meaning or significance of her reproductive labour.

To this one can again reply that it is not true of all surrogacy arrangements. If the surrogate is a relative or close friend, doing it for purely altruistic or compassionate reasons, it is not clear that we can describe her reproductive labour as 'alienating' or 'dehumanising'. The conscious knowledge that she is going to have a child is then not denied, but intensified, since she knows that she is doing it for a higher purpose than solely (or mostly) for her own benefit - the aim of bringing a child into the life of a childless couple with whom she also has a close relationship. If she continues to play an active role in the child's life as a 'second mother', there could be no way in which her labour could be described as 'alienating' or 'dehumanising'. Only in such a situation will the surrogate's important role in the existence of the child and the legitimacy of her claim that it is her child be recognized.

Because surrogacy arrangements by definition involve more than two people, all of whom can legitimately claim that s/he is the parent of the child, a conflict can in principle always arise about who should assume parental rights and responsibilities towards the child. It seems that this is a problem inherent to surrogacy arrangements, since one can never be certain that such a conflict will not arise. It is easy to praise a successful arrangement in retrospect, but the danger always exists that an arrangement one is planning would cause moral harm to the surrogate and/or the commissioning parents. The ideal would be for the surrogate to be a close friend or relative of the commissioning parents who is also deemed psychologically and medically fit to undertake such a venture, but
again there is no guarantee that problems would not arise. A couple usually prefer a surrogate who is (and will remain) a total stranger to them, for the very reason that they do not want a 'second mother' to interfere with the upbringing of their child. This preference cannot, in the light of what we have argued, be defended. Unless one can ensure the legitimacy of the surrogate's bond with the child and her perspective on her pregnancy without thereby denying that of the commissioning couple, the surrogacy arrangement can always be said to be de-humanising or alienating.

Moreover, this perception of intended parents is generally based on the advice given by the professionals, who seldom want them to develop any kind of relation or even motivate them to make a distance even with the prospective surrogates as Lilly stated. A large number of intended couples are following the advice, but some of them in abeyance of it developed intimacy with the surrogates, caused the development of mutual trust resulted into impact of Aluistic Surrogates, her near or dear, never complained about dehumanization of her reproductive labour.

Surrogacy is an area which is fraught with social, ethical and moral questions and dilemmas of far-reaching importance. It is a subject which has crucial social implications and it may give rise to intractable dilemmas for the Indian society and its social fabric. The ease with which relatively rich foreigners are able to ‘rent’ the wombs of poor Indian women creates the potential for exploitation. Though for the government it will become an added feature in its ‘Incredible India’ promotional campaign to publicise India as a medical tourism destination, the crucial question is that in a country crippled by abject poverty, how will the government ensure that women will not agree to surrogacy just to be able to eat two square meals a day? Reports have appeared where young vulnerable girls from orphanages were ‘hired out’ for surrogacy and the surrogate mothers themselves never got any money; and even if they got any money, the poor women had little choice.

The combination of poverty, illiteracy and the lack of power that women have over their own lives in India in general are a deadly combination. There are instances of desperately poor women in India selling their own (biological) babies because they can’t feed the rest of their family. For the woman, even though she knows that she is
undergoing a transaction, parting with or handing over the baby could be an event causing her terrible emotional conflict which at times may be quite devastating for her. Surrogacy is not like donating a kidney; bearing a child is an emotional issue. Driven by the circumstances, a woman, in a way, forces on herself a nine-month-pregnancy which could prove or turn out to be a woefully agonising event in her life. That once or twice upon a time, their mother went through motherhood purely for money or commercial reasons could severely dent the self-esteem of the children when they grow up and come to know about it.

The growing number of western couples seeking surrogates in India has prompted many to view this as an exploitation of women through global inequalities. The charge of exploitation finds the use of bodies or ‘renting of wombs’ of poor women in developing countries in exchange for money disconcerting and dehumanising. Terms such as ‘outsourced pregnancy’ suggest that the practice of surrogacy is akin to other outsourced jobs that seek cheap labour in India. In commercial surrogacy, it is argued, women are viewed primarily as an instrument of childbearing, and their wombs treated as commodities; all of which has implications for the societal view of women, and the emotional relationship between mother and child. There are concerns about the overuse and inappropriate use of commercial surrogacy, facilitated by unscrupulous fertility clinics. Surrogacy is pushed forth as an alternative to other fertility treatments in a bid to expand the industry and make greater profits, and fears loom that surrogacy could spin out of control.

The negative aspects of surrogate motherhood need to be seriously considered. Surrogate motherhood is likely to give rise to a new class of agents/intermediates whose business would be to offer monetary inducement to the poor women for surrogacy with the connivance of some medical practitioners and exploit their vulnerability in the way the notorious kidney racketeers in India have done. The unhealthy practice could lead to the creation of what can euphemistically be described as the springing up of ‘baby ‘factories’. There should be control so that it does not become an open market. Most countries of the world have realised the down-side of surrogacy and do not permit it. The basic questions are: Are wombs meant for renting, and are babies commodities to be planted and harvested? Are women child producing machines? The Ministry of Women and Child Development, which is supposed to be holding
consultations across the country, needs to address these core social issues which have wide importance for society. While the enactment of the law may be fine, much will, however, depend on whether and to what extent the government would be able to enforce the law, that is, the quality of enforcement.

But the question arises that whether these issues reflect true reflections of Indian society or brain child of certain scholars.

Researcher tried to analyse the acceptability of the ART in conservative Indian society of Hyderabad and Nalgonda in Andhra Pradesh, Mumbai in Maharashtra and Gwalior Division of Madhya Pradesh other than Anand, Badodara and Ahemadabad of Gujarat. Humble researcher got an opportunity to work at south Indian city Hyderabad for 5 months, during his assignment with one of his client that is becoming popular surrogacy destination. Researcher discussed with the real actors of this surrogacy arrangement and also with the persons associated with them either as supporter or as critique.

Humble researcher set out to speak directly with the “workers” to see how they are affected by such “work.” He delineated its “structural reality, with real actors and real consequences,” and provided an intimate look at the lot of women serving as commercial surrogates at 3 ART Clinics in Hyderabad.

In-depth interviews were used to explore participants’ motivation, attitudes, and experiences of transnational surrogacy. These interviews were conducted in Hyderabad, during December 2013 to March 2014.

Due to the high rate of illiteracy among participants and cultural norms, it was not appropriate nor a standard of practice to require participants to sign actual consent forms. Consent was established through verbal communications and subsequent participation in the study. Surprisingly, this informed consent technique revealed that participants had a clear understanding of the study, an appreciation for the invasiveness of the questions, and were willing to proceed despite minimal risks involved with discussing sensitive information about them. This methodology brought out in-depth understanding of the issue and highlighted the voices of surrogate mothers. The interviews were semi
structured and the participants could choose to speak on any area of particular relevance to them.

Although several topics and themes emerged from these interviews, the researchers limited the results to two critical themes:

(1) Motivations of surrogate mothers; and
(2) The role of family and community in surrogacy.

However, before elaborating on these themes, the researchers would like to provide a brief background of the participants of this study.

Identifying the Surrogate Mothers

Researcher did not adopt any procedure for selection of surrogate mothers to participate in the study, but on the basis of their oral consent he interviewed all the available surrogates, though there was a similarity between them. The following discussion describes the characteristics of the surrogate mothers who participated in the study.

<table>
<thead>
<tr>
<th>Marital Status of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
</tr>
<tr>
<td>90%</td>
</tr>
</tbody>
</table>

All 21 women who participated in the study were married but two of them had lost their Husbands even prior to enter into respective surrogacy arrangements. Probably to counter financial crisis arising-out of this situation motivated them for the same.

Researcher also found the age of these Surrogate mothers ranging between 25 to 37 years. 12 of them were between 25 to 30 years of age whereas 8 were between 31 to 35 years and a lady was of 37 years of Age.
Similarly all the participants had given birth to at least one biological child prior to becoming surrogate mothers. While analyzing DATA researcher found that 3 of the women having 3 children prior to become surrogate and 7 had 2 children whereas 11 out of 21 had only a child prior to enter into surrogacy arrangement. This DATA shows that the general perception that after giving birth to several children a lady becomes surrogate is not true. Specifically in case of Hyderabad the scenario is entirely different.

While discussing with the Surrogate Mothers, researcher came to know that some of them are third time surrogates. Seven of participants were second time surrogates whereas 2 of them were 3rd time surrogates. This DATA shows that women are participating in the process after once
they entered into arrangement. While the discussion apparent cause was the feeling of crossing the barrier once or thrice has no significance specifically when a handsome amount is the compensation.

Participants were referred to the surrogate clinic by agents hired by the doctor or by husbands and even by Neighbour women who had been Surrogates previously. During the study it appeared that most of the women were motivated by Agents but 3 of them were mobilized by neighbor women. Interestingly 3 of them were also motivated by their Husbands. Another important phenomenon appeared during the study that 2 of the participant themselves took the initiative to be a surrogate, though one of them was employee of an ART Clinic.
A majority of the participants reported to be from very low socioeconomic background and had little to no formal education. Also, participants reported that their husbands were unable to earn sufficient income for the family due to employment status, and surrogacy was seen as a way to alleviate poverty. The commissioning parents were from the United States, Japan, Canada, Australia, England, Japan, India, Germany, Australia, South Africa, Newzealand and Italy.

Motivations to Surrogate Mothers: Economic Necessity or Noble Cause

Each of the participants of this study was asked about her motivation and reasons for becoming a surrogate mother. All the participants stated that their primary motivation was the financial compensation that was offered to them. Each participant stated that she received about Rs. 2,00,000/- to Rs. 2,50,000/- for successfully delivering a baby through surrogacy. The compensation for carrying twins ranged between Rs. 3,00,000/- and 4,50,000/-. However, the received compensation was different for each pregnancy and depended upon the commissioning parents’ economic background as well as the contracts that were signed between the parents and the clinic. The difference in compensation offered to each surrogate in the study can be seen in Table 1.

In describing the motivation for surrogacy, one of the participants, Saritha, a 3-time surrogate stated:

“My husband is patient of cancer and requires regular expensive treatment. I am earning here and spending there. Even though second time I had C-section and didn’t feel up to doing it a third time.”

This quote clearly states that there was a pressing financial need that resulted her decision to become a surrogate mother 3 times.

Sakhu said:

“My husband lost his leg in an accident, who was the only earning member of my family, in such a difficult situation the lady of hospital suggested me, I had no other option except to accept it.”
Sarita stated:

“We were surviving anyhow in financial crisis with all my children, and a husband with no work—I had to do it all myself and it is very difficult. There was no other choice for me.”

While meeting these surrogates, it appears that the only reason they stated was financial. Almost all these lady belong to poor socio-economic class and they did it to fulfill their end meets.

Role of family and community in surrogacy.

It is difficult to understand that most of the Husbands supported their wives and some of them themselves initiated and motivated their wives and bring them to the clinics. Even In-Laws also supported, though not in all cases.

In fact, mother in Laws are supporting against the common perception and typical image of Indian “Saas”, not only morally and by taking care of their children but as Pushpa stated that she also use to send various dishes to hostel\textsuperscript{20}. A widow Asha, live with her Mother in law and 2 children. They both had been discussing it for a long and she encouraged her to take this step. For all nine months she took care of her children well and even after delivery she cares for her also.

But, every lady is not that much lucky, as Sharda Says that when she and her husband discussed the idea with the family member, they strongly opposed it and she left her 7 years’ daughter with her maternal parents and even after delivery they have to left the house and living separately in the village and even there is no communication with the family. But she is still happy, because they overcome from the financial crisis and started a small business by which they are earning, sufficient for our small family.

The role of the family in relation to the gestational surrogate is complex. The most important thing is that most of the women stated the role of the husband in making the decision to become a surrogate, mentioned by

\textsuperscript{20} Pushpa Categorically stated the active support of her family, specifically her mother in law, who not only took care her both the children but also use to send various dishes to hostel.
11 of the 21 participants. Most of the women mentioned that their husband were supportive of the idea, three explained that their husband insisted that they consider it, and three said that their husband needed to be convinced before the decision to become a surrogate could be made.

Apart from the husband’s role in surrogacy, the role of other family members was also considered to be important. Often times parents of the surrogate, siblings and even in-laws participated in the surrogacy process. They either helped and supported the surrogate, or acted indifferently and even criticized her for becoming a surrogate.

A contravening view was presented by Barsha, whose maternal family members opposed this idea and even her brother broke the relations.

Table 1. Demographics of Sample.

<table>
<thead>
<tr>
<th>No.</th>
<th>Pseudonym</th>
<th>Age</th>
<th>No. of surrogates</th>
<th>Marital status</th>
<th>No. of Own children: ages</th>
<th>Husban d’s employment status</th>
<th>Who suggested the idea?</th>
<th>Twins</th>
<th>C-Section</th>
<th>Compensation range (in Lakh Rupees)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Hansa</td>
<td>37</td>
<td>3</td>
<td>Married</td>
<td>1:16</td>
<td>Driver</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>2 – 4</td>
</tr>
<tr>
<td>2</td>
<td>Asha</td>
<td>30</td>
<td>1</td>
<td>Widow</td>
<td>1:13</td>
<td>Neighbor</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>2 – 4</td>
</tr>
<tr>
<td>3</td>
<td>Sakhut</td>
<td>32</td>
<td>2</td>
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<td>1:10</td>
<td>Labour</td>
<td>Self</td>
<td>Yes</td>
<td>Yes</td>
<td>2 – 4</td>
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<tr>
<td>4</td>
<td>Manju</td>
<td>30</td>
<td>1</td>
<td>Married</td>
<td>2:10, 8</td>
<td>Labour</td>
<td>Works at clinic</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>5</td>
<td>Saritha</td>
<td>35</td>
<td>3</td>
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<td>Yes</td>
<td>Yes</td>
<td>3 – 4.5</td>
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<tr>
<td>6</td>
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<td>32</td>
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<td>1:7</td>
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<td>Agent</td>
<td>Yes</td>
<td>Yes</td>
<td>Secret</td>
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<td>7</td>
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<td>8</td>
<td>Pushpa</td>
<td>28</td>
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<td>1:09</td>
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<td>Agent</td>
<td>Yes</td>
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<tr>
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<td>Deepa</td>
<td>33</td>
<td>1</td>
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<td>2:11, 9</td>
<td>Labour</td>
<td>Husband</td>
<td>No</td>
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<tr>
<td>11</td>
<td>Bindu</td>
<td>28</td>
<td>1</td>
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<td>Painter</td>
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<td>29</td>
<td>2</td>
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<td>1:10</td>
<td>driver</td>
<td>Husband</td>
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<td>Yes</td>
<td>2 – 4.5</td>
</tr>
<tr>
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<td>Labour</td>
<td>Husband</td>
<td>Yes</td>
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<td>3 – 4.5</td>
</tr>
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<td>14</td>
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<td>30</td>
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<td>Married</td>
<td>2:11, 10</td>
<td>Labour</td>
<td>Agent</td>
<td>No</td>
<td>Yes</td>
<td>2</td>
</tr>
<tr>
<td>15</td>
<td>Lata</td>
<td>26</td>
<td>1</td>
<td>Married</td>
<td>1:6</td>
<td>Labour</td>
<td>Agent</td>
<td>No</td>
<td>Yes</td>
<td>2</td>
</tr>
<tr>
<td>16</td>
<td>Afrah</td>
<td>28</td>
<td>2</td>
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<td>2:10, 9</td>
<td>Labour</td>
<td>Neighbor woman</td>
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<td>Yes</td>
<td>2 – 4.5</td>
</tr>
<tr>
<td>17</td>
<td>Salma</td>
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<td>2</td>
<td>Widow</td>
<td>3:11, 10,5</td>
<td>Labour</td>
<td>Neighbor woman</td>
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<td>Yes</td>
<td>2 – 4.5</td>
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<td>18</td>
<td>Laxmi</td>
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<td>1</td>
<td>Married</td>
<td>1:8</td>
<td>Labour</td>
<td>Agent</td>
<td>No</td>
<td>Yes</td>
<td>2</td>
</tr>
<tr>
<td>19</td>
<td>Sandhlya</td>
<td>33</td>
<td>2</td>
<td>Married</td>
<td>2:12, 10</td>
<td>Labour</td>
<td>Agent</td>
<td>Yes</td>
<td>Yes</td>
<td>2 – 4</td>
</tr>
<tr>
<td>20</td>
<td>Shailja</td>
<td>27</td>
<td>1</td>
<td>Married</td>
<td>1:6</td>
<td>Labour</td>
<td>Agent</td>
<td>No</td>
<td>Yes</td>
<td>2</td>
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<td>21</td>
<td>Malini</td>
<td>30</td>
<td>1</td>
<td>Married</td>
<td>2:10, 5</td>
<td>Labour</td>
<td>Agent</td>
<td>Yes</td>
<td>Yes</td>
<td>2</td>
</tr>
</tbody>
</table>

Barsha stated: My maternal family members opposed this idea and even my brother broke the relations.
Table shows that 2 Widows were also participated in the survey who were dare to take risk of pregnancy after the death of their husbands.

![Twins or Single](image)

Commonly, after pregnancy was confirmed, participants lived in a surrogacy hostel for the duration of the pregnancy. Surrogates chose whether or not to reside in the hostel. More often than not, surrogates chose to live in the hostel to avoid stigma at home. Because the agency only allowed women who had previously successfully given birth to become surrogates, all the participants had biological children who were forced to remain at home while the surrogates lived in the surrogacy hostel. Typically, the surrogate’s family home was located far from the surrogacy hostel, which resulted in limited contact with family members. Other family members, such as a mother-in-law or husband, stepped in during this time to take on the participant’s responsibilities such as child rearing and cooking meals.

Staying in the surrogate home is hard to the surrogates and they always bother for care of their child. But with the hope that 9 months will go fast and then they will have the money they need.\(^\text{22}\)

Most of the Surrogates did not like staying in the surrogate home and constantly wanted to go back home to their children, but the fear that

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\(^{22}\text{Chanda: I am worried about this second time. Staying in the surrogate home will be hard and I don’t know who will take care of my child. But the 9 months will go fast and then we will have the money we need.}\)
poverty of their house would have been bad for their pregnancy had been compelled them that it was safer to stay in the surrogate house.  

For many of the participants, some or most of her family members did not know she was a surrogate. If the family members did know, they tended to protect her secret to shield others from the truth. In other cases, the women mentioned reluctance to tell their family members about the surrogacy. Five of the participants mentioned that some members of their family or community did not know that they had become a surrogate. 

Response of Community

<table>
<thead>
<tr>
<th>In Laws’ Response</th>
<th>Maternal Home response</th>
<th>Community Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supportive</td>
<td>Negative</td>
<td>Don’t know</td>
</tr>
<tr>
<td>16</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

While family members’ reactions to the surrogacy varied from negative to relatively supportive, community members’ reactions were always negative. Surrogate mothers were typically stigmatized if community members became aware of the surrogacy. This resulted in ostracism and one participant was even forced to move away from her village.

There are so many people that talk badly about what they do. There is much stigma, and people say things like she is after money ... . . and things.

Surrogate mothers employed various strategies to avoid stigma and ostracism. These included living in the surrogacy hostel while engaging in false claims of alternative employment or even lying about the result of the pregnancy.

23 Shailja: I did not like staying in the surrogate home. I constantly wanted to go back home to my children. But the poverty of our house would have been bad for my pregnancy. It was safer to stay in the surrogate house.

24 Lata: I have not told my parents about it. Or my extended family because if they come to know such things they would kill me. They live in the village so they do not understand the process.
As a widow surrogate Asha explained that she had to stay in surrogacy home because people in village would ask about how she got pregnant, especially with no husband. Whereas Manju told everyone that it was their child. When the child was born she told them the baby did not survive.

While the major incentive cited for the creation of the surrogate hostel was the maintenance of the surrogate’s health, the information mentioned above points to an additional reason: To maintain seclusion of the pregnant surrogate, thus shielding her from the eyes of a disapproving community. By providing a means of isolation, the surrogacy clinic is both meeting their own need for supervision of the pregnancy and meeting the need of the women to keep the surrogacy private. A third stakeholder in this arrangement is the community itself. By quarantining the practice of gestational surrogacy out of public view, it is a way to maintain the social norms of traditional reproduction, even as surrogacy becomes more and more common.

Discussion

In this section, we will first discuss the motivating factors that the surrogate mothers described in their interviews. The main motivator was financial, with a secondary factor being altruism. Additional headings of “deciding to become a surrogate and “recruitment” are also included in order to better describe and explore the decision-making process of surrogate mothers. Second, we will discuss the role that the family and the community played in the decision-making and surrogacy processes. The husband’s role, the support of children and family during the surrogate mother’s absence, and the community’s role in surrogacy will each be explored.

Financial Motivators

Earlier, several studies were mentioned that showed how richer countries had outlawed the practice of paying women to be surrogates due to the danger that the large financial transaction would serve as a coercive factor in the decision to become a surrogate. When considering that gestational surrogacy has been labeled as potentially financially exploitative to birth mothers in the Global North, should surrogacy then be alternately
interpreted as liberating for Indian women because they have no other sources of income?

When this idea of financial transactions in surrogacy was explored in this study, it became apparent that severe financial hardship was the main reason that the participants chose to become gestational surrogates at the clinic. There was an overarching theme of choosing surrogacy as an attractive last resort for poorly educated women with few choices to earn enough money to support their family.

Several women used the Hindi word, “majburi,” in their explanation of why they chose to become surrogates. This word translates into English as being “compelled” to do something. Additional aspects of the translation further elaborate on the definition, including the terms obligated, constrained, and helpless. By using this concept, the women communicated how they felt reluctant to refuse the opportunity to become a surrogate due to the overwhelming life burdens they were experiencing. Thus, women chose to participate in surrogacy as a result of poverty regardless of the stigma associated with the practice.

A Noble Cause

Although financial gain was the main motivation for pursuing gestational surrogacy among the participants, many women also indicated that they were doing something noble. They went further in making the distinction between sex work and their work as surrogates. Sex work on one hand was perceived as a dishonorable means of acquiring financial resources for a family in poverty. Surrogacy on the other hand was seen as a way to get much more money and was not seen by the surrogates themselves as being degrading in the same way as sex work.

Although the idea of serving as a surrogate for a couple who were otherwise unable to have children was mentioned as a noble act by the participants, it was not mentioned as the primary motivator. Financial gain was the predominant initial response when women discussed their motivation for pursuing surrogacy. The inclusion of surrogacy as a noble act can be viewed as a moral justification for a decision already made for financial reasons. There is cultural stigma against gestational surrogacy, thus conceiving of surrogacy in this way may legitimate the woman’s role in the process.
Deciding to Become a Surrogate

While the main motivation for becoming a surrogate was financial, surrogacy was not a widely known or understood procedure in this community at the time of these interviews. Because of this, multiple factors were at play in the woman’s ultimate decision to become a surrogate. The woman must first have been made aware of the option of surrogacy. She must then understand the procedure and its implications. She must seek approval, active or tacit, from her husband and close members of her family. Additionally, because these gestational surrogates spent the duration of their pregnancy in an alternate location, she must make arrangements for the care of her family and household in her absence. In order for the woman to make the final decision to be a surrogate, all of these areas were addressed.

Recruitment

The majority of women in the study did not seek out surrogacy. Rather, they were approached by someone else with the idea. Of the 21 participants, 12 had been approached by an agent of the surrogacy clinic. Four had been told about surrogacy by their spouse. Only two said that they had been the one to initiate the surrogacy process. This speaks to the practice of recruitment for gestational surrogates in this community. Because prior surrogates were given a “finder’s fee” of up to Rs. 5,000 for each woman they brought in to be a surrogate, there was motivation for past surrogates to promote the practice positively to other women in the community. This initial external pressure to consider surrogacy may legitimize surrogacy as a noble act and reduce the stigma associated with the practice—the women were not on the whole personally drawn to surrogacy and thus may rationalize their decision to participate by relying on the altruistic aspects of providing a baby to an otherwise infertile couple. That is to say, although the primary motivation for surrogacy was financial, further conceptualizing surrogacy as a noble act may allow the woman to more easily legitimize her decision to herself and her family.

Husbands’ Role

It is worth noting that none of the married women interviewed said that they made the decision to be a surrogate without their husband’s approval. Husband’s approval was considered mandatory not only by the
women but also by the surrogacy clinic. It was a requirement that the husband signs the paperwork providing permission for his wife to become a surrogate mother. This indicates that surrogacy was not the decision of the woman alone and her husband was surely involved in the decision-making process. Thus, the woman’s body belongs not to herself only but to her husband as well. However, the results of this study indicate that the husband’s role varied from being indifferent to being insistent for the wife to become a surrogate. Some of the husbands needed convincing while some were supportive by offering domestic help while their wife was away in surrogate homes.

**Support of Children and Family**

One of the main reasons the husband was involved in the decision-making process is because all of the surrogates had at least one prior successful pregnancy and thus at least one biological child that they were currently caring for. Because most of the women interviewed were in the surrogacy home for the duration of their pregnancies, other arrangements had to be made for the care of their home and their children. The participants stated that they missed their children while they were away and that other family members took care of the young children in their absence. Here, “family members” refer both to nuclear and to extended family members.

**Community’s Role in Surrogacy**

One theme that emerged from the interviews was that the community at large was opposed to gestational surrogacy. Many women reported apprehension to inform extended family members for fear of disapproval or retribution. Participants also reported having to relocate after community members (e.g., neighbors, fellow villagers, and church members) found out about the surrogacy. This lack of support from community is in one aspect unsurprising, as many Indians view surrogacy as comparable to sex work. Women’s roles as wife and mother are important in this community, and fidelity in a monogamous marriage is expected. The in vitro fertilization (IVF) process involved in gestational surrogacy was not understood by all members of the community, and even when it was, the idea of a married mother carrying another couple’s baby was not supported.
Even so, systems of support were necessary for the gestational surrogacy process to occur at all. As explained previously, clinic staff, surrogacy agents, husbands, and family members were all involved in the process. Furthermore, all of these stakeholders benefited financially from the woman’s gestational surrogacy. The genetic parents paid the clinic. The surrogacy brokers received a finder’s fee.

The family members, such as children, husbands, or parents, went to school or at times bought a permanent home that was slightly better than the rental homes or temporary shanties that housed them prior to surrogacy. So, even though the larger community heavily stigmatizes surrogacy, various members of the community directly benefit financially from the practice of gestational surrogacy.

This work illustrates a number of implications for policy, practice, and future research. In terms of policy, this work implores the regulating bodies to begin to develop policy around a number of key concerns. The first is the importance of establishing a well-reasoned and uniformly applied compensation structure for the women that choose to serve as gestational surrogates. The system currently in place is administered on a case-by-case basis and increases the likelihood that some women may experience exploitation. Additionally, no governmental policy exists regarding the education of surrogate mothers. For example, Sarita stated, “After delivery there are some problems everyone has, but no one talks about them. But the doctor gives lots of painkillers.” Therefore, a policy is needed around the level of disclosure and education about the process itself, so that a woman can make a well-informed decision about engaging her body in this type of work.

It is important to note, that every participant’s surrogate pregnancy resulted in a Cesarean section, and many surrogates had undergone multiple Cesarean section procedures. Increased Cesarean sections are associated with increased risks, including morbidity. Although conditions associated with Cesarean sections are rare, many are serious and include pelvic pain, bowel injury, cystostomy, urethral injury, placenta accreta and previa, reduced fetal growth, preterm birth and possibly stillbirth, decreased fertility, increased risk of ectopic pregnancy and spontaneous abortion. Thus, women need to be informed of these risks associated with Cesarean section delivery. Moreover, there should be a policy structured
around the number of times that women may engage in this work and other reproductive services. Women we interviewed demonstrated a wide range of number of surrogate pregnancies.

In terms of practice, level of disclosure continues to be an important element. The women whom we interviewed often demonstrated a dire need for income caused by other systems of services either not being there at all or not being effective. Clear lines of obligation should be established from the professional organizations that oversee social workers employed in this line of work to ensure that the women and their families are advocated for in every possible way. There should also be an effort by practicing social workers in areas of high utilization for these services around awareness rising. A key function of the social work profession is to create awareness around issues, and the issue of gestational surrogacy, as our participants discussed, is a process not clearly understood and rife with stigma. Without identifying women who have engaged in the work, for fears of their safety when discovered, social workers could launch general awareness campaigns that could serve to increase women’s safety when they return to their villages, should their work as a gestational surrogate be discovered.

Future research is needed to continue exploring the experiences of surrogates, as well as the role of recruiting agents and husbands. Future research is needed that examines the mental well-being of surrogates in India. Constructs such as depression, self-esteem, attachment to the fetus, and attitudes toward pregnancy will provide a clearer understanding of the impact of surrogacy post delivery. Longitudinal data are needed to understand the impact of this process on surrogates mentally, emotionally, physically, and financially in the long term. Finally, future research should explore the roles that recruiting agents from the surrogacy clinic play in this process. Other research the team has conducted about the recruitment process suggest surrogacy may be portrayed only in a positive light to successfully recruit women, rather than disclosing the actual experience of the process. Our work illuminated that many other systems support the women in the endeavor to be gestational surrogates, so a further understanding of their level of satisfaction with the process is warranted.

Finally we probe, is it ethical that marginalized and illiterate women are paid to bear children for relatively wealthy women within a larger
globalized medical for-profit undertaking? Is it fair that their health is not insured on a long-term basis? Is it equitable that the amount of money they make is meager compared to what a surrogate mother would receive in the Global North? Are women’s rights being violated in practicing international gestational surrogacy? As social workers concerned about women’s issues, we have these challenges before us. Understanding globalization and its impact on women’s bodies is critical and we need to advocate for the protection of women rights. We encourage dialogue among social workers to examine gestational surrogacy from the perspective of human rights and women’s rights. To do this, it is important to engage the Universal Declaration of Human Rights in this dialogue. In particular, Article 25 of the Universal Declaration of Human Rights (1948) states, “Everyone has the right to a standard of living adequate for the health and well-being of himself/herself and of his/her family, including food, clothing, housing and medical care and necessary social services . . . ”. Additionally, Article 23 states “Everyone has the right to work, to free choice of employment, to just and favourable conditions of work . . . ” (Universal Declaration of Human Rights, 1948). We recommend that the international social work organizations and networks openly discuss the human rights violations behind gestational surrogacy and strive toward spreading awareness about the issue. Finally, we feel that the global social work community needs to develop a protocol on ethical underpinnings of gestational surrogacy and advocate strongly for protecting the rights of women.

Our work was impacted by limitations. The most important one to consider was the sampling method researcher used to engage gestational surrogates. He conducted the work in the facility where women had been gestational surrogates, and in many cases the women still had relationships with the facility. In some cases, these relationships were income generating through performance of general housekeeping work, through other reproductive service engagement (i.e., reproductive egg donation); and in many other cases, they were maintaining close relations for potential future service selection. Therefore, it is possible that the participants did not speak freely, given their ongoing, financial relationship with the surrogacy clinic. Hence, surrogates who have not maintained a relationship with the clinic may describe the process in a more negative light. Thus, this study cannot be generalized to all surrogates seen at this facility.
Another limitation of our study was its cross-sectional nature. Researcher interviewed women at one point in time about an experience that is likely to have a lasting and evolving contextual meaning to the woman over her lifetime. Therefore, this study cannot be generalized to the larger population of surrogate mothers. Future work should explore this role and its interpretation over time to understand the long-term impact on the women.

**General Perception about Surrogacy**

To analyse general perception about surrogacy, humble researcher set out to speak hundreds of persons in the vicinity, where the above discussed surrogates reside to get the response of the persons actually aware of the procedure.

Total 117 Responses were collected in and around Hyderabad and Gwalior. Out of these 117 respondents 32 were women and including 7 women of more than 60 years of age. All the respondents belong to economically backward classes and 23 of them belongs to Schedule Caste also. A survey form was used to get response.

**Gender-wise discrimination among the children**

All the respondents were of the opinion that child is necessary for a couple but their views about the reasons are diversified. Most of the respondents consider the necessity of having a child to support in old age following by to continue pedigree (Vansh).
Gender discrimination was also appeared while analyzing the perception about adoption. In response to a hypothetical question about the availability of choice of adoption among the male and female child, 99 of the respondents specifically commented that they would like to adopt a male child, choice is available, whereas only 16 preferred to adopt a girl child in case of availability of choice.

The most unexpected result researcher got is concerned with the necessity of Boy or Girl. Most of the respondents (78) specifically told that both girl and boys are necessary to complete family, though 27 respondents considered boy and 12 girl as necessary, but the interesting thing appeared from the survey is that only young male respondents told that girls are necessary.

![Boy Necessary or Girl](chart)

**General Awareness about the ART**

During the survey efforts were initially made to explore the general awareness about the ART among the respondents. The vicinity selected for the survey, was that of the surrogates, who interviewed earlier, so naturally level of awareness was expected to be substantially high, but the general opinion was nowhere appears to be affected by the fact. General level of education clearly reflects the fact as most of the respondents hardly get any formal education.
All the respondents were aware of the Adoption and Normal Delivery process and Caesarian but only 72 were able to differentiate the Normal Delivery and C-section. 46 out of 117 respondents were aware of the Artificial Insemination, 33 were aware about the Test Tube baby but the awareness about the sperm donation is relatively high (55), though the egg donation is still a secret for them and only 27 respondents are aware of it. Surprisingly, 80 of the respondents were of the surrogacy arrangements, though they don’t know the procedure of surrogacy.

**Perception about adoption**

Almost all the participants in survey were of the opinion that consent of the elders of the family is necessary for taking step of adoption and most of them they are willing to discuss the process of adoption in their family, however they were divided to consider the adoption as the best alternative method.

Most of the respondents were in favour to adopt a child with known background only and more than two third of them were sensitive about the caste of the child to be adopted before the adoption is taking place or the caste of Biological mother.
Adoption

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Can’t say</th>
</tr>
</thead>
<tbody>
<tr>
<td>In your Opinion adoption is the best alternative way to have a child</td>
<td>63</td>
<td>52</td>
<td>2</td>
</tr>
<tr>
<td>Consent of elders in family is required before adoption</td>
<td>113</td>
<td>....</td>
<td>4</td>
</tr>
<tr>
<td>Will you promote the discussion about process of adoption ..?</td>
<td>107</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Do you have reservation of Caste in adoption ..?</td>
<td>71</td>
<td>33</td>
<td>13</td>
</tr>
<tr>
<td>Would you suggest to adopt a child with known background only ..?</td>
<td>91</td>
<td>17</td>
<td>9</td>
</tr>
<tr>
<td>Do you feel-Adopted child should have same rights in the family ..?</td>
<td>112</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Do you feel-Adopted child gets different treatment in the family ..?</td>
<td>8</td>
<td>98</td>
<td>11</td>
</tr>
<tr>
<td>Do you think adopting mother doesn’t have similar affection to adoptee as her own child ..?</td>
<td>37</td>
<td>73</td>
<td>7</td>
</tr>
<tr>
<td>Whom would you prefer to adopt - A Boy/A Girl ..?</td>
<td>B</td>
<td>G</td>
<td>2</td>
</tr>
</tbody>
</table>

Nobody among the participants denied the equal rights to adopted child in the family though few of them opined that sometime it doesn’t happen. Most of them also think that adopting mother doesn’t have similar affection to adoptee as her own child.

**Perception about IVF/Test Tube Baby**

Social stigma clearly appears in perception about Test tube baby as almost all the respondents were responded to prefer the sperm/egg of same parents, but in case of need they hesitate to accept the donated sperm in comparison to donated egg though in both the situation majority of the respondent negate it.

Test Tube Baby

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Can’t say</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is Test tube baby a good method ..?</td>
<td>41</td>
<td>32</td>
<td>44</td>
</tr>
<tr>
<td>Would you suggest for Test Tube Baby for your dear one ..?</td>
<td>53</td>
<td>24</td>
<td>40</td>
</tr>
<tr>
<td>In such case Would you prefer sperm or/and egg of same parents only ..?</td>
<td>106</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>In case of need, would you prefer donated sperm ..?</td>
<td>14</td>
<td>89</td>
<td>14</td>
</tr>
<tr>
<td>In case of need, Would you prefer donated egg ..?</td>
<td>36</td>
<td>63</td>
<td>18</td>
</tr>
</tbody>
</table>

60
Though, the opinion about the utility of test tube method was divided, but majority of the respondent with some hesitation is ready to accept this method for their dear ones.

When, the participants were asked about Surrogacy, most of them replied against it. The society is not ready to accept a child through “rent a womb”. Though a healthy number of persons accept it as an alternative method, but on the question “will you permit your dear one to rent out the womb” 90% of the respondents denied and 9 respondents were agree to it for dear ones only whereas 3 found no stigma in it even for unknown people.

**General Perception about Surrogacy**

The unanimous opinion of the respondents was that the surrogacy may be permitted only to the persons, who are unable to conceive, but they also favours to the persons who don’t have child. Majority of the respondent is not in favour of giving such permission to the persons, who want a child but don’t want to conceive for personal reasons, not associated with any kind of Medical deficiency.

<table>
<thead>
<tr>
<th>Surrogacy</th>
<th>Yes</th>
<th>No</th>
<th>Can’t say</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you feel surrogacy is a good method ..?</td>
<td>39</td>
<td>69</td>
<td>9</td>
</tr>
<tr>
<td>Child of a Couple through other woman is acceptable ..?</td>
<td>32</td>
<td>77</td>
<td>8</td>
</tr>
<tr>
<td>Do you feel renting out the womb is good ..?</td>
<td>34</td>
<td>62</td>
<td>21</td>
</tr>
<tr>
<td>If good, will you permit your dear one to rent out the womb ..?</td>
<td>12</td>
<td>94</td>
<td>11</td>
</tr>
<tr>
<td>If yes, to transit a baby for dear ones only ..?</td>
<td>9</td>
<td>3</td>
<td>.........</td>
</tr>
<tr>
<td>If not, then for unknowns also..?</td>
<td>3</td>
<td>....</td>
<td>.........</td>
</tr>
</tbody>
</table>

The Hindu adoption and Maintenance Act 1956 does not permit to adopt a male or female child to the person having the child of same gender but the general perception about this is stronger than the legislation as revealed from the opinion of the Respondents in the present study as they are also not in favour to grant the permission of surrogacy arrangement to the persons who either have Boy or girl or want to adopt the procedure to have either boy or girl. Majority of the respondents are not in favour to allow these arrangements to unmarried persons and
more than 90% of the respondents are against to grant such permission to gay Couples.

<table>
<thead>
<tr>
<th>To whom it should be permitted</th>
<th>Yes</th>
<th>No</th>
<th>Can’t say</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who Don’t have children</td>
<td>113</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Who want child but don’t want to conceive for personal reasons</td>
<td>41</td>
<td>73</td>
<td>3</td>
</tr>
<tr>
<td>Who are unable to conceive</td>
<td>116</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Who don’t have either boy or girl child</td>
<td>6</td>
<td>102</td>
<td>9</td>
</tr>
<tr>
<td>To Unmarried</td>
<td>43</td>
<td>72</td>
<td>2</td>
</tr>
<tr>
<td>To Gays</td>
<td>14</td>
<td>97</td>
<td>6</td>
</tr>
</tbody>
</table>

**Economic Necessity or Noble Cause**

When the Peoples were asked regarding the perception about the surrogacy, then everybody bluntly said that surrogates do it for the gain of Money, However 64 of the respondent considered it also a Noble cause or a mean to delivering happiness to the families, who are not able to have their own child. Though majority of the respondents considered it an immoral act but only 18 of the respondents held it amounting to prostitution on the contrary 99 of the respondents specifically told that it does not amounting to Prostitution.

<table>
<thead>
<tr>
<th>Perception about Surrogacy</th>
<th>Yes</th>
<th>No</th>
<th>Can’t say</th>
</tr>
</thead>
<tbody>
<tr>
<td>Earning Money</td>
<td>117</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delivering Happiness or a Noble Cause</td>
<td>64</td>
<td>48</td>
<td>5</td>
</tr>
<tr>
<td>Immoral</td>
<td>71</td>
<td>42</td>
<td>4</td>
</tr>
<tr>
<td>Amounting to prostitution</td>
<td>18</td>
<td>99</td>
<td></td>
</tr>
</tbody>
</table>

The study reveals that conservative Indian Society though considers the surrogacy as an immoral mean of earning money differentiate it from the prostitution but at the same time a large Number of Peoples considers it a Noble cause or a mean to delivering happiness to the families, who are not able to have their own child.
Right Over the child

Opinion about the right over the child is divided and in fact this is divided up to the extent creates confusion about the general perception. It was explained to the respondent that Biological mother is the mother give birth to a child generally in case of Surrogacy, a Surrogate, and Genetical parents are intended parents gave their Sperm or egg or both.

About the right of Biological mother and Genetical parents, opinions of respondents are almost equally divided, so the perception appears from this study is against the alienation of child from the Biological mother, though in legal concept, the same does nowhere stand.

Surprisingly, respondents were able to differentiate between the right of Biological mother and Biological parents and in reference to biological parents they gave preference to the right of the Genetical parents.

<table>
<thead>
<tr>
<th>Rights over child if Genetic Parents are different from Biological parents</th>
<th>Yes</th>
<th>No</th>
<th>Can’t say</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you feel mother giving birth has first right over the child, in spite of genetical parents ..?</td>
<td>53</td>
<td>56</td>
<td>8</td>
</tr>
<tr>
<td>Genetical parents have first right over the child..?</td>
<td>59</td>
<td>55</td>
<td>3</td>
</tr>
<tr>
<td>Biological parents have no right over the child..?</td>
<td>36</td>
<td>62</td>
<td>19</td>
</tr>
<tr>
<td>Care of surrogate mother is the responsibility of Genetical parents..?</td>
<td>106</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>If yes, then how long ..? till Birth</td>
<td>44</td>
<td>.....</td>
<td>.......</td>
</tr>
<tr>
<td>6 months</td>
<td>17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 year</td>
<td>51</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 years</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surrogate Mother has right to select surgeon ..?</td>
<td>51</td>
<td>63</td>
<td>3</td>
</tr>
<tr>
<td>In case of dispute between genetic mother and father who will have right over the child :: Mother</td>
<td>31</td>
<td>.....</td>
<td>.......</td>
</tr>
<tr>
<td>Father</td>
<td>27</td>
<td></td>
<td></td>
</tr>
<tr>
<td>As per their Personal or domestic Law</td>
<td>59</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Post Delivery care of Surrogates

In India most of the surrogates are directly associated with or recruited by the ART Clinics unlike the Thailand, where intended
surrogates publishes there advertisement on message-boards on internet\textsuperscript{25}. DATA emerging out of the study also supports this fact and accordingly the opinion is divided about the right of surrogate to select the Surgeon and majority of the people who participated in the study were not in consonant with the idea and majority of the respondents negate any such right.

**Right of the child over the Property**

Though, everybody intended to put the welfare of the child at prime concern, but where the question about the right over the child in case of dispute was asked, majority of the respondent left the question on their personal or domestic Laws. However 31 of the respondents insisted such right for the Genetic Mother, whereas 27 supported to give custody of the child to Genetic father.

<table>
<thead>
<tr>
<th>Right of child born through ART (Artificial Insemination Technology)</th>
<th>Yes</th>
<th>No</th>
<th>Can’t say</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will ART Child have right in the Property of Biological Parents..?</td>
<td>7</td>
<td>108</td>
<td>2</td>
</tr>
<tr>
<td>Will ART Child have right in the property of Genetic Parents ..?</td>
<td>112</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Should ART child have same rights as normal child in the family of Genetic parents ..?</td>
<td>117</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Perception of the respondents regarding the right of the child born out of the surrogacy arrangements in the property of the Genetic parents is unanimous and all the respondent find absolute right as normal child in the family of Genetic parents. However, 112 of the respondent clarify that the child has the right over the property of Genetic parents, but when the question was asked about the right of the child in the property of the Biological parents, 108 respondents negated it.

In rural India where women’s role in reproduction is taken so much for granted that there is little overt value associated with it, the arrival of paid surrogacy arrangements has the potential to lead to a significant reassessment of women’s childbearing by the family, community and the State. Does the connection between surrogacy as a means to economic

\textsuperscript{25} YURI HIBINO AND YOSUKE SHIMAZONO, Becoming a Surrogate Online : “Message Board” Surrogacy in Thailand, Asian Bioethics Review March 2013 Volume 5, Issue 1, Page 56 Downloaded on 25/11/2014
empowerment bestow greater reproductive autonomy and status to the women who act as surrogates? What does consent actually mean or represent in these conditions? And what does this tell us about the role of the bill in legitimising new reproductive arrangements between those related through surrogacy and those unable to participate in social reproduction. As discussed, aside from the legislative domain, there are two more immediate sites where the dilemmas posed by the commercialisation of childbearing are mediated and reproductive autonomy and subordination experienced: the community.

Women in poor economic circumstances find surrogacy such an attractive option that they ironically have no choice. As one surrogate at Hyderabad, told the researcher, ‘it is our majboori (compulsion) to undertake surrogacy’. The choice to undertake surrogacy in this sense reflects systemic inequities associated with poverty and structural violence, wherein large-scale economic and political inequities predispose the vulnerable to suffering, where ‘compulsion’ makes visible the moral dilemma posed by the choice of surrogacy-or-poverty.

The lack of choice exists in another sense: in India, reproductive decision-making on when and how many children to have, when to have sexual intercourse and whether to use contraceptives, for example, are less the decision of the woman than of her husband and his family.

This is not to imply that women have no decision-making capacity but rather that reproduction is considered more a matter for the patrilineal group and particular kinspersons within them rather than for any one individual. A married woman’s reproduction and sexuality are closely monitored by her affinal family, so despite the collective decision making entailed in matters of childbearing, she usually has the sole responsibility for ensuring that reproductive outcomes, conception and birth, are successful.

Given the conditions that make childbearing imperative, and socially condoned autonomy limited, and under conditions where women’s bodies are regarded (even by themselves) as in the service of the wider collective (As Surrogates talk about their spousal duties of childbearing), it is unsurprising that the surrogates in the region find themselves majboor or lacking choice to avail of the economic opportunities presented by surrogacy.
The right to think about and use women’s bodies for tangible benefits has a longer history in existing practices such as in dowry, where women who are unable to generate a sustained or substantial flow of resources from their natal homes to the affinal home are subject to abuse. However, in the case of dowry payments (which flow from the girl’s family to her husband’s family), it is women’s work value, including her reproductive labour that is ideologically dismissed in the face of the social status that the connection with her spouse’s family will bring. While the lack of choice in surrogacy similarly reflects notions of a collective, kin-based ownership of women’s bodies, a logic also demonstrated through dowry payments, the overt market transactions involved (which put a price to childbearing) nevertheless directly challenge the assumptions of women’s reproductive labour as devalued.

Surrogate arrangements, however, remain devalued by community members when measured in terms of the responsibilities associated with successful and appropriate childbearing. Adultery is a serious social offence across caste and class, especially for women, who are often subject to physical, sexual and domestic violence (PUCL reports following implementation of the Protection of Women from Domestic Violence Act 2005).

While their immediate families support them, surrogates face ostracism and stigma from the wider caste community, often being called ‘prostitutes’ for bearing the child of a man other than their husband. This is the case even when no sexual intercourse is entailed in surrogacy. Even a male Gynaecologist told the researcher that he thought surrogacy was disgusting as it is adulterous to carry another man’s (i.e., not the husband’s) child to term. Surrogates take on the shame of ‘adultery’ and hide their pregnancy from members of the community. Yet, despite facing moral disapprobation from the wider kin and community, surrogates themselves talk about their surrogacy as an act of ‘sacrifice’ to secure the welfare of their family. Another striking feature of the way surrogates recover value from what they do is in their recourse to a language of selfessness and of viewing their ‘baby-work’ as undertaken for securing the future of their own children.

This is in contrast to the language of gifting. In fact, dowry payments in themselves challenge ideas of the gift as altruistic. Gifts (or dan) including that of dowry (kanya-dan) procure the well-being and auspiciousness of the
donor placing them in a higher social status than the receiver. In addition, surrogate women talk of the value they derive from the fact that ‘foreigners’ who come to them for procreative assistance. Tangible reference to this emerges when the surrogates interviewed describe their contribution in terms of substance (blood, breast milk) and the effort/labour of gestation in creating the child, factors which they refer to as creating a relationship with the child which is equal to if not stronger than the genetic tie. Surrogates are recovering reproductive value in what they do through particular and selective renderings of kinship wherein babies are made for others through a mixture of self and others’ substance, and to whom one has obligations of caring and duty to a limited extent. This indicates not the disappearance of notions of parenthood and related responsibility for those participating in embryonic stem cell regeneration, but rather a selective reformulation of existing ideas of relatedness. It is in these accounts that we also see reproductive autonomy and agency expressed, not simply subordination.

The issue of payment is an arena of contestation between those who see the need for reproductive labour to be monetarily rewarded and valued in a capitalistic society and others who believe decisions about childbearing should remain in the domain of maternal altruism. It is also an issue of disagreement between feminists and surrogates across the globe. The popular dichotomy made between gifts (not determined by the market) and commodities (to which market value is attached), cannot properly explain it. The Indian surrogates blur the boundaries between gifts and commodities through recourse to the ideology of dowry. Dowry payments also suggests that while viewed ideologically through the lens of the ‘gift’, in practice such transactions come to be seen as payments associated with a woman’s labour, including her reproductive labour.
Chapter 3

Socio-Legal Complications arise of using ART and Its impact on execution of various Indian Laws

Commercial surrogacy has been legal in India since 2002. India is emerging as a leader in international surrogacy. So far the Indian perspective is concerned; it has left no doubt with the room that Indian surrogates have been increasingly popular with fertile couples in industrialized nations due to the relatively low cost. At the same time, Indian clinics are becoming more competitive, not only in the matter of pricing, but also in the hiring and retention of Indian females as surrogates. Actually, surrogacy in India is much simpler as well as less costly. So, people from western countries are gathering to India get a baby of their own genes.

ART AND ITS ISSUES

The Artificial Insemination is subjected to a lot of controversy. It is due to the various social, legal and ethical problems associated with it such as changing concept of ‘motherhood and family’, ‘mother child bonding’, maternal health and objectification of the surrogate body specifically in case of Surrogacy’. Due to the lack of proper legislation, it has become an unconventional family formation technique as emergence of artificial insemination has not only separated procreation from intimacy but also allowed anonymity, simply allowing the purchase of genetic material. It has a lot of issues may harm to the society, to women and children in general.

Present Indian Legal system is in fact not ready to accommodate this kind of advances in medical Technology, which severely affects traditional Indian family structure and therefore entire family laws in many ways. Validity and enforcement of Contract of ART in general and Surrogacy in particular is also an issue need proper consideration.
ISSUES AFFECTING THE SOCIETY

Any advancement in Technology should examine on the basis of its impact on the society, specifically, the technology, which directly affects the prevailing family structures and systems.

WOMEN AND SURROGACY

A major rationale against the legalization of surrogacy is the potential for actual psychological and physical harm to women. It is associated with several ethical hazards to both the surrogate mother and the child. The concept of surrogacy has turned a normal biological function of a woman’s body into a commercial contract. Surrogate services are advertised. Surrogates are recruited, and operating agencies make huge profits. The commercialization of surrogacy has raised fears of a black market and of baby selling and breeding farms; turning impoverished women into baby producers and the possibility of selective breeding at a price. Surrogacy degrades a pregnancy to a service and a baby to a product. Surrogacy arrangements have made child a saleable commodity, and complications have arisen regarding the rights of the surrogate mother, the child, and the commissioning parents. As there is no legal provision to safeguard the interests of the surrogate mother, the child, or the commissioning parents in India, looking at such an issue from commercial or business point of view has complicated the matter further. For example, the surrogate may be forced to terminate the pregnancy if desired by the contracting couple and she will not be able to terminate it if it is against the desire of the couple. She has no right whether to abort the baby or keep it and continue with the pregnancy even if it her womb which is carrying the baby. There have been instances where the contracting individual has specified the sex of the baby as well and even refused to take the baby if it was born with birth defects and filed a suit against the surrogate saying she had broken the contract. In surrogacy, the rights of the child are rarely considered. Early handover of the child hampers breastfeeding. Transferring the duties of parenthood from the birthing mother to a contracting couple is denying the child its claim to both the mother and the father. It could affect the psycho-social well-being of children who are born as a result of a surrogate motherhood arrangement. A shocking case of surrogacy was recently unearthed in the
Bombay International Airport, where a foreigner couple came for surrogacy arrangements in India in order to get an organ transplant to their sick child in their country\(^1\). The practice of renting a womb and getting a child is similar to outsourcing pregnancy. The volume of this trade is estimated to be around $500 million and the numbers of cases of surrogacy are increasing rapidly.

The practice of surrogacy exploits women economically, emotionally and physically. An important factor is that most women who get involved as surrogates do so because they are in desperate need of the money to maintain their family. In addition, agents are often involved and arrange contracts of questionable legality. Those contracts require the women to undergo all the rigors of childbearing, and eventually they have to give the child away. The surrogate mothers are often unaware of their legal rights and due to their financial situation they cannot afford the services of attorneys. Once the surrogate mother has signed the contract, it is impossible for them to escape. The practice of surrogacy represents a new and unique form of slavery of women. During times of slavery, slave women were often used as birth or genetic mothers and as surrogate mothers nowadays, who possessed no legal rights as mothers. In light of the commoditisation of the children, and actually also of themselves, they have the same status as surrogate mothers have in contemporary times. Another similarity is that slave mothers could not speak freely about their pregnancy and the children they carried; an aspect that is also present in surrogacy as a result of social stigma. Poor women may be transformed into a special caste of hired pregnancy carrier. Further, with the commoditisation of labour services of pregnant surrogate mothers, money is being made, which implies that someone is being exploited. Davis continues by saying that surrogacy appears as a procedure generative of life, what is really generated seems to be sexism and profits. Surrogates are physically exploited once they have signed contracts agreeing to give birth to babies for clients\(^2\). If there is a reason to abort the foetus, because of medical reasons or client’s demands, the surrogate mother must comply. To make matters worse, if the pregnancy is indeed aborted, the surrogates often receive just a fraction of the original payment. The contracts can also place liability on the mother for risks

\(^1\) Hindustan Times, dated 7th August 2008, Nation Page, pg. 13, column 2
including pregnancy-induced diseases, death and post-partum complications. It is further observed that many surrogate mothers face emotional problems after having to relinquish the child.

Further, the thought that if it were okay to think of children as property, then it would be okay to buy and sell them; and if it is not done to buy and sell them, then maybe it is not done to think of children as property. If some (surrogate) children are conceived as market commodities because there is a practice of paying money for relinquishing parental rights, then every child can be considered a commodity. As a matter of fact, we all are commodities, because we used to be children ourselves. If children are viewed as exchangeable market commodities, it might make the self-conception of those children as persons impossible. Therefore, if conceiving children as commodities has a negative effect on personhood, it means that baby selling, and surrogacy for that reason, is wrong. As a consequence: to permit surrogacy would be an irrational exception to the baby selling laws if that distinction is based on genetic relationship does not hold good. If legislation is passed which enables legal surrogacy arrangement, then the laws against baby selling in general should also be reconsidered.

Therefore, the risks and the disadvantages involved in the surrogacy arrangements often prove detrimental to the interests of the surrogate mother, and the child thus resulting in the repugnancy of the human dignity vested with both the surrogate mother and the child.

**COMMERCIALIZATION OF CHILD BIRTH**

Originally, surrogacy happened within families and friends. Known surrogates would give birth for infertile family members or friends. This was an altruistic deed as these surrogates were generally not paid for it. Over the last few decades however, there is a noticeable trend of the commercialization of surrogacy. Surrogacy turns a normal biological function of a woman’s body into a commercial contract. Surrogate services are advertised, surrogates are recruited and operating agencies make large profits. The commercialization of surrogacy raises fears of a black market and baby-selling, breeding farms, turning impoverished women into baby producers and the possibility of selective breeding at a price. Surrogacy degrades a pregnancy to a service and a baby to a product. Commercial surrogacy challenges the conventional assumptions
of maternal bonding which is based on the concept of natural and instinctive link between the mother and her foetus /child. Maternal bonding is effectively an emotion integral to the physiological process of child birth and is deeply rooted in the cultural context of motherhood.

The supposed benefits of surrogacy are created by a capitalist patriarchal society. It is assumed that there is an equal exchange – money paid for the service rendered. In reality the contract between the parties to surrogacy would not exist if the parties were equal. The woman must give more than an egg to gestate a child – an important gender difference. Within this framework the contract is always biased in favour of the financially secure male. Therefore, the freedom of the surrogate mother is an illusion. The arbitration of rights hides central social and class issues, which makes surrogacy contracts possible. In addition, bio-ethicists are concerned that Indian surrogates are badly paid, and working as surrogates in a country with a comparatively high maternal mortality rate.

Moreover, commercial surrogacy has given rise to several ethical issues. It seems not to be ethical for someone to create a human life with the intention of relinquishing it. This appears to be the primary concern for surrogate arrangements since the surrogate mother is providing germinal material only upon the assurance that someone else will take responsibility for the child she helps to create. The surrogate mother provides her ovum with the clear understanding that she has to avoid responsibility for the life she creates and she has to dissociate herself from the child in exchange of some other benefit such as money. In such a way, at the deepest level surrogate arrangements cannot be viewed as ethical, because they involve a change in motive for giving birth for the sake of some other benefits (money).³

LEGAL ISSUES

There are certain legal issues may arise out of the process of Artificial Insemination including matrimonial relations, Legitimacy of child, Child’s right to know Vs. Donor’s right of privacy, Rights of child in various personal Laws and property laws and many more.

In India, where no legislation enacted and at the same time judicial consideration of issues is also required to settle the issues. Though, some issues have been considered by the judiciary in various countries, so as to enable us to analyze the legal principles laid down in those matters, which may consider as settled issues.

DOES IT AMOUNT TO ADULTERY

Whether, marriage may nullify on the ground of non-consummation of marriage in case of Artificial Insemination by Wife.......? The general opinion is that this does not amount to non-consummation leading to nullity of marriage.

Whether, Artificial insemination by wife in absence of Husband’s consent amounts to adultery...? Canadian Supreme Court replied it affirmative and held in Orford Vs. Orford⁴ that recourse to Artificial Insemination without consent of husband amounted to the adultery. This verdict of Canadian Supreme Court was not supported by the Courts in other Countries. In Maclennon Vs. Maclennon⁵ the Scottish trial Court held that it does not amounted to adultery. Now a day it nowhere considered as adultery⁶.

As far as India is concerned, section 497 of I.P.C. sexual Intercourse is pre-condition, so no question of Adultery arises in India in case of Artificial Insemination⁷.

LEGITIMACY OF CHILD IN ARTIFICIAL INSEMINATION

The most important issue arises from the Artificial insemination is the legitimacy of the child.

The desire of a child in particular male was very natural in the all early societies and this was very boldly declared in VEDAS, and also by our ancient writers like YAJNAVALKYA and MANU, and to beget a son various methods were popular and practiced which our ancient laws permit.

⁵ www.plukaservisi.com/alt/58-SLT-12, also referred in ibid at page 236
⁷ Section 497 of Indian Penal Code 1860
AURASA was said to be a legitimate child begotten by man with his own lawfully wedded wife. Other sons were, KSHETRAJA (Son by another man appointed by husband). GUDHAJA (Son by another unknown man, brought forth by wife secretly i.e. unknown adultery). KANINA (Son secretly born by unmarried damsels in her father's house). PUTRIKA PUTRA (Son of an appointed daughter who was given in the marriage to bridegroom). SAHODHAJA (Son begotten when a man marries, either knowingly or unknowingly with a pregnant maiden). POUNARBHAVA (Son begotten by a man on a twice married woman).

SONS BY ADOPTION were DATTAK (Son of same caste given as a gift to a man). KRITA (Son sold by its parent to a man). KRTRIMA (Orphan son being adopted). SVAYAMDATTA (Abandoned son being adopted). APDVIDDHA (Deserted son being adopted).

In the Mahabharat, Gandhari did not deliver a child rather delivered a semi solid material which was divided by Maharishi Vyas into 100 pieces and planted them in different pans. Thus, the 100 Kauravas were born. Similarly, Maharishi Bhardwaj saw a divine nymph coming out of the water after having a bath and seeing such a beautiful woman, he felt discern and deposited his semen in a pot used for yagna called Darona. This is from where Dronacharya was born and named after the vessel. These could also be referred to as test tube babies.8

Worldwide, surrogacy spins a web of emotional, social and legal issues. Mythological surrogate, mothers are well known. Yashoda played mother to Krishna though Devki and Vasudev were biological parents. Gandhari made Dhritrashtra the proud father of 100 children, though he had no biological relation with them.

The Hindu Law and the Mohammedan Law raise similar presumptions as stated in the section 112 of Evidence Act 18729, regarding legitimacy, but while English Law give importance to the time of birth, The Hindu Law and the Mohammedan Law give importance to the time of conception.

8 Dr. Justice B.S. Chauhan, Law, Morality & Surrogacy - with Special Reference to Assisted Reproductive Technology, NYAYA DEEP, October 2012, 3 at page 7
9 Section 112 Indian Evidence Act 1872
Section 16 of Hindu Marriage Act 1955 specifically provides that a child of a null and void marriage under section 11 of the Act or annulled under section 12 shall be legitimate.\textsuperscript{10} Section provides:-

\textit{Legitimacy of children of void and voidable marriages:-}

1. Notwithstanding that a marriage is null and void under section 11, any child of such marriage who would have been legitimate if the marriage had been valid, shall be legitimate...

2. Where a decree of nullity is granted in respect of a voidable marriage under section 12, any child begotten or conceived before the decree is made, who would have been the legitimate child of the parties to the marriage if at the date of the decree it has been dissolved instead of being annulled, shall be deemed to be their legitimate child Notwithstanding the decree of nullity.

3. Nothing contained in subsection 1 or sub-section 2 shall be construed as conferring upon any child of a marriage which is null and void or which is annulled by a decree of nullity under section 12, any right in or to the property of any person other than the parents, in any case where, but for passing of this Act, such child would have been incapable of possessing or acquiring any such rights by reason of his not being the legitimate child of his parents”

It clearly appears from the language of the section that the child will have all rights over the property of his parents but it is clearly mentioned that he will have no right over the property of Hindu Undivided family and he will have no right over the property of others by virtue of being heirs of agnet or cognet categories.

Under Muslim Law the Putative father is not recognized for any purpose. It clings to the concept of “filius nullis”. Under Islamic law, conception during lawful wedlock determines legitimacy of the child. There is no process recognized under the Muslim Law which confers legitimacy on an illegitimate child. However Mohammedan have adopted

\textsuperscript{10} Section 11 and 12 Hindu Marriage Act 1955

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“acknowledgement of paternity” which are preventive measures to save the children from being bastardised. Mohammedan law has made a special provision for conferring legitimacy on or rather recognizing the legitimacy of a child, whether a son or daughter by the doctrine of acknowledgement of Ikrar. It is an acknowledgement of paternity by his putative father. The person acknowledged Zina, which is adultery in Muslim Law, as he would be if his mother could not possibly have been lawful wife of the acknowledger at any time when he could have been begotten, as where the mother was at that time the wife of other man. Adoption or any equivalent of the same is also not recognized in Muslim Law. It is conclusively presumed that a child born within less than 6 months after the marriage of his mother cannot have been begotten by her husband in lawful wedlock11.

As far as maternity is concerned Quran Shareef states 3 stages to ascertain maternity i.e. conception, delivery and feeding. In this concept, child through surrogacy has not a valid child of a mother through surrogacy arrangement.

For the legal purposes, paternity is a question based on genetic factor. Use of the husband’s sperms for insemiating the wife either in vitro or in utero does not pose any problem to the question of paternity of the offspring. However, the use of donated sperms changes the whole scenario.

The main problem with section 112 of the evidence Act is that it presumes sexual intercourse is absolute essential for the conception of a child. In non access clause of this section it is specifically mentioned that if a man could not possibly have had sexual intercourse it cannot be his child. Section 112 read as follows:-

“112. Birth during marriage, conclusive proof of legitimacy. -- The fact that any person was born during the continuance of a valid marriage between his mother and any man, or within two hundred and eighty days after its dissolution, the mother remaining unmarried, shall be conclusive proof that he is the legitimate son of that man, unless it can be shown that the

11 Caesar Roy, Preumption as to legitimacy in section 112 of Indian Evidence Act need to be amended, 54JILJ 2012, 382 at page 388.
parties to the marriage had no access to each other at any time when he could have been begotten.\textsuperscript{12}

Indian Courts have been considered it as it provided in the Act. Hon’ble Apex Court held in Goutam Kundu v. State of W.B. :-

“24. This section requires the party disputing the paternity to prove non-access in order to dispel the presumption. “Access” and “non-access” mean the existence or non-existence of opportunities for sexual intercourse; it does not mean actual “cohabitation\textsuperscript{13}”.

In this Judgement Hon’ble Supreme Court denied the necessity of cohabitation and held that mere access serves the purpose of the section.

Similar view was taken by the Hon’ble Apex Court in Kamti Devi v. Poshi Ram and denied the prayer for DNA test to ascertain the paternity and held that it is irrebuttable presumption. Hon’ble Court held :-

“10. ........The result of a genuine DNA test is said to be scientifically accurate. But even that is not enough to escape from the conclusiveness of Section \textbf{112} of the \textbf{Act} e.g. if a husband and wife were living together during the time of conception but the DNA test revealed that the child was not born to the husband, the conclusiveness in law would remain irrebuttable. This may look hard from the point of view of the husband who would be compelled to bear the fatherhood of a child of which he may be innocent. But even in such a case the law leans in favour of the innocent child from being bastardised if his mother and her spouse were living together during the time of conception........\textsuperscript{14}.”

The concept was further strengthened and Hon’ble Apex Court held in Banarsi Dass v. Teeku Dutta, that:-

\textbf{13. We may remember that Section 112 of the Evidence Act was enacted at a time when the modern scientific advancements with deoxyribonucleic acid (DNA) as well as}
ribonucleic acid (RNA) tests were not even in contemplation of the legislature. The result of a genuine DNA test is said to be scientifically accurate. But even that is not enough to escape from the conclusiveness of Section 112 of the Evidence Act e.g. if a husband and wife were living together during the time of conception but the DNA test revealed that the child was not born to the husband, the conclusiveness in law would remain irrebuttable. This may look hard from the point of view of the husband who would be compelled to bear the fatherhood of a child of which he may be innocent. But even in such a case the law leans in favour of the innocent child from being bastardised if his mother and her spouse were living together during the time of conception. Hence the question regarding the degree of proof of non-access for rebutting the conclusiveness must be answered in the light of what is meant by access or non-access as delineated above.\footnote{Banarsi Dass v. Teeku Dutta, (2005) 4 SCC 449}

In this manner Court held that presumption under section 112 of the evidence Act is ir-rebuttable and even if DNA test reveals that child does not the child of claimed father, even though, the presumption under section 112 will remain ir-rebuttable. Hence, Court denied to permit DNA test to ascertain the paternity and considered only non access as the tool of denial of paternity as provided under non access clause of section 112. Later on, the view was diluted up to some extent and held that:-

“22. In our view, when there is apparent conflict between the right to privacy of a person not to submit himself forcibly to medical examination and duty of the court to reach the truth, the court must exercise its discretion only after balancing the interests of the parties and on due consideration whether for a just decision in the matter, DNA test is eminently needed. DNA test in a matter relating to paternity of a child should not be directed by the court as a matter of course or in a routine manner, whenever such a request is made. The court has to consider diverse aspects including presumption under Section 112 of the Evidence Act; pros and cons of such order and the
test of “eminent need” whether it is not possible for the court to reach the truth without use of such test.”

But recently Hon’ble Apex Court has considered the presumption under section 112 of the Evidence Act as rebuttable presumption if the evidence is sufficient. In Nandlal Wasudev Badwick Vs. Lata Nandlal Badwick Hon’ble Apex Court held:-

“20. As regards the authority of this Court in the case of Kamti Devi (Supra), this Court on appreciation of evidence came to the conclusion that the husband had no opportunity whatsoever to have liaison with the wife. There was no DNA test held in the case. In the said background i.e. non-access of the husband with the wife, this Court held that the result of DNA test “is not enough to escape from the conclusiveness of Section 112 of the Act”. The judgment has to be understood in the factual scenario of the said case. The said judgment has not held that DNA test is to be ignored. In fact, this Court has taken note of the fact that DNA test is scientifically accurate. We hasten to add that in none of the cases referred to above, this Court was confronted with a situation in which DNA test report, in fact, was available and was in conflict with the presumption of conclusive proof of legitimacy of the child under Section 112 of the Evidence Act. In view of what we have observed above, these judgments in no way advance the case of the respondents.”

In this case court differentiated its previous Judgment in Banarsi Dass v. Teeku Dutta regarding the rebuttability of the presumption under section 112 and held that presumption cannot be over-ride conclusive evidence.

Now the question left that in case of donated sperm, the DNA of the child will match with the donor, who never had access to the mother of the child in question.

In a case where a widow uses her dead Husband’s preserved sperms to get pregnant after his death, and the complication is that

17 Nandlal Wasudev Badwick Vs. Lata Nandlal Badwick, 2014 (2) SCC 576
18 Supra Note 16
section 112 requires “continuance of a valid marriage” and the child, in this case will unfortunately born after the marriage has ceased, it can easily be proved to be illegitimate\textsuperscript{19}.

On applying section 112 of Evidence Act to surrogacy, whereby a woman agrees to become pregnant and deliver a child for a contracted party as a gestational carrier to deliver after having been implanted with an embryo. For example Z is the surrogate mother of A, and X is his genetic mother, then according to section 112 Z’s Husband shall be legitimate father of A, who is nowhere involved\textsuperscript{20}.

So, in light of the above discussion it is crystal clear that any kind of conclusive presumption has no scope to ascertain paternity or legitimacy of a child when conclusive evidence can easily be obtained with the aid of technology developed in recent past, though there is apparent conflict between the right to privacy of a person not to submit himself forcibly to medical examination and duty of the court to reach the truth, the court must exercise its discretion only after balancing the interests of the parties and on due consideration whether for a just decision in the matter, DNA test is eminently needed.

Presumption of legitimacy of the child was also considered in various countries in reference to an AI child and a Newyork Court in Strad Vs. Strad refused the plea of husband on the ground that after giving consent of Artificial Insemination to his wife, he potentially adopted or semi adopted the child and child was entitled to same rights as those required by a foster parent, who formally adopted the child\textsuperscript{21}.

In Doomboss Vs. Doomboss, the court found that in the absence of consent of the husband for Artificial Insemination, child do conceived is not a child born in wedlock and therefore considered as Illegitimate.

This issue was resolved in Britain by legislative intervention. British Parliament passed legislation called \textbf{Human Fertilisation and Embryology Act 1990}. Section 28 of the Act provides:-

\begin{quote}
“If a child born as a result of Artificial Insemination or embryo transfer to a woman who was at the time of artificial
\end{quote}

\textsuperscript{19} Caesar Roy, Supra at P. 390  
\textsuperscript{20} Ibid  
\textsuperscript{21} Sandeep Kulshrestha, Supra note 6 at Page 77
insemination or embryo transfer, married, then her husband will be treated as father of the child.\textsuperscript{22}

A number of Countries including Germany, Newzealand, Nigeria, Several states in Australia and USA have resolved this controversy through legislative intervention and have enacted their respective Laws clarifying the legitimacy of child born out of Artificial Insemination or embryo transfer.

In India concept of legitimacy is mainly based on presumption, being the principle of Evidence. Since the language of the Act is quite clear, left very limited scope for judicial intervention, though, the trend shows that court is constructing the issue liberally.

Another problem arose when US gay couple (Fister and Michael) rented a womb in Hyderabad. US Citizen Brad Fister had come to Hyderabad in 2009 when he donated his sperm which was fused with an egg donated by an Indian egg donor. This is a first such case of two fathers.

Since, section 377 of Indian Penal Code provides:

\begin{quote}
377. Unnatural offences.-- Whoever voluntarily has carnal intercourse against the order of nature with any man, woman or animal, shall be punished with imprisonment for life, or with imprisonment of either description for a term which may extend to ten years, and shall also be liable to fine.\textsuperscript{23}
\end{quote}

From the bare perusal of this provision it clearly appears that the homosexuality is an offence in India and thus, Gay marriage is not a recognized marriage form in India. In this situation a child born out by any procedure would not be considered as legitimate child of such couple.

Humble researcher met an Australian Gay father at Hyderabad stayed there to have his child and asked the same question, he simply replied that i nowhere mentioned in the records that we are gay couple. My legal advisor suggested me to register myself as single parent that I did.

\textsuperscript{22} Human Fertilisation and Embryology Act 1990
\textsuperscript{23} Section 377 of Indian Penal Code 1860
CITIZENSHIP

India draws to her shores a large population of foreigners besides the NRIs for surrogacy. The commissioning parents of the child born of surrogacy, especially foreigners, face problems with respect to his/her citizenship. It is the conflict of law complicates situations.

The citizenship act, 1955 provides that citizenship in India can be acquired by birth, descent, registration, naturalization, and incorporation of territory. The issue of citizenship of the child born through surrogacy arrangement of the intended parent’s country does not recognize it, was first arose in the Baby Manzi’s case.

Baby Manji case

Baby Manji is a child born to an Indian surrogate. Her commissioning parents were a couple from Japan, who filed for divorce shortly before the child was born. The father, still wanting to take care of the child, faced severe legal issues as the Indian law prohibits single men to adopt. Neither the intended mother nor the surrogated mother wanted to take custody of baby Manji. The baby was eventually permitted to leave for Japan after the Japanese government issued a one-year visa to her on humanitarian grounds. However her grandmother needed to accompany her, because she was temporarily given custody over the baby. As a result of this case the debate within India about surrogacy has intensified. In the controversy that followed, several infirmities in the arrangement came to light including the absence of a legal contract between the parties, a fact that many saw as a worrying reminder of the potential for exploitation of native surrogates.

JAN BALAZ CASE

Yet another instance of such a nature came up before Gujrat High Court in Jan Balaz’s case. In a land mark judgment, the Gujarat High Court has held the surrogate mother as the ‘Natural Mother’ and her nationality

\[24\] Citizenship Act, 1955, s. 3  
\[25\] Ibid, s 4  
\[26\] Ibid, s 5  
\[27\] Ibid, s 6  
\[28\] Ibid, s 7  
\[29\] Baby Manji Yamada Vs Union Of India and Anr, AIR 2009 SC 84  
has to be considered alone to decide the citizenship of new-born babies irrespective of the nationality of the father. The Judgment was delivered in the case of a German National, Jan Balaz who had sought Indian passport for his turns, Nikolas and Leonard, born to Surrogate mother Martha Khristi in Anand in central Gujarat last year. The facts are Mr. Balaz and his wife, Susanne Lohle, came to India to seek Dr Patel’s help as Susanne could not produce ova and conceived a child. An unnamed Indian woman donated eggs, which were fertilized with Balaz’s sperms and planted in Martha’s womb. She gave birth to the twins. Mr. Balaz a freelance writer then shifted to U.K. since surrogacy was banned in Germany and applied for Indian passports, for his boys so that he can take them to U.K. the passports were initially issued but later he was asked by the Ahmedabad passport office to surrender the passports on the ground that the column of mother’s name carried that of Susanne who did not conceive the children and violated the Birth and Death Registration Act, 1969. Mr. Balaz after surrendering the passports moved to High Court to get them back, so that he could take the boys along with him and make them citizens of his country. At this juncture the Honorable Court observed that a lot of legal, moral and ethical issues arise for consideration, which has no precedents in this country. The court also observed that the main concern is about the two new born innocent babies much more than the rights of the biological parents, surrogate mother or the donor of the ova. Upholding the citizenship rights of the boys, the court said, ‘we, in the present legal frame-work, have no other go but to hold that the babies born in India to the gestational surrogate are citizens of this country and therefore entitled to get passports’ and directed the passport authorities to release the passports withdrawn from them. In this context the court observed that a comprehensive legislation defining the rights of a child born out of a surrogacy agreement, rights and responsibilities of a surrogate mother, egg donor, legal validity of the agreement, the parent child relationship, responsibilities of the infertility clinic was also required.

On the issue of citizenship the court held that on the basis of the Indian Evidence Act, 1872 “No presumption can be drawn that child born out of a surrogate mother, is legitimate child of commissioning parents, so as to have a legal right to parental support, inheritance and other privileges of a child born to a couple through their sexual intercourse.”
The Court observed the babies born to surrogate mothers in India would be Indian Citizen\(^{31}\) and therefore entitled to get Passport. Following this, the German Embassy issued Visas to the children on the condition that the commissioning parents would duly adopt the children under the German Law on arrival.

These problems exist because surrogacy contracts are often not clear and hold no legal value. An explanation for this lies probably in the assumption that up until now, medical technology, especially reproductive technology, needed no justification. Its 'benevolent' nature was taken for granted. However with the commercialization of surrogacy, social, demographic, ethical, legal and philosophical issues have been raised. As the debates have shown, these developments have the ability to alter not only the face, but the very soul of human civilization. It might bring about the restructuring of society on lines of a 'reproductive brothel model' in which women can sell reproductive capacities the same way old time prostitutes sold sexual ones. Currently, in India, due to the fact of non-developed legislation, disputes over surrogate parenting often go to court. Even only few examples of judicial intervention are available, not sufficient to explain this controversy. Therefore, clear and enforceable laws should be implemented.

Though, as a step to curb such issues from cropping up wherein the commissioning couple’s place of domicile doesn’t recognise surrogacy and the issue of determination of citizenship of the children born come up, the Ministry of Home Affairs, Government of India brought about a change in Visa regulations, in 2013,\(^{32}\) the Government made its stand clear on the VISA regulations for foreign nationals coming to India for surrogacy. In its order it is said that a tourist VISA, which is most commonly and frequently used by foreign nationals, is an inappropriate one. It pronounced that so such relaxation would be given and all such couples must obtain the medical visa for such purposes which may be grant on the fulfilment of a number of conditions. Among others are the condition that the couple must have been married for at least two years and letter from the embassy of the their respective country must be enclosed with the visa application stating clearly that “(a) the country recognises surrogacy and

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\(^{31}\) As per section 3 of Citizenship Act 1955  
\(^{32}\) http://mha1.nic.in/pdfs/CS-GrntVISA-29112.pdf (last visited on march 27, 2014)
(b) the child/children to be born to the commissioning couple through the Indian surrogate mother will be permitted entry into their country as a biological child/children of the couple commissioning surrogate.”

Even though, some measures have been taken by the Government, a level of uncertainty nevertheless remains.

ANONYMITY OF DONOR

The technique involves artificial insemination of other women with the sperm of the barren woman’s husband. After surrogate birth the baby is handed over to its Biological father and his wife. It is now also possible to remove a matured healthy ovum from the wife and fertilized it with the Husband’s sperm in-vitro in the specialized laboratory and re-implants this fertilized ovum (Embryo) in the hired womb of another woman. The child born out of this arrangement may search for his surrogate Mother or donor father or mother, so an important aspect of artificial insemination is the identity of donor or surrogates. Whether Surrogates or donor have the right of privacy...

Article 12 of the Universal Declaration of Human Rights (1948) refers to privacy and it states:

“No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence nor to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks."

Article 17 of the International Covenant of Civil and Political Rights (to which India is a party) refers to privacy and states that:

“No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home and correspondence, nor to unlawful attacks on his honour and reputation."

The European Convention on Human Rights, which came into effect on Sept. 3, 1953, also states in Art.8:

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33 Ibid
"1. Everyone has the right to respect for his private and family life, his home and his correspondence.

2. There shall be no interference by a public authority except such as is in accordance with law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the protection of health or morals or for the protection of the rights and freedoms of others."

Anonymity of donor is also an important aspect to be considered with whether it should be secret or a child has right to know his origin is a question of debate.

Sweden is the First Country provides right to a child to trace his origin. Austria also allows a child on maturity to access to information about the origin but Switzerland, France, Canada, Norway and Denmark do not allows offspring any information. In U.S. there is no legislation, it either Federal or State level, that either provided or enforces anonymous donation. The matter is regulated by non legal binding professional guidelines which recommended the anonymity or identity.

In U.K. The Human Fertilisation and Embryology Act 1990 provides limited access to knowledge of origin to get information to an AID child limited to as to whether the person of woman whom he is going to marry is related.

Two cases decided by the Supreme Court of India where the foundations for the right to privacy were laid, concerned the intrusion into the home by the police under State regulations, by way of `domiciliary visits'. Such visits could be conducted any time, night or day, to keep a tag on persons for finding out suspicious criminal activity, if any, on their part. The validity of these regulations came under challenge. In the first one, Kharak Singh v. State of UP, the UP Regulations regarding domiciliary visits were in question and the majority referred to Munn v. Illinois and held that though our Constitution did not refer to the right to privacy expressly, still it can be traced from the right to `life' in Art. 21. The majority did not go into the question whether these visits violated the

34 Kharak Singh v. State of UP, 1964(1) SCR 332
35 Munn v. Illinois (1876) 94 US 113 downloaded from u-s-history.com/pages/h855.html on 15/3/2014
`right to privacy'. But, Subba Rao J while concurring that the fundamental right to privacy was part of the right to liberty in Art. 21, part of the right to freedom of speech and expression in Art. 19(1)(a), and also of the right to movement in Art. 19(1)(d), held that the Regulations permitting surveillance violated the fundamental right of privacy. In the discussion the learned Judge referred to Wolf v. Colorado: (1948) 338 US 25. In effect, all the seven learned Judges held that the `right to privacy' was part of the right to 'life' in Art.21.

We now come to the second case, Govind v. State of MP\textsuperscript{36}, in which Mathew, J. developed the law as to privacy from where it was left in Kharak Singh. The learned Judge referred to Griswold v. Connecticut\textsuperscript{37} where Douglas, J. referred to the theory of penumbras and peripheral rights and had stated that the right to privacy was implied in the right to free speech and could be gathered from the entirety of fundamental rights in the constitutional scheme, for, without it, these rights could not be enjoyed meaningfully. Mathew, J. also referred to Jane Roe v. Henry Wade\textsuperscript{38}, where it was pointed out that though the right to privacy was not specifically referred to in the US Constitution, the right did exist and "roots of that right may be found in the First, Fourth and Fifth Amendments, in the penumbras of the Bill of rights, in the Ninth Amendment, and in the concept of liberty guaranteed by the first section of the Fourteenth Amendment'. Mathew, J. stated that, however, the `right to privacy was not absolute' and that the makers of our Constitution wanted to ensure conditions favourable to the pursuit of happiness as explained in Olmstead v. United States\textsuperscript{39}; the privacy right can be denied only when an `important countervailing interest is shown to be superior', or where a compelling State interest was shown. (Mathew, J. left open the issue whether moral interests could be relied upon by the State as compelling interests). An right to privacy, the learned Judge said, (para 24) must encompass and protect the personal intimacies of the home, the family, marriage, motherhood, procreation and child bearing. This list was however not exhaustive. He explained (para 25) that, if there was State intrusion there

\textsuperscript{36} Govind v. State of MP [1975] 2 SCC 148
\textsuperscript{39} Olmstead v. United States (1927) 277 US 438 (471) www.law.cornell.edu/.../ussc_cr_0277... [downloaded on 25/3/2014]
must be ‘a reasonable basis for intrusion’. The right to privacy, in any event, (para 28) would necessarily have to go through a process of case-by-case development.

The reasons given by Mathew, J. in Govind show that, the right to privacy has been implied in Art. 19(1)(a) and (d) and Art.21; that, the right is not absolute and that any State intrusion can be a reasonable restriction only if it has reasonable basis or reasonable materials to support it.

A two-judges Bench in R. Rajagopal v. State of Tamil Nadu\(^{40}\) held the right of privacy to be implicit in the right to life and liberty guaranteed to the citizens of India by Article 21. "It is the right to be let alone". Every citizen has right to safeguard the privacy of his own. However, in the case of a matter being part of public records, including court records, the right of privacy cannot be claimed. The right to privacy has since been widely accepted as implied in our Constitution, in some other cases, namely, PUCL v. Union of India, (1997) 1 SCC 301; Mr. X v. Hospital `Z', (1998) 8 SCC 296; People's Union for Civil Liberties v. Union of India, (2003) 4 SCC 399; Sharda v. Dharmpal, (2003) 4 SCC 4931 etc.

In Mr. X v. Hospital `Z' Hon’ble Apex Court held that:-

“25. As one of the basic Human Rights, the right of privacy is not treated as absolute and is subject to such action as may be lawfully taken for the prevention of crime or disorder or protection of health or morals or protection of rights and freedoms of others.

26. Right of Privacy may, apart from contract, also arise out of a particular specific relationship which may be commercial, matrimonial, or even political. As already discussed above, Doctor-patient relationship, though basically commercial, is, professionally, a matter of confidence and, therefore. Doctors are morally and ethically bound to maintain confidentiality. In such a situation, public disclosure of even true private facts may amount to an invasion of the Right of Privacy which may sometimes lead to the clash of person’s “right to be let alone” with another person’s right to be informed.

\(^{40}\) R. Rajagopal v. State of Tamil Nadu (1994) 6 SCC 632
27. Disclosure of even true private facts has the tendency to disturb a person’s tranquility. It may generate many complexes in him and may even lead to psychological problems. He may, thereafter, have a disturbed life all through. In the face of these potentialities, and as already held by this Court in its various decisions referred to above, the Right of Privacy is an essential component of right to life envisaged by Article 21. The right, however, is not absolute and may be lawfully restricted for the prevention of crime, disorder or protection of health or morals or protection of rights and freedom of others.

28. Having regard to the fact that the appellant was found to be HIV(+), its disclosure would not be violative of either the rule of confidentiality or the appellant’s Right of Privacy as Ms. Akali with whom the appellant was likely to be married was saved in time by such disclosure, or else, she too would have been infected with the dreadful disease if marriage had taken place and consummated.41”

From the above discussion it is quite clear that right to privacy though protected by the Constitution of India, but it is not absolute right and is subject to such action as may be lawfully taken for the prevention of crime or disorder or protection of health or morals or protection of rights and freedoms of others.

Now another question arises i.e. right of privacy vis-a-vis right to know, but it is also clarified by Hon’ble Apex Court that right of Privacy will prevail over right to know though for the its disclosure would not be violative of either the rule of confidentiality or the appellant’s Right of Privacy in exceptional cases as discussed above.

Even though in India, system of prohibited degree is provided in section 3(g) of Hindu marriage Act 1955 and as per section 5 (iv) of the Act the precondition of a valid Hindu Marriage is:-

“…………………………………………………………………………………………...

41 Mr. X v. Hospital Z (1998) 8 SCC 296
iv. The Parties are not within the degrees of prohibited relationship unless the customs or uses governing each of them permits of a marriage between the two,

v. The Parties are not Sapindas of each other unless the customs or uses governing each of them permits of a marriage between the two,”

Unfortunately, there is no law to regulate such identity of or genetic information and to about any critical circumstances a law like Sweden or at least like U.K.

LEGAL VALIDITY OF SURROGACY AGREEMENTS

In the case of surrogacy, there may be questions about enforcing a contract with the surrogate mother, e.g. whether such contracts may be valid in view of the provisions of public policy, particularly under Section 23 of the Indian Contract Act, 1872; whether the child to be handed over can be considered a saleable commodity for consideration. A party may refuse to have its contract acted upon, or the child is not according to the specifications agreed upon in ordinary law of contract, the finished goods can be rejected and damages can be claimed in such situations. 42

Whether surrogacy contracts are the same as other contracts? It raises a very serious issue of morality and gives rise to the question of whether insemination amounts to adultery and whether a surrogacy agreement is a case of exploitation of the helplessness of poor women who are selected as surrogate mothers. Surrogacy also raises complex questions of succession by a child born of a surrogate mother, as under Section 26 of the Special Marriage Act, 1954 and Section 16 of the Hindu Marriage Act, 1955, children of voidable and void marriages cannot inherit the coparcenary properties of any relative, they can only claim share in self acquired property of the parents. (Vide: Smt. PEK v. Kalliani Amma & Ors. v. K. Devi & Ors. AIR 1996 SC 1963; and Bharatha Matha & Anr. v. R. Vijaya Renganathan & Ors. AIR 2010 SC 2685). 43

The right to procreation is recognized to be implicit in the right to privacy. The legendary American Case of Roe Vs. Wade 44 has been allowed

42 Dr. Justice B.S. Chauhan, Supra Note 9 at page 9
43 Ibid
44 Supra note 38
to by the Supreme Court of India in a number of cases dealing with the subject matter. In the instant case, the U.S. Supreme Court held that a citizen has the right to be safeguarded the privacy of his born. His family, Marriage, Procreation, Motherhood, child bearing and education among other matters\textsuperscript{45} \textit{Skinner Vs. Oklahoma}\textsuperscript{46} is yet another case that had been widely cited by the Indian Judiciary. The American Court in the instant case held that the right to reproduce is one of the basic civil right of man.\textsuperscript{47} The Andhra Pradesh High Court in V.K. Parthsarathi’s case\textsuperscript{48} held that the right to make a decision about reproduction is essentially a very personal decision either on the part of the man or woman. Necessarily, such a right includes the right not to reproduce the intrusion of the state into such a decision making process of the individual is scrutinized by the Constitutional Court both in this Country and in America with great care\textsuperscript{49}. Likewise, in Kasturalal Lakshmi Reddy Vs. State of J&K\textsuperscript{50} the Supreme Court of India underpinning the analogous notion held that the right to life and personal liberty as enshrined Art. 21 must be interpreted in a broad manner so as to include emit all the barriers of rights which go to makeup the personal liberty of man including the right to enjoy all the materialistic pleasures and to procreate as many children as one pleases. The Courts have nevertheless acknowledged the right to procreate can be subject to reasonable restrictions\textsuperscript{51}.

Surrogacy, though an assisted one, is a method of procreation. In light of the above, Surrogacy Agreements must be afforded the same level of Constitutional protection. The American Courts have granted Constitutional protection to the surrogacy agreements and held that the parties to the surrogacy agreement have a Constitutional right to reproductive privacy\textsuperscript{52}. The Indian Courts too have kept pace with the concern. The Courts a way back in the year 2000 held that the personal decision of the individual about the birth and babies called the right of reproductive autonomy, is a fact of a right of privacy.\textsuperscript{53} The State cannot

\textsuperscript{45} Ibid
\textsuperscript{47} Ibid
\textsuperscript{48} V.K. Parthsarathi Vs. State of Andhra Pradesh AIR 2009 A.P 156
\textsuperscript{49} Ibid
\textsuperscript{50} AIR 1998 SC 1992, affirmed in Javed Vs. State of Haryana AIR 2003 SC, 357
\textsuperscript{51} Diksha Munjal-Shankar, Medical Tourism, Surrogacy & the legal Overtones- The Indian tales, 56ILJ (2014) 62, at page 68
\textsuperscript{53} Parthsarthy Supra Note 34
intervene in matters of private ordering and matters as intimate as reprocreation. With the right to privacy and reproductive autonomy in place, the individuals must be afforded protection on who to exercise this right. In other words, the state cannot interfere in matter of mode of procreation, i.e. whether the individuals procreate naturally or through the use of Assisted Reproductive Technology. Art.21 of the Constitution can be stretched to house the use of Assisted Reproductive Technology by the individual under the auspices of the rights to reproductive privacy and reproductive autonomy.

Surrogacy being one of the various methods of Assisted Reproductive Techniques thus stands sheltered under the umbrella provision of Art. 21 of the Constitution of India.

The Indian Contract Act, 1872 codifies the legal principles that govern the agreements which are enforceable in the Court of Law in India. It provides the basis of validity of any agreement which evolves into a contract on the fulfillment of certain prerequisites. Section 10 of the Indian Contract Act provides the parameters of a valid contract. According to section 10 of the aforesaid act, the following conditions must be fulfilled in order to give rise to a valid contract, viz.

a. there must be an agreement, which must have resulted out of a personal by one party and the acceptance of it by the other,

b. The parties to such agreement must be competent to contract,

c. There should be a lawfull consideration,

d. There object should be lawful,

e. The Parties must enter into the agreement with their free consent,

f. The Agreement must not have been expressly declared to be void

In India, the parties of surrogacy are backed by written agreement between the parties. These agreements are an expression of the personal and acceptance between the parties. This document of concurrence also

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54 India Contract Act 1872 section 2(a)
55 Ibid section 2(b)
56 Ibid, section 11
57 Ibid, section 2(d)
58 Ibid, section 23
59 Ibid, section 14
60 Ibid, section 24-30
cites the amount made to the surrogate mother\textsuperscript{61} and hence, meets the requirement of consideration.

As noted above, any contract to perform an illegal act is void. With respect to surrogacy, the aim is to ward off and forbid the selling of a baby in surrogate parenting associated inc. Vs. Armstrong\textsuperscript{62} the Supreme Court of Kentuky observed that, “the essential consideration is to assist a person or couple who want a baby but are unable to conceive one in the customary manner achieve a biologically related offspring”\textsuperscript{63} and thus drew the contrast between the practice of surrogacy and baby selling, such a remark underpins the argument that the practice has a lawful object in place.

Free consent of the parties is a prerequisite of the validity of the contract and therefore, the parties of the surrogacy agreement must enter into the arrangement in exercise of their free will. With respect to the free consent of the surrogate mother, it is however, immaterial whether or not the surrogate mother is driven by altruistic motives against the given backdrop, one may infer that surrogacy agreement are not only entitled to Constitutional protection but are also valid under the domestic contract law.

Questions may also arise regarding the validity of such contracts with or without the consent of the husband as under the Contract Act, only a major i.e. who is 18 years of age as per the provisions of Indian Majority Act, 1875, is competent to enter into a contract. In India, in spite of several statutory provisions the marriage of the children is solemnized before attaining the majority. There is no provision declaring a child born by a girl before she attains majority as illegitimate or illegal. Therefore, the question may arise as to whether the minor girl, or parents, or husband on her behalf can enter into a contract of surrogacy or artificial insemination.\textsuperscript{64}

In Suchita Srivastava v. Chandigarh Admn.\textsuperscript{65} the Supreme Court held:

\textsuperscript{61} ICMR National guidelines for Accreditation supervision and regulation of ART clinics in India downloaded from www.icmr.com/guidelines
\textsuperscript{62} Supra Note 38
\textsuperscript{63} Ibid
\textsuperscript{64} Dr. Justice B.S. Chauhan, Supra Note 9 at page12
\textsuperscript{65} (2009) 9 SCC 1
“There is no doubt that a woman’s right to make reproductive choices is also a dimension of “personal liberty” as understood under Article 21 of the Constitution of India. It is important to recognize that reproductive choices can be exercised to procreate as well as to abstain from procreating. The crucial consideration is that a woman’s right to privacy, dignity and bodily integrity should be respected. This means that there should be no restriction whatsoever on the exercise of reproductive choices such as a woman’s right to refuse participation in sexual activity or alternatively the insistence on use of contraceptive methods. Furthermore, women are also free to choose birth control methods such as undergoing sterilisation procedures. Taken to their logical conclusion, reproductive rights include a woman’s entitlement to carry a pregnancy to its full term, to give birth and to subsequently raise children. However, in the case of pregnant women there is also a “compelling State interest” in protecting the life of the prospective child. Therefore, the termination of a pregnancy is only permitted when the conditions specified in the applicable statute have been fulfilled. Hence, the provisions of the MTP Act, 1971 can also be viewed as reasonable restrictions that have been placed on the exercise of reproductive choices.”

Furthermore, in early 2000s the ICMR formed and brought out the National Guidelines for Accreditation, Supervision and Regulation Of ART Clinics In India which were later updated in 2005. The ICMR guidelines, irrespective of how far reaching they may seem, are purely persuasive in nature and are not binding. These guidelines have been taken to another level of being the blue print of the draft of the Assisted Reproductive Technology (Regulation) Bill, 2010. The ART Bill attempts to iron out a number of issue which were undressed by the ICMR guidelines on the subject. Nonetheless, being a draft bill, it too lacks the force of Law.

The ICMR guidelines as well as the ART Bill endeavour to put into order various points in question. These includes who can act as a surrogate mother, who can be the commissioning couple, what health and age

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66 ICMR Guidelines, SupraNote 38
67 Art. 13, Constitution of India
requirements must be fulfilled before the potential surrogate mother is said to be fit to act as a surrogate mother, how the agreement may be entered into and what all issues must the agreement expressly addressed in its content etc.\textsuperscript{68}

While the ART bill and the ICMR guidelines try to fill the voids, there exist many issues that arise from the practice which need to be focused on and plugged. These include issues of contractual remedies, determination of parentage of the child born and the child’s citizenship, among others.\textsuperscript{69}

Diksha Munjal-Shankar discussed various possible situations in her article “Medical Tourism, Surrogacy & the legal Overtones- The Indian tales”, which is reproduce in her own words as under:-

A surrogacy agreement brings together two parties, viz. the commissioning couple and the Surrogate mother. They would, most typically, have a written agreement between them detailing payments to be made, custody of the child etc. Simply put, the agreements determined the rights and liabilities of the respective parties. In order to be able to understand the type of challenges that the parties could face, it is vital to identify what possible situations may crop up;

i. The Surrogacy agreement has been signed by the parties. Dering the course of the pregnancy however, the commissioning couple which is genetically related to the child, splits and the respective parents separates. The surrogate mother refuses to take custody of the child born.

ii. On account of medical reasons, the commissioning couple has to put to use a donor-oocyte instead of the oocyte of the commissioning mother. The parties have put the agreement in writing and signed it. The surrogate however, during the course pregnancy develops and emotional attachment with the child and on birth refuses to hand-over the child to the commissioning couple.

iii. The commissioning couple, genetically related to the child, agrees upon and signs the surrogacy agreement with the surrogate mother. However, during the course of pregnancy, the

\textsuperscript{68} ICMR guidelines, Ch. 3; ART bill ch. V, VII
\textsuperscript{69} Diksha Munjal-Shankar, Supra Note 37, at page 70
commissioning parents pass away and the surrogate mother refuses to keep the child.

iv. The Commissioning couple and the surrogate mother agree and sign the surrogacy agreement. The Commissioning couple is genetically related to the child. However, during child-birth due to medical complications, the child is born but the surrogate mother passes away.

v. Similar to situation (iv) with the exception that not only does the surrogate mother die but also the child is still-born.

vi. Similar to situation (iv) with the exception that the surrogate mother who is alive give birth to a child that is still-born or born with birth-defect.

vii. The commissioning couple, genetically related to the child, agrees upon and signs the surrogacy agreement with the surrogate mother. The sum of money, which is agreed to be paid to the surrogate, is however, not –paid in full. The surrogate mother nevertheless gives birth to a healthy baby.

viii. The commissioning couple, genetically related to the child, agrees upon and signs the surrogacy agreement with the surrogate mother with respect to the agreement. However, the commissioning parents default in making the full payment and the surrogate refuses to hand-over the child on birth.

ix. The Surrogate mother enters into the agreement with the commissioning parents who are genetically related to the child. However, prior to the birth of the child, the surrogate mother demands a greater sum of money that was agreed to and that only on the fulfillment of such condition would she had-over the child.

The probable cases highlight the presence of a sort of broad spectrum along with the incident may occur. The situations are laden with a number of legal issues which would make their presence felt only when despite between contracting parties come forth.

**CONTRACTUAL REMEDIES**

Surrogacy agreements may be legally protected under the law. However, it is unclear as to what remedy –damage or specific performance – may be available in the event of a breach by either of the party.
Specific performance of the contract may be suitable only under certain circumstances. If the instance is one which is on the lines of situation (i) The Court may be willing to order specific performance of the contract as the child was born as a result of the intention of the commissioning couple. Also in a case where there has been a default in paying the agreed sum of money as a recompense to the surrogate mother, the court grant specific performance on part of the defaulting party, as in situation(vii).

However, if there is a requirement of relinquishing rights over the child that is sought, the court may be vary of granting a relief of specific performance given the fact that under the prevailing domestic law it is birth mother who is considered to be the mother of the child. Thus in the event that a situation like situation (ii) erupts, the court may not permit the specific performance of the contract.

Damages, which are set as yet another remedy under the contractual law, may be tough call for the courts to take. This is due to sensitive nature of the practice and how it may take a step further from commercialization to actually baby-selling. For instance in situation (vi), if the child is born with some abnormality or birth defect, and in case parents file a suit for damages, it would take the practice into the realm of trading of babies. However, by all means, Indian Courts would be cautious and vigilant to not allow mushrooming of any such system70.

COURT’S RESPONSE TO SURROGACY CASES

Besides, Commercial surrogacy potentially creates several ethical conundrums related to parentage, nationality and situations such as miscarriage or multiple births. Commercial surrogacy is fraught with ethical questions such as what happens to the surrogacy contract in case of a miscarriage, what if the baby is born with serious disabilities and is unwanted, what the nationality of the child is, or what happens if the contracting couple changes their mind about wanting a baby, or if the surrogate dies during childbirth. The Baby Manji case has now prompted the Indian Medical Association to debate the ethical aspects of commercial surrogacy. Commercial surrogacy in India is regulated by the Indian Council of Medical Research (ICMR) guidelines. This situation is

70 Diksha Munjal-Shankar, Supra Note 37 at page 72
widely accepted as inadequate, and the ICMR has drafted the Assisted Reproductive Technology (ART) (regulation) Bill, 2008 – and further amended bill in 2010 after incorporating suggestions from various sections of the society, which is itself proving controversial.

Surrogacy (traditional and gestational), like other forms of assisted procreation, is socially significant in that, parenthood emerges as fragmented across persons who contribute biogenetically, socially and financially to the making of a child. As Almeling (2011) among others suggests, women can separate maternity into several parts: one woman can provide the egg, another can carry the embryo and a third can raise the child – all three can lay claim to motherhood. The fact that kinship connections with offspring are forged through means other than ‘blood’ has particularly destabilised notions of a kinship based in ‘biology’.

In the case of surrogacy in particular, the anxieties to do with biological connectedness seem to resolve in the shift away from ‘traditional’ surrogacy arrangements (where the eggs of the surrogate are used) to the more popular practice of gestational surrogacy (where the surrogate gestates the fertilized embryo but does not contribute any of her own reproductive material).

Gestational surrogacy is preferred by commissioning parents as well as surrogates in the USA, for instance, as it removes the surrogate as a contender for having any ‘real’ (i.e., genetic) ties with the baby she gestates.

Reproductive Tourism and Protection of children

Certainly children are the assets of mankind beyond borders, thus their well being is the paramount concern of all laws pertaining to children. Recent hyper growth in reproductive tourism to the third world countries have ample scope of trafficking of children. Though, it may be a hyper-sensitive approach, but certainly well-being of the children born in India is the prime concern of law. To protect the interest of children going out of the country in maintain the track record of such children is necessary.

71 Maya Unnithan Supra
India participated in the United Nations (UN) General Assembly Summit in 1990, which adopted a Declaration on Survival, Protection and Development of Children and has also acceded to the Convention on the Rights of the Child (CRC) on the 11th December, 1992; and whereas CRC is an international treaty that makes it incumbent upon the signatory States to take all necessary steps to protect children's rights enumerated in the Convention;

In order to ensure protection of rights of children one of the initiatives that the Government has taken for Children is the adoption of National Charter for Children, 2003;

The UN General Assembly Special Session on Children held in May, 2002 adopted an Outcome Document titled “A World Fit for Children” containing the goals, objectives, strategies and activities to be undertaken by the member countries for the current decade;


1. Survival, Life and Liberty;
2. Promoting High Standards of Health and Nutrition;
3. Assuring Basic Minimum Needs and Security;
4. Play and Leisure;
5. Early Childhood Care for Survival, Growth and Development;
6. Free and Compulsory Primary Education;
7. Protection from Economic Exploitation and All Forms of Abuse;
8. Protection of the Girl Child;
9. Empowering Adolescents;
11. Strengthening Family;
12. Responsibilities of Both Parents;
13. Protection of Children with Disabilities;
14. Care, Protection, Welfare of Children of Marginalized and Disadvantaged Communities;

15. Ensuring Child Friendly Procedures.

In furtherance of National Charter for Children, 2003 adopted by Government of India, The Commissions For Protection of Child Rights Act, 2005 has been enacted for the constitution of a National Commission and State Commissions for protection of child rights and children's courts for providing speedy trial of offences against children or of violation of child rights and for matters connected therewith or incidental thereto. Section 13 which appears in Chapter III of the Act is of considerable importance. The same reads as follows:


(1) The Commission shall perform all or any of the following functions, namely:-

(a) Examine and review the safeguards provided by or under any law for the time being in force for the protection of child rights and recommend measures for their effective implementation;

(b) Present to the Central Government, annually and at such other intervals, as the Commission may deem fit, reports upon the working of those safeguards;

(c) Inquire into violation of child rights and recommend initiation of proceedings in such cases;

(d) examine all factors that inhibit the enjoyment of rights of children affected by terrorism, communal violence, riots, natural disaster, domestic violence, HIV/AIDS, trafficking, maltreatment, torture and exploitation, pornography and prostitution and recommend appropriate remedial measures.

(e) look into the matters relating to children in need of special care and protection including children in distress, marginalized and disadvantaged children, children in conflict with law, juveniles, children without family and children of prisoners and recommend appropriate remedial measures;
(f) study treaties and other international instruments and undertake periodical review of existing policies, programmes and other activities on child rights and make recommendations for their effective implementation in the best interest of children;

(g) Undertake and promote research in the field of child rights;

(h) spread child rights literacy among various sections of the society and promote awareness of the safeguards available for protection of these rights through publications, the media, seminars and other available means;

(i) inspect or cause to be inspected any juvenile custodial home, or any other place of residence or institution meant for children, under the control of the Central Government or any State Government or any other authority, including any institution run by a social organisation;

Where children are detained or lodged for the purpose of treatment, reformation or protection and take up with these authorities for remedial action, if found necessary;

(j) inquire into complaints and take suo motu notice of matters relating to, -

(i) Deprivation and violation of child rights;

(ii) Non-implementation of laws providing for protection and development of children;

(iii) non-compliance of policy decisions, guidelines or instructions aimed at mitigating hardships to and ensuring welfare of the children and to provide relief to such children, or take up the issues arising out of such matters with appropriate authorities; and

(k) Such other functions as it may consider necessary for the promotion of child rights and any other matter incidental to the above functions.
2) The Commission shall not inquire into any matter which is pending before a State Commission or any other Commission duly constituted under any law for the time being in force."

Commission under section 14(1) of the Act has also been conferred all the powers of a Civil Court while inquiring into any matter referred to in clause (j) of sub-section (1) of section 13. Steps which the Commission may take after inquiry are described in section 15 which reads as under:-

“15. The Commission may take any of the following steps upon the completion of an inquiry held under this Act, namely:-

(i) Where the inquiry discloses, the Commission of violation of child rights of a serious nature or contravention of provisions of any law for the time being in force, it may recommend to the concerned Government or authority the initiation of proceedings for prosecution or such other action as the Commission may deem fit against the concerned person or persons;

(ii) Approach the Supreme Court or the High Court concerned for such directions, orders or writs as that Court may deem necessary;

(iii) Recommend to the concerned Government or authority for the grant of such interim relief to the victim or the members of his family as the Commission may consider necessary.”

For the purpose of providing speedy trial of offences against children or of violation of child rights, State Government has been empowered to specify a Court of Session with the concurrence of the Chief Justice of the High Court and for appointment of Special Public Prosecutor.

It is most unfortunate that after passing so many years to the enactment of the Act, the Governments are not sincere of its implementation. Recently Hon’ble Apex Court in the Re. Exploitation of Children in Orphanages in the State of Tamil Nadu Vs. Union of India & Ors. 72 Observed:-

72 2014 (2) SCC 180
“It has been brought to our notice that inspite of the emphatic directions that have been issued by this court on 3rd January, 2013 directing all the States and the Union Territories to implement the protective provisions contained in the Protection of Rights of Children from Sexual Offences Act, 2012, the Right of Children to Free and Compulsory Education Act, 2009 and the Commission for Protection of Child Rights Act, 2005, many States and Union Territories have not complied with the same. By order dated 3rd January, 2013, we had also directed the States to file an affidavit indicating the time frame within which the State Commission for the protection of children would be established. By a subsequent order dated 7th February, 2013, further directions were issued to all the States and the Union Territories to comply with the obligations under the aforesaid three Acts, with regard to the establishment of protection institutions/implementation institutions, together with necessary Rules and Regulations. The aforesaid order was to be complied with within a period of three months from the date of receipt of the certified copy of the order. Sadly, we have to notice that in spite of the concern shown not only by this Court but also by the learned counsel appearing for the parties, little or no progress has been made in this regard. Although the affidavits have been filed indicating that the State Commissions have been established yet we find that such establishment is only on paper. In many States, Chairman of the Commission has not been appointed and in some other States even Members have not been appointed. This apart, necessary rules and regulations have also not been framed. This, in our opinion, would be sufficient justification for this Court to take a serious view and initiate appropriate proceedings for contempt of court against the defaulting States and the Union Territories.”

National and State Commissions constituted under the Act of 2005 may play key role for protection of children from such risk. Specifically, when no effective DATA base of ART Clinics could be prepared at any level, no record of child born out of ART procedure/Surrogacy arrangement is available with any authority,
and even it is not clear that which authority owe the responsibility to keep such record, record of such children may be kept by these Commissions and the commission may also enquire into the genuineness of these matters, with the powers already wasted.

It is clearly appears from the above discussion that the welfare of the children is paramount consideration in Indian Laws and Indian Laws provide adequate measures for the protection of children, but certain Indian Laws requires to be amended to carp with this new situation arises of this development in technology.

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Chapter 4

LEGAL PROVISIONS RELATING TO ART WORLD WIDE

Thousands of children are born every year worldwide conceived with the use of assisted reproduction technology ("ART"), bringing sought-after babies to couples who would otherwise be childless. Along with this benefit, however, ART raises several difficult legal issues involving parentage, parental responsibilities, and jurisdictional conflicts. In the most “traditional” situation involving ART—where a husband and wife use their own gametes and the wife gestates the child—there may be no issues regarding parentage. In the eyes of the law, the wife is the child’s mother and the husband is the child’s father. Even this situation, however, has raised thorny legal issues. For example, the couple may choose not to gestate all the embryos conceived from their gametes and instead leave some in frozen storage. Legal issues could arise if the couple later disagrees as to the disposition of those embryos\(^1\). If the couple divorces, one spouse may want to dispose of the embryos, but the other spouse (usually the wife) wants to gestate them and raise the child or children.

There are a couple of countries with genuinely surrogacy-friendly laws attracting the majority of worldwide surrogacy to their territories. Amongst them are the US state of California, India, and the Ukraine. Here, surrogacy is deliberately tolerated by the legislator which has enhanced those countries’ reputation as reliable locations for the surrogacy business. Argentina is about to pass a bill which allows for gestational surrogacy even if it has to be preceded by a court judgment, but it must not be remunerated. Several European countries like Greece and the United Kingdom have also liberalized their family laws but have so far not acquired notable mandates from the international side.\(^2\) The Netherlands has not

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\(^1\) See Helene S. Shapo, Frozen Pre-Embryos and the Right to Change One’s Mind, 12 duke j. Comp. & int’l l. 75 (2002).scholarship.law.duke.edu/…./viewcontent [downloaded on 24/7/2014]

\(^2\) Both jurisdictions demand that intended parents have at least a temporary inland domicile, which apparently discourages prospective parents; Section 54 (4) (b) of the British Human Fertilisation and Embryology Act 2008 and Art. 8 of the Greek Law No. 3089/2002.
banned surrogacy but forbidden agencies arranging surrogacies as well as public offers by or searches for surrogate mothers.³

In many, if not most other European countries, surrogacy is forbidden by law.⁴ A typical example of tight regulation is Germany. The German legislator attempts to avoid split motherhood, to protect the social relationship between the gestational mother and the baby, and to prevent the exploitation of poor women. According to § 1 (1) of the German Embryo Protection Act (ESchG) and §§ 13c, 14b of the German Adoption Agency Act (AdVermiG), someone who assists in effecting a surrogacy or who arranges surrogacies is liable to prosecution. Any private agreement to enter into surrogacy is deemed immoral and thus void. A payment claim stemming from such a contract cannot be enforced by means of public authorities. Other European countries like France and Spain have enacted similar restrictions, however with different administrative and criminal sanctions. This indeed effectively averts surrogacies on their territories as it does in most if not all countries with rigid regulation.

The courts in USA have uniformly held for the spouse who wants to dispose of the embryos⁵. In other cases, even more difficult questions have arisen about parentage and the parties’ rights and obligations toward the child. Examples include cases where third parties contribute the eggs or sperm (or both), where a woman agrees to be a surrogate and gestate a child for others to adopt, or where five parties are involved in the conception and birth of a child (the gamete donors, a surrogate, and a couple that contracts with the surrogate). The volume of litigation regarding all of these issues is steadily increasing. Ongoing issues involving artificial insemination and surrogacy, hence required to be reviewed. After reviewing the current legal framework surrounding assisted reproduction, the lack of uniformity surrounding those judicial decisions that address three issues related to assisted reproduction also required comprehensive analysis i.e.: whether the biological mother’s husband or known sperm donor is legally recognized as the father of the child conceived by artificial insemination, whether the biological mother’s same-sex partner is legally recognized as

the child’s second parent, and whether a surrogate is legally recognized as the mother of the child she has gestated.

CURRENT LEGAL FRAMEWORK

American courts have struggled with the issues that arise with ART, often resolving them with a mixture of common law and statutory law developed in a pre-ART age. Because domestic relations law is generally reserved for the states—unless the parties raise federal constitutional issues—a fractured, state-by-state approach to the subject has arisen, thus raising problems of national harmonization. As a result, many ART-related conflicts have arisen among the states, especially in the areas of single-sex couples and of surrogacy.

The primary attempts to harmonize various areas of law across the states have come from uniform acts and restatements. The uniform act that is most relevant to this topic is the Uniform Parentage Act (“UPA”), Section 5, which was first adopted in 1973 and amended in 2000 and 2002 by Articles 7 and 8 (Article 8 concerns gestational agreements). The original Section 5 of the 1973 UPA was adopted in about eighteen states but dealt only with artificial insemination of a married woman with donor sperm (“AID”). Its purpose was to ensure that the woman’s husband was “treated in law” as the natural father of the AID child and required the husband’s written consent to the insemination as well as supervision of the insemination by a licensed physician. In addition, Section 5 shielded the sperm donor from the legal consequences of paternity; the sperm donor was not treated in law as the natural father. A few states adopted a version of Section 5 of the UPA that applied to unmarried women as well as married ones.

In 1988, the Conference passed another uniform act, the Uniform Status of Children of Assisted Conception Act (“USCACA”), which expanded the coverage of the 1973 UPA to determine the parenthood of children born of in vitro fertilization (“IVF”) as well as AID, and included differing

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8 The uniform acts are suggested statutes promulgated by the National Conference of Commissioners on Uniform State Laws (the “Conference”), an unofficial body composed of representatives of every state. Over the years, the Conference has passed numerous acts proposed for state legislative adoption, only one of which, the Uniform Commercial Code, has come near achieving uniformity by being adopted across the states.
options for surrogacy arrangements. One way it did so was to adopt the common law presumptions that a woman who gives birth to a child is the child’s mother and the husband of a married woman is the father of a child born during the marriage. The USCACA, however, was adopted by only two states, and has now withdrawn, and considers the 2002 UPA to be its official recommendation on this topic.

Responding to the increased use, since 1973, of assisted reproduction and surrogacy arrangements, the Conference’s current recommendations, reflected in the 2002 UPA revision, includes among its topics such subjects as egg donors and sperm donors, children conceived by IVF, and gestational (surrogacy) agreements. It defines a donor as “an individual who produces egg or sperm used for assisted reproduction, whether or not for consideration,” but that term does not include a husband or wife who gives sperm or eggs for assisted reproduction by the wife, applies to unmarried as well as married women, does not require that the procedures be supervised by a licensed physician but it require a husband’s written consent for ART.

However, a man who does not sign a consent still will be considered the child’s father if he and the mother live together with the child during the first two years of the child’s life and openly treat the child as their own. Moreover, a husband who did not consent to his wife’s ART may not challenge this presumed paternity unless he begins a proceeding to determine paternity within two years of learning of the child’s birth. If the non-consenting husband never openly treated the child as his own, though, and did not cohabit with his wife since the time of an ART that used another man’s sperm, there is no presumption of paternity and, as a result, adjudication of paternity is not limited to the two-year time frame.

Four states have adopted the amended sections of the UPA, approximately eighteen states still adhere to the 1973 version of the UPA, and two states have adopted the 1988 USCACA. Other states have legislated measures similar to the original UPA, but a substantial number of states have not yet enacted legislation to determine parentage where children

have been conceived from donor sperm or eggs. Thus the statutory landscape is neither harmonized nor uniform\textsuperscript{11}.

ART-RELATED LEGAL ISSUES

Artificial Insemination by Donor (“AID”)

Two sets of issues have predominated in earlier litigation concerning children conceived through AID. One category is litigation involving children born to married women whose husbands did not give written consent to the insemination and then dispute their paternity (and child support obligations). The other is litigation involving unmarried recipients whose known sperm donors or lesbian partners assert their parental rights\textsuperscript{12}.

Paternity Disputes in Cases of No Written Consent.—Litigation involving married women whose husbands did not consent in writing usually occurs in divorce proceedings in which the husband contests a demand for child support by claiming that he is not the child’s parent. There has been substantial uniformity among the states on this issue. Courts have strictly enforced the requirement of written consent, but have also concluded that the statute is not the exclusive means to determine paternity. Instead, courts have employed common law doctrines such as promissory estoppels and an implied contract to impose a child support obligation, based on the husband’s oral consent and his course of conduct during the wife’s pregnancy and their child-rearing years. Because of the importance of the state’s interest in child support, courts also have used promissory estoppels and implied contract theories to impose a support obligation on a male partner who is not the mother’s husband and who did not sign a consent form, but whose conduct evinces his consent\textsuperscript{13}. Moreover, under Sections 704 and 705 of the amended UPA, a court may find that the mother’s male partner who did not sign a consent may be deemed the child’s father if he held the child out as his own.


Parental Rights and Unmarried Women.—

Another issue in the earlier AID cases involves unmarried women who have used a known sperm donor. Here, the donor initiates litigation to establish his paternity and, thus, his right to visitation. The legal argument in these cases will vary depending on state law. If the state has enacted a statute that does not recognize the paternity of a sperm donor but the statute applies only to married women, the statute does not cut off the sperm donor’s paternity when an unmarried woman is involved. The same result occurs if the state has no parentage statute that cuts off the donor’s paternity. If, instead, the state parentage statute applies to unmarried women as well, donors have argued—sometimes successfully—that the paternity of known donors should not be cut off\(^\text{14}\). Donors also have argued successfully that the statute does not apply if the parties have agreed to allow the donor to play a parental role\(^\text{15}\). In California, the parental rights of a known donor were not severed where the mother did not use a physician for the insemination\(^\text{16}\). When the donated sperm was provided to a physician, however, the statute has been found to bar a paternity claim by a known donor\(^\text{17}\). At least one court, though, has found a constitutional issue at stake—namely, that if application of the parentage statute would sever a known donor’s paternity and would override an existing agreement between the parties to give the donor a parental role, the statute would violate due process because it would impose an absolute bar to the donor’s paternity\(^\text{18}\). Traditional AID cases have raised the question: “Who is the child’s father?” Unmarried women, however, also are using AID and in significantly increasing numbers. Where the woman is in a same-sex relationship, an additional question must be asked: “Who is the child’s mother?” If the mother’s lesbian partner adopts the child that was conceived through AID, then that partner is legally the child’s second parent. A number of states, but not all, now permit same-sex partners to adopt the child of one of them. If, however, the partner has not adopted the child and the partners end their relationship, the partner who is not the biological mother may seek parental rights such as shared custody or


\(^{15}\) In re R.C., 775 P.2d 27, 35 (Colo. 1989). http://books.google.co.in/books?id=IQDIAQRDPPA


visitation in parity with the child’s biological mother. If the non-biological partner is successful, the child then has two legally recognized mothers.

Lesbian partners have found relief on various legal theories, such as de facto parenthood, psychological parenthood, and parenthood by estoppel. For example, they use estoppel to argue that the child’s biological mother is estopped from denying the former partner’s parental status. Several states have recognized the partner’s parenthood under one or the other of these theories, although the courts define them similarly. For example, the courts often define a psychological parent similarly to a de facto parent. One court summarized de facto parenthood as “limited to those adults who have fully and completely undertaken a permanent, unequivocal, committed, and responsible parental role in the child’s life.”

More expansive standards for de facto parenthood require that the biological parent consented to and fostered the partner’s parent-like relationship with the child, that the couple lived together in the same household, that the de facto parent fulfilled the obligations of parenthood by taking significant responsibility for the child, and that the de facto parent fulfilled the parental role for a long enough time to have bonded with the child in a parental role. Parents by estoppel and de facto parents are individuals who are not legal parents under state law (that is, not biological or adoptive parents or presumed parents) who have established a parent-like relationship with a child. Under ALI principles, de facto parents are those who, although not necessarily holding themselves out as parents, have lived with the child not less than two years, and, with the legal parent’s agreement that the person form a child-parent relationship, performs either “a majority of the caretaking functions for the child,” or a share of those functions that were at least equal to those performed by the parent. A parent by estoppel is one who is either liable for child support or has lived with the child for at least two years, held himself out as the child’s parent and accepted parenthood responsibilities, has acted “pursuant to an agreement with the child’s parent” or has lived with the child since the child’s birth, and held out the child as his own and accepted parental responsibility. A person can become a parent by estoppel only under an agreement with the child’s legal parent to raise the child together, sharing

19 In re J.D.M., No. CA2003-11-13, 2004 WL 2272063, at *4 (Ohio Ct. App.Oct. 11, 2004) opp. Ct. Helene S. Shapo (One partner had gestated the child; the other had given the ovum, which was fertilized with donor sperm.)
parental rights and responsibilities and only so long as recognition as a parent is in the child’s best interests. A parent by estoppel has the same rights as does a legal parent, and rights that are superior to those of a de facto parent. California courts had until recently not recognized the same-sex partner’s claim to parenthood. This line of decisions has now been judicially overruled, and statutorily overruled by the state’s domestic partner’s registration act. California courts had held that a child cannot have two mothers. This rule originated from an early and influential gestational surrogacy case, Johnson v. Calvert. In Johnson, a child was conceived by IVF using ovum and sperm from a married husband and wife. The embryo was implanted in a surrogate who had contracted with the couple to gestate the child and then give the child to the couple to adopt. However, the surrogate refused to give up the child. The court stated that the child could not have two mothers, and thus three parents, including the contracting husband.21

Both women, the genetic mother and the gestational mother, could be defined as the child’s mother under California’s Parentage Act. In these circumstances, the court held that the genetic mother, and not the surrogate, prevailed because she was the woman who originally intended to raise the child as its mother.22 The Johnson precedent has now been distinguished in a recent case and hold that a partner in a same-sex relationship could not acquire parental rights over the other partner’s children and would not be liable for child support.23

The California Supreme Court reversed, holding that, although a child can have only two parents, both those parents can be women, and that the former partner who was not the biological mother was a parent by virtue of receiving the child into her home and holding the child out as her child.24 On the other hand, New York’s highest court has held that its statute that gives standing to seek visitation to a child’s “parent” does not confer that right on one who is not the biological or adoptive parent. New York case law defines the term “parent” restrictively, thus excluding a person who develops a parent-like relationship with a child. New York courts have not recognized de facto parenthood, psychological parenthood, or equitable estoppel to allow a partner who is not a biological parent and who has not adopted the

22 Supra
23 Maria B. v. Emily B., 13 Cal. Rptr. 3d 494, 498 (Ct. App. 2004); http://books.google.co.in/books?isbn=1847311601, [last accessed on 3/1/2014]
child to attain visitation or custody\textsuperscript{25}. However, a same sex partner can adopt her partner’s child so that the partner becomes legally a parent and the child can have two mothers. A few states now recognize domestic partnerships\textsuperscript{26}. If domestic partners acquire the same rights and responsibilities as married partners and become legal parents to their partner’s children, their status obviates the difficult questions that courts increasingly must decide to determine parentage. Their domestic partnership, however, may not be recognized in other states, especially if the state has passed a defense of marriage statute.

If the domestic partnership dissolves and the biological parent moves to a state that does not recognize domestic partnerships, and the biological parent seeks a determination of child custody, the non-biological parent may lose all legal rights to child custody or visitation. This is the controversy in \textit{Miller-Jenkins v. Miller-Jenkins}. In \textit{Miller-Jenkins}, a Virginia county court exercised jurisdiction to determine parentage and parental rights to a child born by use of AID to a same-sex partner in a Vermont civil union. The couple had begun their partnership in Virginia in the late 1990s and entered into a civil union in Vermont in 2000. One partner, Lisa, gave birth to a baby in Virginia in 2002. The couple then moved to Vermont, but their relationship ended in 2003 when Lisa returned to Virginia with the baby. She filed in Vermont to dissolve the civil union, and the Vermont court issued a temporary custody order giving unsupervised visitation rights to Janet, the partner who is not the biological parent. In 2004, Lisa petitioned in a Virginia county court for the court to determine her sole parentage. The Virginia court ultimately held that Janet had no parental rights to the child, and that neither the Uniform Child Custody Jurisdiction and Enforcement Act (“UCCJEA”) nor the Parental Kidnapping Prevention Act (“PKPA”) prevented the Virginia court’s exercise of jurisdiction. These statutes were enacted to preclude a state from exercising jurisdiction over a custody dispute when a court of another state has already properly exercised jurisdiction, as long as a parent or “any person acting as a parent” continues to live in the other state. The Virginia court held that because Virginia’s Marriage Affirmation Act renders same-sex civil unions null and void, Janet


\textsuperscript{26} 50 In re Jacob, 660 N.E.2d 397, 406 (N.Y. 1995)
had no status as a “parent” or a “person acting as a parent,” and thus neither the UCCJEA nor PKPA applied to preclude Virginia’s jurisdiction.\(^{27}\)

**Surrogacy and Gestational Agreements**

If the surrogate is married, for example, her husband may be the presumed father of the child.\(^{28}\) In addition; the child’s conception may require an egg donor or a sperm donor, or both. The surrogate may become pregnant either by artificial insemination and thus be both the genetic and the gestational mother (sometimes called traditional surrogacy), or by implantation of an embryo conceived by IVF with the gametes of the couple or of one or more donors and thus be the gestational mother only. Gestational surrogacy cases also raise the question: Who is the mother? They have also deepened the disagreements among the states as to their treatment of surrogacy disputes.

Less uniformity exists among the states as to whether they recognize and enforce gestational agreements than as to how they determine parenthood when the parties use AID. The uniform acts reflect that disagreement. The 1973 UPA did not include a surrogacy provision. The 1988 USCACA offered alternative provisions. One alternative declared surrogacy agreements void;\(^{29}\) the other enforced those agreements only if the parties had gone through a statutorily prescribed procedure of judicial review.\(^{30}\) Currently, several states recognize surrogacy agreements, but several states statutorily void them or judicially do not recognize them, and some states do not allow the surrogate to be compensated.\(^{31}\) Article 8 of the 2000 UPA regulates gestational agreements and continues the USCACA approach of requiring a judicial hearing and court ordered validation. If the court approves the arrangement, the contracting couple will be declared the child’s legal parents without adopting the child. All parties must agree in writing to the surrogacy: the couple intending to be parents, the prospective surrogate and her husband, if she is married, and the gamete donor or donors, if known. The terms of agreement must

\(^{27}\) Opp. Ct. Helene S. Shapo ibid note 21 at p. 473

\(^{28}\) The common law presumption is that a child born to a married woman is a child of the marriage. See also Indian Evidence Act, Section 112.


\(^{33}\) KY. REV. STAT. ANN. § 199.590(4) (LexisNexis 2004)
include, inter alia, requirements that the surrogate, her husband, and the
gamete donors relinquish any claims to parenthood, that the contracting
couple will be the legal parents of the child, and that the surrogate may
make all decisions regarding her health and that of the embryo during
pregnancy.

The agreement may provide for compensation for the surrogate\textsuperscript{34}. The 2002 amendment requires that the intended parents be a man and a
woman. Of the four states that have adopted the new version of the UPA,
two states have omitted Article 8.71 unless a state has statutorily approved
surrogacy arrangements, an important hurdle to enforcement of the
contract and the reason that several states do not enforce them is a state’s
adoption laws. These statutes forbid compensation for adoption and
require a waiting period after the child’s birth so that the mother may
revoke her decision to place her child for adoption. It was on the ground
that the parties’ surrogacy contract violated the state’s adoption laws that
the New Jersey Supreme Court in the famous \textit{In re Baby M} case\textsuperscript{35} held that
the parties’ surrogacy contract was void. The contract provided
compensation to the surrogate and did not include a waiting period after
the baby’s birth for the surrogate to change her mind. The court also held
that the contract was coercive because it required the surrogate
contractually to relinquish the child before the child had been conceived.

In \textit{Baby M}, the surrogate conceived through AID using the
contracting husband’s sperm. The court treated the case as a custody
dispute between the child’s mother, that is, the surrogate, and her
biological father, the contracting husband. Thus the surrogacy agreement
also violated New Jersey public policy which requires that a court resolve a
custody dispute between parents according to the child’s best interests.
Making that judgment, the court awarded primary custody to the father
based on the stability that his family could provide. After \textit{Baby M}, several
states enacted legislation that declared surrogacy contracts void and
unenforceable. This type of legislation provided that the surrogate is the
child’s mother and, if she is married, that her husband is the father.
Presumably, in the case of an unmarried surrogate, the contracting male
would be listed as the father on the child’s birth certificate. In New Jersey,
\textit{Baby M} has been applied to gestational surrogacy as well. The result has

\textsuperscript{34} UNIF. PARENTAGE ACT § 801 (amended 2002), 9B U.L.A. 45 (Supp. 2005), supra note 6
\textsuperscript{35} 537 A.2d 1227 (N.J. 1988). Supra
been that even a couple who has contracted with the surrogate to be the child’s legal parents and obtained the surrogate’s consent may be barred from getting a pre-birth order that lists the couple as the parents on the birth certificate, even though both of them are the baby’s genetic parents and the surrogate has agreed. A pre-birth order to record the genetic parents on the birth certificate would mean that the genetic parents would not have to adopt the child in order to establish legal parenthood. A New Jersey court has denied such a pre-birth order and instead required the parties to a gestational surrogacy to wait the seventy-two-hour statutory waiting period for adoption36.

Other states, however, have distinguished the two types of surrogacy, and in a gestational surrogacy will issue pre-birth orders to list the contracting couple as the baby’s parents on the birth certificate, at least where the surrogate has not contested their parenthood. One federal trial court held that the Utah surrogacy statute that conclusively presumed that a surrogate is the child’s mother “for all legal purposes” unconstitutionally burdened the genetic parents’ fundamental right to bear and raise children37. Utah’s statute precluded the genetic parents from attaining legal recognition as parents unless they adopted the child. Contrary to the statute, the court required the state to provide a hearing in which the couple could present evidence to establish their genetic relationship to the child, and deferred to that forum the decision of whether to issue birth certificates declaring the couple as the parents.

If a gestational surrogate changes her mind and decides to keep custody of the child, state law may differ considerably. The surrogate may prevail under the traditional presumption that the woman who gives birth to a child is the child’s mother. A gestational surrogate, however, has a weaker claim to the child than a traditional surrogate because the gestational surrogate is not genetically related to the child. In California, where the state supreme court had determined maternity by intent in the influential Johnson case38, a court distinguished the gestational surrogacy at issue in Johnson from traditional surrogacy. The court ultimately held that a traditional surrogacy contract was unenforceable because it did not comply

with the state’s adoption laws. Parentage by intent still holds some sway as a means to resolve parentage disputes. Maternity by intent has made its way to egg donor cases in which the wife of a couple gestates a child conceived by IVF from the husband’s sperm and a donor egg. In two cases where spouses subsequently divorced, the husband claimed custody as the child’s natural parent, labeling his wife as a gestational surrogate. The courts denied these claims, recognizing the distinction between egg donation to the couple for the wife to gestate and gestational surrogacy, and stating that the wife was the child’s mother because the couple intended that she be the mother. The Massachusetts Supreme Court, which had held that the state’s adoption statute precluded enforcement of a surrogacy contract, has limited its previous decision to traditional surrogacy. The court held that an adoption statute does not apply to gestational surrogacy, where the child has no genetic connection to the surrogate. In the later case, the court said that the child was not “[the gestational mother’s] child to be surrendered for adoption.” The court held that the genetic parents were the child’s legal parents and required that their names be listed on the birth certificate as the child’s mother and father.

The lack of harmonization of the law among states is clearly revealed in a case in which a Connecticut couple and a New York surrogate chose Massachusetts law to govern their gestational surrogacy contract. In that case, the surrogate was impregnated with the couple’s embryo in Connecticut. The parties’ agreement included a provision that the surrogate would “take all reasonable steps to give birth . . . at a hospital located in the State of Massachusetts.” The parties also agreed to take steps necessary for Massachusetts law to apply so that the couple would be named as the child’s parents on the birth certificate and would immediately take physical custody of the child, obviating the need for them to adopt. The parties chose Massachusetts law because New York law declares surrogate contracts void and unenforceable as against public policy, while Connecticut has no surrogacy statute. The Massachusetts Supreme Court held that the parties’ choice of Massachusetts law applied and the names of the

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contracting couple would be entered as the child’s legal parents. To reach that conclusion, the court analyzed its choice of law principles and the *Restatement (Second) of Conflict of Laws*. Applying that analysis, the court held that Massachusetts had a “substantial relationship to the parties or the transaction” because the birth and some prenatal care would take place at a Massachusetts hospital and Massachusetts officials would issue the birth certificate.

In *Hodas v. Morin*, by contrast, the court held that application of Massachusetts law would not “be contrary to a fundamental policy of a state which has a materially greater interest than Massachusetts,” and opined that Massachusetts law would have applied even if the parties had not specified their own choice of law. The court regarded New York and Connecticut law as at cross-purposes and concluded that it could not determine a fundamental policy that applied to both those states. The court concluded that the parties’ choice of law would be honored, and the contracting couple would be listed on the child’s birth certificate.

Thus, many years after the first child born by artificial insemination and seventeen years after the celebrated *Baby M* case, a small number of decisions present polar positions on issues raised by assisted reproduction. Judicial disagreements on the status of various types of parents in AID and surrogacy arrangements reflect far-reaching social issues. The divisions among the courts manifest complex cross-currents in societal opinions about the technology of reproduction, about gender and marriage, and about what it means to be a parent. Indeed, “issues of bioethics increasingly underlie controversies that dominate public and political discussion. They have become flashpoints for front-page news day after day.” Almost certainly the reported decisions and jurisdictional conflicts will grow significantly in number, accompanying a likely increase in the number of private arrangements of heterosexual and homosexual couples who desire children, donors, and surrogates. New issues are sure to arise—for example, whether a female partner who consents to her partner’s ART is to be treated in law as the child’s second parent, on par with a male who consents to his female partner’s ART, and who the law treats as the legal father. It does not require a seer to predict that as the cases mount over the coming decades, the best chance of national harmonization among courts is that social dissonance on these issues will cease.
AUSTRALIA

Although there are no legal provisions relating to the issues raised by the practice of surrogacy on a federal level, the vast majority of the Australian states have recently introduced legislation that allows for and expressly regulates surrogacy. The individual state legislatures are free to impose their own specific conditions that set limits, ban, or impose (sometimes severe) hurdles to the legal acknowledgement of the family relationships stemming from a surrogacy contract. Commercial surrogacy is prohibited in all states, and a criminal conviction is more than a mere possibility. Surrogacy services for the provision of which no money exchange is arranged, namely the form of altruistic surrogacy, is allowed by all state legislations, with the exception of the Tasmanian Surrogacy Contracts Act 1993, which unequivocally renders all surrogacy arrangements void and unenforceable as contrary to the social ethos and policy (paragraph 7).

According to recently published statistical data, the incidence of surrogacy in Australia was not very widespread, with just seventy four reported cases of fertilisation for the purpose of surrogacy in 2007, which resulted in only four live births. However, this may well be an underestimate given the accepted dearth of empirical research about surrogacy in Australia, both in relation to up-to-date statistical and experiential data, as well as studies which consider children conceived outside of the jurisdiction in cross-border surrogacy agreements. In a report by the Victorian Law Reform Commission, reference was made to an unpublished study involving interviews with thirteen gestational surrogates.

With respect to law, a series of major reforms in 2008 to the Federal-Level Family Law Act 1975 (FLA) brought the issue of surrogacy and legal parenthood to the fore. In its previous form, the FLA did not deal with the

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matter of legal parenthood in cases of collaborative reproduction involving same-sex lesbian couples or surrogacy.

Under the 2008 amendments of subsection 60HB of the FLA, the definitions of “parent” and “child” in federal law have been extended to include lesbian parents who have a child through collaborative reproduction and/or fertility treatment, and to some parents who have children through surrogacy arrangements. The effect of subsection 60HB FLA is to clarify that any transfer of legal parenthood by state and territory courts for surrogacy families alters legal parental status under the FLA.

Up until 2010, surrogacy laws in Australia varied significantly from state to state. However, some uniformity was accomplished when all states – except Tasmania – adopted laws that prohibited commercial surrogacy and accepted the occurrence of (gestational) surrogacy in limited circumstances.

The legal regimes in most states now currently present the option of a court-based issuance of a ‘parentage order’ that leads to the transfer of legal parenthood to the commissioning couple. This possibility is generally available to all opposite and same-sex couples in legal or ‘de facto’ relationships. The above mentioned legal process was deemed to be in accordance with the ‘best interests of the child’ because it ensures that the child will not be left stateless or parentless, as well as protecting the surrogate mother from a coerced consent when offering her gestational services.

The following table illustrates the different pieces of legislation that cover the issue of surrogacy in each Australian state and briefly explains the basic content of the legal provisions.

<table>
<thead>
<tr>
<th>State</th>
<th>Legal response</th>
<th>Content of legal provisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>No express federal legal response to surrogacy other than the Family Law Act 1975, 60HB, which allows for federal-level recognition of any transfer of legal</td>
<td>Summary of generally applicable legal provisions:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Commercial type of surrogacy is a criminal offence.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• The rule of medical necessity exists.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The commissioning couple should provide sufficient evidence of their</td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
parenthood in the context of surrogacy by state or territory courts.
Most states have express legislation permitting some form of surrogacy.

<table>
<thead>
<tr>
<th>Australian Capital Territory (ACT)</th>
<th>Parentage Act 2004</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inability to produce a child or carry a pregnancy to term.</strong></td>
<td></td>
</tr>
<tr>
<td>• The surrogate mother must be over 25 years old, able to carry a pregnancy, and have a history of a previous live childbirth.</td>
<td></td>
</tr>
<tr>
<td>• Only gestational surrogacy arrangements are accepted. The eggs should not come from the surrogate.</td>
<td></td>
</tr>
<tr>
<td>• Criminal records check to all participants in the arrangement.</td>
<td></td>
</tr>
<tr>
<td>• The parties must undergo counselling.</td>
<td></td>
</tr>
<tr>
<td>• Informed consent free from coercion is a prerequisite in some states.</td>
<td></td>
</tr>
<tr>
<td>• Legal advice prior to the drafting of a surrogacy contract should be sought.</td>
<td></td>
</tr>
<tr>
<td>• If state laws do not provide otherwise, it is accepted that the person(s) who have parental responsibilities towards the child is/are the intended parent(s). Parentage is acquired through adoption.</td>
<td></td>
</tr>
<tr>
<td>• Surrogacy contracts are unenforceable.</td>
<td></td>
</tr>
<tr>
<td>• The best interests of the child are paramount.</td>
<td></td>
</tr>
<tr>
<td><strong>This legislation was closely based upon s. 30 of the UK HFEA 1990, but its scope is arguably more limited. Only altruistic gestational surrogacy is acceptable, and the courts have no power on the authorisation of any payments made or to be made.</strong></td>
<td></td>
</tr>
<tr>
<td>• Commercial surrogacy is prohibited (para. 41).</td>
<td></td>
</tr>
<tr>
<td>o Parental recognition under strict requirements (par. 24-25):</td>
<td></td>
</tr>
<tr>
<td>o the child should be conceived via...</td>
<td></td>
</tr>
</tbody>
</table>
IVF performed in a fertility clinic based in the ACT;
- the surrogate mother and/or her potential partner should not have offered their genetic material;
- the parties have come to an agreement for substitute parenthood;
- the child is the product of the genetic material of at least one of the intended parents;
- intended parents’ residence in the ACT.

<table>
<thead>
<tr>
<th>New South Wales (NSW)</th>
<th>Surrogacy Act 2010 No 102</th>
<th>Altruistic surrogacy allowed.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Assisted Reproductive Technology Act 2007</td>
<td>Presumption of motherhood for the birth mother. It is difficult for the intended mother to gain legal rights to parenthood.</td>
</tr>
<tr>
<td></td>
<td>Assisted Reproductive Technology Regulations 2009</td>
<td>Any surrogacy agreements must be drafted prior to the pregnancy, but they are unenforceable</td>
</tr>
<tr>
<td></td>
<td>Births, Deaths and Marriage Registration Act 2010 (See also NSW Legislative Council Standing Committee on Law and Justice, ‘Legislation on Altruistic Surrogacy in NSW’, May 2009).</td>
<td>Single and same-sex parenting is acceptable.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Age limit for the surrogate (she must be over 25) and the intended parent(s) (he/she/they must be over 18) Payment of reasonable expenses is allowed.</td>
</tr>
</tbody>
</table>

| Queensland | Surrogacy Act 2010 | This state’s laws regarding surrogacy have been criticised as harsh. Under the previous regime (Surrogate |
Parenthood Act 1988) all forms of surrogacy were prohibited and criminal sanctions were in force. The maximum penalty was 100 penalty units309 or three years of imprisonment for entering into or offering to enter into a surrogacy arrangement.


Queensland’s law is said to be the most controversial one, as it allows for state intervention in matters relating to private contracting and intimate personal relationships. ☛ Altruistic surrogacy.

- No requirement of a genetic link between the intended parents and the child. ☛ Conception can be accomplished by any means, not necessarily through the use of ARTs.

- Same-sex and single parenting acceptable.

- No residence requirements: the court has discretion to grant parenthood orders even in cases where the intended parents do not live in Queensland (Surrogacy Act 2010, s. 23 (2)).

- Payment for reasonable expenses allowed.

<table>
<thead>
<tr>
<th>South Australia</th>
<th>Family Relationships Act 1975, as amended.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Altruistic surrogacy.</td>
</tr>
<tr>
<td></td>
<td>• Criminal penalties for intermediaries.</td>
</tr>
<tr>
<td></td>
<td>• Automatic transfer of legal parentage</td>
</tr>
<tr>
<td></td>
<td>(s. 10 (c)). The intended mother’s</td>
</tr>
</tbody>
</table>

309 The units are the currency of the country.
husband is considered to be the legal father of the child (s. 10 (d)).

- Surrogacy is only available to heterosexual married couples or couples in a de facto relationship for a period of 3 years or more.
- The intending couple must reside within the state’s jurisdiction.
- Pregnancy must be accomplished through the use of fertility treatment, which will take place in a licensed fertility clinic based in South Australia.

| Tasmania | Surrogacy Contracts Act 1993 | • ALL types of surrogacy are prohibited for reasons of public policy.
• Surrogacy contracts are void and unenforceable (par. 7)
• Third-party intervention in a surrogacy agreement is a criminal offence (par. 5-6). |

• Surrogacy for commercial reasons is prohibited (par. 8-9).
• Payments for reasonable expenses related to the pregnancy and insurance claims are allowed (par. 6 (3)).
• A court authorisation process for parental orders and transfer of legal parentage to the intended parents is provided by law, and the child’s best interests are paramount to this decision.
• The intended parents must persuade the court for their fitness to parent the child (par. 13 (2)).
• A plan of communication and contact between the parties must be |
• The surrogate mother must be at least 25 years old and have a child of her own.
• The progressiveness and innovation of this piece of legislation can be found in the availability of surrogacy also to a single man or a male couple.
• At the same time, however, there are limitations which point to the requirement for the residency of the intended parent/couple within the state’s jurisdiction; the requirement of a pre-conceptual written surrogacy agreement; as well as that of a “cooling-off” period of 3 months for the surrogate mother to decide whether she would like to relinquish the child or not.
• The request for a parental order can be reviewed by a government appointed Tribunal court.

Victoria

• The state of Victoria was the first to adopt a law on surrogacy.
• In 1995 the legislature introduced the Infertility Treatment Act, which classified commercial surrogacy as a criminal offence. Altruistic surrogacy was passively accepted, but in some cases it was practically impossible for intended parents to be allowed to perform fertilisation with the purpose of surrogacy, as under the Act the woman who would be treated (i.e. the surrogate mother) must have been infertile (para 20).
• In 2008, the Assisted Reproductive Treatment Act was passed (it came into force on 1 January 2010), and rendered surrogacy contracts void and submitted to the court.
unenforceable (par. 44).

- However, the practice of surrogacy was not illegal if the IVF treatment of the surrogate occurred within the Victorian jurisdiction.
- The law states an age limit for the surrogate (she must be over 25), as well as the precondition of a previous live birth and experience of motherhood, and requires prior consultation of all the participants with a legal professional, as well as counselling (dictated by the Assisted Reproduction Regulations of 2009).
- With regards to the intending mother, she must be infertile, and she and her partner must undergo and succeed in a criminal record and child protection check.
- Moreover, a number of organisations, such as the Victorian Assisted Reproductive Treatment Authority (VARTA) function in this state.
- More specifically, VARTA is responsible for the administrative matters of the ART Act 2008 and ensures that the participants have complied with the state law requirements.
- The Act refers to a Parent Review Panel, before which the parties of the surrogacy arrangement must present their case and provide evidence for their altruistic motives, their need for surrogacy in order to procreate, and their suitability to become parents. The decisions of this Panel are reviewable by the Victorian Civil and Administrative Tribunal.
- The Victorian Supreme Court holds the ultimate decisive power for the
BELGIUM

A. Legislation

1. Absence of legislation framing surrogacy and proposed legislation

Currently, Belgium does not have specific legislation in matters of surrogacy. The nullity of surrogacy conventions results from the illegality of its object and its 'cause', its opposition to the principles of non-availability of the human body and the civil status as well as the inalienable and non-available right of the mother who bears and gives birth to a child to determine parentage\(^\text{46}\). However, some hospitals take advantage of the legislative gap to attend to requests of surrogacy\(^\text{47}\). Doing so outside any legal framework, these hospitals have established strict rules to condition the practice of surrogacy.

Considering the nullity affecting it, when surrogacy takes place on Belgian territory, the contract cannot be subjected to enforcement. Besides, parentage cannot be established in relation to the intended mother unless an adoption procedure takes place, the surrogate mother being considered the legal mother according to Belgian law\(^\text{48}\), while the intended father will have to, according to the circumstances, either acknowledge the child if the surrogate mother is not married, or engage an adoption procedure.

Facing this legislative gap, legislative propositions have been tabled at the parliamentary assemblies with the objective of either expressly forbidding for-profit surrogacy\(^\text{49}\), or to authorise and frame surrogacy under

\(^{46}\) Cf. Articles 6 ("Statutes relating to public policy and morals may not be derogated from by private agreements") and 1128 of the Civil code ("Only things which may be the subject matter of legal transactions between private individuals may be the object of agreements") www.jus.uio.no/lm/belgium.code.judicature.1998.html last accessed on 7/5/2014


\(^{48}\) Art. 312 Civil code Supra Note 46

\(^{49}\) Supra Note 47
certain conditions\textsuperscript{50}. In order to expose the state of the legislative reflections on the subject, the core ideas of the four propositions aiming at accepting the legalisation of surrogacy in certain circumstances are summarised in an overview table, which appears in the main body of this Report. An accent will be made on the analysis on the ways these propositions aim to answer the different questions arising from the issues of surrogacy, namely: the type of accepted surrogacy, the conditions to accede to it (profile of intended parents and medical indications), the financial aspects of the convention, the standards of protection provided for the surrogate mother and the intended parents, the rules determining parentage, the dispositions legislating the donation of gametes, the attribution of Belgian citizenship to a child, the existence and content of a model of contract for surrogacy as well as the existence of centres organising surrogacy on the Belgian territory. The example of Belgium can be particularly enriching to the extent that the need to legislate surrogacy, agreed by all, can give rise to numerous reflections and propositions. A study of the proposed laws allows us to concentrate on the construction of legislation in matters of surrogacy, with its uncertainties, interrogations and doubts. To this extent, Belgium is quite a laboratory of ideas.

2. Type of surrogacy

Currently, only altruistic and gestational surrogacy (altruistic and gestational surrogacy arrangements) are authorised by hospitals receiving requests for surrogacy in Belgium. In the majority of the circumstances, both of the parents have a genetic relation with the child, a situation that is perceived as ideal by the hospitals receiving these requests. If, however, the intended mother is not in the capacity of providing the oocyte, the donation of ovules can be provided for. It would seem that hospitals deal with each request on a case-by-case basis.

In the context of the proposed laws, only the altruistic surrogacy has been considered. Three propositions expressly forbid the payment of a contribution to the surrogate mother even if they provide that the expenditures linked to pregnancy and medical exams required by law are to be covered by the sterile couple. From the four proposed laws analysed, two demand at least one genetic relation with the intended parents, authorising implicitly the situations when the surrogate mother provides

\footnote{Ibid}
the oocyte (traditional surrogacy arrangement). Only one of the four proposed laws that were tabled authorises only the gestational surrogacy arrangement providing that the oocyte cannot be provided by the surrogate mother when it is not provided by the intended mother.

3. Access to surrogacy: profile of requesting parents and medical indications

Currently, only heterosexual couples have access to surrogacy as carried out in certain Belgian hospitals. These restrictions are related to the medical indications set by these hospitals conditioning the access to surrogacy to the sterility of the intended mother or to her incapacity to complete a successful pregnancy.

In the context of the proposed laws analysed, very different responses were given to the question of the profile to be satisfied by the intended parents. The proposed law tabled by Mr. Tommelein and associates seems to reserve surrogacy to heterosexual couples (married or not) and single women. The proposed law tabled by Mrs. Defraigne reserves it to heterosexual couples, married or not. The proposed law tabled by Mrs. Temmerman and Mr. Swennen concerns heterosexual and homosexual couples, married or cohabiting and ‘lasting’ (a minimum of 3 years of affective life). Finally, the proposed law tabled by Mr. Mahoux opens surrogacy to all profiles.

As for medical indications, all the proposed laws concerned demand the intended mother to be in the physiological impossibility of bearing a child or that her pregnancy constitutes a danger for her health, her life or that of her child. One of the analysed laws enumerates these medical indications in a very precise manner: congenital or acquired absence of the womb or dysfunction of it; counter-indicated pregnancy due to a risk for her health, her life or those of the child.

4. Financial aspects

Currently, the financial aspect of surrogacy is not regulated by any convention. Such a contract would be in effect illicit and, thus, null and void. It would seem, then, that the parties convene arrangements between themselves on the responsibility for the financial aspects.
In what concerns the proposed laws analysed, they all provide the responsibility of the costs related to the pregnancy to be assumed by the intended parents. Two of them detail these costs:

Costs include but are not limited to: clothing for pregnancy; costs of transportation, namely ... euros per km, for each travel carried out in the context of the surrogacy; where necessary, a compensation for the loss of salary (... euros/day); an arrangement for the hypothetic situation where the surrogate mother would suffer an accident, a medical complication or an illness related to the pregnancy. Except for the case of a multiple pregnancy, the surrogate mother receives monthly an amount not exceeding ... euros. In case of a multiple pregnancy, the monthly provision cannot exceed the amount of ... euros. Medical costs: (To be detailed by the parties, taking into account the fees of the fertility centre). All the medical costs linked to the surrogacy are paid by the intended parents. legal and administrative costs: The requesting parents pay the centre a basic compensation of ... euros to cover administrative fees. Insurances includes healthcare insurance and life insurance.

5. Standards of protection for the surrogate mother and the intended parents

-Age of the surrogate mother: all the proposed laws set conditions relating to the age of the surrogate mother, the minimum and the maximum age ranging between 21 to 49 years.

-Condition related to the fact that the surrogate mother has already given birth to a healthy child: three of the proposed laws analysed demand that the surrogate mother has given birth to at least one living child and two also provide that this child must be living.

Verification of the free an informed consent given by the surrogate mother

Medical and psychological consultation of the surrogate mother:

-Age of intended parents: Maximum age of intended parents ranges between 43 to 47 years in three proposed bills.

-Provision aiming at ensuring the impossibility for the intended parents to withdraw their consent
Conditions linked to the residence, domicile and/or the nationality of the intended parents and/or the surrogate mother: of the four proposed laws analysed, only three fix conditions of residence, domicile and/or nationality for the intended parents and/or for the surrogate mother: ° the first one demands that the surrogate mother and the intended parents are of Belgian nationality and that one of the two intended parents is domiciled in the Belgian territory for at least the last two years (proposition tabled by Mrs Temmerman and Mr Swennen); ° the second one demands that the intended parents are domiciled in Belgium for at least the last two years (proposed law tabled by Mr Mahoux); ° the third one demands that the intended parents and the surrogate mothers are of Belgian nationality or have a fixed residence in Belgium (proposed law tabled by Mr B. Tommelein and associates).

- Demand of legal advice: some of the proposed laws analysed provide that the parties will be assisted by a legal expert attached to the surrogacy centre and that they will have to be assisted by an independent lawyer.

6. Laws determining parentage

-Current system

° Maternal parentage: As there is no legislation enacted on matters on surrogacy, the rules determining the establishment of maternal parentage follow the traditional adage mater semper certa est by establishing that the legal mother is the mother giving birth51. In other words, the surrogate mother is the legal mother of the child, even if she has no genetic relation to the child, while the intended mother has no legal relation to the child, even if she is the genetic mother.

° Paternal parentage: In the absence of modifications to the rules related to paternal parentage, the husband of the surrogate mother is

51 Art. 312 Civil code: “The child has as a mother the person designed as such at the act of childbirth” Supra Note 46
considered as the legal father of the child, in compliance to the rule relating to the presumption of paternity.\(^{52}\)

The intended parents will have to engage an adoption procedure to establish parentage to the child.

Finally, surrogacy being practiced outside of any legal framework, there is currently no system of “birth order” or of “pre-birth order” in the Belgian legal body. Only one of the four proposed laws, opting for a system of establishment of parentage through an adoption procedure, proposes a system of “pre-adoption”, giving the surrogacy convention a status of “exante adoption declaration”.

**Proposed laws:** The proposed laws analysed seek to establish maternal parentage proposing two different models:

- **Conventional model:** Of the four proposed laws taken into account, two propose establishing maternal parentage through a convention (proposed law tabled by Mrs Defraigne and proposed law tabled by Mme Temmerman and Mr Swennen). According to the first proposed model, the civil registrar mentions directly in the birth certificate the names of the intended mother and father after receiving notice of the child delivery as well as a copy of the surrogacy convention. Maternal and paternal parentage is, thus, established directly in the birth certificate and the child born of the surrogacy bears the surname of the intended father (proposed law tabled by Mrs Defraigne). According to the second model proposed, maternal parentage in the case of the intended mother results from the mention of her name in the birth certificate while paternal parentage is ruled by the classic rules of parentage (proposed law tabled by Mrs Temmerman and Mr Swennen). Thus, if the intended mother is married, the child bears the surname of the intended father. However, if she is not married, the child bears the surname of the intended mother.

As a result, this conventional model does not allow to establish maternal parentage to the surrogate mother, and its does not guarantee a right of “retention” of the child after birth. Also,

\(^{52}\) Art. 315 Civil code: “The child born within marriage or within the 300 days following its dissolution or annulment, has the husband as a father”. Supra Note 46
there is no judicial control provided for, before or after. Finally, this model provides that the surrogate mother cannot engage any action to contest the maternity or paternity (proposed law tabled by Mrs Defraigne and proposed law tabled by Mme Temmerman and Mr Swennen) even if she is the genetic mother of the child (only the proposed law tabled by Mrs Defraigne provides for the possibility of the surrogate mother to be the genetic mother of the child).

**Parentage model of the “classic” type or “pre-adoption”:** the other two proposed laws analysed provide for the establishment of the parentage of the intended parents through the figure of adoption: one provides for a classic adoption procedure (proposed law tabled by Mr Mahoux), the other one attributing to the surrogacy convention the status of “ex-ante adoption declaration” (proposed law tabled by Mr Tommelein and associates). In both hypotheses, maternal parentage is established with regards to the surrogate mother in conformity with the rules of the Civil code. As a result, the child bears the surname of the husband of the surrogate mother if she is married or the surname of the surrogate mother is she is single, in conformity with the rules of the Civil code regarding the attribution of name\(^53\).

7. **Donation of gametes**

The donation of gametes is governed by the law related to the medically assisted procreation and the destination of supernumerary embryos and gametes. According to article 57 of this law, the donation of gametes can be anonymous or non-anonymous\(^54\).

8. **Attribution of Belgian citizenship to the child**

A child can acquire Belgian citizenship either on the basis of the nationality of his/her parents, or his/her birth on Belgian territory, or by the collective effect of an acquisition act.

\(^{53}\) Art. 335 Civil code: “§ 1. The child of whom only paternal parentage is established or of whom maternal and paternal parentage are established at the same time, bears the name of the father. § 2. The child of whom only maternal parentage is established bears the name of the mother”. Supra Note 46

\(^{54}\) Art. 57: “When gametes are assigned to a donation programme, the consulted fecundation centre is liable not to give access to any information allowing the identification of the donor. The non-anonymous donation that results from an agreement between the donor or the donors is authorised”. Supra Note 46
A child is automatically Belgian if he/she is born in Belgium to a Belgian parent at the moment of birth, if he/she is born abroad to a Belgian parent born in Belgium or to a Belgian parent with the condition that the child does not possess another nationality before coming of age. The Belgian nationality is attributed to a child born abroad to a Belgian parent with the condition that his/her parent undertakes a declaration to request the attribution of the Belgian nationality to the child before he/she is 5 years of age. By birth in Belgium also a child can undertake Belgian nationality on the basis of his/her birth on Belgian territory even if his/her parents are not Belgian.

Finally, the Belgian nationality can also be attributed to children of the so-called “second generation”, meaning born in Belgium from parents born abroad. This attribution is conditioned to a declaration made by the parents.

If a parent or an adopting parent who has parental authority on the child acquires or recovers the Belgian nationality, the nationality is automatically attributed to the child (collective effect).

**Model of surrogacy convention**

Currently, the parties agree on the surrogacy arrangements without a contract, as any convention dealing with surrogacy would be illegal and, thus, void.

Of the four proposed laws analysed, only one proposes a project for a standard convention on surrogacy, annexed to this report (proposed law tabled by Mrs Temmerman and Mr Swennen). This project of standard convention, very detailed, contains dispositions relating to the psychological and medical exam that the intended parents and the surrogate mother will have to undertake, the dispositions ruling the sexual relations and the behaviour of the surrogate mother, another one organising the psychological and medical support for the surrogate mother, a disposition relating to the possibility of the surrogate mother to get an abortion and the measures to be taken if the prenatal diagnostic reveals that the child will suffer from a physical or psychological retardation or that he/she will have a severe hereditary disease as well as a disposition concerning the follow-ups in case of miscarriage or stillbirth. The convention rules also the attribution of parental rights in case of separation or death of the intended
parents. The costs that are a responsibility of the intended parents are detailed. Finally, dispositions ruling the possibility of an early termination of the convention, unilaterally or by common agreement, and specifying the consequences of an eventual violation of a disposition of the convention enumerating in a non-limitative manner the hypotheses of the non-respect of the convention by the surrogate mother or the intended parents. The final disposition provides that the parties will be assisted by the legal expert attached to the surrogacy centre and that they will be also assisted by an independent lawyer in case of conflict.

9. Institutions organising surrogacy

Currently, only some hospitals practice surrogacy in Belgium. The absence of legislation on the matter justifies that there is neither a specific institution dedicated to surrogacy nor an association organising the procedure, for this would be illegal.

B. Case Laws

The analysis of the case law demonstrates that the Belgian courts are confronted to questions of very diverse nature in matters of surrogacy.

1. In the domestic cases of surrogacy, the legal action is almost systematically undertaken by the intended parents seeking to establish parentage in relation to the child, either through a procedure of adoption, undertaken by the intended mother\(^{55}\) or by both of the intended parents\(^{56}\), or by a procedure of approval of the acknowledgement of paternity by the intended father\(^{57}\). One of the published cases concerns, however, a different hypothesis; that of the contestation of paternity, introduced by the husband of the surrogate mother, on the basis of the absence of his consent to the insemination of his wife by the sperm of the intended father. As, by definition, the surrogacy contract is illegal, no action has been undertaken, until today, with the purpose of requesting the enforcement of an eventual contract concluded between the parties. In the disputes implicating a


surrogacy taking place abroad, the action undertaking can aim to condemn the Belgian State into delivering the travel documents to the child, or to obtain the recognition of a birth certificate established in a foreign country (State nonmember of the EU). Of the three sentences concerning the deliverance of a travel document to the child, only one succeeds, allowing the child born from surrogacy to join his/her intended father. When it comes to actions undertaken to obtain the recognition of birth certificates, the tribunal accept to recognise these not as *birth certificates* (on the basis that these certificates mention either the name of the intended mother or do not indicate any name, which is contrary to Belgian law according to which the name of the woman giving birth has to be mentioned in the birth certificate), but as *authentic and legally valid certificates*, from which results the recognition of the paternity in relation to the child born from the surrogate mother. However, the courts refuse to consider that a foreign birth certificate could establish the maternal parentage of the intended mother when her name is mentioned, as it is the case in Ukrainian law, or double paternal filiations with regards to the spouse of the intended father, as the Californian law allows it. It would seem that after the partial recognition of the foreign certificate establishing the parentage of the intended father, the Ministry of Foreign Affairs accepts to deliver a passport to the child allowing him/her to travel to Belgium. As a consequence, the child can always, it would seem, to join his/her intended parents either at the state of the procedure of interim relief through the conviction of the Belgian State into delivering urgently the travel documents, or at the state of the main proceedings through the partial recognition of the foreign certificate establishing the parentage of the intended father.

In one of the cases implicating a surrogacy taking place on Belgian territory but concluded with foreign intended parents, the action was undertaken by the surrogate mother to contest the parentage of the intended mother. By settling in favour of the request of the surrogate mother and re-establishing her maternal parentage, the tribunal also nullified the paternal parentage of the intended father that had been established in conformity to the principle of presumption of paternity of the husband of the mother. Concerning the nationality of the child, it results from the establishment of the parentage of the intended father
(when it is established through the recognition of the foreign birth
certificate), which explains that no action undertaken has as direct
objective the transmission of the Belgian citizenship to the child.

Amongst the decisions taken in matters of surrogacy, most of them
have been settled by civil courts through substantive proceedings or,
through interim relief actions when the request concerns the
deliverance of travel documents.

The only case leading to a penal conviction is the Donna case, in
which both the surrogate and the Belgian and Dutch intended parents
were judged by a correctional court for inflicting “inhuman and
degrading treatment” to the child. On the 12th of October 2012, the
correctional court of Oudenaarde sentenced the surrogate mother and
her husband to a year of suspended prison as well as to pay a fine of
1,650 EUR. The Dutch couple that had bought the child was equally
condemned to a fine of 1,650 EUR while the sentence for the Belgian
intended couple was suspended.

A case of surrogacy led to the application of the youth protection
law. In this case, the surrogate mother had given the child to the
intended mother after a surrogacy convention convened before
childbirth. At first instance, the youth court considered that it was not
necessary to pronounce an enforceable pedagogical measure with
regards to the child. In appeal, this decision was, however, reformed
and the child was placed in a childcare and family assistance centre.
While initially the placement was extended as demanded by the public
prosecutor, the youth court settled in favour of the request of the social
service, requesting the attribution of the child to the intended mother,
in whose household the child currently lives58.

2. Best interest of the child

The notion of best interest of the child takes a considerable
importance in the cases of surrogacy, both in the domestic and the
international cases. Thus, in a domestic case, the interests of the child was
invoked by the judge in order to justify the approval of the adoption
requested by the intended mother in order for the legal situation to

correspond to the social reality, the child being reared by the intended mother and not by the surrogate mother\textsuperscript{59}.

The best interests of the child has also been invoked in international cases to justify the deliverance of travel documents to a child born in India in order to allow him to join his intended father in Belgium (in the framework of an interim relief action), to justify the establishment of the parentage of the biological father in relation to the children born in California, independently of the nullity of the contract of surrogacy or even to justify the adoption of the child by the intended mother after a surrogacy concluded in Ukraine in order to match the legal reality with the genetic and social-psychological reality. In a strange and perhaps somewhat inconsistent way, the best interest of the child was invoked by the Court of First Instance of Brussels to justify the non-recognition of an Indian birth certificate and a recognition of paternity on the basis that it would not be “in the interest of child”. This isolated decision does however not reflect the dominant position that the Belgian Courts seem to be developing.

Thus in domestic cases, the control of the best interest of the child serves as a basis for the legal decision pronouncing the adoption to the extent that the court before which the action is undertaken has to verify if the adoption is founded on “fair basis”, within which is included the best interest of the child. When this notion is invoked in an international case dealing with a request for the recognition of birth certificates established abroad, it seems to allow to “neutralise” the illegality of the surrogacy contract without constituting by doing so the autonomous foundation of the recognition of parentage. Indeed, it is because the parentage of the biological father can be established by rules on the acknowledgement of paternity, that the tribunal admits to recognise this parentage as it is established by the birth certificates\textsuperscript{60}.

3. Family life

The notion of family life seems to be invoked by courts to support the reference to the principle of the best interest of the child. Thus, it seems

\textsuperscript{59} Civ. Brussels (youth), 4\textsuperscript{th} of June 1996, Jurisprudence de Liège, Mons et Brussels, 1996, p. 1182 Supra note 54

\textsuperscript{60} J. SOSSON, « La filiation d’enfants nés d’une gestation pour autrui à l’étranger », note on Liège, 6\textsuperscript{th} of September 2010, Revue trimestrielle de droit familial, 2010, n° 4, p. 1153 Opp.cit. “A Comparative Study on the Regime of Surrogacy in EU Member States 2013” P. 227 Supra Note 47
to play a complementary role in order to, for example, justify the issuance of travel documents to a child born abroad.

4. Donation of ovules and importance of the genetic link

In the cases of surrogacy concerning questions of international nature (recognising the parentage established by a foreign birth certificate), the reasoning of the courts does not change, whether there was ovule donation or the intended mother is the genetic mother, as the case-law refuses systematically to recognise the parentage of the intended mother because in Belgian law the maternal parentage is established by childbirth. The circumstance in which the intended mother is the genetic mother does not modify at all the outcome of the dispute. In all cases, she will have to engage a procedure of adoption in order to establish parentage in relation to the child born from a surrogate mother.61

5. The translation into the Belgian legal order of parentage established following a case of surrogacy taking place abroad

The cross-border aspect of surrogacy triggers the application of rules of international private law, which leads Belgian courts to apply their rules of conflict of laws or of indirect competence to translate into the Belgian legal order parentage established abroad following a case of surrogacy. In the absence of a specific disposition to surrogacy in the Code of international private law, the translation into the Belgian legal order of parentage established abroad following a case of surrogacy is done taking into account distinct rules whether the question is to recognise a birth certificate established following a case of surrogacy (a) or if the question is to recognise a sentence establishing parentage following a case of surrogacy (b) The recognition of a birth certificate established following a case of surrogacy taking place abroad

A birth certificate established abroad following a case of surrogacy is recognised in Belgium if its validity is established in conformity with the national law of the persons in relation to whom parentage is being established. This solution results from the combined application of articles 27 and 62 of the Code of international private law, dealing respectively with

61 Supra note 47
the recognition of foreign authentic certificates and with the law applicable to parentage. In other words, in order to recognise parentage as established by a foreign birth certificate, the validity of the parentage has to be verified in relation to the national law of the intended parents.

If the intended parents are foreigners, the foreign law has to be verified to determine its provisions:

- if the foreign law prohibits the establishment of parentage following a case of surrogacy, as the French law, for example, parentage cannot be established, unless the foreign law is considered contrary to Belgian international public order (in the absence of legislation framing surrogacy in Belgium, it would seem difficult, currently, to affirm that a foreign law ignoring surrogacy can be discarded for being contrary to the Belgian international public order),

- if the foreign law admits the establishment of parentage by surrogacy, the conditions of parentage need to be verified to determine if it can be established and if this foreign law is not contrary to the Belgian international public order,

- moreover, it will be needed to verify that the parties have not attempted to escape the law normally applicable by travelling abroad to obtain the establishment of a right they could not have obtained otherwise (fraudulent evasion of the law).

6. Need to legislate

In certain sentences, the judges highlight the absence of Belgian legislation on the matter. Thus, when they are called to approve a request of adoption introduced by the intended mother, the judges point to the gaps in the law and specify that it is not their duty to make a fundamental political choice in lieu of the legislator. However, it is mostly doctrine, and not case law, that denounces the absence of legislation and insists on the urgency of legislating on the matter.

7. Financial aspects

The financial aspects related to a contract of for-profit surrogacy are rarely debated by Belgian courts. In the case Hanne and Elke, it was revealed that an amount of 30,000 EUR was paid by the intended parents to
the Ukrainian law firm. According to the parties, these costs aimed at covering not only judicial advice but also all practical aspects of surrogacy: fees related to travels, translations, contact with professionals in a private clinic of fertilisation, attempts to perform IVF, ultrasounds, medical follow-up of the surrogate mother, etc... When the procedure of adoption was engaged by the adopting mother, the tribunal considered it did not possess enough objective information to know if the amount exceeded the normal amount of compensation concerning the costs resulting from surrogacy and concluded that the parties acted without the intention to make profit.

In the case of a domestic case of surrogacy, the Court of Appeal of Ghent took a more severe position. Realising that an amount of 1.600 EUR per month was paid monthly by the parents to the surrogate mother, the Court refused to approve the adoption, considering that an adoption resulting from a contract of for-profit surrogacy could not be based on fair basis, regardless of the de facto parents-child relation existing between the child and the intended mother. The Court considers that a contract of for-profit surrogacy is contrary to human dignity and that an adoption aiming at dissimulating the buy/sale of a child is illegal\(^{62}\). In the case, it must be highlighted that the surrogate mother was also the genetic mother of the child, which seems to justify the position taken by the Court more than the fact that a for-profit surrogacy contract was concluded.

When surrogacy requires an adoption, the judges dispose of a certain margin of appreciation through the notion of the best interest of the child of which the control is required by law. Thus, it has been judged that it was in the best interest of the child to be adopted by the intended mother (also the genetic mother) regardless of the amount of money probably paid to the surrogate mother (case Hanne and Elke)\(^{63}\), while other court refused to pronounce the adoption, requested by the intended mother (not genetically related to the child) in the framework of a for-profit surrogacy, regardless of the de facto child-parent relation existing between the child and the intended mother. This assessment could allow to conclude that Belgian courts consider that it is in the interest of the child to see his/her parentage maintained or establish in relation to his/her genetic parents, regardless of the for-profit or non-profit nature of the surrogacy.


\(^{63}\) Youth court Antwerp, 22\(^{nd}\) of April 2010, *Tijdschrift voor Familierecht*, 2012, p. 43 EU Report supra note 47
GERMANY

A. LEGISLATION, DRAFT LEGISLATION, FORMAL GUIDELINES

1. In Germany, surrogacy in itself is not explicitly prohibited or punishable. However, the bringing together of the party who is willing to adopt a child born through surrogacy or is in some other way ready to take permanently care of it (ordering parents) with a woman who is willing to serve as a surrogate, is subject to sanctions. Also, surrogacy agreements are ineffectual and unenforceable.

Three legal sources deal with surrogacy (no amendment is under discussion):

i) The German Civil Code (Bürgerliches Gesetzbuch – BGB): §134- any legal transaction violating a statutory prohibition is void if the law does not say otherwise; §138(1)- any legal transaction violating the public policy (bonos mores) is void.

ii) The Embryo Protection Act 1990: according to §1(1)(7), “anyone will be punished with up to three years imprisonment or a fine, who .... attempts to carry out an artificial fertilisation of a woman who is prepared to give up her child permanently after birth (surrogate mother) or to transfer a human embryo into her”. Under this provision, no “agreement” in a technical sense is required; the mere willingness of the surrogate to relinquish the child to a third party is sufficient.

Neither the surrogate, nor the ordering parents can be punished. According §1(3)(2), “...the surrogate mother and likewise the person who wishes to take long-term care of the child will not be punished”. If a woman is being inseminated with the sperm of the ordering father with no medical assistance.

iii) The Procurement Adoption Act: according to §13(a), the surrogate mother is a woman who by agreement has consented (1) to an artificial or natural insemination, or (2) to having somebody else’s embryo implanted, and, after giving birth to it, to hand the child over in view of an adoption or other permanent accommodation. Once more, this kind of activity is not in itself prohibited. According to §13(b), the procurement of a surrogate
mother means the bringing together of the party who is willing to adopt a child born by a surrogate or is in some other way ready to take permanently care of it (ordering parents) with a woman who is willing to serve as a surrogate mother. Such procurement is formally prohibited (§13(c), and even, following §14(b), punishable (imprisonment up to one year or a fine). Any publicity is prohibited (§13(d)). With an imprisonment up to 2 years or a fine can be punished who has a pecuniary benefit or the promise of such a benefit out of the procurement of a surrogate mother. If the offender turns it into a business activity for financial profit or proceeds on commercial basis, the punishment amounts even to an imprisonment of 3 years or to a fine. §14(b)(3) confirms that the surrogate and the ordering parents cannot be sanctioned.

2. There is no type of surrogacy (commercial, altruistic, traditional and gestational) legally authorised in Germany; no distinction, nor any reference of “reasonable costs” is made.

3. Given the legal frame of surrogacy, in particular §134 and 138(1), BGB, surrogacy agreements are not enforceable by the courts, and cannot in any way, be pre-approved by a court in order to be considered as enforceable. The sole fact that a woman has been a part to a surrogacy agreement is not a reason to take back the child to whom she gave birth subject to certain exceptions, despite the biological relation between the ordering father and the child, and the financial motivation of the surrogate.

4. **Laws determining parentage**

   Under German law, there is a legal presumption, according to which the mother is the woman bearing the child (§1591, BGB). No indication can rebut this presumption, as ovum donation and surrogacy are illegal. The mother’s identity has to be mentioned in the act of birth. There is no formal possibility of giving birth anonymously. The child has only one legal mother. In case of surrogacy, the surrogate would be considered as the legal mother.

   Under German law, the father is: the husband of a woman while bearing the child (§1592(1) BGB); a man who has recognised his paternity (§1592(2) BGB) or a man whose paternity has been stated by
court (§1592(3) BGB). No specific provisions have been made for the case of surrogacy. If the surrogate was married while the child was born, her husband will be considered as the legal father of the child.

The names entered on the child’s birth certificate are exclusively those of his parents also in case of surrogacy.

The ordering parents can adopt the child born through surrogacy under the following conditions: the consent of the surrogate, since the consent of the biological parents in general is mandatory, subject to certain exceptions, which cannot be given before the child is 8 weeks old (§1747 BGB).

According to §1741(1) BGB, while deciding upon the adoption, the judge has to take into account the well-being (Kindeswohl) of the child, and only if it is to be expected that a parent – child relationship will result between the adopting party and the child. Nevertheless, whoever participates in an unlawful and unethical arrangement or transportation of a child with regard to an adoption, or delegates such an undertaking to a third party against payment, shall only be able to adopt the child, if this is necessary to the welfare of the child. In this context, a surrogacy agreement would not necessarily exclude adoption, and the judge would decide case by case. In any event, the mother is allowed to hand over the child to the ordering parents only under the condition that an order has been given by a court.

The child might be adopted by the couple (if the couple is married) or by one parent (§1741(2) BGB). The guardianship court (Vormundschaftsgericht) decides on the adoption of the child.

5. **Donation of gametes**

Germany is one of the very few countries, if not the only one, in which there has never been a rule concerning anonymity of the sperm donor. The anonymity is guaranteed in most Länder. But on 06.02.2013, a regional appeals court in Hamm added legal weight to the claim that sperm donation shouldn’t be anonymous with its verdict that the children of anonymous sperm donors have the right to know the names of their fathers.
The right of children to the knowledge of their origins has been confirmed by the German Federal Constitutional Court in 1989\textsuperscript{64}, considered as derivative from another right, a constitutional one, concerning the right to one’s own personality development. This right concerns the donation - conceived child in relation to the donor, as an anonymity principle between the donor and the donation receivers has never been contested. There is no official register set, which would insure the realisation of such right. The parents are not obliged to tell their children that they have been conceived through sperm donation.

6. Attribution of German citizenship to the child

A child is considered to be a German citizen if at least one of his parents is German\textsuperscript{65}, thus requiring his / her filiation to be determined. According to §19(1) of the Introductory Law of the Civil Code, in respect to the filiation of a child at first the law of the state in which the child has its habitual residence is applicable. However, the filiation, in relation to each parent, can be decided according to the law of the state to which this parent belongs.

These kinds of presumptions often do not exist in countries where German citizens choose to make a surrogacy agreement, like India or Ukraine, where the ordering parents are considered as legal parents, and where children born within their territory are not always automatically given the local nationality. This conflict of law can cause painful situations, where these children have neither a filiation in relation to the ordering parents, nor any citizenship, even if the ordering parents (who are, sometimes, also the biological parents) are German. Nevertheless, this state of the law has been confirmed by the Federal State Department, warning that entrance to Germany of these children, who don’t have German passports, is impossible.

B CASE LAWS

Surrogacy cases are predominantly dealt with by administrative (Verwaltungsgericht) and civil (Landesgericht, Oberlandesgericht) courts,\textsuperscript{65}


\textsuperscript{65} §4(1) Staatangehörigkeitsgesetz –StAG : « Durch die Geburt erwirbt ein Kind die deutsche Staatsangehörigkeit, wenn ein Elternteil die deutsche Staatsangehörigkeit besitzt » EU Report supra note 47
whose jurisprudence seems convergent. There is no clear separation of competence between civil and administrative courts.

Generally, the “best interest of the child” consideration is used by German judges against surrogacy. In certain cases, the well-being (Kindeswohl) of the child was considered to be hurt by the mere fact of him being treated as a subject of an agreement, a merchandise, or by his / her impossibility to ever discover the identity of his biological mother, if the surrogacy agreement includes an ovum donation.

On the other hand, this consideration was also used in order to facilitate the child’s situation: firstly, it has been judged that adoption was not contrary to the child’s best interest because of the sole fact of the existence of a surrogacy agreement; the court was not in charge of pronouncing his vision of bonos mores, but only of the question which was submitted, the one which concerns the child’s best interest.

Secondly, this consideration was used in a case concerning an adoption request in favour of the partner (an American citizen) of the biological father of a child (a German citizen), the men having concluded a civil partnership in Germany. The couple had concluded a surrogacy agreement in the US, which involved an ovum donation from a third party, and the German citizen’s sperm. The American birth certificate mentions the surrogate as the mother, and the German citizen as the father. The men (ordering parents) returned to Germany in order to settle down, and asked for an adoption judgment in favour of the American citizen, partner of the biological father, with the surrogate’s consent (which was made before a notary in California). This adoption request was refused in first instance by the Amtsgericht, but was admitted by the Landesgericht, on the basis of the “best interest of the child” consideration. The court has decided that German law was applicable, as the civil partnership was concluded in Germany: following §19(1)(1) EGBGB, the child’s filiation is to be determined according to the law of the state where he / she resides habitually. In German filiation law, the legal mother was the surrogate (§1591 BGB), and, as she wasn’t married when she gave birth, and as no paternity recognition has been made, no paternal filiation could be established (the fact that the birth certificate mentioned the biological father was irrelevant). The court has therefore declared that the paternal filiation would be
determined following rules respecting the most the child’s best interest. Several “child’s best interest theories” could be possible. The one which respects the child’s need to determine his paternity as soon as possible, even up to his birth; the one which respects the child’s need to access, as soon as possible, the knowledge of his genetic origins. Following both theories, the Californian law was applicable, recognising the German citizen (the biological father) as the father. Nevertheless, the judges decided that in this precise case, §1741(1), al. 2 BGB would be the most respectful of the child’s need to have a stable relationship with the people who take care of him, thus an adoption. Also, according to §9(7) of the Lebenspartnerschaftsgesetz, under the condition of the child’s best interest (which, in this case, is respected, given the harmonious environment in which the child was growing up), the biological child of one of the civil partners could be adopted by the other partner, thus considering both civil partners as legal parents. The judges considered that, in this particular case, the subjective relationship between the parties and the child, and the fact that he would have to face objective difficulties in the future, were sufficient to justify a legal solution, namely an adoption. The child’s need for a double filiation would be fulfilled; he would be allowed to inherit and to get other financial rights.

The “best interest of the child” consideration has never been used to allow the administration of travel documents to children born through foreign surrogacy agreements; this question had to be examined according to nationality and filiation legal provisions. The decisions taken by the administrative court of Berlin, which dealt with the child’s right to enter German territory without a visa, don’t mention these criteria, and refuse these requests.

However, this criteria has been mentioned while considering the request to admit a paternity recognition of a child, which was made in Russia, in order to determine the child’s filiation. The judges decided that the interest of the child was that his parents’ identity would be established as soon as possible in order to get the German citizenship, and the travel documents.

1. The protection of “family life” (as between the child and the intended parents) has never provided an alternative
consideration for the courts, nor a challenge for the “best interest of the child” principle.

2. In Germany, neither ovum donation, nor surrogacy, are authorised. There is no difference in the judges’ way of reasoning if the intended mother is the biological mother or not, the origin of the egg being irrelevant. We can see that the reasoning of the administrative court of Berlin (Verwaltungsgericht) is the same in three of its decisions, although only the later concerns a case where the intended parents are also the biological parents. In another case, the judges have mentioned that ovum donation is illegal in Germany (§1(1)(2), Embryo Protection Law), but even if the egg were the one of the intended mother it would not have changed the result.

The intended parents can adopt a child after he / she has been delivered and handed over to them by the surrogate; this has been confirmed implicitly through legal provisions, and explicitly by courts: firstly, despite the refusal of an adoption request, the judges declared that adoption was not contrary to the child’s best interest because of the sole fact of the existence of a surrogacy agreement; the court was not in charge of pronouncing his vision of bonos mores, but only the question which was submitted, the one which concerned the child’s best interest. Secondly, the administrative court of Berlin, while dealing with requests for travel documents for children born abroad through surrogacy agreement, proposed twice to the intended parents, in order to establish a filiation for the child with them, to undergo a genetic test, and then to ask for an adoption. This kind of proposition was also made by the Regional Appeal Court (Oberlandesgericht) of Stuttgart in 2012.

Nevertheless, in a decision from 2011, the administrative court of Hamm rejected an adoption request of a child born through surrogacy in the US. The judges justified their decision by declaring that even if §1741(1) BGB might have allowed the adoption in the interest of the child (although surrogacy agreements are contrary to §134 and 138(1) BGB, as well as to §1(1)(7) of the Embryo Protection Law, and to §1(1)(2) when ovum donation is included, as in the present case), the child is growing up under optimal conditions with the care of the intended parents, this situation should continue in the future, and authorising adoption cannot make his
situation better. The judges mentioned that the intended parents, along with the surrogate, have planned to continue their cooperation in making an adoption request, and, in full conscience and knowledge, took the decision to undergo such a risk of legal uncertainty for the child, whose only paternal filiation could be determined. Adoption is therefore seen as a try to regulate an illegal situation under the Embryo Protection Law. This situation hurts the child’s interest, being unable to know the identity of his biological mother, and being conscientious of the fact that he was considered as the object of a commercial agreement. For the abovementioned reasons, the court has decided to refuse this request for adoption, and proposed to take some testimonial dispositions to guarantee the inheritance rights of the child.

German courts have admitted a paternity recognition act, made by the intended father, and issued in Russia, and considered it not contrary to public policy (ordre public). The judges declared that the document at stake was not a foreign judgment, and even if it were, there would be no contradiction with public policy (ordre public), for two reasons: first, because of the right to know one’s own origins, considered as derivative from another right, a constitutional one, concerning the right to one’s own personality development (§2 and 1 of the German Constitution); this kind of right cannot be voided by any party to a surrogacy agreement (intended father, surrogate, etc.). Second, even if this surrogacy agreement would have taken place within the German territory, there would be no infringement to public policy, as §1594 BGB sets conditions to paternity recognition, which do not include any genetic tie between the recognizing father and the child, this provision being possible to use also in a surrogacy context. Accordingly, any foreign decision, which achieved the same result, cannot be considered as contrary to public policy.

On the contrary, German courts do not recognise foreign birth certificates related to surrogacy agreements. A request to recognise a birth certificate issued in California has been refused, on the ground of §36(1) PStG (Personal Status Law), according to which only the transcription of German citizens born abroad is possible. This provision requires German citizenship. §19 EGBGB provides that German law is applicable for questions of nationality. In the present case, the children were not German citizens, as their legal mother is the one who was bearing them (§1591 BGB), and their legal father the husband of the surrogate.
In other cases dealing with surrogacy, foreign birth certificates, even if at least one of the biological and intended parents is mentioned, were not considered as sufficient to establish a filiation. In cases of surrogacy agreements concluded in India or in the US, neither the intended mother, nor the intended father (‘despite his genetic relation to the child), were able to establish their filiation, even though they were mentioned as legal parents on the foreign birth certificates.

It seems much easier to establish the paternity of the intended father (several court decisions suggested it, and also, establishing the paternity of the sperm donor has never been excluded in German Law), than the maternal filiation of the intended mother, which can only be made through adoption (given §1591 BGB).

As far as we know, there is no case law published concerning a surrogacy agreement where there was no genetic relation between the intended father and the child.

Birth certificates issued abroad, in the context of surrogacy agreement, were not recognised (see question n° 9, Part B). In different cases dealing with surrogacy concluded abroad, the mere existence of foreign birth certificates was not even taken into consideration in order to establish filiation. Also, §16(a)(4) of the Law of Jurisdiction excludes the recognition in domestic law of any foreign decision if it is in contradiction with the law, and in particular with fundamental rights.

The administrative court of Berlin gave as reason for not recognising the paternity of the intended father, despite the fact that he was mentioned as such in the Indian birth certificate, the contradiction of the regulations published by the Indian Council for Medical Research to public policy (ordre public), in the sense of §6 EGBGB, because §1591 BGB (the mother is the woman bearing the child) is part of it.

Nevertheless, the notion of « ordre public » was used to facilitate the situation of a child conceived through surrogacy, and recognised by the intended father, this act of recognition, made in Russia, being considered as non contradictory with the “ordre public”, and thus, recognised.

German judges, while dealing with surrogacy agreements concluded abroad, have to decide about giving travel documents to the children, under the condition of being German citizens. In fact, German Law being ius
sanguinis, a child whom at least one of his / her parents is a German citizen, can get the German citizenship. According to §19(1) of the Introductory Law of the Civil Code, in respect to the filiation of a child, at first the law of the state in which the child has its habitual residence is applicable. However, the filiation, in relation to each parent, can be decided according to the law of the state to which each parent belongs. In the context of surrogacy, the establishment of a filiation is complicated, given that, under German law, the mother is the woman bearing the child (§1591 BGB), and, if she is married, her husband is considered as the legal father (§1592(1) BGB), and not the ordering father.

German courts have been forced to consider foreign law in cases where the habitual residence of the child, unable to get back to Germany because deprived of travel documents, was abroad. In a case of surrogacy which took place in India, the court disregarded the claim of the intended father to the recognition of his paternity, founded on the genetic relation between him and the child, considering that the question of the nationality has to be determined following Indian law, where the child resides. Under Indian Law, no specific provision has been set in the field of surrogacy, and in general, the mother is the woman bearing the child, even if she doesn’t have any genetic relation to the child; the father is this woman’s husband, so if the surrogate was married when she gave birth to a child, her husband is the legal father. However, the judges insist on explaining that even under German law, the intended father is not the child’s legal father, as he wasn’t married to the surrogate when she gave birth to him, nor has he recognised his paternity, nor has his paternity been judicially established.

The German legislator has never defined the application domain of the Embryo Protection Law, nor the Adoptionsvermittlungsgesetz. Therefore, German criminal law is only applicable in regard to offences committed within the national territory.

Even in cases where surrogacy agreements were considered as void, because of their contradiction with the notion of bonos mores (based on §134 and §138(1) BGB), and as being degradation to the child’s status. The judges use the same neutral terms, namely « Leihmutterschaft », and sometime « Ersatzmutterschaft » (substitution motherhood). On rare occasions, more negative qualifications are used, the surrogate is named « Mietmutter »(rent mother), and the intended parents « Bestelleltern »
(commanding parents). Generally, the judges prefer to name the intended parents according the place they have in the procedure (adoptive parents, biological father, spouse of the pretender, etc.), or name them by abbreviations (Mrs. X, for example). No court decision regarding surrogacy has ever mentioned any need for a legal reform.

In Germany, a written law country, judges refer to legal provisions, which, in the field of surrogacy, may concern contract law (§134 and 138(1) BGB), filiation law (§19(1), Introductory Law of the Civil Code – EGBGB); §1591-1592 et §1741(1), BGB), and nationality law (§4(1) StAG). They are not guided by any jurisprudential construction. German courts have never approved any payments in the context of surrogacy, as surrogacy in itself is not authorised. The judges do mention the existence of this kind of payment, in order to condemn them morally, but the sole fact of paying has never been the main issue, rather nationality and filiation law.

Despite the legal frame of surrogacy, German judges have much discretion as adoption rules are flexible, in particular §1741(1) BGB, which can serve as a legal foundation for decisions of adoption, under the condition of respect of the child’s best interest, even in cases of surrogacy. Once the paternal filiation established, the intended mother could ask for an adoption, as has been confirmed by several courts.

RUSSIA

Legal Sources

Russian legal regulation of assisted reproduction in general and surrogate motherhood specifically, although being permissive on the whole, is fragmentary and not always consistent. The most recent changes in Russian law in this regard were made in 2011 by the Federal Law on the Fundamentals on Protection of Citizens’ Health. However this Law did not fill all gaps that existed in the legal regulation of assisted reproduction. Particularly in the part which regulates surrogate motherhood, the Law is contradictory and not always clear. This will be explained in due course when related issues are discussed.

Currently, the main legal sources that govern surrogate motherhood in Russia are the following:
1) The Family Code 1995 (as amended), enacted from the 1\textsuperscript{st} of March 1996 (hereafter – FC);


3) The Federal Law on the Acts of Registration of Civil Status 1997 (as amended), enacted from the day of its official publication;


Definitions and Key Concepts

The first mentioning of surrogate motherhood in Russian law relates to 1995, when the Family Code was adopted, and since enactment of the Code, i.e. from the 1\textsuperscript{st} of March 1996, surrogate motherhood became legally available.\textsuperscript{66}

The Law on Citizens’ Health 2011 defines assisted reproduction technology as the methods of infertility treatment when some or all stages of conception and early development of an embryo are performed outside mother’s body (including the use of donor’s and (or) frozen gametes, tissues of reproductive organs, and embryos, as well as surrogate motherhood) (s. 55 (1)). This means that use of surrogate motherhood is possible, at least under the law, only by medical indications, as a method of infertility treatment.

The same Law defines surrogate motherhood as gestation and birth of a child (including premature birth) under a contract made between a surrogate mother (woman who gestates a fetus after transfer of a donor’s embryo) and prospective parents whose gametes were used for fertilization or a single woman for whom gestation and birth of a child is impossible by medical reasons (s. 55 (9)). To avoid any confusion, the Law specifies in the next sub-section that “a surrogate mother shall not be an oocytes donor”.

From this it particularly follows that Russian Law allows only full, or gestational, surrogacy because it is clearly stated that surrogate mother shall not be genetically related to the fetus she gestates.

Before the Law on Citizens’ Health 2011 was enacted, technically there had been no clear prohibition of “partial”, or “traditional” surrogacy. However, under the previous legal regime, traditional surrogacy has not anyway been permitted. Instead, what is called “traditional surrogacy” was, in fact, considered an artificial insemination with a donor’s sperm, i.e. the “traditional” surrogate mother is a biological or genetic mother of a child she gives birth to. Therefore, she is not a “surrogate” but a true mother in a biological sense. Under Russian law, if a woman does not want to bring up and take care of her child, she may give her consent to her child to be placed for adoption. The adoption procedure is very special and very strict; it is not applicable in cases of surrogate motherhood, and violation of the adoption procedure is a serious offense.

Regulation of surrogate motherhood in Russia is based on a very important and key idea that a surrogate mother has the right to keep the child if she wants. This is considered to be one of the main safeguards against the exploitation of a woman involved in surrogacy arrangements. It is fixed in FC, in s. 51, which states that:
Persons who are married to each other and who gave their consent in a written form to implantation of an embryo in another woman for the purpose of its bearing may be entered as the child’s parents only with the consent of the woman who gave birth to the child (surrogate mother).

This provision is based on the concept that the woman who gave birth to a child is considered at law as the mother of this child. In this regard, drafters of the Russian Family Code were guided by the recommendations made by a group of European experts in biomedical science in 1989.67

Recently, the constitutionality of FC provision that permits the registration of the intended couple as the child’s parents only with the consent of the surrogate mother who gestated and gave birth to the child was questioned in a case considered by RF Constitutional Court (Constitutional Court Ruling of 15.05.2012 No. 880-O). In this case the surrogate mother refused to give her consent to the prospective parents’ registration as the legal parents and registered the child herself in a civil status state registry as her own child (accordingly she was registered as the legal mother). The Constitutional Court confirmed the constitutionality of this provision of FC and rejected the application of the intended/prospective parents.

Requirements that a potential surrogate mother shall meet

The Law on Citizens Health 2011 sets out the requirements that a woman who is going to serve as a surrogate mother should meet. Before, they were stipulated at a lower level of regulation (governmental/ministerial) – in the Ministry of Health Order 2003. Thus, under the Law 2011 (s. 55 (10)), a woman who gave her written informed consent to medical intervention may serve as a surrogate mother provided she:

- is between 20 and 35 years old;

---

has at least one healthy child; and

received a medical statement that she is healthy (in ‘satisfactory state of health’).

The Law does not require a surrogate mother to be married or, on the opposite, to be a single woman. However, if she is married, her husband’s consent to her serving as a surrogate mother is required (s. 55 (10)). It should be noted in this regard that by “marriage” the Law means a marriage officially registered in the order stipulated by Russian legislation, i.e. in the state bodies for registration of civil status.

Access to assisted reproduction technologies (ART)

Under Russian law, a man and a woman, married as well as not married, have the right to have access to assisted reproduction technologies, provided they gave their mutual informed consent to medical interference; a single woman also has the right to have access to assisted reproduction technologies if she gave her informed consent to medical interference.

Two comments are necessary in this regards.

1. The previous Law on Citizens’ Health 1993 spoke only about the right of “every adult woman of reproductive age” to benefit from assisted reproduction technologies (s. 35). This Law did not specify whether a woman should be married or not. However, Family Code 1995, when regulating the order of registration of intended parents as legal parents of a child born for them by a surrogate mother, speaks only about a married couple in s. 51 (para 4, part 2) cited above. As the result of this contradiction, many applications to register the birth of a child born by a surrogate mother presented by cohabitating couples or single women were rejected by the civil status state registries with the reference to this provision of FC. This, in turn, resulted in suits filed to the courts where the intended parents or intended single mothers claimed their right to be registered as legal parents or legal mothers respectively. It is known that in many cases

68 the Law on Citizens Health 2011, s. 55 (3)www.ncbi.nlm.gov/pubmed/23373332
such claims were satisfied, and the registries were ordered to register birth of the children.

The Law on Citizens Health 2011, having stated, firstly, that a man and a woman who are not married (to each other) may benefit from assisted reproduction and, secondly, that a contract on surrogacy contract may be made between a surrogate mother and intended parents (without any reference to their marriage status), clearly indicates that surrogate motherhood is open not only for the spouses but for cohabitating couples as well.

2. Whether a single man may have access to surrogate motherhood under Russian law is an issue that also raises questions. Literal interpretation of the above-mentioned provisions of the Law on Citizens Health 2011 that concern access to assisted reproduction and define the main terms of a contract on surrogate motherhood suggests a negative answer to this question because neither sub-paragraph 3 nor sub-paragraph 9 of s. 55 name a single man. Therefore, in accordance with this provision a contract on surrogate motherhood shall not be made between a single man and a surrogate mother. At the same time, we can hardly assume that the Law on Citizens’ Health 2011 meant to close access to fertility treatment for single men. To claim this would mean to go into contradiction with the principles of Russian Constitution 1993 on equality of rights and freedoms of men and women and equal opportunities for their realization (Art. 19), on the right of everyone to health care and medical help (Art. 41) and with the constitutional provision on state support of the family, maternity, paternity and childhood (Art. 7), not to mention contradiction with the social reality of male infertility. It is enough just to say that methods of medical treatment of male infertility had been already widely applied in medical practice for several decades, and as long as in 1993, the previous Ministry of Health Order on ART stipulated the male fertility as one of the grounds for IVF treatment. Infertility treatment has been conventionally associated with medical treatment of women,

69 RF Supreme Court Ruling on the case No. 78-08-1314 of 8 September 2008 opp. cited supra note 47
and in practice, these were and still are usually couples, which would come to medical clinics, even if male, and not female, infertility was a medical problem. It is not surprising, therefore, that the previous Law on Citizens’ Health 1993 spoke only about the right of “every adult woman of reproductive age” to benefit from assisted reproduction technologies, without any mentioning of an adult man (s. 35). This did not raise particular problems before, because same-sex cohabitation was not a topical issue in Russia until recently. Nowadays, the situation is changing, and the sexual equality angle of access to assisted reproduction technologies may certainly turn out to be on the agenda one day.70

**Contract on Surrogate Motherhood v. Donors’ Gametes**

The Law on Citizens’ Health 2011 is confusing on another important issue, i.e. whether it is possible to use the genetic material of a donor(s) for IVF with surrogate mother participation. To recall, the Law defines surrogate motherhood as gestation and birth of a child under a contract made between a surrogate mother (woman who gestates a fetus after transfer of a donated embryo) and prospective parents whose gametes were used for fertilization or a single woman for whom gestation and birth of a child is impossible by medical reasons (s. 55 (9)).

According to a literal interpretation of this provision, it is clear that the use of a donor’s genetic material is available for a single women only but not for couples, whether married or not. Therefore, under this provision prospective parents shall be genetic parents of a child that a surrogate mother will gestate for them and give birth to. It is hard to say now what the idea was behind such wording, as there are still no comments or official explanations of this provision. Before the Law on Citizens’ Health 2011 was adopted, there was neither prohibition nor differentiation between these situations in the law, which meant that an infertile couple could use both donated oocytes and sperm in a surrogate motherhood program, if there were medical indications. As far as the author of this report is aware, currently the situation in medical practice is the same as before, and if there are medical indications, donor gametes are used in surrogate motherhood programs with regard to infertile couples.

Finalizing parents-child relations

To finalize parental rights with regard to a child born by a surrogate mother no court judgment is required (provided there is no dispute over the child’s origin). The child’s parents are registered as his or her legal parents at the registration of the child’s birth at the civil status registry.

If a surrogate mother gave her written consent to the registration of the intended parent(s) as the legal parents in the birth registry book and on the child’s birth certificate, the child birth registration procedure is the same as the registration of a birth of a child conceived in a natural way, with one exception. The Federal Law on the Acts of Registration of Civil Status 1997 (s. 16 (5)) requires that, apart from other documents that should be usually presented to the birth registration body (for instance, parents ID/passports and a medical statement on child’s birth), the intended parent(s) also present an “official note” (medical statement) that was issued by a medical clinic and that confirmed that the surrogate mother gave her consent to the registration of the intended parent(s) as the legal parents. Given the registration of the intended parent(s) as the legal parents of a child born by a surrogate mother, a surrogate mother is considered by law as a strange person to this child and does not have any legal right to claim to maintain contact with him or her.

If a surrogate mother used her right to keep the child and did not give her consent the registration of the intended parent(s) as the child’s legal parents, she can be registered as the child’s mother in the birth registry book and on the child’s birth certificate upon presenting to a civil status registration body her passport and a “statement” from the medical clinic certifying that she delivered the child. If she is married, her husband is registered as the child’s father (to recall, under the law his consent to his wife serving as a surrogate mother is required).

To finalize parental rights before a child is born is not allowed by Russian law; the child’s birth certificate can be issued only after the child’s birth. After a child’s birth has been officially registered, parent-child relations are considered to be finalized. The child’s status in the family is absolutely the same as the status of a child conceived in a natural way.
Contesting paternity or maternity

Although Russian law permits contesting paternity or maternity in general, it does not allow to contest paternity or maternity if it is based on assisted reproduction technology grounds. In this regard, Russian law is straightforward. Particularly on surrogate motherhood, FC (s. 52 (3 (2)) says:

“a married couple who has agreed to implantation of an embryo to another woman, as well as a surrogate mother... when contesting paternity or maternity, cannot refer to these circumstances after registration of the child’s parents in a birth registration book.”

By “these circumstances”, FC means that the child was conceived through IVF with surrogate mother involvement.

If donated genetic material has been used in the course of infertility treatment, it has no legal consequences with regard to parentage for the donors. The Ministry of Health Regulation 2003 (para 6) stipulates that the donors “provide their gametes... to other persons to overcome infertility and do not undertake parental obligations towards a future child”.

Citizenship (nationality) of a child

The basic principle of Russian law concerning child’s nationality/citizenship is that a child shall not be stateless (the Federal Law on Citizenship of RF 2002, s. 12). With regard to the children born on the territory of Russia, whose parents are foreign citizens, this Law stipulates that these children acquire Russian citizenship by birth only if their parents (foreign citizens) are permanently residing in the Russian Federation, and the country of the parents’ citizenship will not provide children born in Russia with the parents’ citizenship. Therefore, a child born on the Russian Federation territory acquires the citizenship of its parent(s) under the parent(s)’ personal law. Only in cases whereby the state of which the parent(s) are citizens does not provide citizenship to the child, may the child acquire Russian citizenship.

Cross-border Surrogate Motherhood Issues

There is not that much information about cross-border surrogacy arrangements available in legal scholarship and in the mass media; there
are no reported cases either. It is known, however, that international programs in surrogate motherhood have started to develop in the country.

As cross-border surrogacy develops in Russia, additional problems connected, for instance, with taking a child born by a surrogate mother abroad or settling disputes between the parties of cross-border surrogacy arrangements will arise.

As far as taking a child abroad, getting entry visa for a child and further legalization of the child in a home country of the child’s parents may be a problem. Particularly, to finalize parent-child relations in some countries a court judgment is required. In contrast, in Russia these issues, as has been noted, are administratively regulated (by registration of a child’s birth in a state body for registration of civil status), and no court is involved.

As to the private international law context, Russian law does not contain any specific rules that directly regulate cross-border surrogate motherhood issues. General conflict of laws rules are included in Part III of the Russian Civil Code. However, those rules that address family law issues and, particularly, parenthood issues, are contained in the Family Code. Thus, FC refers to nationality/citizenship as a connecting factor with regard to legal parenthood. It is stated in FC that establishment and contest of legal parenthood is determined under the law of the state whose citizenship a child has by birth (s. 162 (1)). Parental rights, however, in accordance with FC, shall be determined under the law of the state where parents and children have common place of residence. The law of the country of the child’s nationality/citizenship in such a case is used as a connecting factor only if there is no common place of residence. With regard to child maintenance issues and other parent-child relations, the law also allows, upon a petitioner’s request, application of the law of the country where a child permanently resides (s. 163).
Table 1. Summary of ART, PGD, surrogacy, gamete donation, and social limitation regulations in selected nations

<table>
<thead>
<tr>
<th></th>
<th>Australia</th>
<th>Canada</th>
<th>New Zealand</th>
<th>United Kingdom</th>
<th>USA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ART regulated</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>Regulator</strong></td>
<td>Reproductive Technology Accreditation Committee (RTAC)</td>
<td>Assisted Human Reproduction Canada Act</td>
<td>Human Assisted Reproductive Technology (HART) Human Fertility and Embryology Act (HFEA)</td>
<td>None federally</td>
<td></td>
</tr>
<tr>
<td><strong>PGD Testing Regulations</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>Sex Selection for social reasons</strong></td>
<td>Prohibited</td>
<td>Prohibited</td>
<td>Prohibited</td>
<td>Prohibited</td>
<td>Acceptable, depending on medical reason; discouraged for sex selection</td>
</tr>
<tr>
<td><strong>To prevent the transmission of a genetic disease or disorder</strong></td>
<td>Permitted</td>
<td>Permitted</td>
<td>Permitted</td>
<td>Permitted</td>
<td>Permitted</td>
</tr>
<tr>
<td><strong>Maternal surrogacy available</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Commercial Surrogacy</strong></td>
<td>Illegal</td>
<td>Illegal</td>
<td>Illegal</td>
<td>Illegal</td>
<td>Vary by clinic</td>
</tr>
<tr>
<td><strong>Non-commercial surrogacy</strong></td>
<td>Varies by state</td>
<td>Legal</td>
<td>Legal</td>
<td>Legal</td>
<td>Vary by clinic</td>
</tr>
<tr>
<td><strong>Human Gamete and Embryo Donations</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Monetary Compensation</strong></td>
<td>Prohibited</td>
<td>Prohibited</td>
<td>Prohibited</td>
<td>Permitted</td>
<td>Permitted</td>
</tr>
<tr>
<td><strong>Other criteria for</strong></td>
<td>Anonymous or</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gamete donation</th>
<th>unknown donations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Limitations</td>
<td>Yes</td>
</tr>
<tr>
<td>Homosexual Partners</td>
<td>Available, if the women in the relationship are infertile</td>
</tr>
<tr>
<td>Single woman/man</td>
<td>Available, if woman is infertile</td>
</tr>
</tbody>
</table>

Table 2. Summary of immigration regulations, policies and/or procedures concerning repatriation of children born abroad from ART.

<table>
<thead>
<tr>
<th>Sl.</th>
<th>Australia</th>
<th>Canada</th>
<th>New Zealand</th>
<th>U.K.</th>
<th>USA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Genetic Relationship between the child and at least one of the intended parents:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Parental status at child's birth</td>
<td>---</td>
<td>Legal Parent</td>
<td>Not considered legal parents. parents must file for an adoption order</td>
<td>No guarantee that intended parents are the legal parents; by default, the surrogate and her husband are considered legal parents</td>
</tr>
<tr>
<td></td>
<td>Child's citizenship at birth</td>
<td>Can apply for Australian citizenship by descent</td>
<td>Can apply for Canadian citizenship by descent</td>
<td>Not eligible to claim citizenship by descent; can claim citizenship through</td>
<td>US citizen</td>
</tr>
</tbody>
</table>

72 Ibid
2. When there is no genetic relationship between the child and intended parents:

| Options Available | 1. Inter-country Adoption When adoption is not possible:  
2. Submit a written confirmation from the foreign jurisdiction or expertise at the visa office.  
OR  
3. Obtain a temporary resident permit card for the child, an application for humanitarian and compassionate permanent resident and a citizenship or grant under “Citizenship Act” [21] | Cannot obtain parental order | Intended parents can file for Consular Report of Birth Abroad (CRBA) of an American Citizen and for a US passport |

3. Required Documents From intended parents

| Completed Australian citizenship by descent application form; DNA tests confirming parentage; attestation from lawyer in birth country; certificate from hospital where birth took place; proof of payment of hospital bills; contract between intended parents and lab | Birth Certificate with intended parents’ names; proof of payment of hospital bills; contract between intended parents and lab | New Zealand Family Court adoption order; and approval of a social worker | Must obtain parental order | Evidence of: child’s conception and birth; identity and citizenship of intended parents; physical presence in the USA; DNA tests |
4. From the Surrogate

<table>
<thead>
<tr>
<th>of payment of all medical and hospital bills</th>
<th>confirming parentage</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Letter of no objection</th>
<th>Contract agreement between surrogate and intended parents</th>
<th>Consent; details of surrogacy arrangement; identity and information of any gamete donor(s)</th>
<th>Surrogate and legal father must give consent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>If surrogate is the genetic mother, she must provide consent</td>
</tr>
</tbody>
</table>

*Blank cells indicate that no information was found relating to that issue*

The heterogeneity of the ART global regulation landscape has been one of the complicating factors in the evolution of the global ART industry. In countries like the USA, jurisdictional disputes between federal and state-level regulators are one of the causes of a lack of a national ART strategy. As ARTs involve many of the more ethically challenging issues of our day—including women’s health, abortion, the evolving definition of family, sex selection, and genetic manipulation—the extent to which federal law in a liberal democracy reflects the values of a given population must be considered. Thus, it can be argued that the expression of such value via federal regulation also represents the culmination of a national dialogue on those issues; and, relatedly, absence of such regulation might be indicative of either a deep heterogeneity in public opinion, or of a comfort with the ability of private industry to self regulate on these matters. The question arises, then, to what extent does such regulation reflect the true value of the population, versus the extent to which it serves the commercial needs of the industry. Of particular note is the observation that commercial surrogacy is either illegal or heavily restricted in all of the examined nations. Yet, in at least three countries (Australia, Canada, and the USA) there exists an established legal process for the repatriation of a child produced.

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abroad via commercial surrogacy, without any penalty for the domestic regulation that that reproduction seemingly violated.

A society’s ethical framework manifests through both its articulation and application of such rules, not just through its overt phraseology. An example of this oversight is the Assisted Human Reproduction Act in Canada, elements of which were successfully challenged in a Supreme Court Case in 2010\(^77\). The law remains on the books, but is interpreted selectively, according to the specifics of the court challenge.

There are, of course, many other examples of domestic laws for which governments will not prosecute their citizens if violated abroad in a jurisdiction in which the act is not a crime; recreational substance use, for example. Notable exceptions are those concerning sex tourism, as in the US PROTECT Act of 2003\(^78\), which allows for the legal prosecution of American citizens who purchase the sexual services of minors outside of American soil. Commercial surrogacy tourism, especially when it involves surrogates in LMICs, has been compared to both organ tourism and sex tourism, in terms of its reliance on the paid physical participation of a third party, often at the expense of their own health or safety.

Inasmuch as surrogacy may involve the exploitation of a vulnerable woman, as is one point of view, it may warrant similar consideration for the extension of prosecution beyond a user’s home nation. Clearly, commercial surrogacy is a service whose ethical parameters are troubling to many, and thus arguably deserving of a government-overseen regulatory framework, at the very least. Across all of the examined countries for which a regulator was identified, policies concerning surrogacy sought to distinguish between the practical and ethical impacts between traditional and gestational surrogacy. The former involves the surrogate’s ova, while the latter involves the gestation by the surrogate of an embryo created from another woman’s ovum. This is because two separate definitions of motherhood are thus disentangled: via the process of birthing versus via a genetic relationship. All nations also sought to distinguish between paid and unpaid surrogacy, with most choosing to criminalize the former but not the latter. One of the


results of both of these decisions is the rapid growth of a gestational commercial surrogacy market in nations that have not taken these regulatory steps, India prime among them. The existence of global reproductive tourism, then, is due not just to an economic gradient that drives HIC clients to less expensive LMIC providers, but perhaps also due to a regulatory gradient, which drives clientele from more regulated to less regulated jurisdictions. As India’s domestic regulations evolve, it is interesting to see how their decisions will affect the global industry, given how that nation’s limited restrictions have helped to grow their industry. While India has not yet made new law on the matter, their most recent draft bill indicates that their focus is on clinical matters, and not on the restriction or limitation on the scope or complement of service provision, a tack which is unlikely to diminish the flow of foreign clientele to Indian ART clinics. Activist groups accuse the government of structuring its bill to best service ART commercial interests, and not sufficiently protecting Indian surrogates or properly reflecting the true sentiment or values of the electorate.\(^79\)

The provision of PGD is a new service in Indian clinics, but one that is fast being adopted and advertised [3]. It is, however, prohibited in almost all of the HICs examined, especially with respect to its application for sex selection. However, HIC regulators are aware of PGD’s strong potential for disease screening. The challenge, of course, is to balance PGD’s undeniable medical value against its potential for quasi-eugenic social engineering. To make this distinction in law is somewhat meaningless without the resources and wherewithal to both monitor and enforce the technology’s application and disposition in actual labs.

We included PGD as a service whose regulatory culture is of particular interest to gauge whether existing policy frameworks are sensitive to technologies that are, in some ways, still on the horizon. The fact that testing regulations are present in all examined nations, save Israel, may indicate an ethical concern. Despite the technique’s comparative novelty, at least relative to its sister technologies IVF and ICSI (intracytoplasmic sperm injection), it is of sufficient ethical interest to warrant specific regulation. Some might view the existence of such

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79 Deonandan and Bente, Supra Note 71
regulations as a sign of a government’s evolving rapid responsiveness to technologies that are as yet not fully in the public lay lexicon.

More countries, both established and emerging economies, are formulating ART regulations. Forces shaping new policy are not merely the values and desires of the domestic population, but also the agents of a global, growing industry. What must not be lost in the tension between these forces is the ultimate need for the preservation of the rights, health, and safety of all actors: children born via ART, potential parents, gamete donors, surrogate mothers, and service providers. Future research in this topic should include a description of the patterns and demographics of individuals traveling internationally to seek ART services, along with the extent to which regulations have influenced their choices.

Reproductive tourism is an expanding international industry that is complicated by heterogeneous regulatory patterns in nations most likely to be providing clients seeking reproductive services abroad.

**Status of Surrogacy in Asian Countries**

In Japan, the Science Council of Japan proposed a ban on surrogacy and doctors, agents and clients will be punished for commercial surrogacy arrangements. In Saudi, Arabia religious authorities do not allow the use of surrogate mothers.\(^{80}\)

In China, Ministry of Health banned surrogacy in 2001. Despite this regulation it is reported that illegal surrogacy “black market” is still flourishing in China. Anxious about such situation strict legislation has been suggested by the political parties.\(^{81}\)

Thailand is the country emerging as alternative destination in Asia for Commercial Surrogacy and on Message Boards of various Web-sites a number of messages of lady may be observed unlike India.


\(^{81}\) Anu, Pawan Kumar, Deep Inder, Nandini Sharma. Ibid
Chapter 5

Efforts made to regularise ART in India

Renting the wombs has become an easy and cheap option in India\(^1\). Relatively low cost of medical services, easy availability of surrogate wombs, abundant choices of donors with similar racial attributes and the lack of any law to regulate these practices is attracting both foreigners and NRIs to sperm banks and surrogate mothers.

Surreptitiously, India has become a booming centre of a fertility market with its reproductive tourism” industry reportedly estimated at Rs 25,000 Crore today. Clinically called ART, it has been in vogue in India since 1978 and today an estimated 200,000 clinics across the country offer artificial insemination, IVF and surrogacy.

In Baby Manji Yamada’s case, the Supreme Court observed that “commercial surrogacy reaching industry proportions is sometimes referred to by the emotionally charged and potentially offensive terms wombs for rent, outsourced pregnancies or baby farms”\(^2\). It is presumably considered legitimate because no Indian law prohibits surrogacy. But then, as a retort, no law permits surrogacy either. Surely, the proposed law will usher in a new rent-a-womb law as India is set to be the only one to legalise commercial surrogacy.

In the absence of any law to govern surrogacy, the Indian Council of Medical Research guidelines (2005) for accreditation, supervision and regulation of ART clinics in India are often violated. Exploitation, extortion and ethical abuses in surrogacy trafficking are rampant and surrogate mothers are misused with impunity.

In fact, after legalisation of surrogacy in India ICMR came forward with the guidelines for ART Clinics in India. These guidelines are still the only regulations, that governing ART clinics in India, though does not having force of Law in true sense.

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\(^1\) Hindustan Times, dated 7th August 2008, Nation Page, pg. 13, column 2.

\(^2\) Baby Manji Yamada Vs. Union Of India AIR 2009 SC 84
“There are no guidelines for the practice of ART, accreditation of infertility clinics and supervision of their performance in India. This document aims to fill this lacuna and also provide a means of maintaining a national registry of ART clinics in India. The document has been widely publicized, discussed and debated by expert groups of the ICMR and the National Academy of Medical Sciences and then by practitioners of ART and the public in Chennai, Jodhpur, Kolkata, Bangalore, Hyderabad and Mumbai. These discussions involved over 4000 participants including doctors, scientists, bureaucrats, legal experts, infertile couples and the general public. This document was also put on the Council’s website and elicited many comments and responses.”


FEATURES OF THE ICMR GUIDELINES

Minimum Physical requirement of ART Clinics

Essential Qualifications of the ART Team

The practice of ART requires a well-orchestrated teamwork between the gynaecologist, the andrologist and the clinical embryologist supported by a counsellor and a programme coordinator/director. The staff requirements given below would be mandatory for Level 2 and Level

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3 National Guidelines for Accreditation, Supervision and Regulation of ART Clinics in India, Page xii
3 clinics (see Section 2.5.3 and 2.5.4). In the case of small Level 2 and Level 3 clinics, the services of the andrologist, the clinical embryologist and/or the counselor could be shared.

**ART Procedures**

One of the primary concerns of all ART treatments is the safety of the patients and of their gametes and embryos which constitute the very beginning of a new individual’s life.

A variety of ART procedures have been described in the literature. Only those procedures that have been widely tested and proven to be satisfactory as of writing this document are listed here. It would be the responsibility of the National Accreditation Committee (Chapter 9) to ensure that the list given in this document is enlarged in real time as progress occurs in the field. It is hoped that the practitioners of ART in the country will bring to the notice of the Committee on a continuing basis, any new procedure for the practice of which there would appear to be a sound scientific case. The National Accreditation Committee or a body appointed by it will approve or disapprove the new procedure within six months of its having been made aware of in writing: if this is not done, the clinic could continue to use the procedure until the above body has taken a decision on it. No new procedure that has not been approved as above should be permitted to be used by an infertility clinic for more than the period mentioned above.

The Guidelines approved following procedures with detailed description of the procedures and reference of common indications:

1. Artificial insemination with husband’s semen (AIH)
2. Artificial insemination with donor semen (AID)
3. Intrauterine insemination with either husband’s or donor semen (IUI-H or IUI-D)
4. *In vitro* fertilization and embryo transfer (IVF-ET)
5. IVF-associated techniques
6. Intracytoplasmic sperm injection (ICSI) with ejaculated, epididymal or testicular spermatozoa
7 Oocyte donation (OD) or embryo donation (ED)

8 Cryopreservation

9. *In vitro* culture media

   The Guidelines also direct to Caution, precautions and concerns about ART practice specifically in Ovarian stimulation Indiscriminate use of ICSI Possible misuse of ART – sale of embryos and stem cells

   The guidelines also deals with the Screening of Patients for ART and direct the Selection Criteria and Possible Complications. It also clarify the criteria for selection of specific method of ART.

   Code of Practice, Ethical Considerations and Legal Issues Clinics which should be Registered. *This Code of Practice* deals with all aspects of the treatment provided and the research done at registered clinics. Those areas which most affect the doctors, scientists and patients and includes Staff, Facilities, Confidentiality, Information to patient, Consent, Counseling, Use of gametes and embryos, Storage and handling of gametes and embryos, Research and procedures for acknowledging and investigating complaints. It also describes the **Responsibilities of the Clinic including responsibility to** give adequate information to the patients, explain to the patient the rationale of choosing a particular treatment and indicate the choices the patient has (including the cheapest possible course of treatment), with advantages and disadvantages of each choice, help the patient exercise a choice, which may be best for him/her, taking into account the individual’s circumstances, maintain records in an appropriate proforma (to be prescribed by the authority) to enable collation by a national body, have the schedule of all its charges suitably displayed in the clinic and made known to the patient at the beginning of the treatment. There must be no extra charges beyond what was intimated to the patient at the beginning of the treatment, ensure that no technique is used on a patient for which demonstrated expertise does not exist with the staff of the clinic, and be totally transparent in all its operations. The ART clinics must, therefore, let the patient know what the success rates of the clinic are in regard to the procedures intended to be used on the patient and have all consent forms available in English and local language(s).
Confidentiality has included as paramount consideration while assigning responsibilities to ART Clinics even when commercial DNA fingerprinting becomes available, to keep on its record, if the ART clinic desires and couple agrees, DNA fingerprints of the donor, the child, the couple and the surrogate mother should be done, keep all information about donors, recipients and couples confidential and secure. The information about the donor (including a copy of the donor’s DNA fingerprint if available, but excluding information on the name and address – that is, the individual’s personal identity) should be released by the ART clinic after appropriate identification, only to the offspring and only if asked by him/her after he/she reaches the age of 18 years, or as and when specified and required for legal purposes, and never to the parents (excepting when directed by a court of law), maintain appropriate, detailed record of all donor oocytes, sperm or embryos used, the manner of their use (e.g. the technique in which they are used, and the individual/couple/surrogate mother on whom they are used). These records must be maintained for at least ten years after which the records must be transferred to a central depository to be maintained by the ICMR.

If the ART clinic/centre is wound up during this period, the records must be transferred to the central repository in the ICMR.

Information must be given to couples seeking treatment, on the basis, limitations and possible outcome of the treatment proposed, variations in its effectiveness over time, including the success rates with the recommended treatments obtained in the clinic as well as around the the possible side-effects (e.g. of the drug used) and the risks of treatment to the women and the resulting child, including (where relevant) the risks associated with multiple pregnancy, the need to reduce the number of viable foetuses, in order to ensure the survival of at least two fetuses, Possible disruption of the patient’s domestic life which the treatment may cause, the techniques involved, the cost (with suitable break-up) to the patient of the treatment proposed and of an alternative treatment, if any (there must be no other “hidden costs”), the importance of informing the clinic of the result of the pregnancy in a pre-paid envelope, make the couple aware, if relevant, that a child born through ART has a right to seek information (including a copy of the DNA fingerprint, if available) about his genetic parent/surrogate mother on reaching 18 years, excepting information on the name and address – that is, the individual’s
personal identity – of the gamete donor or the surrogate mother. The couple is not obliged to provide the information to which the child has a right, on their own to the child when he/she reaches the age of 18, but no attempt must be made by the couple to hide this information from the child should an occasion arise when this issue becomes important for the child, the advantages and disadvantages of continuing treatment after a certain number of attempts. It also provides that a third party donor of sperm or oocytes must be informed that the offspring will not know his/her identity.

There would be no bar to the use of ART by a single women who wishes to have a child, and no ART clinic may refuse to offer its services to the above, provided other criteria mentioned in this document are satisfied. The child thus born will have all the legal rights on the woman or the man.

The ART clinic must not be a party to any commercial element in donor programmes or in gestational surrogacy.

A surrogate mother carrying a child biologically unrelated to her must register as a patient in her own name. While registering she must mention that she is a surrogate mother and provide all the necessary information about the genetic parents such as names, addresses, etc. She must not use/register in the name of the person for whom she is carrying the child, as this would pose legal issues, particularly in the untoward event of maternal death (in whose names will the hospital certify this death?).

The birth certificate shall be in the name of the genetic parents. The clinic, however, must also provide a certificate to the genetic parents giving the name and address of the surrogate mother. All the expenses of the surrogate mother during the period of pregnancy and post-natal care relating to pregnancy should be borne by the couple seeking surrogacy. The surrogate mother would also be entitled to a monetary compensation from the couple for agreeing to act as a surrogate; the exact value of this compensation should be decided by discussion between the couple and the proposed surrogate mother. An oocyte donor can not act as a surrogate mother for the couple to whom the oocyte is being donated.
A third-party donor and a surrogate mother must relinquish in
writing all parental rights concerning the offspring and vice versa. No ART
procedure shall be done without the spouse’s consent.

The provision or otherwise of AIH or ART to an HIV-positive woman
would be governed by the implications of the decision of the Supreme
Court in the case of X – vs – Hospital 2 (1998) 8 Sec. 269 or any other
relevant judgement of the Supreme Court, or law of the country,
whichever is the latest.

Gametes produced by a person under the age of 21 shall not be
used. The accepted age for a sperm donor shall be between 21 and 45
years and for the donor woman between 18 and 35 years.

Sex selection at any stage after fertilization, or abortion of foetus of
any particular sex should not be permitted, except to avoid the risk of
transmission of a genetic abnormality assessed through genetic testing of
biological parents or through pre-implantation genetic diagnosis (PGD).
No ART clinic shall offer to provide a couple with a child of the desired sex.

Collection of gametes from a dying person will only be permitted if
the widow wishes to have a child. No more than three eggs or embryos
should be placed in a woman during any one treatment cycle, regardless
of the procedure used, excepting under exceptional circumstances {such
as elderly women (above 37 years), poor implantation (more than three
previous failures), advanced endometriosis, or poor embryo quality} which
should be recorded.

Use of sperm donated by a relative or a known friend of either the
wife or the husband shall not be permitted. It will be the responsibility of
the ART clinic to obtain sperm from appropriate banks; neither the clinic
nor the couple shall have the right to know the donor identity and
address, but both the clinic and the couple, however, shall have the right
to have the fullest possible information from the semen bank on the
donor such as height, weight, skin colour, educational qualification,
profession, family background, freedom from any known diseases or
carrier status (such as hepatitis B or AIDS), ethnic origin, and the DNA
fingerprint (if possible), before accepting the donor semen. It will be the
responsibility of the semen bank and the clinic to ensure that the couple
does not come to know the identity of the donor. The ART clinic will be
authorized to appropriately charge the couple for the semen provided and
the tests done on the donor semen. What has been said above also would
be true of oocyte donation.

When DNA fingerprinting technology becomes commercially
available, the ART clinic may offer to the couple, a DNA fingerprint of the
donor without revealing his/her identity, against appropriate payment
towards the cost of the DNA fingerprint. An ART clinic will then have DNA
fingerprinting done of the couple and keep the DNA fingerprints on its
records.

Trans-species fertilization involving gametes of two species is
prohibited. Ova derived from fetuses cannot be used for IVF but may be
used for research. Semen from two individuals must never be mixed
before use, under any circumstance. Transfer of human embryo into a
human male or into any animal belonging to any other species, must
never be done and is prohibited.

The data of every accredited ART clinic must be accessible to an
appropriate authority of the ICMR for collation at the national level. Any
publication or report resulting out of analysis of such data by the ICMR
will have the concerned members of the staff of the ART clinic as co-
authors.

The consent on the consent form must be a true informed consent
witnessed by a person who is in no way associated with the clinic.

Requirements for a Sperm Donor

The individual must be free of HIV and hepatitis B and C infections,
hypertension, diabetes, sexually transmitted diseases, and identifiable
and common genetic disorders such as thalassemia.

The age of the donor must not be below 21 or above 45 years.

An analysis must be carried out on the semen of the individual,
preferably using a semen analyzer, and the semen must be found to be
normal according to WHO method manual for semen analysis, if intended
to be used for ART.

The blood group and the Rh status of the individual must be
determined and placed on record. Other relevant information in respect
of the donor, such as height, weight, age, educational qualifications, profession, colour of the skin and the eyes, record of major diseases including any psychiatric disorder, and the family background in respect of history of any familial disorder, must be recorded in an appropriate proforma.

**Surrogacy: General Considerations**

A child born through surrogacy must be adopted by the genetic (biological) parents unless they can establish through genetic (DNA) fingerprinting (of which the records will be maintained in the clinic) that the child is theirs.

Surrogacy by assisted conception should normally be considered only for patients for whom it would be physically or medically impossible/undesirable to carry a baby to term.

Payments to surrogate mothers should cover all genuine expenses associated with the pregnancy. Documentary evidence of the financial arrangement for surrogacy must be available. The ART centre should not be involved in this monetary aspect.

Advertisements regarding surrogacy should not be made by the ART clinic. The responsibility of finding a surrogate mother, through advertisement or otherwise, should rest with the couple, or a semen bank.

A surrogate mother should not be over 45 years of age. Before accepting a woman as a possible surrogate for a particular couple’s child, the ART clinic must ensure (and put on record) that the woman satisfies all the testable criteria to go through a successful full-term pregnancy.

A relative, a known person, as well as a person unknown to the couple may act as a surrogate mother for the couple. In the case of a relative acting as a surrogate, the relative should belong to the same generation as the women desiring the surrogate.

No woman may act as a surrogate more than thrice in her lifetime. A prospective surrogate mother must be tested for HIV and shown to be seronegative for this virus just before embryo transfer. She must also provide a written certificate that (a) she has not had a drug intravenously
administered into her through a shared syringe, (b) she has not undergone blood transfusion; and (c) she and her husband (to the best of her/his knowledge) has had no extramarital relationship in the last six months. (This is to ensure that the person would not come up with symptoms of HIV infection during the period of surrogacy.) The prospective surrogate mother must also declare that she will not use drugs intravenously, and not undergo blood transfusion excepting of blood obtained through a certified blood bank.

**Preservation, Utilization & Destruction of Embryos**

Couples must give specific consent to storage and use of their embryos. The Human Fertilization & Embryology Act, UK (1990), allows a 5-year storage period which India would also follow.

Consent shall need to be taken from the couple for the use of their stored embryos by other couples or for research, in the event of their embryos not being used by themselves. This consent will not be required if the couple defaults in payment of maintenance charges after two reminders sent by registered post.

Research on embryos shall be restricted to the first fourteen days only and will be conducted only with the permission of the owner of the embryos. No commercial transaction will be allowed for the use of embryos for research.

**Rights of a Child Born through various ART Technologies**

A child born through ART shall be presumed to be the legitimate child of the couple, having been born in wedlock and with the consent of both the spouses. Therefore, the child shall have a legal right to parental support, inheritance, and all other privileges of a child born to a couple through sexual intercourse.

Children born through the use of donor gametes, and their “adopted” parents shall have a right to available medical or genetic information about the genetic parents that may be relevant to the child’s health.

Children born through the use of donor gametes shall not have any right whatsoever to know the identity (such as name, address, parentage,
etc.) of their genetic parent(s). A child thus born will, however, be provided all other information.

About the donor as and when desired by the child, when the child becomes an adult. While the couple will not be obliged to provide the above “other” information to the child on their own, no deliberate attempt will be made by the couple or others concerned to hide this information from the child as and when asked for by the child.

In the case of a divorce during the gestation period, if the offspring is of a donor programme – be it sperm or ova – the law of the land as pertaining to a normal conception would apply.

**Minimum age for ART:**

For a woman between 20 and 30 years, two years of cohabitation/marriage without the use of a contraceptive, excepting in cases where the man is infertile or the woman cannot physiologically conceive. For a woman over 30 years, one year of cohabitation/marriage without use of contraceptives. Normally, no ART procedure shall be used on a woman below 20 years.

**Legal Issues**

**Legitimacy of the child born through ART**

A child born through ART shall be presumed to be the legitimate child of the couple, born within wedlock, with consent of both the spouses, and with all the attendant rights of parentage, support and inheritance. Sperm/oocyte donors shall have no parental right or duties in relation to the child, and their anonymity shall be protected.

**Adultery in the case of ART**

ART used for married woman with the consent of the husband does not amount to adultery on part of the wife or the donor. AID without the husband’s consent can, however, be a ground for divorce or judicial separation.

**Consummation of marriage in case of AIH**

Conception of the wife through AIH does not necessarily amount to consummation of marriage and a decree of nullity may still be granted in
favor of the wife on the ground of impotency of the husband or his willful refusal to consummate the marriage. However, such a decree could be excluded on the grounds of approbation.

Rights of an unmarried woman to AID

There is no legal bar on an unmarried woman going for AID. A child born to a single woman through AID would be deemed to be legitimate. However, AID should normally be performed only on a married woman and that, too, with the written consent of her husband, as a two-parent family would be always better for the child than a single parent one, and the child’s interests must outweigh all other interests.

Posthumous AIH through a sperm bank

Though the Indian Evidence Act, 1872, says that a child born within 280 days after dissolution of marriage (by death or divorce) is a legitimate child since that is considered to be the gestation period, it is pertinent to note that this Act was enacted as far back as 1872 when one could not even visualize ART. The law needs to take note of the scientific advancements since that time. Thus a child born to a woman artificially inseminated with the stored sperms of her deceased husband must be considered to be a legitimate child notwithstanding the existing law of presumptions under our Evidence Act. The law needs to move along with medical advancements and suitably amended so that it does not give rise to dilemma or unwarranted harsh situations.

ICMR guidelines although had defined certain issues very meticulously but has certain controversial views. Researches permitted are those which are in public interest, but it fails to define “public interest”. It has redefined legitimacy of Indian Evidence Act 1872 that limits legitimacy of a child born to only within 280 days after dissolution of marriage (by death or divorce).4

The guidelines should ideally encourage adoption and foster parenthood, and avoid statements such as: “Infertility, though not life threatening, causes intense mental agony and trauma that can only be

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best described by infertile couples themselves”. It should not accept the social stigma attached to infertility as a norm.

Guidelines should be broad and flexible in the commercial transfer of embryonic material, stem cells, etc. Chapter 3, talks only about written consent, but fails to make informed consent mandatory.

There are no clear guidelines for the groups other than married couples, who want to bear child like, homosexuals, divorced or single. Recently CARA (Central adoption resource agency) has sought to ban gay and lesbian couples from adopting childrens, in its newly framed guidelines. As now section 377 have been made more liberal and decriminalized, this issue should now be raised and hence accordingly the words “husband” and “wife” must be substituted by “male partner” and “female partner”.

Off-spring should not be allowed to know the donor even after 18 years just like adopted children.

Use of sperm / oocyte donated by a relative or a known friend of couple should be permitted, as these are the commonest sources of donor in IVF clinics all over the world today, and this will decrease the cost of treatment. Relative or a known person may act as a surrogate to discourage commercial surrogacy. The Doctors should discuss their charges with the patient and not display it. Requirements to have 13 separate rooms to run ART clinics is a big concern since the cost of IVF would go up drastically. Small space can be used for good results.

The guidelines are more or less like the one followed in the UK , which should not be the case considering the Indian mindset and scenario.

The ethical guidelines should go beyond technicalities and build effective safeguards so that the unequal power relationship between the providers and users of new technology is minimized. It is critical to envision future trends and lay down an ethical framework for biomedical research, especially in the new frontier of human reproduction that could change the very face of humanity.

Whatever shape this guideline takes when it comes out of the parliament in the form of an act the doctors should make it a practice to
absorb certain precautions, so as to prevent various ethical social and legal issues which may arise pre and post delivery like: Should obtain signed request from wife & husband; Written informed consent from both and also from donor and his wife; Detail clinical records to be well preserved; Details of donor should be kept secret in AID; Female attender nurse should be present at the time of insemination. The agreement made with the donor is that if the child birth resulted, donor would have parental rights and obligation associated with child.

In this manner ICMR Guidelines are detailed guidelines covers broadly all the important issues, but this is still a guideline issued by regulatory authority, have no legislative force. Though several questions arises from the analysis of this guideline, but the same is an interim arrangement, so researcher didn’t focus on in-depth analysis of this guideline rather he focuses on analysis of the proposed ART Bill of 2008 and proposed regulation of 2010, which is unfortunately still are in pipeline.

FEATURES OF THE ART BILL

The draft Bill contains 50 clauses under nine chapters. The Bill acknowledges surrogacy agreements and their legal enforceability. This will ensure that surrogacy agreements are treated on par with other contracts and the principles of the Indian Contract Act 1872 and other laws will be applicable to these kinds of agreements. The Bill provides that single persons may also go for surrogacy arrangements.

Surrogacy is defined in the Bill as, ‘an arrangement in which a woman agrees to a pregnancy, achieved through assisted reproductive technology, in which neither of the gametes belong to her or her husband, with the intention to carry it to term and hand over the child to the person or persons for whom she is acting as a surrogate’.

It defines a surrogate mother as, ‘a woman who agrees to have an embryo generated from the sperm of a man who is not her husband and the oocyte of another woman, implanted in her to carry the pregnancy to full term and deliver the child to its biological parent(s)'. In the 2010 version of the Bill, this has been changed to 5 live births, to include those of the surrogate.

\[^5\] pp. 45, Chapter 1, Preliminaries.
Surrogacy is considered as legal in the regulations if undertaken by a woman who

1. is between 21 and 45 years of age provided she acts as surrogate for not more than three live births for any couple,

2. consents to giving up the baby and relinquish all parental rights to the commissioning individual or couple who has consent from her spouse if married, and

3. consents to undergo medical tests relating to sexually transmitted diseases and other communicable diseases which may endanger the health of the child.

As a legal document, the ART bill is commendable for its detail and clarity. It clearly lays out the procedures involved, responsibilities, terms and conditions under which processes such as surrogacy are to be undertaken. The bill is progressive in the sense that it recognises the debilitating social, economic and stigmatising effects of involuntary childlessness. It also upholds the right of the infertile to bear, and to try for, children, and more radically acknowledges the responsibility of the state to fulfil this need through the provision of appropriate services, technology and regulation. More controversially, it acknowledges the rights of surrogates to be paid for their reproductive labour (fuelling concerns related to the commercialisation of women’s reproduction) as well as the expenses they incur during pregnancy.6

The 2010 version of the Bill stipulates that the payment to the surrogate be made in 5 instalments rather than 3 (2008 version) with the bulk of the payment in the final transaction following the delivery of the child, further disabling the poor household and devaluing the labour of the surrogate, the issue of payment is a cause for concern among feminists in the South and scholars who rightly suggest that financially poor victims of structural violence have less choice or bargaining power in such situations, since the specific amount for surrogacy Agreement with Surrogates is left as a matter for negotiation between the surrogate and the commissioning couple.

The Bill provides that a foreigner or foreign couple not resident in India or a non-resident Indian individual or couple, seeking surrogacy in India, shall appoint a local guardian who will be legally responsible for taking care of the surrogate during and after pregnancy till the child is delivered to the foreigner or foreign couple or the local guardian. It is further provided that the commissioning parents or parent shall be legally bound to accept the custody of the child irrespective of any abnormality that the child may have, and the refusal to do so shall constitute an offence. A surrogate mother shall relinquish all parental rights over the child. The birth certificate in respect of a baby born through surrogacy shall bear the name(s) of genetic parents/parent of the baby. The Bill also provides that a child born to a married couple or a single person through the use of ART shall be presumed to be the legitimate child of the couple or the single person, as the case may be. If the commissioning couple separates or gets divorced after going for surrogacy but before the child is born, then also the child shall be considered to be the legitimate child of the couple. The Bill further provides that a couple or an individual shall not have the service of more than one surrogate at any given time. A couple shall also not have simultaneous transfer of embryos in the woman and in a surrogate. Chapter I of the Bill contains definitions. Chapter II provides for constitution of a National Advisory Board for ART and State Boards for ART for laying down policies, regulations and guidelines, and Registration Authorities for registering ART clinics. Chapter III lays down procedure for registration of ART clinics. Chapter IV prescribes duties of ART clinics. One of the duties is to make couples or individuals, as the case may be, aware of the rights of a child born through the use of ART. The duties also include the obligation not to offer to provide a couple with a child of a pre-determined sex. Chapter V provides for sourcing, storage, handling and record-keeping for gametes, embryos and surrogates. Chapter VI regulates research on embryos. Chapter VII discusses rights and duties of patients, donors, surrogates and children. Chapter VIII deals with offences and penalties therefore. Chapter IX is titled ‘Miscellaneous’ and includes power to search and seize records etc. and the power to make rules and regulations. This legislation is intended to be in addition to, and not in derogation of, other relevant laws.

7 ART (Regulation) Bill 2010, n. 2, Chapter V, pg. 20-35
AN APPRAISAL OF THE DRAFT BILL

In light of the Assisted Reproductive Technology (ART) Bill draft proposed, it reflects that there is no standardization of the drugs used, no proper documentation of the procedure, insufficient information for patients about the side-effects of the drugs used, and no limit to the number of times a woman may be asked to go through the procedure. They do not disclose the fact that a successful cycle need not lead to a baby being born. Further, the clinics need not give exact information on the procedures and their possible side-effects.

A noticeable trend is that the ART clinics are becoming the central hub of all surrogacy-related activities. Some of the duties of the clinics involve selecting the surrogate mothers – the bill lays down conditions that the surrogate mothers have to meet – and obtaining relevant information, informing all parties involved about their rights and obligations. The bill specifies what is and is not allowed regarding these topics. ART clinics are also required to treat all the information they obtain with utmost confidentiality. In practice this entails that ART clinics are not allowed to provide any information about surrogate mothers or potential surrogate mothers to any person. This creates a problem for intended parents since they have to turn to a middleman in order to find a surrogate mother. This is rather controversial, not just because of the involvement of agents, but also because it seems unfair that the intended parents, who are about to make a significant investment, have little control over the selection process. A better option could be to release personal information at the discretion of the surrogate.

The Draft Bill lacks the creation of a specialist legal authority for adjudication and determination of legal rights of parties by a judicial verdict and falls in conflict with the existing laws. These pitfalls need to be examined closely before enacting the legislation. In the UK, no contract or surrogacy agreement is legally binding. In most states in the US, compensated surrogacy arrangements are either illegal or unenforceable. In some states in Australia, arranging commercial surrogacy is a criminal offence and any surrogacy agreement giving custody to others is void. In Canada and New Zealand, commercial surrogacy has been illegal since 2004, although altruistic surrogacy is allowed. In France, Germany and Italy, surrogacy, whether commercial or not, is unlawful.
While analyzing the Draft bill various shortcomings found by the researcher, so he recommend following legislative measures:-

- There should be legislation directly on the subject of surrogacy arrangement involving all the three parties i.e. the surrogate mother, the commissioning parents and the child.

- There is a need of right-based legal framework for the surrogate mothers, as far as the ICMR guidelines are not enough

- A clearly defined law needs to be drafted immediately which will pronounce in detail the Indian government’s stand on surrogacy; so that discrete activity leading to exploitation of the surrogate mother can be stopped.

- There should be a substantial regulation designed to protect the interests of the child.

- Legal recognition of termination and transfer of parenting rights.

- It is crucially important to maintain and monitor the anonymity of the surrogate mothers.

- The surrogate mother should be provided by the copy of the contract as she is a party in the agreement and her interests should be taken into account. It happens that very often decision is taken by the intended parents and clinic, while surrogate mother does not have any say in this matter.

- There should be an interpreter (other than doctor) for the communication linkage between the surrogate and intended parents in order to convey the message from surrogate mother time to time. As far as often doctors speak on behalf of surrogate mothers, but there is no guarantee that their interests are conveyed without any misinterpretation.

- Typically, after the birth the surrogate mother is left without any medical support, it is recommended that there should be a provision of intensive care and medical check-ups of their reproductive organs during the 3 months after pregnancy.
• The commissioning couple should try to establish a relationship of trust with the surrogate, yet such a relationship creates reciprocal rights and duties and might create demands for an undesired relationship after the birth.

• The citizenship right of the surrogate baby is also of crucial importance. The Indian government needs to take a stand in terms of conferring the surrogate baby Indian citizenship as she/he is born in the womb of an Indian (the surrogate mother) and in India.

• The rights of the child should be protected and in case s/he is not taken by the commissioning parents, then the child should be given Indian citizenship.

• Health Insurance for both the surrogate mother and the child is essential to ensure a healthy life.

• There is a need of debate and discussion of the stance that public policy and the law should take toward surrogate mothering. Actually, there exists a range of choices from prohibition and regulation to active encouragement.

It is unrealistic to believe that all the harms associated with surrogacy can be eliminated. However, the harms associated with either the legalization or banning of surrogacy will be felt by society as a whole. Women as a group need to explore any and all possibilities which can minimize the harm to women. Women are identified by their ability to reproduce because, up to this point, only women can do so. The only way for women to seize and stay in control of any existing or new reproductive technology is to present viable legislation for the decision-making bodies of government to act upon. If women, as a group, do not allow themselves to compromise they may end up with an unbearable situation completely out of their control rather than a tolerable situation they helped develop.

The Law Commission of India in its 228th report “Need for Legislation to Regulate Assisted Reproductive Technology Clinics As well as Rights and Obligations of Parties to a Surrogacy” specifically emphasised on need of a comprehensive legislation on ART and rights and obligations of parties.
The legal issues related with surrogacy are very complex and need to be addressed by a comprehensive legislation. Surrogacy involves conflict of various interests and has inscrutable impact on the primary unit of society viz. family. Non-intervention of law in this knotty issue will not be proper at a time when law is to act as ardent defender of human liberty and an instrument of distribution of positive entitlements. At the same time, prohibition on vague moral grounds without a proper assessment of social ends and purposes which surrogacy can serve would be irrational. Active legislative intervention is required to facilitate correct uses of the new technology i.e. ART and relinquish the cocooned approach to legalization of surrogacy adopted hitherto. The need of the hour is to adopt a pragmatic approach by legalizing altruistic surrogacy arrangements and prohibit commercial ones.\(^8\)

The following observations had been made by the Law Commission:

- Surrogacy arrangement will continue to be governed by contract amongst parties, which will contain all the terms requiring consent of surrogate mother to bear child, agreement of her husband and other family members for the same, medical procedures of artificial insemination, reimbursement of all reasonable expenses for carrying child to full term, willingness to hand over the child born to the commissioning parent(s), etc. However, such an arrangement should not be for commercial purposes.

- A surrogacy arrangement should provide for financial support for surrogate child in the event of death of the commissioning couple or individual before delivery of the child, or divorce between the intended parents and subsequent willingness of none to take delivery of the child.

- A surrogacy contract should necessarily take care of life insurance cover for surrogate mother.

- One of the intended parents should be a donor as well, because the bond of love and affection with a child primarily emanates from

\(^8\) The Law Commission of India in its 228\(^{\text{th}}\) report at page 7
biological relationship. Also, the chances of various kinds of child-abuse, which have been noticed in cases of adoptions, will be reduced. In case the intended parent is single, he or she should be a donor to be able to have a surrogate child. Otherwise, adoption is the way to have a child which is resorted to if biological (natural) parents and adoptive parents are different.

- Legislation itself should recognize a surrogate child to be the legitimate child of the commissioning parent(s) without there being any need for adoption or even declaration of guardian.

- The birth certificate of the surrogate child should contain the name(s) of the commissioning parent(s) only.

- Right to privacy of donor as well as surrogate mother should be protected.

- Sex-selective surrogacy should be prohibited.

- Cases of abortions should be governed by the Medical Termination of Pregnancy Act 1971 only.

The Report has come largely in support of the Surrogacy in India, highlighting a proper way of operating surrogacy in Indian conditions. Exploitation of the women through surrogacy is another worrying factor which the law has to address. Also, commercialization of surrogacy is something that has been issue in the mind of the Law Commission. However, this is a great step forward to the present situation.

The legal issues related with surrogacy, as we have seen, are very complex and need to be addressed by a comprehensive legislation. After a long wait for so many years, the Indian Council of Medical Research (ICMR) has come out with a draft Assisted Reproductive Technology (Regulation) Bill and Rules 2008. The draft Bill contains 50 clauses under nine chapters.

The Bill acknowledges surrogacy agreements and their legal enforceability. This will ensure that surrogacy agreements are treated on

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9 Smith Chandra, Surrogacy and India A Legal Perspective http://ssrn.com/abstract=1762401
with other contracts and the principles of the Indian Contract Act 1872 and other laws will be applicable to these kinds of agreements. The Bill provides that single persons may also go for surrogacy arrangements. The Bill provides that a foreigner or foreign couple not resident in India or a non-resident Indian individual or couple, seeking surrogacy in India, shall appoint a local guardian who will be legally responsible for taking care of the surrogate during and after pregnancy till the child is delivered to the foreigner or foreign couple or the local guardian. It is further provided that the commissioning parents or parent shall be legally bound to accept the custody of the child irrespective of any abnormality that the child may have, and the refusal to do so shall constitute an offence. A surrogate mother shall relinquish all parental rights over the child. The birth certificate in respect of a baby born through surrogacy shall bear the name(s) of genetic parents/parent of the baby.

The Bill also provides that a child born to a married couple or a single person through the use of ART shall be presumed to be the legitimate child of the couple or the single person, as the case may be. If the commissioning couple separates or gets divorced after going for surrogacy but before the child is born, then also the child shall be considered to be the legitimate child of the couple.

The Bill further provides that a couple or an individual shall not have the service of more than one surrogate at any given time. A couple shall also not have simultaneous transfer of embryos in the woman and in a surrogate.

Chapter I of the Bill contains definitions. Chapter II provides for constitution of a National Advisory Board for ART and State Boards for ART for laying down policies, regulations and guidelines, and Registration Authorities for registering ART clinics. Chapter III lays down procedure for registration of ART clinics. Chapter IV prescribes duties of ART clinics. One of the duties is to make couples or individuals, as the case may be, aware of the rights of a child born through the use of ART. The duties also include the obligation not to offer to provide a couple with a child of a pre-determined sex. Chapter V provides for sourcing, storage, handling and record-keeping for gametes, embryos and surrogates. Chapter VI regulates research on embryos. Chapter VII discusses rights and duties of patients, donors, surrogates and children. Chapter VIII deals with offences.
and penalties therefore. Chapter IX is titled ‘Miscellaneous’ and includes power to search and seize records etc. and the power to make rules and regulations. This legislation is intended to be in addition to, and not in derogation of, other relevant laws in force.

A seminar on “Surrogacy – Bane or Boon” was held at the India International Centre on 13.02.2009. The discussion focused on the aforesaid draft Bill and Rules. Certain lacunae were noted in the Bill.

The Bill neither creates, nor designates or authorizes any court or quasi-judicial forum for adjudication of disputes arising out of surrogacy, ART and surrogacy agreements. Disputes may, *inter alia*, relate to parentage, nationality, issuance of passport, grant of visa. There is already a conflict on adoption and guardianship as non-Hindus cannot adopt in India. Such disputes need to be resolved before a child is removed from India to a foreign country.

A suggestion at the above Seminar emerged that if a specialized court called “Surrogacy Court” is created, it could comprehensively look at all the above problems for adjudicating disputes.

The points highlighted in the discussion at the Seminar included:

(i) What would be the remedy available to biological parents to obtain exclusive legal custody of surrogate children,

(ii) How can the rights of the surrogate mother be waived completely,

(iii) How can the rights of the ovum or sperm donor be restricted,

(iv) How can the genetic constitution of the surrogate baby be established and recorded with authenticity,

(v) Whether a single or a gay parent can be considered to be the custodial parent of a surrogate child,

(vi) What would be the status of divorced biological parents in respect of the custody of a surrogate child, and

(vii) Would a biological parent/s be considered the legal parent of the surrogate child?

The answers discussed at the Seminar were:
a) Surrogacy in India is legitimate because no Indian law prohibits surrogacy. To determine the legality of surrogacy agreements, the Indian Contract Act would apply and thereafter the enforceability of any such agreement would be within the domain of section 9 of the Code of Civil Procedure (CPC). Alternatively, the biological parent/s can also move an application under the Guardians and Wards Act 1890 for seeking an order of appointment or a declaration as the guardian of the surrogate child.

b) In the absence of any law to govern surrogacy, the 2005 Guidelines apply. But, being non-statutory, they are not enforceable or justiciable in a court of law. Under paragraph 3.10.1 of the Guidelines a child born through surrogacy must be adopted by the genetic (biological) parents. However, this may not be possible in case of those parents who cannot adopt in India.

c) Under Section 10 of the Contract Act, all agreements are contracts, if they are made by free consent of parties competent to contract, for a lawful consideration and with a lawful object, and are not expressly declared to be void. Therefore, if any surrogacy agreement satisfies these conditions, it is an enforceable contract. Thereafter, under section 9, CPC, it can be the subject of a civil suit before a civil court for adjudication of all disputes relating to the surrogacy agreement and for a declaration/injunction as to the relief prayed for.

d) As of today, it may be stated that a single or a gay parent can be considered to be the custodial parent by virtue of being the genetic or biological parent of the child born out of a surrogacy arrangement. Japanese baby Manji Yamada’s case and the Israel gay couple’s case who fathered the child in India are clear examples to establish that this is possible. Under paragraph 3.16.1 of the Guidelines dealing with legitimacy of children born through ART (which was the basis of the claim in the Japanese baby’s case in the Supreme Court), this claim can be made. However, only in a petition for guardianship under the Guardians and Wards Act and/or in a suit for declaration in a civil court, the exclusive custodial rights can be adjudicated by a
court of competent jurisdiction upon appreciation of evidence and considering all claims made in this regard.

e) Essentially, this is a question which will require determination in accordance with the surrogacy agreement between the parties. There would apparently be no bar to either of the divorced parents claiming custody of a surrogate child if the other parent does not claim the same. However, if the custody is contested, it may require adjudication by a court of competent jurisdiction.

f) In answer to this question it can be stated that the biological parents would be considered to be the legal parents of the child by virtue of the surrogacy agreement executed between them and the surrogate mother. Under paragraph 3.16.1 of the Guidelines dealing with legitimacy of the child born through ART, it is stated that “a child born through ART shall be presumed to be the legitimate child of the couple, born within wedlock, with consent of both the spouses, and with all the attendant rights of parentage, support and inheritance”. Even in the 2008 draft Bill and Rules, a child born to a married couple, an unmarried couple, a single parent or a single man or woman, shall be the legitimate child of the couple, man or woman, as the case may be.

g) However, the moot question which may arise for determination is as to whether a judicial verdict determining rights of parties in a surrogacy arrangement is essential in respect of a foreign biological parent who wishes to take the surrogate child to his/her country of origin or permanent residence. It can be said that either a declaration from a civil court and/or a guardianship order ought to be a must to conclusively establish the rights of all parties and to prevent any future discrepancies arising in respect of any claims thereto.

Surrogacy only furthers Right to Life under Article 21 of the Constitution:

The relation of the surrogated mother to the child she is carrying is nothing but womb leasing or womb for rent. After the birth of the child she has no right to keep the child because she is neither the mother (where both ova and sperm are from different persons) nor the owner of
the genetic material. She is only a contractor who is willing to give the end product once the contract between her and the person is fulfilled.  

However, to deal with legal pre-requisites for a commercial surrogacy, there is no uniform law in India till today. The growing demand for surrogacy in India has also raised issues, including those of child rights. This led to the government drafting a bill which is called the Assisted Reproductive Technology (Regulation) Bill 2008. But the draft is still pending with the Union law ministry, whose approval will take it to the Union cabinet before being presented in the Indian parliament. However, even if the bill gets passed in the 2015, it will take another year before the resulting Act redefines commercial surrogacy in India. For the time being guidelines (as given in the year 2005) for accreditation, supervision and regulation of Assisted Reproductive Technology clinics formulated by the Indian Council of Medical Research and National Academy of Medical Sciences are used as a basic platform and the code for the purpose of conducting surrogacy in India. The extract form of the guideline is given below:

- A child born through surrogacy must be adopted by the genetic (biological) parents unless they can establish through genetic (DNA) fingerprinting (of which the records will be maintained in the clinic) that the child is theirs.

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12 The proposed legislation provides for the following:
- A cap on the age of the surrogate mother (who has not exceeded 45 years of age); the surrogate mother must not carry more than five pregnancies to term (including her own children); and mandates medical insurance during pregnancy.
- It will prohibit any sort of contact between the surrogate mother and the child after birth. Any such contact is punishable by a fine or imprisonment for up to two years.
- Foreign couples should provide proof that the child born to a surrogate mother will automatically get the citizenship of the intended parents’ home country. This includes registering with their Embassy or High Commission in India, and providing a signed and notarised statement accepting the terms as laid out by the law.
- It proposes to set up a database of surrogate mothers throughout the country.
- It will limit the role of those monitor clinics (which are dealing with surrogacy and surrogate mothers) to conducting the actual IVF procedure, as opposed to their current role of arranging the entire process.

✓ Surrogacy by assisted conception should normally be considered only for patients for whom it would be physically or medically impossible/undesirable to carry a baby to term.

✓ Payments to surrogate mothers should cover all genuine expenses associated with the pregnancy. Documentary evidence of the financial arrangement for surrogacy must be available. The ART centre should not be involved in this monetary aspect.

✓ Advertisements regarding surrogacy should not be made by the ART clinic. The responsibility of finding a surrogate mother, through advertisement or otherwise, should rest with the couple, or a semen bank.

✓ A surrogate mother should not be over 45 years of age. Before accepting a woman as a possible surrogate for a particular couple’s child, the ART clinic must ensure (and put on record) that the woman satisfies all the testable criteria to go through a successful full-term pregnancy.

✓ A relative, a known person, as well as a person unknown to the couple may act as a surrogate mother for the couple. In the case of a relative acting as a surrogate, the relative should belong to the same generation as the women desiring the surrogate.

✓ A prospective surrogate mother must be tested for HIV and shown to be seronegative for this virus just before embryo transfer. She must also provide a written certificate that (a) she has not had a drug intravenously administered into her through a shared syringe, (b) she has not undergone blood transfusion; and (c) she and her husband (to the best of her/his knowledge) has had no extramarital relationship in the last six months. (This is to ensure that the person would not come up with symptoms of HIV infection during the period of surrogacy.) The prospective surrogate mother must also declare that she will not use drugs intravenously, and not undergo blood transfusion excepting of blood obtained through a certified blood bank.

✓ No woman may act as a surrogate more than thrice in her lifetime.¹⁴

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Thus, till today no uniform law as to regulating commercial surrogacy is there in India.

COMMERCIAL SURROGACY AND INDIAN CULTURE:

Commercial surrogacy has been legalized in India albeit it is the question that how far such legalization has been accepted by Indian culture or not. In India, surrogate mothers face high levels of social stigma (which may be due to several contributing factors) and ostracism.

As a practice surrogacy involves the bodies of poor women, which in India’s socially conservative culture, is cause enough for derision. The surrogate mothers are treated as disposable objects, and the surrogacy industry highlights the “unnatural” aspects of pregnancy and reproduction. In addition, many Indians associate surrogacy with paid sex-work and this comparison to prostitution further stigmatizes the surrogate women.\(^{15}\)

Thus, Commercial surrogacy continues to be highly stigmatized in India. Many surrogates are spending the term of their pregnancy in surrogate hostels (e.g. in Anand, a town in the western state of Gujarat), away from their families and communities. They may want to keep what they do secret, because reproduction is regarded as acceptable only within marriage; taken outside the domestic sphere of family, childbearing for economic achievement may be seen as ‘dirty work,’ ‘baby-selling’ or ‘womb-renting.’\(^{16}\)

Statistics indicate that Indian surrogacy clinics handled around 1,500 surrogacy births for domestic and overseas couples in 2010. This indicates a jump of 50 percent in two years.

At the end of this discussion, it can be said that the right to reproduce is a fundamental and an inborn human right. Surrogacy is the only way to conquer both biological and social infertility. It provides medically infertile couples as well as socially infertile individuals who are unwilling to get married with a chance to have a child of their own. Blocking every way for minority members to obtain the treatment they


\(^{16}\) That is why, some argue that altruistic surrogacy is more acceptable than commercial.
desire would be perilous because it could increase feelings of frustration, suppression, and indignation. Actually, legalization of gestational surrogacy aims to protect the surrogate’s interests as well as those of the intended parents and the baby born after the surrogacy.

**New India Surrogacy Regulations**

The Union health ministry of India has finalized the Assisted Reproductive Technologies (ART) Regulation Bill 2010. Here’s a quick look at some of the revolutionary stipulations:

- If a surrogate mother is married, the consent of her spouse is mandatory.
- No ART bank or clinic can send an Indian citizen for surrogacy abroad.
- The donor’s identity cannot be revealed and both parties will have to sign legally-binding surrogacy agreements.
- It allows surrogacy for individuals as well as couples. A couple is defined under the Indian law as two people living together and having a sexual relationship that is legal in the country.

Even though it may take some time before the surrogacy laws are actually put into practice, surrogacy clinics in India continue to attract thousands of visitors to the country every year who visit the country in the hope of achieving parenthood.

The issue of citizenship was not directly dealt with, but after Jan Balaz Case, Government took certain steps to ensure the well being of children born in India through ART Procedure. As a step to curb such issues from cropping up wherein the commissioning couple’s place of domicile doesn’t recognise surrogacy and the issue of determination of citizenship of the children born come up, the Ministry of Home Affairs, Government of India brought about a change in Visa regulations, in 2013, the Government made its stand clear on the VISA regulations for foreign nationals coming to India for surrogacy. In its order it is said that a tourist VISA, which is most commonly and frequently used by foreign nationals intending to visit India for commissioning Surrogacy and condition for grant Visa for the purpose, available at [http://mha1.nic.in/pdfs/CS-GrntVISA-29112.pdf](http://mha1.nic.in/pdfs/CS-GrntVISA-29112.pdf) (last visited on March 27, 2014)
nationals, is an inappropriate one. It pronounced that so such relaxation would be given and all such couples must obtain the medical visa for such purposes which may be grant on the fulfilment of a number of conditions. Among others are the condition that the couple must have been married for at least two years and letter from the embassy of the their respective country must be enclosed with the visa application stating clearly that “(a) the country recognises surrogacy and (b) the child/children to be born to the commissioning couple through the Indian surrogate mother will be permitted entry into their country as a biological child/children of the couple commissioning surrogate.”

This step has also called for criticism from Law Firms and ART Surgeons. A Senior Art Surgeon on the promise of privacy says that “Government is trying to change the laws of entire world instead of passing her own law”.

Even though, some measures have been taken by the Government, a level of uncertainty nevertheless remains.

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\[\text{\textsuperscript{18} Ibid}\]
Chapter 6

Limitations of efforts made in India

With the growing technical possibilities of assisted reproduction, the once monolithic idea of parenthood falls into pieces. Motherhood in particular splits up into genetic, gestational, and social motherhood – three roles that, once bound together, can now be taken over by two or even three different women. An increasingly popular and socially somewhat accepted model involving multiple mothers for one child is surrogacy: A surrogate mother commits herself to carry an embryo for another woman who for reasons of reluctance, age, or medical conditions cannot or does not want to do so. Usually,¹ one of the intended parents gives his sperm for the fertilization of an egg that may stem either from the surrogate mother herself (traditional surrogacy) or from the intended mother or an egg donor (gestational surrogacy).

Whereas public opinion is split as to whether surrogacy should be supported, intended parents and their children hardly face discrimination or any other lack of acceptance.

As the law of parentage is striving to meet the challenges of new reproductive technologies, dealing with cross-border surrogacies emerges as one of the most pressing topics in international family law. The current legal situation as regards surrogacy is quite diverse – throughout the world but also within Europe. Legal diversity has recently made a lot of people engage in so-called “procreative tourism”:

Coming from a country with a rather strict approach, they commission women in one of the more liberal countries like India to bear a child for them, and once the baby is born, they try to take it to their home country, thereby obviating the surrogacy ban that prevents them from entrusting a surrogate mother at home. European courts are struggling with a coherent approach on how to treat those citizens who have gone abroad to have a baby. Meanwhile, legal research and the

¹ As only in rare cases are both intended parents lacking in fertility, it is only once in a blue moon that the sperm comes from a donor
Hague Conference on Private International Law are thinking about a convention in order to ease the cross-border recognition of surrogacy.

Researcher tried to explore the views of various Clinician on the aspect of necessity of regulation and all of them were of the opinion that some form of regulation are required, and though the ICMR Guidelines provides sufficient regulatory provisions for the same, but they don’t deny the necessity of further improvement on some of the issues. Although the debate surrounding issues such as the regulation of ART and by whom is still unsettled, most clinicians in the Western world believe that some form of regulation of ART is necessary. At the present time many countries, even in the Western hemisphere, have not established legislation pertaining to the various aspects of the practice of ART.

In a number of countries including India ART is practiced according to regulations which have been laid down by professional bodies. In some parts of the world such bodies are appointed by government (Ministry of Health and/or Social Security) or by medical associations. In other countries, reproductive scientific centres impose their own ethical standards. In most Asian countries, however, ART is still practiced free of any statutory legislation, regulations, or voluntary guidelines, in most Asian countries, practicing groups set their own standards. Furthermore, a cause for concern is the fact that a registry of all centres performing ART exists only in five of the countries. The data about ART programmes, including pregnancy rates, in all other countries, if available, is partial at best. Concern should be further heightened by the fact that supervision, or any kind of quality control on clinics and laboratories offering ART, exists in only few countries. Under these circumstances, where there is no promulgation of laboratory standards, and as ART programme success is closely related to quality control in human embryo laboratories, it is obvious that much progress is still to be expected in this aspect of ART in Asia.

Fortunately, ICMR Guidelines provides sufficient standards for the control of Physical infrastructure including Embryo Laboratory, but execution or rather implementation of the guideline is still required close scrutiny. While his visit to Hyderabad researcher found that only 10% of the ART Clinics were registered with the National Registry of ART clinics.
He reproduces the report published in Times of India to understand the real scenario of the ART Clinics in Hyderabad:

"The burgeoning fertility industry of India currently going through rapid growth is also trying to deal with its fair share of malpractice with many fertility clinics out to make a quick buck by duping vulnerable couples who are eager to become parents."

"Several clinics in India continue to perform various IVF and surrogacy procedures despite lacking the necessary infrastructure facilities and medical expertise, top officials said. Efforts to regulate the industry are not proving to be very successful, officials said as clinics are unwilling to come under the scanner with only six out of 60 clinics in Hyderabad registering itself with the Indian Council of Medical Research (ICMR) since January."

Many experts said this is now sowing doubts about the quality of expertise offered at the city's fertility clinics.

When non-registered clinics in the city were contacted, many said that they had already sent in their applications and are awaiting their identification numbers, but ICMR officials were not sure about it.

"Complications like distress, blood infections and a condition called ovarian hyper stimulation syndrome (OHSS) have been reported which is fatal for both the mother and the unborn child," Sekhar, a well-known expert with a city facility added.

The Assisted Reproductive Technology (ART) industry in Hyderabad is massive with experts estimating that surrogacy sector alone garners an annual revenue of Rs 14 crore. However, dubious centres are duping vulnerable couples of not only their money but also having drastic impact on the health of the mother and child.

A top fertility specialist in the city recalls a number of cases where distraught couples have approached him to salvage

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2 Times of India, Hyderabad ed. July 16, 2013
cases of 'embryo mix-up' or extreme reaction to hormonal injections that have been administered at other smaller and clandestine clinics.

"ART methods require high medical expertise and procedures must be performed in specific environments under constant monitoring", Dr Nirmala Agarwal, another IVF expert said.\(^3\)

In fact, the ICMR launched the National Registry of Assisted Reproductive Technology (ART) clinics in India as the first step of implementation of the soon-to-be-tabled Assisted Reproductive Technology (ART) Bill in Parliament.

"Forming a database of all ART clinics and banks is the first step of regulation of this industry. This will enable the people to choose the right centres and also help the government to keep a check on the defaulting ones," said Hyderabad based Dr Pushpa M Bhargava, who is a part of the drafting committee of the ART bill.

The ART bill has detailed out the various committees to be formed to oversee all ART procedures, guidelines, rights of the parties involved and the penalties in case of non adherence. The bill, which has been pending with the government for five years now, is likely to be tabled this year in Parliament.\(^4\)

In India, there are around 3,00,000 ART Clinics performs various ART procedures and a large number of them performs Complicated processes, but as per the list published by the National Registry of ART Clinics only 148 were confirmed as ART Clinic.\(^5\)

Though, it is specifically mentioned on the list that Enrollment Number has been given to those ART Clinics who have successfully submitted their duly filled prescribed proforma for minimum infrastructure facilities, trained manpower and procedure being

\(^3\) Ibid
\(^4\) Ibid
undertaken at the ART Clinic. The Enrollment Number is not the certificate of quality in regard to services provided by the enrolled ART Clinic. The information provided by the enrolled ART Clinics has not yet been verified by the Experts Committee of the ICMR. The process of verification of their claim, by the ICMR Experts Committee, is in process currently.

Situation is really critical, that the regulatory body is not aware of the standard of the clinics and services they are providing. A billion Dollar business is going on without any proper monitoring, regulations and care, specifically when it is directly connected with the health of the persons and rights of children. Without hesitation it can be easily said that practically entire ART Business is running in dark and the Government left the mothers and children, on the disposal of ART clinics.

Unfortunately, while discussing with the clinicians, most of them refused to cooperate as they were of the opinion that any kind of publication about their clinic may cause trouble to them. Few of them provided support to the researcher, but it was limited to fill the questionnaire and informal discussion about the procedure, its complications, regulatory mechanism, requirement of a comprehensive legislation etc. Some of them were afraid of the negative publicity of ART Clinics in Hyderabad just because of the Act of Unauthorised ART Clinics. “There have been a number of cases in the city where surrogate mothers have died because they were not treated properly at the right time,” said Dr Samit Sekhar, a senior embryologist in Hyderabad.

Focusing on the Assisted Reproductive Technology (Regulation) Bill and Rules 2010 (2008) in India, this research suggests that, although progressive in some respects, the bill only partially addresses the concerns raised above. Further, ethical procedures relating to surrogacy appear to co-exist with structural violence in a manner similar to clinical trials in India, and with the growth of global bio-capital more generally.

Parties to an agreement are bound by the terms of agreement, but as appears from the field study of the researcher that no surrogate had any opportunity to consult an Advocate of his choice and at the same time no copy of the agreement was supplied to them so as to enable them to contest for their rights and further specific performance of the
agreement. Though, intending parents always have an opportunity to take the shelter of the Court.

In this manner the limitations of the Bill stem firstly, from its attempts to introduce Euro-American notions of autonomy (with an emphasis on the distinctiveness and separateness of the subject) and informed consent into a setting with very different cultural values. A second limitation is that the proposed law offers quality medical healthcare services for those who can afford ART intervention in a context of significant class and gender based inequalities in access to reproductive healthcare, thus determining who can fully participate in reproduction and enjoy the rewards of this labour. When seen from the perspective of poor Indian women and men who are infertile, the access to ART becomes a privilege: the rights of some individuals and couples to reproduce and exercise procreative agency is valued and not others.\(^6\)

The researcher examined how, though intended to minimize health inequities for surrogates, the Bill promotes inequality between women of different childbearing capacities based on their ability to pay for and access quality health services as the automatic access to healthcare for surrogates is qualified in the 2010 draft Bill where quality medical care is contingent on their proving that their symptoms stem from their surrogacy.

The emerging scholarship on the political, social-cultural and moral meanings of surrogacy outside the Euro-American context rightly focuses on how surrogates and trans-national couples negotiate the processes and cultural work involved.

This Research extended this work by approaching the issue of surrogacy from the perspective of poor infertile women living in the same social and moral world as the surrogate and for whom private sector infertility services are inaccessible due to the high costs involved.\(^7\) Even though conditions of secondary sterility are easily treatable through the existing public health infrastructure these services are virtually non-existent in the public health sector in India where the focus has


\(^7\) As the researcher visited the surrogates and vicinity around them in and around Hyderabad.
historically been on controlling the fertility of poor women rather than on fertility promotion.

It draws upon ethnographic research that intersects with, rather than overlaps with the population of women who are or have been gestational surrogates, to bring attention to wider processes of structural inequality in thinking through the proposed law.

The emerging legislation on surrogacy in India is used as a means to reflect on the first two of three interrelated conceptual issues: reproductive stratification, relational autonomy and the commodification of reproduction. Toward this end it draws on anthropological studies of surrogacy as lived experience, feminist notions of relational autonomy and the idea of informed consent as a primarily ‘communicative transaction’ where it is the quality of information that is provided and how it is received that is critical in ensuring the process as ethical.

An analysis of these texts as well as field based material, lead us to suggest:

i) That despite an explicit framing which acknowledges the rights of the infertile to bear children, the Bill promotes this right selectively, for those who have the resources to pay for assisted reproductive services, and,

ii) That even though the Bill ostensibly focuses on the welfare of Indian surrogates, legal guarantees are not deep enough to ensure surrogate women’s relationally determined autonomy to choose.8

The ART Bill Serves Whose Interest

The ART regulation Bill and Rules, as drafted by the Indian Council of Medical Research in 2008 (and its modified version of 2010) set out guidelines ranging from the duties of clinics to the rights and duties of patients, donors, surrogates and children. Part I of the 2008 Bill sets out the definitions and provisions in nine chapters on subjects ranging from the registration and duties of clinics to the regulation of research, offences and penalties. Chapter 7 is devoted to ‘the rights and duties of patients, donors, surrogates and children’. In addition, Part 2 of the Bill

8 MAYA UNNITHAN, Supra Note 6
describes in greater detail the rules as set out in Part 1, and Part 3 provides samples of the schedules, forms and contracts pertaining to the parties involved in the processes of assisted reproduction, including forms for the agreement for surrogacy, consent for donor eggs and information on the surrogate. The ART regulation Bill of 2010 covers only part I of the 2008 Bill.\(^9\)

**Protection to Surrogates:**

The ART process is quite complicated and even after due care certain birth defects may occur in the child, in such a case, the Bill safeguards the rights of Surrogates as meeting the surrogacy requirements in the case of a child born with birth defects. It also states that she can terminate her pregnancy at will\(^10\). However, the clause on the termination of the pregnancy at will, needs to be considered in relation to a condition suffixed that all payments received by the surrogate be refunded in such an event, except in case of medical complication.

The provision certainly pushes the surrogates of back-foot as given the extreme poverty and indebtedness which drives surrogacy in the first place, it is unrealistic to believe that the surrogate’s choice to terminate her pregnancy will be exercised or that she has any real bargaining power when it comes to negotiating the terms and amount of money, as the researcher found during his discussion with 21 Surrogates that they all were compel to chose the option to enter into surrogacy arrangement in extreme poverty conditions.

On the option of Commissioning Couple, the Bill subjects surrogates to invasive procedures such as foetal reduction in the event of multiple pregnancies, and Caesarean sections if recommended by the doctors. More routinely, the surrogate consents to a continuous medical regimen of injections, blood tests, screening and diagnostic procedures.

Less explicit, but of major implication, is the discrimination against the surrogate which arises from the language (English) in which the agreement and consent form are written. Given that English is not the first language of most surrogates and that a majority is indeed illiterate rural women, the understanding of what consent entails is left to the

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\(^9\) MAYA UNNITHAN, Supra Note 6  
\(^10\) Appendix 1 for Form J, Agreement for Surrogacy
vagaries of a conscientious translator. In legal terms it is important to note that the surrogate is not provided any legal support by the state, with the clinic acting as legal representative including as representative with any commercial agency. Given that the clinics also act as providers of counseling services, it may be apt to regard the surrogate as a ‘captive of the clinic’. 11

Clinicians, however negate the probability in light of recent development in Technology, which enabled the Doctors to carry-out the procedure with almost no risk. They also point-out that they are providing legal services and necessary counseling to surrogates with utmost care and to protect their interest; other-wise in case of even a single miss-happening the clinics will lose their reputation both the ways, among the intended couples and prospective surrogates. In this manner they are moving on the edge of sword.

Maya Unnithan12 criticized the bill for predominantly upholding the research and promotion of ART services and the interests of the providers, especially private clinics. Other important criticisms of the bill raised by these scholars and activists include,

i) the fact that in denying the surrogate the possibility to register as the birthing mother, the Bill protects the rights of the buyer,

ii) in ensuring that the surrogate underwrites all the major risks of the procedures, including her own death, natal and postnatal complications, foetal reduction, any risk of HIV transmission, the bill clearly protects the interests of the clinics and sperm banks,

iii) the health risks to the surrogate are further disregarded in the clause that enables her to have three surrogate births and three cycles of ova transfer (increased to 5 live births with no specification of the number of IVF cycles, in the 2010 version of the Bill) and,

iv) in favouring a quick transfer of baby from surrogate to commissioning parents, the bill downplays the developmental needs of the baby (though it may be easing the bonding-related anxieties of commissioning parents as well as the commercial

11 MAYA UNNITHAN, Supra note 2
12 Ibid
surrogate). The rights of the newborn baby are further undermined in terms of its survival, right to a safe home and the automatic right to know its identity (only if sought out and not before 18 years unless for medical purposes). Even the rights of the child to citizenship were not addressed until 2008.¹³

I.B. Verma of a Feminist organisation VAMA, criticizes the bill and says “It is drafted to serve the Interest of money, not the person”.

On plane thinking Researcher fails to disassociate himself from such opinion as India have particularly the few instances in which the surrogacy guidelines (2005) have been invoked are particularly revealing of what and for whom recourse to the law is taken. Of the two cases known so far, both were in 2008 and concerned the custodial rights of the commissioning parents (in one case a Japanese father and in the other a German couple) and their difficulty in securing travel documents, visas and citizenship from their own countries for the surrogate children, Baby Manji¹⁴ in the first case and German twins¹⁵ in the other. In both instances, the social parents were eventually able to adopt these children in their respective countries. The surrogacy bill was tightened, especially as a response to the experience of the German couple, permitting surrogacy arrangements to take place only if proof of citizenship for the child was presented by the intended parents. In both cases, the guidelines revealed lacunae regarding the ability of the surrogacy legislation to protect the rights of the new born baby to an assured and safe home (as identified by the 18th Law Commission Review in 2009). One of the few modifications in the 2010 version of the Bill is the mandatory requirement for foreign couples to produce a certificate from their countries ensuring the child will be considered a legal citizen of that country.

Other clauses in the ART Bill(s) reveal it as a document through which ‘culture work’ is carried out as I suggest in the following lines. In only recognising gestational surrogacy but not traditional surrogacy where the eggs of the surrogate (rather than those of a donor or of the commissioning woman) are used, the Bill reinforces biologically

¹³ Ibid
¹⁴ Baby Manji Yamada Vs. Union Of India AIR 2009 SC 84
¹⁵ Jan Balaz
deterministic models of motherhood by emphasising that it is genetic substance of the commissioning couple rather than the gestation by the surrogate which defines motherhood.\(^\text{16}\)

In contrast to Israel where the law specifically demands that surrogates are single and unmarried women except under ‘severe circumstances, the main criterion for a woman to legally undertake surrogacy in ART Bill is that she has to have already given birth to a healthy child. Given the Indian context where childbearing is mostly undertaken by women after marriage, in reality, only divorced or widowed women, rather than unmarried single women, would be considered as surrogates.

The rules regarding the surrogate’s marital status, as specified in the Indian ART bill, determine who can participate in surrogacy and who cannot, and become important in understanding how the bill works both to maintain as well as to shift widely prevalent ideas of appropriate parenthood. The Bill upholds hetero-normative ideals of parenthood in its reference to married couples, although there is an acknowledgement that women who are single can both commission and undertake surrogacy. Same-sex couples living in India or other places where such alliances are regarded as illegal are excluded from seeking surrogacy.

Finally, any analysis of the impact of the surrogacy legislation on the ground would also need to be situated in terms of the historically informed ability of local people to seek recourse in the law, which is limited, as is their trust in the State. State legislation and policies to do with conception in India demonstrate a long history of, and stubborn focus on, drastic measures to limit the population birth rate (for example, through the two-child norm to gain political office, as well as the promotion of tubectomy despite the rhetoric of contraceptive choice, as acknowledged in the National Population Programme. However, in contrast to state population policies thus far which have emphasised family planning programmes to restrict fertility, the law and policies to do with surrogacy promote and celebrate fertility, representing a watershed shift in State population perspectives. But in a context where the state and the law have been regarded suspiciously and circumvented, to what

\(^{16}\) MAYA UNNITHAN, Supra note 6
extent will the policies supposedly promoting surrogate welfare make a difference with regard to women’s autonomy on the ground?

Another way of putting it would be to think of surrogacy legislation in terms of the limits of the State to exercise biopower as witnessed in the recent challenges it has faced to regulate sex selective abortion despite a history of legislation to do with the Pre-Conception and Prenatal Diagnostic Testing Acts (PNDT Act 1994, PC-PNDT Act 2002) which were promulgated to deter sex determination and related abortion.

The existing bill does not take adequate measures beyond the standard protocols to ensure that the potential surrogate has full knowledge of the implications of her consent. There is little evidence that Indian surrogates’ human rights and physical or psychological health are adequately protected. In the study conducted by the researcher it appears that most of the commissioning Couples after getting the child don’t want to continue any kind of contact, on the contrary some of them provided fake contact details to surrogates.

An intended mother from USA, Lilly Jaferson, while discussing with the researcher in Hyderabad, specifically stated that the Surrogacy Advocates in USA cautioned her about the consequences and therefore not to make any kind of contact with the Surrogate.

Though, the Public opinion about the post Natal care of the surrogate imposes a responsibility on intending parents as well as on clinics undertook the surrogacy for a substantial period, se 1 year, as the majority in the survey conducted by the researcher is of the opinion.\(^\text{17}\)

Commercial surrogacy complicates practices of consent further, as it is suggested that a high payment to a surrogate is likely to compromise her capacity to give informed consent by encouraging her to minimize the risks involved in the procedures. This is one of the main reasons why, the Indian legislation falls short of the International Federation of Social Work (IFSW) ethical standards, as it institutionalises commercial surrogacy by allowing payments.

Researcher met an Australian Homosexual at Hyderabad and also gone through a recent news piece that has caught everyone’s eye is that

\(^{17}\) Chapter 2 P. 82
an Israeli homosexual couple has got a surrogate child from India. Everywhere, people seem to be pleased about it, but when analyzed legally, it leaves us in a very befuddled state of mind.

A Senior ART Surgeon, who made the couple’s dream of having a child come true, confirmed that almost 16 homosexual couples of different nationalities (such as Swedish, French etc.) have approached him for the surrogacy. Reasons for choosing India as a destination are also quite obvious - less paper work and also, cost of whole treatment is much lesser than other countries.

In the light of the aforesaid, it is pertinent to note that under Section 377 of Indian Penal Code, 1860 (“IPC”), “Whoever voluntarily has carnal intercourse against the order of nature with any man, woman or animal shall be punished with imprisonment for life, or with imprisonment of either description for term which may extend to ten years, and shall also be liable to fine.”

Since as per IPC homosexuality is treated as an act that entails criminal liability in India, how can a foreign homosexual couple be legally allowed to get a surrogate child? It is often alleged that Section 377 of IPC violates the fundamental rights of homosexuals in India. Despite the existence of literature drawn from Hindu, Buddhist, Muslim as well as modern fiction to testify the presence of same-sex affinity in various forms, homosexuality is still considered a taboo by both the civil society and the government in India.

However, there are certain confusing definitions in the bill which need further explanation and clarifications. Section 32(1) of the Bill, which is the enabling provision, states: “That subject to the provisions of this Act and the rules and regulations made there under, Assisted Reproductive Technology (“ART”) shall be available to all persons including single persons, married couples and unmarried couples”.

Therefore, it becomes pertinent to understand that how a couple is defined here. Under Section 2(e) of the Bill, a couple means: “The persons living together and having a sexual relationship that is legal in the country / countries of which they are citizens or they are living in”.

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This definition is inclusive in nature and covers all kinds of couples, whether they are homosexuals or not. Furthermore, the definition does not prevent the citizens of a country (where homosexual marriage is legal), from having a surrogate child. So, if section 377 of IPC is amended so as to be in consonance with the scheme of the Bill (as and when it is passed by both the houses to give it a legal effect), there will be no impediment in including same-sex couples within the definition of ‘couple’ as defined under Section 2(e) of the Bill. The effect of the definition appears to do away with the legal limitation imposed by Section 377 of IPC, and is not just a mere co-incidence of legal drafting.

As we ponder upon some other definitions in the Bill, an “unmarried couple” is defined under Section 2(w) to mean: “A man and a woman, both of marriageable age, living together with mutual consent but without getting married.”

So when these two definitions are read simultaneously, it clearly delineates that for an unmarried couple to get a surrogate child, they have to be heterosexual; but on the other hand, no such condition is applicable to married couples i.e. they might be homosexual or heterosexual.

This leaves us in sheer confusion as Section 32(1) is not restricted, but extended to include 'single persons', 'married couples' and 'unmarried couples' as well. There is perhaps a window left open for a foreign married homosexual couple who, according to the two definitions under the Bill, are a ‘couple’ having a valid married status under their jurisdiction. The non-exhaustive language used herein should allow the courts to fill in the gap.

Discrimination

Since a homosexual relationship or marriage is not legal in India, this Bill by ICMR seems discriminatory in nature towards Indian homosexuals as homosexuality is legally prohibited in the country. On the other hand, homosexuals from the countries (where homosexual marriages are legal) can freely come to India and get a surrogate child. Moreover, an Indian homosexual couple cannot have a surrogate child; an Indian homosexual person can do so only by invoking his status as a ‘single person’ under the Bill, and not as a homosexual. Marital status of a
homosexual individual, therefore, does not matter either for having a surrogate child.

In addition, Section 34 (10) of the Bill states that “The birth certificate issued in respect of a baby born through surrogacy shall bear the name(s) of the genetic parents / parent of the baby.” This implies that the child belongs to them (him) who contribute(s) to the genetic make-up of the child (excludes anonymous donors). Only one of the two partners in a homosexual couple can make such a contribution; under Section 33(3) of the Bill states that: “A donor shall relinquish all parental rights over the child which may be conceived from his or her gamete.” For this purpose and therefore, the child will bear only the name of the contributing partner of the homosexual couples.

The question now is: ‘is marital status going to be a restrictive factor preventing Indian unmarried homosexual couples from having a surrogate child?’ In the light of above stated, the answer for this question would certainly be no, but still there is a discriminating factor against Indian homosexual couples and in favor of foreign homosexual couples (who can legally get a surrogate child as per ICMR).

This kind of problem can be conveniently solved by passing the bill only when the status of the Indian homosexual couples is brought at par with the foreign homosexual couples; either legalize homosexual relationships/ marriages in India or else, put such restrictions on a foreign homosexual married couple as are faced by Indian homosexuals (where the issue of getting a surrogate child is concerned).

**Limitation in Cross-border surrogacy arrangements**

Whereas the industry works quite smoothly on the national level, problems arise with respect to cross-border business. There is considerable legal diversity as to medically assisted reproduction all over the world leading to difficulties for courts which have to decide on the recognition of foreign official certificates and judicial decisions. Surrogacy is sometimes seen as a legitimate way to overcome infertility and to realize the desire for a child in mixed as well as in same-sex
relationships. At the same time, surrogacy opponents point out the degradation of children to a merchant good and the exploitation of needy women. Legal diversity leads to legal uncertainty, which in turn is mirrored by intended families experiencing a stage of factual precariousness as private international law lacks a coherent approach on the applicable law and the recognition of awards.

**LEGAL DIVERSITY IN INTERNATIONAL SURROGACY LAW**

Surrogacy laws are everything but internationally coherent: Regulations range from a total ban to liberal approaches, whereas some countries do not rule on surrogacy at all. At the same time, there is a lot of movement in the field: Some of the rigid regulators currently consider allowing surrogacy at least in certain specified cases in order to cope with the factual problems of legal arbitrage, while some of the liberal countries try to ban foreigners from the market in order to prevent a systematic violation of women’s rights. This leads to intended parents travelling to the most favourable jurisdiction but still facing severe problems when returning home.

**Procreational legal arbitrage**

The fact that surrogacy to a large extent emerges as a cross-border phenomenon is partly due to intended parents trying to exploit price differences. However, the so called “procreative tourism” is also a result of maximum legal diversity in the international realm. The legislative power of restrictive countries factually ends at their borders: So far, there is a considerable number of their citizens whom they could not effectively prevent from obtaining a baby abroad. In theory, they might consider to punish intended parents for obtaining the baby abroad; however, so far this has not seemed to be feasible for those legislators who have thought about it; an example is France where a commission proposed in 2008 that children born to a non-authorized surrogate should pay for their parents’ mistake.

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The phenomenon of legal arbitrage is well known from other fields of law where it works perfectly well because the rather restrictive countries rarely attempt to rule on activities outside their borders. This is, however, different in the ethically coined realm of family law. Here, the jurisdictions with strict approaches regarding surrogacy do not want their citizens to evade their rules. Family Law, however, is the only means which the legislator can use to prevent reproductive tourism.

Reproductive tourism may also be considered as a “safety valve that reduces moral conflict” – apparently according to the principle “out of sight, out of mind”. Their law eventually catches the refugees as soon as they return to its reach, i.e., as soon as the intended parents bring the newborn baby home. The result is a clash between two quite different systems of family law, which materializes in the home country authorities not recognizing the legal effects surrounding surrogacy in general and parenthood in particular which the intended parents were aiming at. If the child was born in a jus-soli country like the United States, the child will be easily issued with a passport and often be able to follow the intended parents to their home country. In this case, problems do not arise before the new family could settle at home. If, however, child nationality depends on parentage, this means that the intended parents need their own jurisdiction to acknowledge their parenthood right from the beginning because without at least one of them being recognized as a legal parent, the child will not be issued with a passport from the local embassy at his place of birth. To establish legal parentage here is anything but quick and easy: In the vast majority of jurisdictions, motherhood is initially attached to the woman who carried the child. Furthermore, many surrogate mothers are married, which makes the laws of most countries presume her husband to be the father. This impedes the child in getting the same passport as his intended parents who thus have to challenge the parenthood of the surrogate or her husband.

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21 In the field of international corporate law. There is no reasonable difference between “legal arbitrage” and “regulatory arbitrage”.
24 § 1592 No. 1 of the German Civil Code (BGB) ibid
Motherhood is contestable almost nowhere;\(^\text{25}\) and while fatherhood is contestable almost everywhere, this takes a significant amount of time—time that intended parents are not willing to spend in a foreign country. They will thus apply for a passport on the uncertain ground of general legal principles or try to be immediately entered on the birth certificate—which, in turn, is not recognized by many European authorities and courts due to reasons of public policy.

The question thus arises whether intended parenthood should be internationally recognized so that the babies do not end up “stateless and parentless”. This issue is not only of momentary importance: It will remain urgent even if some European countries permit certain forms of surrogacy in the near future, because as long as there is any legal diversity in the field, legal arbitrage and therefore the problem of recognition will remain.

The surrogacy professionals clarifies that there is no need of a DNA test in order to get the birth certificate in surrogacy. It is only done if a consulate asks to confirm paternity or maternity of the new born. With affordable cost of surrogacy in India, internationally trained doctors and latest technology in surrogacy clinics, couples from different countries are coming to India for surrogacy.

Doing a DNA test is not a prerequisite for getting a birth certificate. The birth certificate is issued by the concerned municipal corporation based on the application that the genetic parents themselves fill out. It is only certain consulates ask for DNA ID, paternity check and only on those specific requests is a DNA ID check done to confirm paternity or maternity as may be.

The issue of citizenship was not directly dealt with, but after Jan Balaz Case, Government took certain steps to ensure the well being of children born in India through ART Procedure. As a step to curb such issues from cropping up wherein the commissioning couple’s place of domicile doesn’t recognise surrogacy and the issue of determination of citizenship of the children born come up, the Ministry of Home Affairs, Government of India brought about a change in Visa regulations, in

\(^{25}\) *One example of legislation that opens motherhood to being declared void is Greece; see Art.1464 of the Greek Civil Code accessed on www.ladwise.landesa.org/record/1066 on 14/4/2014.*
2013. Imposes a number of conditions. Among others are the condition that the couple must have been married for at least two years and letter from the embassy of the their respective country must be enclosed with the visa application stating clearly that “(a) the country recognises surrogacy and (b) the child/children to be born to the commissioning couple through the Indian surrogate mother will be permitted entry into their country as a biological child/children of the couple commissioning surrogate.”

**Enforceability in Court of Law**

Sample contract in the proforma annexed to the ICMR Guidelines and also provided in the proposed ART bill a sentence specifically drawn the attention of the researcher provides:-

“Any party may attempt to enforce this Agreement in court. However, all Parties understand that a court may refuse to enforce this Agreement, in whole or in part. The Parties assume the risk of unenforceability in entering into this Agreement”

In these circumstances, though enforceability nowhere affects, wealthy nations. It is an open secret that it is first and foremost well-off people from industrialized countries who can afford to commission a surrogate and that it is frequently indigent women from Third World countries who – often under substantial pressure – “opt” for surrogacy in order to improve the living conditions for themselves, their husbands, and their children.

There is disagreement amongst legal scholars as to the extent to which surrogate mothers voluntarily and without any pressure agree to carry a baby for the intended parents “the experience of being a surrogate mother is neither problem-free nor necessarily as horrendous” as stated by a surrogate mother at Hyderabad during the study, she said that leaving the baby was the worst part of their experience; however, there was a general notion that unhappy feelings soon disappeared.

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26 Ministry of Home Affairs, Government of India, Type of Visa for foreign Nationals intending to visit India for commissioning Surrogacy and condition for grant Visa for the purpose, available at http://mha1.nic.in/pdfs/CS-GrntVISA-29112.pdf (last visited on march 27, 2014)
27 Ibid
Does Private International Law helps anyway...?

A recent proposal for legislation by certain feminist groups would – if implemented – ban foreigners from surrogacy in India. Critics and pressure groups have promptly issued a warning that this might diminish the surrogacy business by 90% and cause significant economic damage to a whole commercial sector.

When it is widely accepted an intervention of Government of India is warranted to protect the interest of the Surrogate mother through the process provided in Private international Law. Bilateral treaties and International Convention on this issue may create difference.

Response of Indian Authorities is invariably hopeless, as even after developing as a hub of Medical tourism specifically ART, the legislation is dealing the issue as Tabu and similarly no will appears to regularise this burgeoning industry from the Government, thus expectation of initiation of process for a convention appears to be a full moon in a black-night.

Against this background of lacking, incoherent, and changing regulation, European courts struggle to deal with the growing number of cases in which surrogacies have already taken place and the intended parents fight for the legal recognition of their parenthood.

Legal problems occasionally occur with respect to cases where child immigration and thus the recognition of parenthood is complicated by a missing genetic linkage of the child to either of the parents. However, the vast majority of cases tried in European courts concern situations in which the child is consanguineous with the intended father, but the intended parents are not willing to run through the time-consuming process of paternity acknowledgment and/or adoption before taking the baby home.

These cases either relate to denied passport applications at embassies located in iussanguinis countries (“child abroad”) or to the rejected establishment of parenthood in the parents’ home country (“child at home”). Examining overall patterns from cases recently dealt with by European courts, it is important to differentiate those two types of cases as the respective judicial decisions appear to be remarkably different in nature.
Child abroad

Many restrictive jurisdictions attempt to disincentivize surrogacies abroad by refusing to issue a passport for the newborn child, thus preventing the child from entering its territory. The calculus behind this policy is not meant to disadvantage the child – however, it factually complicates the process of child immigration to the intended parents’ home country. Hence, the authorities in those countries and their embassies abroad perceive this legal situation as being highly unsatisfactory because they are advised to prevent similar cases in the future by denying the child and – indirectly – the intended parents the right to enter the country in cases where prevention has already failed.

Within the last few years the numbers of cases contesting dismissive decisions from embassies and similar authorities has been steadily low, but however remarkable. In 2008, the English case X & Y (Foreign Surrogacy)\(^\text{28}\) caused a public stir as two children born in the Ukraine had to bring suit in order to be allowed to enter the United Kingdom. In Jan Balaz v. Union of India (2009), the intended parents did not succeed as the High Court of Gujarat decided that twins born through surrogacy were Indian citizens and did not assume German nationality from the intended parents.\(^\text{29}\)

Strictly rights-based decisions, however, do not eventually prevent the intended parents from taking the baby home. Courts and other state authorities try to acknowledge the confused situation even if they are afraid to set precedents. In an attempt to cope with the deadlock, they often slur over the legal question of child nationality and sooner or later allow for child immigration. Their reasoning shows that they shrink back from perpetuating the current situation, instead they stress the exceptionality of their decision. The intended parents’ passport application is often not legally successful as the child is not issued with a passport from their home country. But courts and authorities have regularly permitted them to take the baby home “outside the rules”, issued a one-time travel permit, or settled the dispute without any judicial

\(^{28}\)Royal High Court of Justice, decision dated December 9, 2008, no. 2008 EWHC 3030, “X&Y (Foreign Surrogacy)”; http://read.bi/19PRXHQ (last accessed 18.1.2014)

\(^{29}\)High Court of Gujarat, decision dated November 17, 2009, file no. LPA 2151/2009, downloaded from www.gujhc.nic.in/judment/09/lpa/2151
decision at all.\textsuperscript{30} Sometimes, the children born through surrogacy have had to stay in their birth countries for about a year, but there is no known case in which a child would have eventually had to stay and was never allowed to follow the intended parents to their country as appears from both the Indian cases (Jan Balaz and Manji Yamada).

\textbf{Child at home}

The factual situation is somewhat different in cases where the child has already moved to the place where the intended parents live. Court decisions in these cases are no longer under the immediate pressure of the intended family living under unfamiliar circumstances. Such cases occur where the baby was born in a ius-soli country like the United States and could easily enter the parents’ European home country or where the intended parents succeeded in carrying the baby home after somehow evading the embassy or border controls. In these cases, the child is living with her intended parents according to plan, but their parenthood lacks legal recognition. Here, one does not observe patterns of non-bureaucratic decisions; instead, courts are rather relentless and tend to show rigour by sticking to their restrictive surrogacy laws, denying motherhood for the intended mother and referring the intended father to a formal acknowledgement of paternity. On several occasions, intended parents have unavailingly attempted to achieve recognition of a foreign birth certificate that identified them as the legal parents. Courts refer the intended parents to an acknowledgement of paternity and the adoption procedure explicitly disregarding the birth certificate for reasons of law or public policy.\textsuperscript{31} At the same time, it should be noted that a few decisions point in a different direction, recognizing foreign decisions on the parenthood of the genetic father even under the public policy restriction.\textsuperscript{32}

It can thus be concluded that, when the best interests of the child are at stake because the newborn child has become stuck in a foreign

\textsuperscript{30} Royal High Court of Justice, Supra Note 28
\textsuperscript{31} Administrative Court (VG) of Cologne, decision dated February 20, 2013, file no. 10 K 6710/11 http://ti.me/VY75g9 (last accessed 18.1.2014)
country, courts temper justice with mercy. However, once the child is safe, the domestic laws are widely enforced; exceptions prove the rule.

Consequences Of Legal Diversity In The Recognition Of Parenthood

Even though the courts obviously do their best to cushion the negative effects of international surrogacy cases on the involved children, critics argue that the problems with which young families are confronted are still considerable and have to be dealt with by an international approach.

The first disadvantage children face after being born to a surrogate mother is often an extension of their stay in an underdeveloped country that the intended parents are not living in. For example, a French couple might have to stay a couple of months or even a year with the newborn child in India until the husband of the surrogate has contested his fatherhood, the intended father has acknowledged paternity, and the French embassy has eventually issued a French passport for the child. Sure enough, some local authorities issue birth certificates identifying the intended parents as the only parents of the child (even if this is against the local law), which in turn increases the chances to veil the surrogacy and to obtain a passport for the child at the foreign embassy. Anyway, this is not a solution that satisfies a lawyer.

At least, many surrogacies take place in countries which have agreed to a visa waiver programme with the intended parents’ home country, enabling the intended parents to take the (legally foreign) baby home without any waiting period, though in absence of any legislation on this issue and failure in entering into a bilateral or collateral treaties in this behalf, India is not among them.

The second considerable difficulty children face arises at home out of the at least temporarily open questions of parentage: The legal uncertainty as to who is assigned with legal parenthood over the child may translate into questions of custody and child maintenance. The intended parents will need the right to exercise child custody soon after child immigration to their home country, be it for consultations or for an application for a day nursery. Anyway, child custody largely depends on parental status. Thus, as long as paternity is not acknowledged and the
intended mother has not adopted the child, most jurisdictions\textsuperscript{33} still see the surrogate mother and her husband as legal parents. If a personal custody decision cannot to be postponed, family courts will often assign a legal guardian to make those decisions until parenthood is established.\textsuperscript{45} The situation is further complicated where the intended parents split up before parenthood is legally arranged. If the intended parents terminate their relationship, the child will need support. The worst-case scenario here would be the intended parents denying responsibility and the child being reliant on his legal parents who live far away under possibly quite different living conditions.

Some surrogacy organizations will try to avoid such a situation by asking intended parents to reach an agreement on child support before entrusting a surrogate mother, but this is not the rule.

Anyway, there is no known case where the intended parents have denied the responsibility for child support because of a split-up before or immediately after childbirth.\textsuperscript{34} If this happened, the child would most likely not be returned to the legal parents but – with their consent – be put up for adoption. However, in the vast majority of cases, parenthood questions will be solved before custody and maintenance problems arise – either due to a timely acknowledgement of paternity or because the registrar who is in charge of the domestic birth registration does not (want to) notice the possibility that the baby could have been carried by someone other than the intended mother.

After all, it is questionable to which extent the concerned children will really sense the complications their parents face. If immigration is delayed they may suffer from being looked after by only one intended parent instead of two. If quick immigration works out but legal parentage cannot be established immediately, they will barely notice anything. Of course, if their parents separate before their parenthood is legally acknowledged they may incur significant disadvantages. However, such a case has not yet become public. Thus, the main factual difficulties which are the result of legal diversity are apparently caused by the intended

\textsuperscript{33} One example for a jurisdiction immediately assigning motherhood to the intended mother is the Ukraine; see Art. 139 of the Ukrainian Family Code accessed on www.refworld.org/docid/4c4575d92.html on 14/4/2014

\textsuperscript{34} Even in the case of Baby Manji, the (genetic) father tried to meet his obligations
parents. Here, it is important to remember that the rather rigid legislators have deliberately chosen to follow a restrictive approach and have hazarded the consequences on the intended parents.

Thus, the fact that the intended parents face severe difficulties with cross-border surrogacies does not necessarily call for criticism as they know in advance that they are following illegal plans. One can even argue that only from the struggle of those cases comes the power of prevention – and comes the invisible advantage that surrogacy mandates from citizens of countries with rather strict legislation so far remain a fringe phenomenon.

LEX FERENDA

The examination of the most pressing problems in recent European legislation on surrogacy shows that only in rare cases does legal uncertainty eventually materialize at the expense of the children in question. However, one might ask whether any international legal approach can still smooth out unfavourable effects for the persons involved without undermining the legitimate decisions of rigid regulators. Is there a need for an international convention on cross-border surrogacy...? Does parenthood have to be redefined with regard to the intention of would-be parents, or do the existing legal measures suffice for the protection of the child...?

A new Hague Convention

The Hague Conference on Private International Law is currently attempting to map out a convention on issues arising from international surrogacy arrangements.

Building on previous work from two reports on this topic from 2011 and 2012 and drawing from a study carried out by a research team from the University of Aberdeen published in 2013, the Conference has recently issued four questionnaires on the private international law

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issues surrounding the status of children with particular emphasis on international surrogacy arrangements. A draft convention in 2015 would be the next logical step here. The goal of such an international treaty – to protect children from the downsides of legal diversity – is honourable. However, the practical feasibility of such a convention remains questionable. An international convention brings about legal certainty, which is also brought about with the recognition of foreign decisions. As regards surrogacy, this means that the home legislations of intended parents would have to recognize certain assessments from the courts or authorities in the country where the surrogacy took place. Most likely, these assessments first and foremost concern questions of parentage as these are central to the legal problems of today. However, to ratify a new Hague Convention on international surrogacy cases would not only mean a pullback from the regulation of families living abroad, it would indeed open the floodgates to national definitions of parentage as the domestic family law could then most easily be evaded by shifting registry decisions abroad. It seems highly unlikely that the rather restrictive European jurisdictions are willing to sacrifice a fundamental principle of family law to international regulatory competition.

**Leeway for cross-border recognition of surrogacy**

There are a number of renowned voices in the international realm who see sufficient leeway for a surrogacy-friendly interpretation of the prevailing Western family laws.

Their main reasoning can be traced back to Art. 8 ECHR, which protects private and family life, and to Arts. 7, 8, and 9 of the UN Convention on the Rights of the Child.

The idea is that the rules on parenthood have to be reinterpreted so that in surrogacy cases the intended mother is to be immediately considered to be the legal mother even though this conflicts with the letter of the law. According to this approach, public policy should no longer be used to ward off the application of foreign parenthood laws but be liberalized in respect of the children’s rights mentioned above.

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However, by acknowledged legal methodology, the cited conventions can influence the interpretation of national family laws on maternity but not overrule them.38

Furthermore, Art. 8 ECHR as well as Art. 3 UNCRC are not violated as long as the children born through surrogacy can live with their intended parents, because here, the question of how parenthood is established turns out to be a mere technicality that the children do not effectively suffer from. Even if a child has marginally suffered, the reasoning with the interests of the children might be circular: As was described above, the idea of preventive law is to discourage certain behaviour, accepting negative effects where prevention does not work. By accepting very few children to live abroad for a while39 and to be possibly left without child support (no case is known so far!) the legislator scares many people off from international surrogacy and prevents many future children from ending up in a similar situation. This calculus is reasonable not least because it is still scientifically plausible that the separation of a child from his birth mother significantly impairs his welfare. Whether or not this is perceived to be a favourable legal policy is anyway not a question of legal methodology but a decision by the respective legislator.

**Shifting the parenthood rationale from genetic linkage to intention**

Of course, the legislators in different countries might want to think about a redefinition of parentage. It is a valid question to ask whether parenthood should stick to genetic linkage or be shifted or complemented by parenthood through intention. The question comes up because it is only a quite recent development that motherhood can be split between the woman giving the egg and the one carrying the child. Most current European family laws irrevocably assign motherhood to the latter. The reason here is – quite surprisingly – not predominantly a closer link between the gestational mother and the child but the preventive argument mentioned above. This tells us a great deal about the unsettled question of which aspect eventually matters for a modern understanding

38 In some countries such as in Austria, the said conventions were indeed elevated to constitutional status; however, in other legislations, the constitution overrules the convention.

39 In the view of the law, the child does not live “abroad” because as long as the surrogate is his mother, her country is his country.
of parenthood. Is it the genetic link, the social relationship, the bare intention, or a mixture of the latter...?

A view on recent European jurisdiction shows that there is a growing perception that children have a right to at least know about their genetic origin. The performance of such a right is somewhat hampered in the international realm as long as surrogacy friendly states do not record data from surrogate mothers. Apparently, responsibility through genetic linkage is widely perceived as disposable as long as someone else is willing to take over.68 One might induce from this observation that parentage has to be open to contracting. However, this argument turns out to be weak: As contracting on parentage is highly susceptible to child trafficking and thereby severely violating the value of human dignity from Art. 1 of the Charter of Fundamental Rights of the European Union, any agreement could be put on hold until some state authority has approved it. Such state approval seems necessary because human trafficking has to be prevented, because even the intention to be parents might sometimes be (too) fungible, and because with the children, there is a voiceless third party involved which needs someone to speak up for her. To legalize surrogacy in this way might comply with children’s rights as well as with the fundamental family law principles of most, if not all European countries. In fact, a legal model for such an intentional parenthood already exists in coexistence with the parentage based on genetic linkage: it is nothing other than adoption.

Relying on adoption

Adoption is a model of parenthood which is not based on genetic linkage but on someone’s intention. Today, it functions as an emergency mechanism for cases in which the genetic parents can – for whatever reason – no longer take the responsibility to care for the child. This is quite similar to what can be observed in surrogacy cases: There is some kind of a factual emergency when the intended parents try to import a baby and acquire legal parenthood even though they know they were not allowed to do so. The baby is not responsible for this awkward situation, and the law has to deal with this. Given that the intended parents deliberately chose to create the emergency, it is only just and equitable to gear the legal mechanism which deals with the situation exclusively to the well-being of the innocent child and not to the goals of the parents. This is
exactly what adoption procedures all over the world look like. It is important to notice here that the best interests of the child do not necessarily argue for assigning the child to the intended parents.

They can indeed follow the surrogate (and possibly her husband) in their status as legal parents; however, only subject to the necessary condition that this is the best solution for the child. Here, the law provides a possibility for double parenthood, sure enough the sequential and not the simultaneous way.

Critics might argue that subsuming surrogacy under adoption cannot provide certainty for the intended parents that they will eventually obtain the child because – at least in theory – the child might be given to someone else. However, the question is how much certainty someone deserves who orders a child to be born as a (legal) orphan. Also, any deviation from the best interests of the child as the sole guideline for the allocation of the child result would seem iniquitous as it would mean that intended parents can take home a child whose interests would be better served by being assigned to someone else. Apart from that, it is also the rights of the surrogate which argue against “parental certainty” for the intended parents: It is a factum that many surrogates do their job only under serious financial and social pressure and that their assurance to be fine with relinquishing the child does not express their real feelings; if this does not anyway lead to a complete prohibition of commercial surrogacy, at least it calls for the surrogate’s right to eventually decide whether to keep the child only after birth. However, if the surrogate mother is granted this right, the law has to assign initial motherhood to the woman who gives birth. The proponents of surrogacy thus have to decide whether they want to keep this understanding of motherhood or whether they are really willing to entitle intended parents to enforce the surrogacy agreement, if need be in the delivery room.

Further, the absence of an effective binding law on surrogacy in India makes the situation grim as during the pendency of the Bill there is no mechanism or no official government-appointed body responsible for maintaining records on the issue.

The draft law on surrogacy in India, the ART Bill 2010, provides for maintaining records under its relevant provisions. There is a duty imposed
on the ART clinics to maintain accurate records on the manner, technique and use of ART technologies, the individual or intending couple or surrogate mother, in respect of whom it was used.\textsuperscript{40} The ART Bill provides for maintaining and preserving records, and the setting up of the National ART Registry.\textsuperscript{41}

Further, the ART Bill also provides for setting up of a National Advisory Board for Assisted Reproductive Technology established by the Central Government and State Advisory Board for Assisted Reproductive Technology by the State Government for regulating the conduct of ART procedures or treatment, including surrogacy by fertility or ART clinics, and for ensuring necessary compliance with the law.\textsuperscript{42}

In addition to these, the Bill provides for the constitution of a State level ART Registration Authority\textsuperscript{5} for granting registration to the ART Clinics for their functioning\textsuperscript{6} and to exercise supervision over the ART clinics and to check any malpractice by such clinics.\textsuperscript{7} As the Bill awaits its enforcement, these provisions remain non-functional.

But despite these laudable provisions, there is no clear measure on the data or facts or figures on the surrogate children born till date at the State level and other related information.

Attempts have been made to understand the size and scheme of the large-scale operation of surrogacy as a burgeoning IVF Industry, and a brief empirical study has been conducted on the plight of surrogate mothers in South India.

A sample of surrogate mothers based in Bangalore had been studied through the interview schedule but as the issue of surrogacy is heavily guarded by privacy concerns, in order to know the correct proportion of this thriving business of surrogacy, RTIs had been filed at the regional level in Karnataka as well as at the apex national level for securing accurate and exact information on surrogate mothers and surrogate children and other incidental issues concerning surrogacy in India.

There is absolutely no information on the number of surrogate children born in Karnataka annually or the total number of surrogate

\textsuperscript{40} Sec 22 of ART Bill 2010
\textsuperscript{41} Section 22 (1) of ART Bill 2010
\textsuperscript{42} Section 3, Section 6 of ART Bill 2010.
children born in Karnataka till date. There is no information on the Infant Mortality Rate (IMR), sex ratio of the surrogate children born in Karnataka; and there is also no information on the total number of birth certificates issued to the surrogate children in that State. Besides, there is no concerned official government authority at the State level collecting and maintaining records on the same.

Regarding the RTI filed with the Office of the Project Director (RCH), the Directorate of Health and Family Welfare Services, Government of Karnataka replied: “No separate report of surrogate children is maintained in any of the hospitals of Karnataka, hence report of total number of surrogate child born in Karnataka and report of Infant Mortality Rate (IMR) of surrogate child born in Karnataka is not available.”

On the RTI filed with the Joint Director, Statistics, Birth and Death, the BBMP head office, Bangalore replied that there was no information on the Infant Mortality Rate (IMR), sex ratio and total number of surrogate children born in Karnataka.

Besides, on the RTIs filed with the Karnataka State Commissions, namely, the Human Rights Commission, Child Rights Commission, Women’s Commission, these Commission denied having any information on the same by summarily dispensing with the queries and stating that no information was available on the mentioned subject (surrogacy or surrogate mother or surrogate child) and thus replied that all the queries should be treated as negative.

The Karnataka State Human Rights Commission replied that

“neither complaint or case relating to surrogacy or surrogate mother or surrogate child has been received and nor suo moto action has been taken up. As such no information is available and thus replies to all the queries may be treated as negative.”

The Karnataka State Commission for Protection of Child Rights replied that “no complaints related to surrogate child has been registered in the Commission and not much work has been done in the Commission on this topic”.

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Thus there is no State-level official statistical record on the status of surrogate children born in India annually or in each State per annum.

Despite all these developments, there is unfortunately no data or facts and figures on the same.

However, in the recent past, the Indian Society for Assisted Reproduction has taken the initiative of collecting the data by establishing the National ART Registry of India which has been instrumental in collecting and publishing data related to Assisted Reproduction Technology carried out in India since the year 2001. But there are certain limitations in this. Firstly, this is a voluntary process as the data is submitted by the ART clinics voluntarily to the ISAR. Neither has the ISAR powers to check the authenticity and nor has it powers to enforce all clinics to submit data. Hence the NARI does not cover all the ART clinics as well as does not have all the information concerning surrogacy. Further, the last data published by the ISAR under the NARI is of the year 2006.

Correspondingly, RTIs were filed with the National Commission for the Protection of Child Rights (NCPCR), National Commission of Women (NCW), National Human Rights Commission (NHRC) at the national level in order to ascertain necessary facts and figures on surrogate mothers. However, these have also not yielded any result.

Meanwhile the NCW has informed that it “had approved one research study on surrogate mothers in Gujarat by an NGO based in Delhi and also held one Consultation on Surrogacy and ART to discuss the rights of surrogate mothers in the year 2008 but despite this the NCW has not issued any Guidelines on the same”.

It is also important to note that none of these bodies have taken sue moto cognizance of the matter even when they have the necessary statutory powers to do so in the light of the rampant legal, health and ethical issues concerning surrogate mothers and children.

Thus there is a serious lacuna and omission on the part of the government to maintain the necessary and accurate records as well as facts and figures on the surrogate child, particularly when surrogacy is not only regularised in India but is rampantly practiced and the government
earns a whopping amount of revenue from the same. Information and record-keeping must be considered by the government as the immediate recourse.

Today, legal arbitrage persuades droves of Europeans to cross borders in order to have access to surrogacy services which are prohibited under their home legislation.

Once the intended parents attempt to return home with the newborn child, legal diversity translates into problems of legal recognition for the parental status acquired under the foreign legislation. These problems can hardly be satisfactorily solved by European courts; the judges thus tend to avoid precedents and look for informal and non-legal solutions as long as the child is still in her country of birth. The consequences of legal diversity and stagnant jurisdiction, however, turn out to be less serious than one might think: No baby born through surrogacy is known to have permanently stayed in her country of birth, and there is so far no public case in which the length of an acknowledgment of paternity or adoption procedure has made the child lose a claim for child support.

As to the lex ferenda, legal research does not have to decide whether to follow a restrictive or a rather open approach towards surrogacy. The range of possible legislative decisions goes from penalizing the placement of a surrogacy order to the recognition of foreign decisions on parentage to entirely permitting surrogacy. Legal research should point out that, as long as there is any legal diversity and procreative tourism is not criminalized, there will definitely be legal arbitrage and the circumvention of domestic laws. For any European legislator which has decided to prohibit surrogacy, the adoption procedures are completely sufficient to meet the interests of the persons involved, placing the welfare of the child clearly above the interests of the intended parents. In order to protect weaker individuals, i.e., the children and the surrogate mothers, the focus of the discussion anyway deserves to be rather on the protection of their rights than on legalizing the technically possible. And even if some European legislators should decide to liberalize their laws they cannot evade answering the fundamental question whether they will keep their current definition of motherhood or entitle the intended
parents to wrest away the newborn child from the surrogate right in the maternity room.

Surrogacy is a $ US 2.8 billion trade across the world and India's commercial surrogacy is a $ 2.5 billion industry in the country.\textsuperscript{43} This is as per the estimate of the Confederation of Indian Industry.

It is an admitted and well-known fact that in India surrogacy is legal in the commercial form with the Supreme Court judgment since the year 2002 in the absence of an effective binding law. The proposed law regulating surrogacy in India—the Assisted Reproductive Technologies (ART) Draft Bill 2010— is awaiting its long due enforcement.

The Law Commission of India submitted the 228\textsuperscript{th} Law Commission Report titled “Need for Legislation to regulate Assisted Reproductive Technology Clinics as well as Rights and Obligations of parties to a Surrogacy” to the Union Minister of Law and Justice, Ministry of Law and Justice, Government of India On 5\textsuperscript{th} of August, 2009. The report expressed the view of the Law Commission on the Indian Counsel for Medical Research Guidelines 2005 on Surrogacy, the draft Assisted Reproductive Technology (Regulation) Bill and Rules 2008 and the Seminar on “Surrogacy – Bane or Boon”. The report had also made recommendations to be kept in mind while legislating on surrogacy.

Though the report has highlighted several issues on surrogacy, the report has failed to move in deeper into the aspects of surrogacy. The report is highly superficial and fell far below the expectations for providing recommendations taking into consideration the Indian situation.

The report has failed to notice many glowing issues which require immediate attention. The Report lacks clarity in thought and has found it best to limit itself to what is happening today, instead of suggesting a better tomorrow. The report has not considered the prevailing socio-economic situation in India, which has lead to present boom in Surrogacy. The report has not also been able to identify the future of surrogacy in India, and has not made recommendations for regulating the practice of surrogacy.

Paragraph 1.7 of the Report is extracted hereunder:

“1.7 In commercial surrogacy agreements, the surrogate mother enters into an agreement with the commissioning couple or a single parent to bear the burden of pregnancy. In return of her agreeing to carry the term of the pregnancy, she is paid by the commissioning agent for that. The usual fee is around $25,000 to $30,000 in India which is around 1/3rd of that in developed countries like the USA. This has made India a favourable destination for foreign couples who look for a cost-effective treatment for infertility and a whole branch of medical tourism has flourished on the surrogate practice. ART industry is now a 25,000 crore rupee pot of gold. Hyderabad, a small town in Gujarat, has acquired a distinct reputation as a place for outsourcing commercial surrogacy. It seems that wombs in India are on rent which translates into babies for foreigners and dollars for Indian surrogate mothers.”

A specific mention has been made regarding “Commissioning Agent” in the above extract from the report. In the immediate sentence preceding this sentence, mention has been made about the “Commissioning Couple”. The meaning of “Commissioning Agent” is nowhere explained in the report and causes great confusion as to who is making the payment to the surrogate mother. The mention of ‘commissioning agent’ assumes importance for the reason it signifies the existence of an agent communicating in-between the surrogate mother and the intended parent. This practice is not appreciated internationally and is not in line with the Indian Council for Medical Research Guidelines, 2005.

In the same paragraph, i.e., in 1.7 of the Report, it has been stated that the usual fee for surrogacy in India is around $ 25000 to $ 30000. This again lacks clarity for the reason that the sentence preceding that was dealing with surrogate mothers. This fee referred to in the Report is the total cost which the Intended Parents would be required to spend on surrogacy in India, and not just for the Surrogate mother.
Again, in paragraph 1.7 of the Law Commission Report, specific observation has been made that the Assistant Reproductive Technology Industry is worth about Rs.25 crores. This figure is not based on any official report and lacks accuracy.

Paragraphs 1.9, 1.10 and 1.11 has been extracted hereunder:

“1.9 As far as the legality of the concept of surrogacy is concerned it would be worthwhile to mention that Article 16.1 of the Universal Declaration of Human Rights 1948 says, inter alia, that “men and women of full age without any limitation due to race, nationality or religion have the right to marry and found a family”. The Judiciary in India too has recognized the reproductive right of humans as a basic right. For instance, in B. K. Parthasarthi v. Government of Andhra Pradesh, the Andhra Pradesh High Court upheld “the right of reproductive autonomy” of an individual as a facet of his “right to privacy” and agreed with the decision of the US Supreme Court in Jack T. Skinner v. State of Oklahoma, which characterised the right to reproduce as “one of the basic civil rights of man”. Even in Javed v. State of Haryana, though the Supreme Court upheld the two living children norm to debar a person from contesting a Panchayati Raj election it refrained from stating that the right to procreation is not a basic human right.

1.10 Now, if reproductive right gets constitutional protection, surrogacy which allows an infertile couple to exercise that right also gets the same constitutional protection. However, jurisdictions in various countries have held different views regarding the legalization of surrogacy. In England, surrogacy arrangements are legal and the Surrogacy Arrangements Act 1985 prohibits advertising and other aspects of commercial surrogacy. In the US also, commercial surrogacy seems prohibited in many states. In the famous Baby M case, the New Jersey Supreme Court, though allowed custody to commissioning parents in the “best interest of the child”, came to the conclusion that surrogacy contract is against
public policy. It must be noted that in the US, surrogacy laws are different in different states.

1.11 If the 1988 Baby M case in the US forced many to put on legal thinking caps, then that year also saw Australia battling with societal eruptions over the Kirkman sisters’ case in Victoria. Linda Kirkman agreed to gestate the genetic child of her older sister Maggie. The baby girl, called Alice, was handed over to Maggie and her husband at birth. This sparked much community and legal debate and soon Australian states attempted to settle the legal complications in surrogacy. Now in Australia, commercial surrogacy is illegal, contracts in relation to surrogacy arrangement unenforceable and any payment for soliciting a surrogacy arrangement is illegal.”

In paragraph 1.10 of the Report, the Law Commission of India has rightly pointed out that the right to procreate is held to be a constitutional right by the Supreme Court and High Courts in India. But the Law Commission has gone to the extent of assuming “if reproductive right gets constitutional protection, surrogacy which allows an infertile couple to exercise that right also gets the same constitutional protection.” The Law Commission has failed to realize that the issue involved in the case of surrogacy is much larger than the ambit of these decisions as these decisions have not considered the rights of a third party i.e. “surrogate mother”. The right to procreation is the constitutional right, but this right does not include the role of a third party, the surrogate mother. Therefore, a simple analogy of the sort done by the Law Commission Report cannot be extended to a third party reproduction without considering its own pros and cons.

The report has failed to note that the problems surrounding Surrogacy in India are not limited to the domestic issues, but goes to an international level. The proposed legislation on surrogacy is required to be addressing the international requirements of surrogacy, and not only domestic. India has made a mark in the recent times for surrogacy in the international level, and is required to address this need of its new found importance. Legislation on surrogacy which does not cater to the needs of the international arena is merely incomplete.
The proposed legislation on surrogacy is required to take into consideration the surrogacy arrangement models followed world-over and has to choose the right combination of the different models, so as to serve Indian scenario. Though the world’s second IVF baby was born in India in 1978, Indian Courts did not have many opportunities to deal the complex questions of law about paternity and nationality. The Indian Law on surrogacy is yet on a pre-mature stage, and not many issues have transgressed into the form of litigation except for one or two. This scene therefore gives the Indian law makers an opportunity to learn from the experience world-over through the decision of the courts abroad. The problems that arise over surrogacy are admittedly very complex, and therefore a world-class legislation competent to handle every such issue is the need of the hour.

The proposed legislation on surrogacy is required to address the issues that the Intended Parents, both from India and abroad, who are taking up surrogacy in India. The draft should cater the needs of the intended parents on the lines of nationality, paternity of the child etc.

The report has failed to make any mention on the rights of the Intended Parents in a surrogacy arrangement. The present situation demands that the drafters have in mind not only the domestic intended parents, but also intended parents world over. Intended parents are bothered to a great extent about their rights before they enter into a surrogacy arrangement. The intended parents opt for surrogacy only as a last resort, with great longing for a child. This desire is what compels the intended parents choose alternative means of reproduction such as surrogacy.

The availability of surrogate mothers at less costly compensation is the stimulation for intended parents from abroad who choose surrogacy India. This being so, it is of utmost importance that specific measures are given for the rights of the surrogate mother. Also, measures should be taken for protection of those rights of the surrogate mother.

Legal Counseling of the surrogate mother plays a very important role in the process of surrogacy as it helps surrogate mothers understand the actual process in surrogacy. It is required that the legal counseling of the surrogate mother is given by a lawyer or by a social activist, explaining
to her the process of surrogacy and also her rights and liabilities. Moreover, the legal counseling is the best method to identify that the surrogate mothers are not forced into surrogacy by her family members. Therefore, it should be recommended that the surrogate mothers should attend the counseling with her relatives.

The Law Commission of India has failed to address the need of an international surrogacy agreement. The international surrogacy agreement is required to serve the needs of the intended parents as well as the surrogate mother, so as to protect their interest. The international surrogacy agreement should be enforceable in the Indian Courts, and should be acceptable by the embassy of the nation of the intended parents.

The Law Commission report has failed to highlight the need for a national database of surrogacy being done in India. Such statistics is of required to keep track of the statistics in the field of surrogacy.

The Law Commission had submitted the report without having done a field study of the present situation prevalent in India with regard to surrogate mothers and Assisted Reproductive Technique Hospitals. Therefore the findings of the Law Commission cannot be clearly serving the needs of today with regard to surrogacy.

The Part IV of the Law Commission Report is extracted hereunder:

“IV. Conclusion and Recommendation

Surrogacy involves conflict of various interests and has inscrutable impact on the primary unit of society viz. family. Non-intervention of law in this knotty issue will not be proper at a time when law is to act as ardent defender of human liberty and an instrument of distribution of positive entitlements. At the same time, prohibition on vague moral grounds without a proper assessment of social ends and purposes which surrogacy can serve would be irrational. Active legislative intervention is required to facilitate correct uses of the new technology i.e. ART and relinquish the cocooned approach to legalization of surrogacy adopted hitherto.
The need of the hour is to adopt a pragmatic approach by legalizing altruistic surrogacy arrangements and prohibit commercial ones.”

The above paragraph from the Law Commission Report has caused undue confusion from many international intended parents and journalists, especially because of the last line stating that commercial surrogacy arrangements required to be prohibited. This sentence has paved way for so many doubts including whether the commercial surrogacy arrangements are going to be banned in India.

The only observation which can formed from the above is that the Law Commission intends to recommend a system which is a line between the one followed in the United States and the United Kingdom. The Law Commission recommends that the birth certificate shall be in the name of Intended Parents, and it also recommends that the commercial surrogacy needs to be prohibited. This means that the only those reasonable expenses for the surrogate mother to bear the child shall be given by the intended parents. However, this issue is largely unclear and requires deliberation from the Law Commission of India.

The Law Commission has fallen off from its expectations by making no recommendations regulating the medical institutions who undertake surrogacy. The absence of such recommendations was conspicuously felt.

20] The Law Commission turned blind eye to the amendments required to various other existing legislations. For example, the Indian Evidence Act, 1872 gives a conclusive presumption that it shall be presumed that the husband of woman who gives birth to the child is presumed to be the father of the child. This legislation requires amendment, so as to accept the later scientific developments.

The Law Commission of India in it 228th Report has made a feeble impact in its recommendations compared to the need of the hour. India Legislation has got a long way to go in evolving the right sort of system suiting Indian conditions for surrogacy.

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Chapter 7

Conclusion and recommendations

While analyzing the Draft bill various shortcomings were found by the researcher, so he recommend following legislative measures:-

- There should be legislation directly on the subject of surrogacy arrangement involving all the three parties i.e. the surrogate mother, the commissioning parents and the child.

- There is a need of right-based legal framework for the surrogate mothers, as far as the ICMR guidelines are not enough

- A clearly defined law needs to be drafted immediately which will pronounce in detail the Indian government’s stand on surrogacy; so that discrete activity leading to exploitation of the surrogate mother can be stopped.

- There should be a substantial regulation designed to protect the interests of the child.

- Legal recognition of termination and transfer of parenting rights.

- It is crucially important to maintain and monitor the anonymity of the surrogate mothers.

- The surrogate mother should be provided by the copy of the contract as she is a party in the agreement and her interests should be taken into account. It happens that very often decision is taken by the intended parents and clinic, while surrogate mother does not have any say in this matter.

- There should be an interpreter (other than doctor) for the communication linkage between the surrogate and intended parents in order to convey the message from surrogate mother time to time. As far as often doctors speak on behalf of surrogate mothers, but there is no guarantee that their interests are conveyed without any misinterpretation.

- Typically, after the birth the surrogate mother is left without any medical support, it is recommended that there should be a
provision of intensive care and medical check-ups of their reproductive organs during the 3 months after pregnancy.

- The commissioning couple should try to establish a relationship of trust with the surrogate, yet such a relationship creates reciprocal rights and duties and might create demands for an undesired relationship after the birth.

- The citizenship right of the surrogate baby is also of crucial importance. The Indian government needs to take a stand in terms of conferring the surrogate baby Indian citizenship as she/he is born in the womb of an Indian (the surrogate mother) and in India.

- The rights of the child should be protected and in case s/he is not taken by the commissioning parents, then the child should be given Indian citizenship.

- Health Insurance for both the surrogate mother and the child is essential to ensure a healthy life.

- There is a need of debate and discussion of the stance that public policy and the law should take toward surrogate mothering. Actually, there exists a range of choices from prohibition and regulation to active encouragement.

The following observations had been made by the Law Commission:

- Surrogacy arrangement will continue to be governed by contract amongst parties, which will contain all the terms requiring consent of surrogate mother to bear child, agreement of her husband and other family members for the same, medical procedures of artificial insemination, reimbursement of all reasonable expenses for carrying child to full term, willingness to hand over the child born to the commissioning parent(s), etc. However, such an arrangement should not be for commercial purposes.

- A surrogacy arrangement should provide for financial support for surrogate child in the event of death of the commissioning couple or individual before delivery of the child, or divorce between the intended parents and subsequent willingness of none to take delivery of the child.
A surrogacy contract should necessarily take care of life insurance cover for surrogate mother.

One of the intended parents should be a donor as well, because the bond of love and affection with a child primarily emanates from biological relationship. Also, the chances of various kinds of child-abuse, which have been noticed in cases of adoptions, will be reduced. In case the intended parent is single, he or she should be a donor to be able to have a surrogate child. Otherwise, adoption is the way to have a child which is resorted to if biological (natural) parents and adoptive parents are different.

Legislation itself should recognize a surrogate child to be the legitimate child of the commissioning parent(s) without there being any need for adoption or even declaration of guardian.

The birth certificate of the surrogate child should contain the name(s) of the commissioning parent(s) only.

Right to privacy of donor as well as surrogate mother should be protected.

Sex-selective surrogacy should be prohibited.

Cases of abortions should be governed by the Medical Termination of Pregnancy Act 1971 only.

what would be the remedy available to biological parents to obtain exclusive legal custody of surrogate children,

how can the rights of the surrogate mother be waived completely,

how can the rights of the ovum or sperm donor be restricted,

how can the genetic constitution of the surrogate baby be established and recorded with authenticity,

whether a single or a gay parent can be considered to be the custodial parent of a surrogate child,

what would be the status of divorced biological parents in respect of the custody of a surrogate child, and

Would a biological parent/s be considered the legal parent of the surrogate child?
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ICMR guidelines although had defined certain issues very meticulously but has certain controversial views. Researches permitted are those which are in public interest, but it fails to define “public interest”. It has redefined legitimacy of Indian Evidence Act 1872 that limits legitimacy of a child born to only within 280 days after dissolution of marriage (by death or divorce).

The guidelines should ideally encourage adoption and foster parenthood, and avoid statements such as: “Infertility, though not life threatening, causes intense mental agony and trauma that can only be best described by infertile couples themselves”. It should not accept the social stigma attached to infertility as a norm.

Guidelines should be broad and flexible in the commercial transfer of embryonic material, stem cells, etc. Chapter 3, talks only about written consent, but fails to make informed consent mandatory.

There are no clear guidelines for the groups other than married couples, who want to bear child like, homosexuals, divorced or single. Recently CARA (Central adoption resource agency) has sought to ban gay

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1 Sen Nirupam, ICMR spurs public debate on infertility clinic, current science, vol-83, No. 10, 2002 Nov. 25; p 1185
and lesbian couples from adopting childrens, in its newly framed guidelines. As now section 377 have been made more liberal and decriminalized, this issue should now be raised and hence accordingly the words “husband” and “wife” must be substituted by “male partner” and “female partner”.

Off-spring should not be allowed to know the donor even after 18 years just like adopted children.

Use of sperm / oocyte donated by a relative or a known friend of couple should be permitted, as these are the commonest sources of donor in IVF clinics all over the world today, and this will decrease the cost of treatment. Relative or a known person may act as a surrogate to discourage commercial surrogacy. The Doctors should discuss their charges with the patient and not display it. Requirements to have 13 separate rooms to run ART clinics is a big concern since the cost of IVF would go up drastically. Small space can be used for good results.

The guidelines are more or less like the one followed in the UK , which should not be the case considering the Indian mindset and scenario .

The ethical guidelines should go beyond technicalities and build effective safeguards so that the unequal power relationship between the providers and users of new technology is minimized. It is critical to envision future trends and lay down an ethical framework for biomedical research , especially in the new frontier of human reproduction that could change the very face of humanity.

Whatever shape this guideline takes when it comes out of the parliament in the form of an act the doctors should make it a practice to absorb certain precautions , so as to prevent various ethical social and legal issues which may arise pre and post delivery like- Should obtain signed request from wife & husband; Written informed consent from both and also from donor and his wife; Detail clinical records to be well preserved; Details of donor should be kept secret in AID; Female attainer nurse should be present at the time of insemination. The agreement made with the donor is that if the child birth resulted, donor would have parental rights and obligation associated with child.
The Indian ART Bill only permits gestational surrogacy arrangements, following the same model of relatedness as is prevalent in Northern Europe and America, with the intent to sever the possibilities of any long-term claims and relationships developing between the surrogate and the child she carries. But as gestation in surrogacy, as the accounts above suggest, establishes maternal connections through substances other than blood or reproductive tissue in Western India, gender ideologies in the region elevate gestation as a means through which women establish ties of relatedness with their offspring.

In this context, men are given primacy in procreation, where they are regarded as creators of children with women contributing the womb ‘vessel’ to carry or nurture the baby. Here, gestation, unlike in Northern Europe and America is regarded as the primary means through which motherhood is conferred.

Even the process of ‘giving away’ offspring, as a surrogate does, is not alien to indigenous caste-based conceptions of appropriate parenting. Children are given away for adoption amongst close kin (such as the bua (FZ), Mausi (MZ), Nana-Mama (mother’s brothers’) if the close relatives are infertile. Daughters are given away at marriage through economic prestations (dowry or dahej) and ritual gifting (kanya dan) to people who become kin. Like daughters born to be ‘given away’ at marriage, surrogate babies are also given away. In this context gestational surrogacy can be regarded as an expression of a more familiar form prevalent in existing kinship practice: surrogacy is appropriated into local kinship worlds at the same time that it is derided as an adulterous relationship, or undertaken ‘without choice’.

Attention to notions of relationality and the morally appropriate processes (ritual gifting, for example) through which people marry and become parents in western India is central to an understanding of how ‘regulatory’ the ART Bill is in reality. In terms of its ‘culture work’, the Bill, as argued in the lines above, thus reaffirms and appropriates for national

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purposes two indigenous, caste-based notions of procreation: i) of women’s role in conception as primarily defined by ‘nurturing’ and, ii) the idea that women’s reproductive bodies serve collective interests (of the family, community, caste). On the other hand, in enabling payments to be received and in legalising surrogacy, the Bill contributes to challenging the ideological devaluation of women’s childbearing (as ‘natural’, taken for granted and not being valued in monetary terms). We also see for the first time an alignment taking place between a state encouraging childbirth (in a context where it is more widely discouraged, as evident in its wider anti-natalist population policies) and the strongly natalist patrilineal ideologies still in place in much of rural India, where fertility is widely celebrated in the religious festivals such as Teej and Gangaur. Living in such contexts, Indian surrogates are in a similar position, as Israel, wherein surrogates have to reconcile their personal ideas regarding maternity within a wider context where, ‘reproduction is celebrated as the (Jewish-Israeli) women’s ‘national mission’… a product of both social pressure and explicit government encouragement’.

However until the legislation has the means to redress the pressures which propel women to undertake surrogacy as a ‘compulsion’ (lack of choice), it is unlikely that the instrument of consent alone, however comprehensively formulated, will ensure surrogate welfare. I suggest that the ethical formulations that accompany global bio-capital in the South will always be voluntary however much attention is paid to the ethical instruments themselves. I have looked at how these processes impact not only on the subjects of direct intervention (patients of clinical trials or surrogates) but also how the lives of people who share their local moral worlds are profoundly affected. Following Manson and O’Neill (2007) I suggest that it is not so much the detail of the instrument of consent itself that is important but equally the context in which it is applied and made relevant that should be of concern.

The idea of exploitation which is systemic is of significance when we consider the commercial aspects of trans-national surrogacy for surrogates in India. The commodification of surrogacy, while of benefit to

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3 Ibid
the surrogate, has also opened channels for their monetary exploitation and corruption.

There has arisen a whole set of people – clinicians, nurses, middle-men, brokers, family members – who view the legalisation of surrogacy as a further opportunity to make money. The significance of this fact is reflected in emphasis of the ART bill on both the pressing need to regulate private fertility clinics and to encourage these clinics at the same time. State legislation, however, does not go far enough in enforcing checks on clinics, for instance, in examining their recruitment and selection procedures, the kinds of counseling provided, the quality of medical procedures carried out. Amendments to the guidelines have mainly focused on ensuring commissioning couples have more documentation (e.g., proof of citizenship for the intended child) which, though necessary, does not address the issue of monetary exploitation.

**Surrogacy only furthers Right to Life under Article 21 of the Constitution:**

The relation of the surrogated mother to the child she is carrying is nothing but womb leasing or womb for rent. After the birth of the child she has no right to keep the child because she is neither the mother (where both ova and sperm are from different persons) nor the owner of the genetic material. She is only a contractor who is willing to give the end product once the contract between her and the person is fulfilled.  

However, to deal with legal pre-requisites for a commercial surrogacy, there is no uniform law in India till today. The growing demand for surrogacy in India has also raised issues, including those of child rights. This led to the government drafting a bill which is called the **Assisted Reproductive Technology (Regulation) Bill 2008.** But the draft

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6 The proposed legislation provides for the following:

- A cap on the age of the surrogate mother (who has not exceeded 45 years of age); the surrogate mother must not carry more than five pregnancies to term (including her own children); and mandates medical insurance during pregnancy.
- It will prohibit any sort of contact between the surrogate mother and the child after birth. Any such contact is punishable by a fine or imprisonment for up to two years.
is still pending with the Union law ministry, whose approval will take it to the Union cabinet before being presented in the Indian parliament. However, even if the bill gets passed in the 2015, it will take another year before the resulting Act redefines commercial surrogacy in India.\(^7\) For the time being guidelines (as given in the year 2005) for accreditation, supervision and regulation of Assisted Reproductive Technology clinics formulated by the Indian Council of Medical Research and National Academy of Medical Sciences are used as a basic platform and the code for the purpose of conducting surrogacy in India.\(^8\)

Basically we will talk only about what are the advantages of a surrogacy program in India. One is the cost. In USA an average surrogacy procedure would cost 2,00,000 to 2,50,000 US dollars and as compared to India where an entire program would cost not more than 40 thousand US dollars inclusive of travel, hotel stay, legal fees and the whole package. Secondly, India is an English speaking country where most of the medical staff, the paramedical staff, and the support staff – all speak English. So, the clients especially from English speaking country are very comfortable here. Because of the recent economic boom in India have wonderful health care facilities that are comparable to the best in the world and one could compare it with a modern hospital in New York. Along with the doctors who have trained abroad and come down and are can be compared to the best in the world.

“I think with all this one cannot have a more favorable destination than India for surrogacy and all that need to do is now focusing on the right clinic so that you have a very smooth process and the exit process is also well thought of and is well oiled mechanism. And I am sure that if you are coming in through a medical tourism company they have huge experience working with us for three years and they can help your hand hold through the process.”

- Foreign couples should provide proof that the child born to a surrogate mother will automatically get the citizenship of the intended parents’ home country. This includes registering with their Embassy or High Commission in India, and providing a signed and notarised statement accepting the terms as laid out by the law.
- It proposes to set up a database of surrogate mothers throughout the country.
- It will limit the role of those monitor clinics (which are dealing with surrogacy and surrogate mothers) to conducting the actual IVF procedure, as opposed to their current role of arranging the entire process.

\(^7\)India’s Legislation of Commercial Surrogacy. Supra Note 14 at paragraph 3.
Surrogacy opens an option for the infertile couples, gay couples and single parents, to be parents, that too at an affordable cost. Attractions like low-cost egg donors, internationally trained doctors, cutting edge technology at surrogacy clinics and low cost of surrogate mothers in India, draw people from different parts of the world visit India for their dream to come true. Not only this, the surrogacy clinic staff is also well versed with English language, so there is no communication gap.

The growth in the ART methods is recognition of the fact that infertility as a medical condition is a huge impediment in the overall wellbeing of couples and cannot be overlooked especially in a patriarchal society like India. A woman is respected as a wife only if she is mother of a child, so that her husband's masculinity and sexual potency is proved and the lineage continues.

Contemporary Medical Technology has in recent times made extraordinary advances in responding to desire of women/men to have children. Assisted Reproductive Technology (ART) allows reproduction without actual physical contact between partners.

Whereas surrogacy has been technically feasible for decades, it has only recently become a thriving business and thereby created various socio-legal complications. In India alone, the volume of business amounted to roughly $2.3 Billion in 2012. In India, though no authentic DATA is available but we presume, it might have cross $7 Billion in the year 2014.

It is most unfortunate that this huge business is going on in the Country without any legislation to govern entire ART procedure. Though certain efforts were made to regularize it but it is the Professional body, The Indian Council for Medical Research came forward to prepare a detailed guideline on the issue.

National Guidelines for Accreditation, Supervision and Regulation of ART Clinics in India was first sincere effort in 2005. ICMR further prepared a Draft for “The Assisted Reproductive Technology (Regulation) Bill 2008” and further prepared a draft of “The Assisted Reproductive Technology (Regulation) Rules 2010” but in absence of any initiation from
the Government and any positive action of Law makers, the Bill is still pending without any discussion over it.

In 2009 Law Commission of India *suo motu* prepared its 228th Report on “Need for Legislation to regulate Assisted Reproductive Technology Clinics as well as Rights and Obligations of Parties to a Surrogacy” discussing ethical, Social and legal aspects of Surrogacy and recommended for a comprehensive legislation on the subject matter.

India became most popular surrogacy destination, provides ART services to the Peoples across the Globe. Study of this growing industry has remained on the journalistic level till date. Some literary studies were also conducted, but the same have certain limitations, thus could not bring actual status in India. Very little empirical evidence exists around the effects of surrogacy on the woman’s health, family, and other social contexts and at the same time issue concerned with the legal complication arising out of this. Similarly, only a few examined Indian women’s decision-making process to become surrogates.

Since ART procedure is very personal and even in case of sperm donation the privacy of couple remains safe and society has no objection on the same, but this issue becomes of wide importance, when it associates with the Surrogacy arrangement or commonly said “Womb on rent”, Whereas public opinion is split as to whether surrogacy should be supported, though, intended parents and their children hardly face discrimination or any other lack of acceptance.

Since, there is no legislation in India to regulate the thriving industry of ART and Bill is pending long back and still waiting for Legislative approval, it is right time to discuss the shortcomings and limitations of proposed legislation.

Humble researcher set out to speak directly with the “workers” to see how they are affected by such “work.” He delineated its “structural reality, with real actors and real consequences,” and provided an intimate look at the lot of women serving as commercial surrogates at ART Clinics in Hyderabad. He also examined the social acceptability of ART including Surrogacy in the vicinity around those Surrogates and had long discussions with the intended parents across the globe. He also discussed with the clinicians, Surrogacy Advocates and the Agents. Although, a lot of the
information he gathered was beyond the scope of the present research, but certainly the experience he gain is above all the peripheries.

Researcher tried to examine the perception of scholars across the globe, in light of the information he gathered through primary sources and direct interaction with real actors, which is too in Indian Circumstances.

Western feminist, hold motherhood as a new branch of female prostitution with the help of scientists who want access to the womb for experimentation and power.... Women can sell reproductive capacities the same way old-time prostitutes sold sexual ones but without the stigma of whoring because there is no penile intrusion. It is the womb, not the vagina that is being bought. Although, primarily certain similarities between prostitution and surrogacy appears, but are superficial and relatively unimportant compared to the differences between the two cases. They are also characteristic features of most transactions where physical labour is traded for material compensation. It happens every day that we trade money for services without forming a 'deep personal or emotional relationship' with each other.

However, Study conducted by the researcher reveals entirely different notion about surrogacy. General perception about the surrogacy is more or less based upon misconceived information or on impression that the Surrogate conceives through actual physical contact. While discussing with the people of the vicinity of surrogates, Researcher explained them the procedure of Surrogacy, once, they could not believe, but on explaining through graphics, most of them realized their wrong perception. They even considered it as highest sacrifice. Though it is for money, still the sacrifice for the contentment of being mother/father of their genetic child for others is a Noble Cause. Undoubtedly, all the surrogates participated in the study, entered into this arrangement only for the money, but their sacrifice cannot be devalued and it should be regarded as a “Noble Cause”.

Western writers hold the surrogacy as wrong because it commodifies women's reproductive labour. The application of economic norms to the sphere of women's labour violates their claim to respect and consideration. But, beyond above theoretical analysis and opinion of western ideologist the surrogates are in high spirit being an instrument of
exultant to others, specifically with whom they don’t have any previous contact.

Pregnancy is the phenomenon, which develops an intimacy with the child in womb. During the pregnancy mother falls in love with the baby so also her family members waiting for the birth. It is common perception that intended parents are away from this feeling. The researcher does not agree with this perception as he met a number of intending mothers and observed their involvement in the process. An intended mother from USA Lilly Jafferson expressed her relations with the Surrogate “May be that's friendship but it felt like sisterhood”. The Socio-Psychological Phenomenon appears from the experience of Lilly, beyond any barricade of culture, religion or even of the language, appears as an Indian lady expecting her child. In this situation biological mother is secure about the future of intended child and also ensure the better life for rest of her family.

This also explains the 'change of perspective' that many surrogates experience as their pregnancy develops. The problem with surrogacy arrangements is therefore that it causes a woman to be pregnant while expecting her not to acknowledge the fact that she is expecting her child. It tries to divorce pregnancy from the conscious knowledge that you are going to give birth to your child. In this way the surrogate becomes a mere 'environment' or 'human incubator' for someone else's child.

The only solution to this problem is in the theory of “well being”, which have been adopted world-over to deal with in case of dispute about who the social parents of the child should be, Instead of asking who the 'real' parents of the child are one should rather consider who would be best able to care for the child. From the perspective of those who compete for the status of legal parents, however, there is no easy solution.

Some surrogacy agencies have reported a high percentage of successful transactions. It is said that in these cases all the parties to the contract are better off than before: the commissioning parents are somewhat poorer financially, but with their much desired child, while the surrogate is well compensated materially for her labour, without feeling that she has performed alienated labour. Does any moral harm result from these instances of surrogacy?
The most one can object to in these cases are that the surrogate's labour is 'dehumanising'. The distinguishing feature of human pregnancies is that they may also entail a conscious knowledge of the significance of this physiological state and an active expectation of, and preparation for, the birth of a child. It is easy to praise a successful arrangement in retrospect, but the danger always exists that an arrangement one is planning would cause moral harm to the surrogate and/or the commissioning parents. Unless one can ensure the legitimacy of the surrogate's bond with the child and her perspective on her pregnancy without thereby denying that of the commissioning couple, the surrogacy arrangement can always be said to be dehumanising or alienating.

Moreover, this perception of intended parents is generally based on the advice given by the professionals, who seldom want them to develop any kind of relation or even motivate them to make a distance with the prospective surrogates as Lilly stated. A large number of intended couples are following the advice, but some of them in abeyance of it developed intimacy with the surrogates, caused the development of mutual trust resulted into impact of Altruistic Surrogates, her near or dear, never complained about dehumanization of her reproductive labour. Russian Citizen Act 2011, however, give right to Surrogate to keep the child after birth, which may also added in India also, subject to fulfillment of certain conditions.

The negative aspects of surrogate motherhood need to be seriously considered. The basic questions are: Are wombs meant for renting, and are babies commodities to be planted and harvested? Are women child producing machines?

The Researcher tried to hold consultations across the country to address these core social issues which have wide importance for society. While the enactment of the law may be fine, much will, however, depend on whether and to what extent the government would be able to enforce the law.

Surrogates were referred to the surrogate clinics by agents hired by the doctor or by husbands and even by Neighbour women who had been Surrogates previously, even 2 of the participants themselves took the
initiative to be a surrogate. This phenomenon reflects the changing perception of the society.

All the participants in the study stated that their primary motivation was the financial compensation that was offered to them. Compensation ranges about Rs. 2,00,000/- to Rs. 2,50,000/- for successfully delivering a baby through surrogacy. The compensation for carrying twins ranged between Rs. 3,00,000/- and 4,50,000/-. However, the received compensation was different for each pregnancy and depended upon the commissioning parents’ economic background as well as the contracts that were signed between the parents and the clinic. However, it ranges between 10 to 20 percent of the total expenditure on such procedure. Special attention is required to regulate the compensation to control the exploitation of surrogate and intended couples both.

Most of the Husbands supported their wives and some of them themselves initiated and motivated their wives and bring them to the clinics. Even In-Laws also supported, though not in all cases. In fact, mother in Laws are supporting against the common perception, not only morally but also by taking care of their children. Apart from the husband’s role in surrogacy, the role of other family members was also considered to be important. Often times parents of the surrogate, siblings and even in-laws participated in the surrogacy process. They either helped and supported the surrogate, or acted indifferently and even criticized for becoming a surrogate.

Commonly, after pregnancy was confirmed, participants lived in a surrogacy hostel for the duration of the pregnancy. Most of the Surrogates did not like staying in the surrogate home and constantly wanted to go back home to their children, but the fear that poverty of their house would have been bad for their pregnancy had been compelled them that It was safer to stay in the surrogate house. Surrogate mothers also like to stay there to avoid stigma and ostracism. These included living in the surrogacy hostel while engaging in false claims of alternative employment or even lying about the result of the pregnancy.

While the major incentive cited for the creation of the surrogate hostel was the maintenance of the surrogate’s health, the information mentioned above points to an additional reason: To maintain seclusion of the pregnant surrogate, thus shielding her from the eyes of a disapproving
community. By providing a means of isolation, the surrogacy clinic is both meeting their own need for supervision of the pregnancy and meeting the need of the women to keep the surrogacy private. A third stakeholder in this arrangement is the community itself. By quarantining the practice of gestational surrogacy out of public view, it is a way to maintain the social norms of traditional reproduction, even as surrogacy becomes more and more common.

Earlier, several studies were showed how richer countries had outlawed the practice of paying women to be surrogates due to the danger that the large financial transaction would serve as a coercive factor in the decision to become a surrogate. When considering that gestational surrogacy has been labeled as potentially financially exploitative to birth mothers in the Global North, should surrogacy then be alternately interpreted as liberating for Indian women because they have no other sources of income?

The majority of women in the study did not seek out surrogacy. Rather, they were approached by someone else with the idea. This initial external pressure to consider surrogacy may legitimize surrogacy as a noble act and reduce the stigma associated with the practice—the women were not on the whole personally drawn to surrogacy and thus may rationalize their decision to participate by relying on the altruistic aspects of providing a baby to an otherwise infertile couple. That is to say, although the primary motivation for surrogacy was financial, further conceptualizing surrogacy as a noble act may allow the woman to more easily legitimize her decision to herself and her family.

One theme that emerged from the interviews was that the community at large opposed to gestational surrogacy. Many women reported apprehension to inform extended family members for fear of disapproval or retribution. Participants also reported having to relocate after community members (e.g., neighbors, fellow villagers etc.) found out about the surrogacy. This lack of support from community is in one aspect unsurprising, as many Indians view surrogacy as comparable to sex work. However, researcher found that the perception is based on the lack of knowledge and awareness. The in vitro fertilization (IVF) process involved in gestational surrogacy was not understood by all members of the community, and even when it was, the idea of a married mother carrying another couple’s baby was supported up to some extent.
Even so, systems of support were necessary for the gestational surrogacy process to occur at all. As explained previously, clinic staff, surrogacy agents, husbands, and family members were all involved in the process. Furthermore, all of these stakeholders benefited financially from the woman’s gestational surrogacy. The genetic parents paid the clinic. The surrogacy brokers received a finder’s fee.

It is important to note, that every participant’s surrogate pregnancy resulted in a Cesarean section, and many surrogates had undergone multiple Cesarean section procedures. Increased Cesarean sections are associated with increased risks, including mortality. Although conditions associated with Cesarean sections are rare, many are serious and include pelvic pain, bowel injury, cystostomy, urethral injury, placenta accreta and previa, reduced fetal growth, preterm birth and possibly stillbirth, decreased fertility, increased risk of ectopic pregnancy and spontaneous abortion. Thus, women need to be informed of these risks associated with Cesarean section delivery. Moreover, there should be a policy structured around the number of times that women may engage in this work and other reproductive services. In terms of practice, level of disclosure continues to be an important element.

All the respondents were of the opinion that child is necessary for a couple. Social stigma clearly appears in perception about Test tube baby, but majority of the respondent with some hesitation is ready to accept this method for their dear ones.

The society is not ready to accept a child through “rent a womb”, though a healthy number of persons accept it as an alternative method. General opinion is that the surrogacy should be permitted only to the persons unable to conceive or don’t have child but, not in favour of giving such permission to the persons, who want a child but don’t want to conceive, not associated with any kind of Medical deficiency, unmarried persons or gay Couples. Sex determination was also condemned.

The study reveals that conservative Indian Society though considers the surrogacy as an immoral mean of earning money differentiate it from the prostitution but at the same time a large Number of Peoples considers it a Noble cause or a mean to delivering contentment to the families, who are not able to have their own child.
Surprisingly, respondents were able to differentiate between the right of Biological mother and Biological parents and in reference to biological parents they gave preference to the right of the Genetic parents.

In India most of the surrogates are directly associated with or recruited by the ART Clinics unlike the Thailand, where intended surrogates publishes there advertisement on message-boards on internet. DATA emerging out of the study also supports this fact and accordingly the opinion is divided about the right of surrogate to select the Surgeon and majority of the people who participated in the study were not in consonant with the idea and majority of the respondents negate any such right.

Perception of the respondents regarding the right of the child born out of the surrogacy arrangements in the property of the Genetic parents is unanimous and all the respondent find absolute right as normal child in the family of Genetic parents, but right in the property of the Biological parents, was negated.

The practice of surrogacy exploits women economically, emotionally and physically. An important factor is that most women who get involved as surrogates do so because they are in desperate need of the money to maintain their family. In addition, agents are often involved and arrange contracts of questionable legality.

Further, the thought that if it were okay to think of children as property, then it would be okay to buy and sell them; and if it is not done to buy and sell them, then maybe it is not done to think of children as property. If some (surrogate) children are conceived as market commodities because there is a practice of paying money for relinquishing parental rights, then every child can be considered a commodity. As a matter of fact, we all are commodities, because we used to be children ourselves. If children are viewed as exchangeable market commodities, it might make the self-conception of those children as persons impossible. Therefore, if conceiving children as commodities has a negative effect on personhood, it means that baby selling, and surrogacy for that reason, is wrong. As a consequence: to permit surrogacy would be an irrational exception to the baby selling laws if that distinction is based on genetic relationship does not hold good. If legislation is passed which enables
legal surrogacy arrangement, then the laws against baby selling in general should also be reconsidered.

Therefore, the risks and the disadvantages involved in the surrogacy arrangements often prove detrimental to the interests of the surrogate mother, and the child thus resulting in the repugnancy of the human dignity vested with both the surrogate mother and the child.

Originally, surrogacy happened within families and friends. Known surrogates would give birth for infertile family members or friends. This was an altruistic deed as these surrogates were generally not paid for it. Over the last few decades however, there is a noticeable trend of the commercialization of surrogacy. Surrogacy turns a normal biological function of a woman’s body into a commercial contract. Surrogate services are advertised, surrogates are recruited and operating agencies make large profits. The commercialization of surrogacy raises fears of a black market and baby-selling, breeding farms, turning impoverished women into baby producers and the possibility of selective breeding at a price. Surrogacy degrades a pregnancy to a service and a baby to a product. Commercial surrogacy challenges the conventional assumptions of maternal bonding which is based on the concept of natural and instinctive link between the mother and her foetus/child. Maternal bonding is effectively an emotion integral to the physiological process of child birth and is deeply rooted in the cultural context of motherhood.

Moreover, commercial surrogacy has given rise to several ethical issues. It seems not to be ethical for someone to create a human life with the intention of relinquishing it. The surrogate mother provides her ovum with the clear understanding that she has to avoid responsibility for the life she creates and she has to dissociate herself from the child in exchange of some other benefit such as money. In such a way, at the deepest level surrogate arrangements cannot be viewed as ethical, because they involve a change in motive for giving birth for the sake of some other benefits (money).

There are certain legal issues may arise out of the process of Artificial Insemination including matrimonial relations, Legitimacy of child, Child’s right to know Vs. Donor’s right of privacy, Rights of child in various personal Laws and property laws and many more.
In India, where no legislation enacted and at the same time judicial consideration of issues is also required to settle the issues. Though, some issues have been considered by the judiciary in various countries, so as to enable us to analyze the legal principles laid down in those matters, which may consider as settled issues.

In India, neither marriage nullifies on the ground of non-consummation of marriage in case of Artificial Insemination by wife, nor by wife in absence of Husband’s consent, it does amount to adultery.

The most important issue arises from the Artificial insemination is the legitimacy of the child.

Under Muslim Law Conception during lawful wedlock determines legitimacy of the child, though “acknowledgement of paternity” is another way to legitimize the children. Concept of maternity according to Quran does not extend to Surrogacy arrangement.

Section 112 of the evidence Act need to be reconsidered in light of these advances, as it presumes sexual intercourse is absolute essential for the conception of a child. In non access clause of this section it is specifically mentioned that if a man could not possibly have had sexual intercourse it cannot be his child. The Court held the presumption under section 112 of the evidence Act is irrebuttable and even denied to permit DNA test to ascertain the paternity and considered only non access as the tool of denial of paternity as provided under section 112. However, recently Hon'ble Apex Court has rebutted the presumption in light of DNA test, which also raised the question that in case of donated sperm, the DNA of the child will match with the donor, who never had access to the mother of the child in question. Similarly in case of Gay couples child born out by any procedure would not be considered as legitimate child of such couple.

India draws to her shores a large population of foreigners besides the NRIs for surrogacy. The commissioning parents of the child born of surrogacy, especially foreigners, face problems with respect to his/her citizenship. It is the conflict of law complicates situations.

As far as Citizenship of child concerned, obviously, in light of Surrogacy agreement, should be the Citizen of the country of the Commissioning parents, but, some countries do not recognize or even
condemned it, in such case the child will be stateless, unless the country in which the child born do not recognize as citizen. Gujrat High Court in Jan Balaz’s case held that “No presumption can be drawn that child born out of a surrogate mother, is legitimate child of commissioning parents, so as to have a legal right to parental support, inheritance and other privileges of a child born to a couple through their sexual intercourse.” The Court observed the babies born to surrogate mothers in India would be Indian Citizen by virtue of section 3 of The Citizenship Act and therefore entitled to get Passport.

Right to privacy though protected by the Constitution of India, but it is not absolute right and is subject to such action as may be lawfully taken for the prevention of crime or disorder or protection of health or morals or protection of rights and freedoms of others.

Right of privacy vis-a-vis right to know was also clarified by Hon’ble Apex Court that right of Privacy will prevail over right to know though for its disclosure would not be violative of either the rule of confidentiality or the Right of Privacy of others. Unfortunately, there is no law to regulate such identity of or genetic information, and about any critical circumstance, a law like Sweden or at least like U.K.

In the case of surrogacy, there may be questions about enforcing a contract with the surrogate mother, e.g. whether such contracts may be valid in view of the provisions of public policy, particularly under Section 23 of the Indian Contract Act, 1872; whether the child to be handed over can be considered a saleable commodity for consideration. A party may refuse to have its contract acted upon, or the child is not according to the specifications agreed upon in ordinary law of contract, the finished goods can be rejected and damages can be claimed in such situations.

Surrogacy, though an assisted one, being a method of procreation, Surrogacy Agreements must be afforded the Constitutional protection as “Right to privacy and Reproductive Autonomy”. The personal decision of the individual about the birth and babies called the right of reproductive autonomy, is a fact of a right of privacy. The State cannot intervene in matters of private ordering and matters as intimate as re-procreation. Surrogacy being one of the various methods of Assisted Reproductive Techniques stands sheltered under the umbrella provision of Art. 21 of the Constitution of India.
In India, the parties of surrogacy are backed by written agreement between the parties. These agreements are an expression of the proposal and acceptance between the parties. This document of concurrence also cites the amount made to the surrogate mother and hence, meets the requirement of consideration. Free consent of the parties is a prerequisite of the validity of the contract and therefore, the parties of the surrogacy agreement must enter into the arrangement in exercise of their free will.

Any contract to perform an illegal act is void. With respect to surrogacy, the aim is to ward off and forbid the selling of a baby. Indian Supreme Court also held that even the Commercial Surrogacy is legal in India. With above discussions one may infer that surrogacy agreement are not only entitled to Constitutional protection but are also valid under the domestic contract law.

The ICMR guidelines as well as the ART Bill Endeavour to put into order various points in question. These includes who can act as a surrogate mother, who can be the commissioning couple, what health and age requirements must be fulfilled before the potential surrogate mother is said to be fit to act as a surrogate mother, how the agreement may be entered into and what all issues must the agreement expressly addressed in its content etc. While the ART bill and the ICMR guidelines try to fill the voids, there exist many issues that arise from the practice which need to be focused on and plugged. These include issues of contractual remedies, determination of parentage of the child born and the child’s citizenship, among others.

A Legislation must include or explain certain possible instances with the help of illustrations, so as to avoid confusion such as If the instance is one that the commissioning couple which is genetically related to the child, splits and the respective parents separates, the Court may be willing to order specific performance of the contract as the child was born as a result of the intention of the commissioning couple. Also in a case where there has been a default in paying the agreed sum of money as a recompense to the surrogate mother, the court grant specific performance on part of the defaulting party. However, if there is a requirement of relinquishing rights over the child that is sought, the court may be vary of granting a relief of specific performance given the fact that under the prevailing domestic law it is birth mother who is considered to be the mother of the child. Thus in the event that a surrogate, on birth refuses to
hand-over the child to the commissioning couple, the court may not permit the specific performance of the contract.

Damages, may be tough call for the courts to take. This is due to sensitive nature of the practice and how it may take a step further from commercialization to actually baby-selling. For instance if the child is born with some abnormality or birth defect, and in case parents file a suit for damages, it would take the practice into the realm of trading of babies. However, by all means, Indian Courts would be cautious and vigilant to not allow mushrooming of any such system.

Certainly children are the assets of mankind beyond borders, thus their well being is the paramount concern of all laws pertaining to children. Recent hyper growth in reproductive tourism to the third world countries have ample scope of trafficking of children. Though, it may be a hyper-sensitive approach, but undoubtedly well-being of the children born in India is the prime concern of law. To protect the interest of children going out of the country maintenance of the track record of such children is necessary.

In many, if not most European countries, surrogacy is forbidden by law. Germany, France and Spain have enacted restrictions, with administrative and criminal sanctions. This indeed effectively averts surrogacies on their territories as it does in most if not all countries with rigid regulation. Some Countries have their legislation and in some other countries professional bodies have issued guidelines including India.

Guidelines should be broad and flexible in the commercial transfer of embryonic material, stem cells, etc. But it talks only about written consent, but fails to make informed consent mandatory, which is though, an essential element of a valid contract.

There are no clear guidelines for the groups other than married couples, who want to bear child like, homosexuals, divorced or single. Recently CARA (Central adoption resource agency) has sought to ban gay and lesbian couples from adopting childrens, in its newly framed guidelines. Off-spring should not be allowed to know the donor even after 18 years just like adopted children. Use of sperm / oocyte donated by a relative or a known friend of couple should be permitted, as these are the commonest sources of donor in IVF clinics all over the world today, and this will decrease the cost of treatment.
The guidelines are more or less like the one followed in the UK, which should not be the case considering the Indian mindset and scenario.

The ethical guidelines should go beyond technicalities and build effective safeguards so that the unequal power relationship between the providers and users of new technology is minimized. It is critical to envision future trends and lay down an ethical framework for biomedical research, especially in the new frontier of human reproduction that could change the very face of humanity.

Whatever shape this guideline takes when it comes out of the parliament in the form of an act the doctors should make it a practice to absorb certain precautions, so as to prevent various ethical social and legal issues which may arise pre and post delivery like: Should obtain signed request from wife & husband; Written informed consent from both and also from donor and his wife; Detail clinical records to be well preserved; Details of donor should be kept secret in AID; Female attainer nurse should be present at the time of insemination. The agreement made with the donor is that if the child birth resulted, donor would have parental rights and obligation associated with child.

ICMR Guidelines are detailed guidelines covers broadly all the important issues, but this is still a guideline issued by regulatory authority, have no legislative force Though several questions arises from the analysis of this guideline, but the same is an interim arrangement, so researcher didn’t focus on in-depth analysis of this guideline rather he focuses on analysis of the proposed ART Bill of 2008 and proposed regulation of 2010, which is unfortunately still are in pipeline.

The ART Bill only permits gestational surrogacy arrangements, with the intent to sever the possibilities of any long-term claims and relationships developing between the surrogate and the child she carries. But as gestation in surrogacy, as the accounts above suggest, establishes maternal connections through substances other than blood or reproductive tissue. In this context, men are given primacy in procreation, where they are regarded as creators of children with women contributing the womb ‘vessel’ to carry or nurture the baby.

Even the process of ‘giving away’ offspring, as a surrogate does, is not alien to indigenous caste-based conceptions of appropriate parenting. Children are given away for adoption and ritual gifting (kanya dan) to
people who become kin. Like daughters born to be ‘given away’ at marriage, surrogate babies are also given away. In this context gestational surrogacy can be regarded as an expression of a more familiar form prevalent in existing kinship practice. Surrogacy is appropriated into local kinship worlds at the same time that it is derided as an adulterous relationship, or undertaken ‘without choice’.

Attention to notions of relationality and the morally appropriate processes (ritual gifting, for example) through which people marry and become parents in India is central to an understanding of how ‘regulatory’ the ART Bill is in reality.

In light of the Assisted Reproductive Technology (ART) Bill draft proposed, it reflects that there is no standardization of the drugs used, no proper documentation of the procedure, insufficient information for patients about the side-effects of the drugs used, and no limit to the number of times a woman may be asked to go through the procedure. They do not disclose the fact that a successful cycle need not lead to a baby being born. Further, the clinics need not give exact information on the procedures and their possible side-effects.

A noticeable trend is that the ART clinics are becoming the central hub of all surrogacy-related activities. ART clinics are also required to treat all the information they obtain with utmost confidentiality. In practice this entails that ART clinics are not allowed to provide any information about surrogate mothers or potential surrogate mothers to any person. This creates a problem for intended parents since they have to turn to a middleman in order to find a surrogate mother. This is rather controversial, not just because of the involvement of agents, but also because it seems unfair that the intended parents, who are about to make a significant investment, have little control over the selection process. A better option could be to release personal information at the discretion of the surrogate.

The Draft Bill lacks the creation of a specialist legal authority for adjudication and determination of legal rights of parties by a judicial verdict and falls in conflict with the existing laws.

However until the legislation has the means to redress the pressures which propel women to undertake surrogacy as a ‘compulsion’
(lack of choice), it is unlikely that the instrument of consent alone, however comprehensively formulated, will ensure surrogate welfare.

The commodification of surrogacy, while of benefit to the surrogate, has also opened channels for their monetary exploitation and corruption. There has arisen a whole set of people – clinicians, nurses, middle-men, brokers, family members – who view the legalisation of surrogacy as a further opportunity to make money. Legislation, however, does not go far enough in enforcing checks on clinics, for instance, in examining their recruitment and selection procedures, the kinds of counselling provided, the quality of medical procedures carried out. Amendments to the guidelines have mainly focused on ensuring commissioning couples have more documentation (e.g., proof of citizenship for the intended child) which, though necessary, does not address the issue of monetary exploitation.

It is unrealistic to believe that all the harms associated with surrogacy can be eliminated. However, the harms associated with either the legalization or banning of surrogacy will be felt by society as a whole. Women as a group need to explore any and all possibilities which can minimize the harm to women. Women are identified by their ability to reproduce because, up to this point, only women can do so. The only way for women to seize and stay in control of any existing or new reproductive technology is to present viable legislation for the decision-making bodies of government to act upon. If women, as a group, do not allow themselves to compromise they may end up with an unbearable situation completely out of their control rather than a tolerable situation they helped develop.

Fortunately, ICMR Guidelines provides sufficient standards for the control of physical infrastructure including Embryo Laboratory, but execution or rather implementation of the guideline is still required close scrutiny. While his visit to Hyderabad researcher found that only 10% of the ART Clinics were registered with the National Registry of ART clinics. Though, it is specifically mentioned on the list that Enrollment Number has been given to those ART Clinics who have successfully submitted their duly filled prescribed proforma for minimum infrastructure facilities, trained manpower and procedure being undertaken at the ART Clinic. The Enrollment Number is not the certificate of quality in regard to services provided by the enrolled ART Clinic. The information provided by the
enrolled ART Clinics has not yet been verified by the Experts Committee of the ICMR. The process of verification of their claim, by the ICMR Experts Committee, is in process currently.

Situation is really critical, that the regulatory body is not aware of the standard of the clinics and services they are providing. A billion Dollar business is going on without any proper monitoring, regulations and care, specifically when it is directly connected with the health of the persons and rights of children. Without hesitation it can be easily said that practically entire ART Business is running in dark and the Government left the mothers and children, on the disposal of ART clinics.

Focusing on the Assisted Reproductive Technology (Regulation) Bill and Rules 2010 (2008) in India, this research suggests that, although progressive in some respects, the bill only partially addresses the concerns raised above. Further, ethical procedures relating to surrogacy appear to co-exist with structural violence in a manner similar to clinical trials in India, and with the growth of global bio-capital more generally.

Parties to an agreement are bound by the terms of agreement, but as appears from the field study of the researcher that no surrogate had any opportunity to consult an Advocate of his choice and at the same time no copy of the agreement was supplied to them so as to enable them to contest for their rights and further specific performance of the agreement. Though, intending parents always have an opportunity to take the shelter of the Court.

The researcher examined how the Bill promotes inequality between women of different childbearing capacities based on their ability to pay for and access quality health services as the automatic access to healthcare for surrogates is qualified in the 2010 draft Bill where quality medical care is contingent on their proving that their symptoms stem from their surrogacy.

It draws upon ethnographic research that intersects with, rather than overlaps with the population of women who are or have been gestational surrogates, to bring attention to wider processes of structural inequality in thinking through the proposed law.

The emerging legislation on surrogacy in India is used as a means to reflect on the first two of three interrelated conceptual issues:
reproductive stratification, relational autonomy and the commodification of reproduction.

An analysis of these texts as well as field based material, lead us to suggest that despite an explicit framing which acknowledges the rights of the infertile to bear children, the Bill promotes this right selectively, for those who have the resources to pay for assisted reproductive services, and, that even though the Bill ostensibly focuses on the welfare of Indian surrogates, legal guarantees are not deep enough to ensure surrogate women’s relationally determined autonomy to choose.

The ART process is quite complicated and even after due care certain birth defects may occur in the child, in such a case, the Bill safeguards the rights of Surrogates as meeting the surrogacy requirements in the case of a child born with birth defects. It also states that she can terminate her pregnancy at will. However, the clause on the termination of the pregnancy at will, needs to be considered in relation to a condition suffixed that all payments received by the surrogate be refunded in such an event, except in case of medical complication. The provision certainly pushes the surrogates on back-foot as given the extreme poverty and indebtedness which drives surrogacy in the first place, it is unrealistic to believe that the surrogate’s choice to terminate her pregnancy will be exercised or that she has any real bargaining power when it comes to negotiating the terms and amount of money, as the researcher found during his discussion with 21 Surrogates that they all were compel to chose the option to enter into surrogacy arrangement in extreme poverty conditions.

On the option of Commissioning Couple, the Bill subjects surrogates to invasive procedures such as foetal reduction in the event of multiple pregnancies, and Caesarean sections if recommended by the doctors. More routinely, the surrogate consents to a continuous medical regimen of injections, blood tests, screening and diagnostic procedures.

The discrimination against the surrogate which arises from the language (English) in which the agreement and consent form are written specifically when the English is not the first language of most surrogates and a majority is indeed illiterate rural women, the understanding of what consent entails is left to the vagaries of a conscientious translator. In legal terms it is important to note that the surrogate is not provided any legal
support by the state, with the clinic acting as legal representative including as representative with any commercial agency. Given that the clinics also act as providers of counseling services, it may be apt to regard the surrogate as a ‘captive of the clinic’. Clinicians, however negate the probability in light of recent development in Technology, which enabled the Doctors to carry-out the procedure with almost no risk. They also point-out that they are providing legal services and necessary counseling to surrogates with utmost care and to protect their interest; closely associated with their goodwill.

**MAYA UNNITHAN** criticized the bill for predominantly upholding the research and promotion of ART services and the interests of the providers, especially private clinics. Other important criticisms of the bill raised by these scholars and activists include,

v) the fact that in denying the surrogate the possibility to register as the birthing mother, the Bill protects the rights of the buyer,

vi) in ensuring that the surrogate underwrites all the major risks of the procedures, including her own death, natal and postnatal complications, foetal reduction, any risk of HIV transmission, the bill clearly protects the interests of the clinics and sperm banks,

vii) the health risks to the surrogate are further disregarded in the clause that enables her to have three surrogate births and three cycles of ova transfer (increased to 5 live births with no specification of the number of IVF cycles, in the 2010 version of the Bill) and,

viii) in favouring a quick transfer of baby from surrogate to commissioning parents, the bill downplays the developmental needs of the baby (though it may be easing the bonding-related anxieties of commissioning parents as well as the commercial surrogate). The rights of the newborn baby are further undermined in terms of its survival, right to a safe home and the automatic right to know its identity (only if sought out and not before 18 years unless for medical purposes). Even the rights of the child to citizenship were not addressed until 2008.

On plane thinking Researcher fails to disassociate himself from such opinion as India have particularly the few instances in which the
surrogacy guidelines (2005) have been invoked are particularly revealing of what and for whom recourse to the law is taken.

The existing bill does not take adequate measures beyond the standard protocols to ensure that the potential surrogate has full knowledge of the implications of her consent. There is little evidence that Indian surrogates’ human rights and physical or psychological health are adequately protected. In the study conducted by the researcher it appears that most of the commissioning Couples after getting the child don’t want to continue any kind of contact, on the contrary some of them provided fake contact details to surrogates.

Though, the Public opinion about the post Natal care of the surrogate imposes a responsibility on intending parents as well as on clinics undertook the surrogacy for a substantial period, se 1 year, as the majority in the survey conducted by the researcher is of the opinion.

Commercial surrogacy complicates practices of consent further, as it is suggested that a high payment to a surrogate is likely to compromise her capacity to give informed consent by encouraging her to minimize the risks involved in the procedures.

However, there are certain confusing definitions in the bill which need further explanation and clarifications. Section 32(1) of the Bill, which is the enabling provision, states: “That subject to the provisions of this Act and the rules and regulations made there under, Assisted Reproductive Technology (“ART”) shall be available to all persons including single persons, married couples and unmarried couples”. Therefore, it becomes pertinent to understand that how a couple is defined here. Under Section 2(e) of the Bill, a couple means: “The persons living together and having a sexual relationship that is legal in the country / countries of which they are citizens or they are living in”.

This definition is inclusive in nature and covers all kinds of couples, whether they are homosexuals or not. Furthermore, the definition does not prevent the citizens of a country (where homosexual marriage is legal), from having a surrogate child. So, if section 377 of IPC is amended so as to be in consonance with the scheme of the Bill (as and when it is passed by both the houses to give it a legal effect), there will be no impediment in including same-sex couples within the definition of ‘couple’ as defined under Section 2(e) of the Bill. The effect of the definition
appears to do away with the legal limitation imposed by Section 377 of IPC, and is not just a mere co-incidence of legal drafting.

As we ponder upon some other definitions in the Bill, an “unmarried couple” is defined under Section 2(w) to mean: “A man and a woman, both of marriageable age, living together with mutual consent but without getting married.” It clearly delineates that for an unmarried couple to get a surrogate child, they have to be heterosexual; but on the other hand, no such condition is applicable to married couples i.e. they might be homosexual or heterosexual. This leaves us in sheer confusion as Section 32(1) is not restricted, but extended to include 'single persons', 'married couples' and 'unmarried couples' as well. There is perhaps a window left open for a foreign married homosexual couple who, according to the two definitions under the Bill, are a ‘couple’ having a valid married status under their jurisdiction. The non-exhaustive language used herein should allow the courts to fill in the gap.

**Statelessness of children**

The fact that surrogacy to a large extent emerges as a cross-border phenomenon. The legislation of a large number of countries not only prohibits the surrogacy, but also prevent child born-out beyond their borders. Although, there is a considerable number of their citizens whom they could not effectively prevent from obtaining a baby abroad. In theory, they might consider to punish intended parents for obtaining the baby abroad; however, so far this has not seemed to be feasible for those legislators who have thought about it.

The phenomenon of legal arbitrage is well known from other fields of law where it works perfectly well because the rather restrictive countries rarely attempt to rule on activities outside their borders. In the field of international corporate law, though, there is no reasonable difference between “legal arbitrage” and “regulatory arbitrage. This is, however, different in the ethically coined realm of family law. Here, the jurisdictions with strict approaches regarding surrogacy do not want their citizens to evade their rules. Family Law, however, is the only means which the legislator can use to prevent reproductive tourism.

The question thus arises whether intended parenthood should be internationally recognized so that the babies do not end up “stateless and parentless”. This issue is not only of momentary importance: It will remain
urgent even if some European countries permit certain forms of surrogacy in the near future, because as long as there is any legal diversity in the field, legal arbitrage and therefore the problem of recognition will remain.

In these circumstances, though enforceability nowhere affects, it is an open secret that it is first and foremost well-off people from industrialized countries who can afford to commission a surrogate and that it is frequently indigent women from Third World countries who—often under substantial pressure—“opt” for surrogacy in order to improve the living conditions for themselves, their husbands, and their children.

When it is widely accepted, an intervention of Government of India is warranted to protect the interest of the Surrogate mother through the process provided in Private international Law. Bilateral treaties and International Conventions on this issue may create difference.

Response of Indian Authorities is invariably hopeless, as even after developing as a hub of Medical tourism specifically ART, the legislation is dealing the issue as Tabu and similarly no strong will appears to regularise this burgeoning industry from the Government, thus expectation of initiation of process for a convention appears to be difficult.

Many restrictive jurisdictions though attempt to dis-incentivize surrogacies abroad by refusing to issue a passport for the newborn child, but in an attempt to cope with the deadlock, they often slur over the legal question of child nationality and sooner or later allow for child immigration. The intended parents’ passport application is often not legally successful as the child is not issued with a passport from their home country. But courts and authorities have regularly permitted them to take the baby home “outside the rules”, issued a one-time travel permit, or settled the dispute without any judicial decision at all. There is no known case in which a child would have eventually had to stay and was never allowed to follow the intended parents to their country as appears from both the Indian cases (Jan Balaz and Manji Yamada).

However, step was taken by the foreign department and issue a notification required a declaration to the effect that their respective country recognizes the child born-out through this process beyond their borders and there is no legal bar in granting citizenship, supported by their respective embassies before issuing a Visa for ART in India.
The factual situation is somewhat different in cases where the child has already moved to the place where the intended parents live. In these cases, the child is living with her intended parents according to plan, but their parenthood lacks legal recognition. On several occasions, intended parents have unavailingly attempted to achieve recognition of a foreign birth certificate that identified them as the legal parents. Courts refer the intended parents to an acknowledgement of paternity and the adoption procedure explicitly disregarding the birth certificate for reasons of law or public policy. It can thus be concluded that, when the best interests of the child are at stake because the newborn child has become stuck in a foreign country, courts temper justice with mercy. However, once the child is safe, the domestic laws are widely enforced.

At least, many surrogacies take place in countries which have agreed to a visa waiver programme with the intended parents’ home country, enabling the intended parents to take the (legally foreign) baby home without any waiting period, though in absence of any legislation on this issue and failure in entering into a bilateral or collateral treaties in this behalf, India is not among them.

The second considerable difficulty children face arises at home out of the at least temporarily open questions of parentage: The legal uncertainty as to who is assigned with legal parenthood over the child may translate into questions of custody and child maintenance. Child custody largely depends on parental status. Thus, as long as paternity is not acknowledged and the intended mother has not adopted the child, most jurisdictions still see the surrogate mother and her husband as legal parents. If the intended parents terminate their relationship, the child will need support. The worst-case scenario here would be the intended parents denying responsibility and the child being reliant on his legal parents who live far away under possibly quite different living conditions. Some surrogacy organizations will try to avoid such a situation by asking intended parents to reach an agreement on child support before entrusting a surrogate mother, but this is not the rule. Anyway, there is no known case where the intended parents have denied the responsibility for child support because of a split-up before or immediately after childbirth.

The fact that the intended parents face severe difficulties with cross-border surrogacies does not necessarily call for criticism as they know in advance that they are following illegal plans.
The examination of the most pressing problems in recent legislation on surrogacy world over shows that only in rare cases does legal uncertainty eventually materialize at the expense of the children in question. However, questions remain that Is there a need for an international convention on cross-border surrogacy...? Does parenthood have to be redefined with regard to the intention of would-be parents, or do the existing legal measures suffice for the protection of the child...?

The Hague Conference on Private International Law is currently attempting to map out a convention on issues arising from international surrogacy arrangements.

There are a number of renowned voices in the international realm who see sufficient leeway for a surrogacy-friendly interpretation of the prevailing Western family laws. The idea is that the rules on parenthood have to be reinterpreted so that in surrogacy cases the intended mother is to be immediately considered to be the legal mother even though this conflicts with the letter of the law

**Shifting the parenthood rationale from genetic linkage to intention**

Of course, the legislators in different countries might want to think about a redefinition of parentage. This tells us a great deal about the unsettled question of which aspect eventually matters for a modern understanding of parenthood. Is it the genetic link, the social relationship, the bare intention, or a mixture of the latter...?

A view on recent European jurisdiction shows that there is a growing perception that children have a right to at least know about their genetic origin. One might induce from this observation that parentage has to be open to contracting. To legalize surrogacy in this way might comply with children’s rights as well as with the fundamental family law principles. In fact, a legal model for such an intentional parenthood already exists in coexistence with the parentage based on genetic linkage: it is nothing other than adoption. Adoption is a model of parenthood which is not based on genetic linkage but on someone’s intention.

Critics might argue that subsuming surrogacy under adoption cannot provide certainty for the intended parents that they will eventually obtain the child because – at least in theory – the child might be given to someone else. However, the question is how much certainty someone
deserves who orders a child to be born as a (legal) orphan. Also, any deviation from the best interests of the child as the sole guideline for the allocation of the child result would seem iniquitous as it would mean that intended parents can take home a child whose interests would be better served by being assigned to someone else. Apart from that, it is also the rights of the surrogate which argue against “parental certainty” for the intended parents: It is a factum that many surrogates do their job only under serious financial and social pressure and that their assurance to be fine with relinquishing the child does not express their real feelings; if this does not anyway lead to a complete prohibition of commercial surrogacy, at least it calls for the surrogate’s right to eventually decide whether to keep the child only after birth. However, if the surrogate mother is granted this right, the law has to assign initial motherhood to the woman who gives birth. The proponents of surrogacy thus have to decide whether they want to keep this understanding of motherhood or whether they are really willing to entitle intended parents to enforce the surrogacy agreement, if need be in the delivery room.

Further, the absence of an effective binding law on surrogacy in India makes the situation grim as during the pendency of the Bill there is no mechanism or no official government-appointed body responsible for maintaining records on the issue. Despite laudable provisions, there is no clear measure on the data or facts or figures on the surrogate children born till date at the State level and other related information.

Attempts have been made to understand the size and scheme of the large-scale operation of surrogacy as a burgeoning IVF Industry, and a brief empirical study has been conducted on the plight of surrogate mothers in India. There is absolutely no information on the number of surrogate children born annually or the total number of surrogate children born till date. There is no information on the Infant Mortality Rate (IMR), sex ratio of the surrogate children born on the total number of birth certificates issued to the surrogate children. Besides, there is no concerned official government authority at the any level collecting and maintaining records on the same. There is no State-level official statistical record on the status of surrogate children born in India annually or in each State per annum.

However, in the recent past, the Indian Society for Assisted Reproduction has taken the initiative of collecting the data by
establishing the National ART Registry of India which has been instrumental in collecting and publishing data related to Assisted Reproduction Technology carried out in India since the year 2001. But there are certain limitations in this. Firstly, this is a voluntary process as the data is submitted by the ART clinics voluntarily to the ISAR. Neither has the ISAR powers to check the authenticity and nor has it powers to enforce all clinics to submit data. Hence the NARI does not cover all the ART clinics as well as does not have all the information concerning surrogacy. Further, the last data published by the ISAR under the NARI is of the year 2006.

There is a serious lacuna and omission on the part of the government to maintain the necessary and accurate records as well as facts and figures on the surrogate child, particularly when surrogacy is not only regularised in India but is rampantly practiced and the government earns a whopping amount of revenue from the same. Information and record-keeping must be considered by the government as the immediate recourse.

Today, legal arbitrage persuades droves of Europeans to cross borders in order to have access to surrogacy services which are prohibited under their home legislation.

Once the intended parents attempt to return home with the newborn child, legal diversity translates into problems of legal recognition for the parental status acquired under the foreign legislation. These problems can hardly be satisfactorily solved by European courts; the judges thus tend to avoid precedents and look for informal and non-legal solutions as long as the child is still in her country of birth. The consequences of legal diversity and stagnant jurisdiction, however, turn out to be less serious than one might think: No baby born through surrogacy is known to have permanently stayed in her country of birth, and there is so far no public case in which the length of an acknowledgment of paternity or adoption procedure has made the child lose a claim for child support.

As to the lex ferenda, legal research does not have to decide whether to follow a restrictive or a rather open approach towards surrogacy. The range of possible legislative decisions goes from penalizing the placement of a surrogacy order to the recognition of foreign decisions on parentage to entirely permitting surrogacy. Legal research should point out that, as long as there is any legal diversity and procreative tourism is not
criminalized, there will definitely be legal arbitrage and the circumvention of domestic laws. For any European legislator which has decided to prohibit surrogacy, the adoption procedures are completely sufficient to meet the interests of the persons involved, placing the welfare of the child clearly above the interests of the intended parents. In order to protect weaker individuals, i.e., the children and the surrogate mothers, the focus of the discussion anyway deserves to be rather on the protection of their rights than on legalizing the technically possible. And even if some European legislators should decide to liberalize their laws they cannot evade answering the fundamental question whether they will keep their current definition of motherhood or entitle the intended parents to wrest away the newborn child from the surrogate right in the maternity room.

Surrogacy is a $US 2.8 billion trade across the world and India’s commercial surrogacy is a $ 2.5 billion industry in the country.\(^9\) This is as per the estimate of the Confederation of Indian Industry.

It is an admitted and well-known fact that in India surrogacy is legal in the commercial form with the Supreme Court judgment since the year 2002 in the absence of an effective binding law. The proposed law regulating surrogacy in India—the Assisted Reproductive Technologies (ART) Draft Bill 2010— is awaiting its long due enforcement.

Future research is needed to continue exploring the experiences of surrogates, as well as the role of recruiting agents and husbands. Future research is needed that examines the mental well-being of surrogates in India. Constructs such as depression, self-esteem, attachment to the fetus, and attitudes toward pregnancy will provide a clearer understanding of the impact of surrogacy post delivery. Longitudinal data are needed to understand the impact of this process on surrogates mentally, emotionally, physically, and financially in the long term. Finally, future research should explore the roles that recruiting agents from the surrogacy clinic play in this process. Other research Researcher has conducted about the recruitment process suggest surrogacy may be portrayed only in a positive light to successfully recruit women, rather than disclosing the actual experience of the process. Our work illuminated that many other systems support the women in the endeavor to be

gestational surrogates, so a further understanding of their level of satisfaction with the process is warranted.

A limitation of our study was its cross-sectional nature. Researcher interviewed women at one point in time about an experience that is likely to have a lasting and evolving contextual meaning to the woman over her lifetime. Therefore, this study cannot be generalized to the larger population of surrogate mothers. Future work should explore this role and its interpretation over time to understand the long-term impact on the women.

In conclusion, whatever the legal arrangements, the global availability and movement of reproductive technologies which assist procreation have ensured that surrogacy arrangements will continue to take place, bypassing the state if necessary. Arrangements between clinicians and surrogates were already in place several years before the ART bill in India was formulated – showing how the legislation is in response to, rather than pre-emptive of, trans-national surrogacy. The state needs to do more ‘work’ in regaining the trust of the people that it will uphold their welfare and move beyond the provision of informed consent which is inadequate given the compulsions and complexities of decision-making accompanying reproduction in India. To ban surrogacy in India runs the fear of pushing this practice ‘underground’ and further removed from any kind of legislation ensuring the welfare of those most vulnerable. The 18th Law Commission set up in 2009 to review the ART bill in respect to surrogacy states clearly that the prohibition of surrogacy is undesirable. Recognising surrogacy as a ‘supreme saviour’ of the distresses faced by infertile couples, it advocates active legislative intervention to facilitate the correct use of new technologies.

As discussed above, for the new legislation to fully act ‘as defender of human liberty and an instrument of the distribution of positive entitlements’ (18th Law Commission review 2009) the focus has to move beyond the standard bioethical instruments to consider the languages, economies, kinship and moralities which frame issues of reproductive choice and consent on-the-ground. Of further consideration is the extent to which the state and legislation are popularly perceived and trusted to work for the welfare of those they seek to regulate.
Researcher tried to best of his efforts to point out every possible avenue from a Lawyer’s perspective and looking into sheer need of legislative intervention long awaited. Since Bill is still pending, humble researcher find this occasion as an opportunity to present certain recommendations for consideration by the legislation while discussing the bill. Certain recommendations are as under:-

1. Intended parents at least mother should stay with the Surrogate at least for a month to ensure her that her child will be safe.
2. Optional to surrogate to keep child with her birth should be provided as it is incorporated in Russian Citizen Act 2011
3. Theory of well-being is the sole of the custody of the children in Indian family Laws, the same principle should adopt in case of surrogacy.
4. Compensation to surrogates ranges between 10 to 20 percent of the total cost on such procedure. Special attention is required to regulate the compensation to control the exploitation of surrogate and intended couples both. Permission should be granted only in case where minimum 33% of the cost is provided to transfer the surrogates.
5. Wide awareness about the procedure is required to clarify that there is no physical contact between intended father and the surrogate to avoid social stigma associated with the surrogacy arrangements.
6. Future research is needed to continue exploring the experiences of surrogates, as well as the role of recruiting agents and husbands. Future research is needed that examines the mental well-being of surrogates in India
7. The surrogacy may be permitted only to the persons, who are unable to conceive or who don’t have child. Such permission should not be granted to the persons, who want a child but don’t want to conceive for personal reasons, not associated with any kind of Medical deficiency.
8. Gay/lesbian Couples should not be permitted to have child through ART procedure.
9. Sex Selection should not be permitted.
10. Child has all succession rights and intended parents need to submit a certificate of the embassy that their family law provides such right to the intended children.

11. It should be declared the child born out of this procedure shall be legitimate child of the intended parents and the same certificate should be required to obtain from the respective embassy in case of foreign nationals.

12. A child should not be left stateless, hence, only the intended parents of countries recognize the child as the citizen of the respective country of the intended parent should be permitted.

13. Anonymity to donor/Surrogate should be regarded and not be permitted to disclose in any condition, however, DNA profiles should be preserved to meet the future challenges, medical or legal.


15. Permission from Commission constituted under the Commission for child rights Act 2005 should be mandatory and the Commission for child rights should carried-out an inquiry putting well-being of child as paramount consideration, before granting such permission.

16. In case of split between intended parents during the pregnancy, the custody of the child should be determined through their family laws.

17. Insurance of surrogate and child must be prerequisite of a surrogacy arrangement with at least double of compensation determined.

18. Compensation agreed should be guaranteed by the state authorities with extended sum in the event of default by intended parents or frustration of contract.

19. There should be legislation directly on the subject of surrogacy arrangement involving all the three parties i.e. the surrogate mother, the commissioning parents and the child.

20. There is a need of right-based legal framework for the surrogate mothers, as far as the ICMR guidelines are not enough

21. A clearly defined law needs to be drafted immediately which will pronounce in detail the Indian government’s stand on surrogacy; so
that discrete activity leading to exploitation of the surrogate mother can be stopped.

22. There should be a substantial regulation designed to protect the interests of the child.

23. Legal recognition of termination and transfer of parenting rights.

24. It is crucially important to maintain and monitor the anonymity of the surrogate mothers.

25. The surrogate mother should be provided by the copy of the contract as she is a party in the agreement and her interests should be taken into account. It happens that very often decision is taken by the intended parents and clinic, while surrogate mother does not have any say in this matter.

26. There should be an interpreter (other than doctor) for the communication linkage between the surrogate and intended parents in order to convey the message from surrogate mother time to time. As far as often doctors speak on behalf of surrogate mothers, but there is no guarantee that their interests are conveyed without any misinterpretation.

27. Typically, after the birth the surrogate mother is left without any medical support, it is recommended that there should be a provision of intensive care and medical check-ups of their reproductive organs during the 3 months after pregnancy.

28. The commissioning couple should try to establish a relationship of trust with the surrogate, yet such a relationship creates reciprocal rights and duties and might create demands for an undesired relationship after the birth.

29. The citizenship right of the surrogate baby is also of crucial importance. The Indian government needs to take a stand in terms of conferring the surrogate baby Indian citizenship as she/he is born in the womb of an Indian (the surrogate mother) and in India.

30. The rights of the child should be protected and in case s/he is not taken by the commissioning parents, then the child should be given Indian citizenship.

31. Health Insurance for both the surrogate mother and the child is essential to ensure a healthy life.

32. There is a need of debate and discussion of the stance that public policy and the law should take toward surrogate mothering.
Actually, there exists a range of choices from prohibition and regulation to active encouragement.

33. Surrogacy arrangement will continue to be governed by contract amongst parties, which will contain all the terms requiring consent of surrogate mother to bear child, agreement of her husband and other family members for the same, medical procedures of artificial insemination, reimbursement of all reasonable expenses for carrying child to full term, willingness to hand over the child born to the commissioning parent(s), etc. However, such an arrangement should not be for commercial purposes.

34. A surrogacy arrangement should provide for financial support for surrogate child in the event of death of the commissioning couple or individual before delivery of the child, or divorce between the intended parents and subsequent willingness of none to take delivery of the child.

35. A surrogacy contract should necessarily take care of life insurance cover for surrogate mother.

36. One of the intended parents should be a donor as well, because the bond of love and affection with a child primarily emanates from biological relationship. Also, the chances of various kinds of child abuse, which have been noticed in cases of adoptions, will be reduced. In case the intended parent is single, he or she should be a donor to be able to have a surrogate child. Otherwise, adoption is the way to have a child which is resorted to if biological (natural) parents and adoptive parents are different.

37. Legislation itself should recognize a surrogate child to be the legitimate child of the commissioning parent(s) without there being any need for adoption or even declaration of guardian.

38. The birth certificate of the surrogate child should contain the name(s) of the commissioning parent(s) only.

39. Right to privacy of donor as well as surrogate mother should be protected.

40. Sex-selective surrogacy should be prohibited.

41. Cases of abortions should be governed by the Medical Termination of Pregnancy Act 1971 only.

42. what would be the remedy available to biological parents to obtain exclusive legal custody of surrogate children,

43. how can the rights of the surrogate mother be waived completely,
how can the rights of the ovum or sperm donor be restricted,
how can the genetic constitution of the surrogate baby be established and recorded with authenticity,
whether a single or a gay parent can be considered to be the custodial parent of a surrogate child,
what would be the status of divorced biological parents in respect of the custody of a surrogate child, and
would a biological parent/s be considered the legal parent of the surrogate child?

Surrogacy in India is legitimate because no Indian law prohibits surrogacy. To determine the legality of surrogacy agreements, the Indian Contract Act would apply and thereafter the enforceability of any such agreement would be within the domain of section 9 of the Code of Civil Procedure (CPC). Alternatively, the biological parent/s can also move an application under the Guardians and Wards Act 1890 for seeking an order of appointment or a declaration as the guardian of the surrogate child.

In the absence of any law to govern surrogacy, the 2005 Guidelines apply. But, being non-statutory, they are not enforceable or justiciable in a court of law. Under paragraph 3.10.1 of the Guidelines a child born through surrogacy must be adopted by the genetic (biological) parents. However, this may not be possible in case of those parents who cannot adopt in India.

Under Section 10 of the Contract Act, all agreements are contracts, if they are made by free consent of parties competent to contract, for a lawful consideration and with a lawful object, and are not expressly declared to be void. Therefore, if any surrogacy agreement satisfies these conditions, it is an enforceable contract. Thereafter, under section 9, CPC, it can be the subject of a civil suit before a civil court for adjudication of all disputes relating to the surrogacy agreement and for a declaration/injunction as to the relief prayed for.

As of today, it may be stated that a single or a gay parent can be considered to be the custodial parent by virtue of being the genetic or biological parent of the child born out of a surrogacy arrangement. Japanese baby Manji Yamada’s case and the Israel gay couple’s case who fathered the child in India are clear examples to establish that this is possible. Under paragraph 3.16.1
of the Guidelines dealing with legitimacy of children born through ART (which was the basis of the claim in the Japanese baby’s case in the Supreme Court), this claim can be made. However, only in a petition for guardianship under the Guardians and Wards Act and/or in a suit for declaration in a civil court, the exclusive custodial rights can be adjudicated by a court of competent jurisdiction upon appreciation of evidence and considering all claims made in this regard.

53. Essentially, this is a question which will require determination in accordance with the surrogacy agreement between the parties. There would apparently be no bar to either of the divorced parents claiming custody of a surrogate child if the other parent does not claim the same. However, if the custody is contested, it may require adjudication by a court of competent jurisdiction.

54. In answer to this question it can be stated that the biological parents would be considered to be the legal parents of the child by virtue of the surrogacy agreement executed between them and the surrogate mother. Under paragraph 3.16.1 of the Guidelines dealing with legitimacy of the child born through ART, it is stated that “a child born through ART shall be presumed to be the legitimate child of the couple, born within wedlock, with consent of both the spouses, and with all the attendant rights of parentage, support and inheritance”. Even in the 2008 draft Bill and Rules, a child born to a married couple, an unmarried couple, a single parent or a single man or woman, shall be the legitimate child of the couple, man or woman, as the case may be.

55. However, the moot question which may arise for determination is as to whether a judicial verdict determining rights of parties in a surrogacy arrangement is essential in respect of a foreign biological parent who wishes to take the surrogate child to his/her country of origin or permanent residence. It can be said that either a declaration from a civil court and/or a guardianship order ought to be a must to conclusively establish the rights of all parties and to prevent any future discrepancies arising in respect of any claims thereto.

56. Successful handling of surrogacy for with international parents requires special attention to addressing every country’s needs and legal circumstances and partnering with local
organizations and lawyers to provide a complete solution for prospective parents before and after the birth.

57. International parents should make sure to find an agency with such understanding of the laws to help determine which legal strategy would work best to ensure that they can return and gain full legal rights for both parents and newborns back home.

58. In India, there is a need to pass a new legislation by which commercial surrogacy related matters will be governed. Moreover, sufficient steps are necessary to take so that people can at least understand the positive sign (i.e. it is helpful for maintaining familiar peace) of legalization of commercial surrogacy and try to change their conservative approach.

59. Before the Parliament passes the Assisted Reproductive Technology (Regulation) Bill, 2010 the answers to these questions are to be found – i) Ethically, should women be paid for being surrogates? ii) Can the rights of women and children be bartered? iii) If the arrangements fall foul, will it amount to adultery?

60. The law should provide for the right to termination of pregnancy for the surrogate mother in case of any mental or physical trauma that she may experience during the pregnancy.

61. The minimum time up to which the surrogate mother should be allowed to nurse the child should be laid down as without such a provision the child’s health may suffer.

62. The Bill safeguards the rights of Surrogates as meeting the surrogacy requirements in the case of a child born with birth defects. It also states that she can terminate her pregnancy at will. However, the clause on the termination of the pregnancy at will, needs to be considered in relation to a condition suffixed that all payments received by the surrogate be refunded in such an event, except in case of medical complication.

63. Since, language is a major constraint in surrogacy agreement, The clinician should hold responsibility to prepare a copy of the agreement in local Language also signed and Notarized along with the Agreement to rule out the possibility of any kind of cheating.

64. Section 32(1) of the Bill, which is the enabling provision, states: “That subject to the provisions of this Act and the rules and regulations made there under, Assisted Reproductive Technology (“ART”) shall be available to all persons including single persons,
married couples and unmarried couples”. An explanation to exclude Gay couples or unmarried man should be suffix.

65. Similarly Under Section 2(e) of the Bill, a couple means: “The persons living together and having a sexual relationship that is legal in the country / countries of which they are citizens or they are living in” also requires modification.

66. Precondition may be imposed on intended parents to reach an agreement on child support before entrusting a surrogate mother to avoid critical condition in the case of split between intended parents.

It is unrealistic to believe that all the harms associated with surrogacy can be eliminated. However, the harms associated with either the legalization or banning of surrogacy will be felt by society as a whole. Women as a group need to explore any and all possibilities which can minimize the harm to women. Women are identified by their ability to reproduce because, up to this point, only women can do so. The only way for women to seize and stay in control of any existing or new reproductive technology is to present viable legislation for the decision-making bodies of government to act upon. If women, as a group, do not allow themselves to compromise they may end up with an unbearable situation completely out of their control rather than a tolerable situation they helped to develop.

It becomes incumbent upon neutral bodies to ensure that ethical guidelines are adhered to and also to bring to light any violations. For this, well-formulated guidelines drafted with foresight and long-term perspectives are essential.

In conclusion, whatever the legal arrangements, the global availability and movement of reproductive technologies which assist procreation have ensured that surrogacy arrangements will continue to take place, bypassing the state if necessary. Arrangements between clinicians and surrogates were already in place several years before the ART bill in India was formulated – showing how the legislation is in response to, rather than pre-emptive of, trans-national surrogacy. The state needs to do more ‘work’ in regaining the trust of the people that it will uphold their welfare and move beyond the provision of informed consent which is inadequate given the compulsions and complexities of decision-making accompanying reproduction in India. To ban surrogacy in
India runs the fear of pushing this practice ‘underground’ and further removed from any kind of legislation ensuring the welfare of those most vulnerable. Recognising surrogacy as a ‘supreme saviour’ of the distresses faced by infertile couples, The Law Commission advocates active legislative intervention to facilitate the correct use of new technologies.

As this Research has shown, for the new legislation to fully act ‘as defender of human liberty and an instrument of the distribution of positive entitlements’ the focus has to move beyond the standard bioethical instruments to consider the languages, economies, kinship and moralities which frame issues of reproductive choice and consent on-the-ground. Of further consideration is the extent to which the state and legislation are popularly perceived and trusted to work for the welfare of those they seek to regulate.

At this juncture we are looking forward for a new legislation on ART that may meet-out the expectations of all the stakeholders, specifically the most important and so also the weakest part of this entire system, the Surrogates and intending couples on the other hand. It is also expected that the forthcoming legislation shall clear enough to meet-out the ambiguities involve in the system.