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 7\(^{th}\) 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.³


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

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 indicatios:-

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
Oocyte donation (OD) or embryo donation (ED)

Cryopreservation

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 children, 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.

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. 4–5, 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

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8 The Law Commission of India in its 228th 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.9

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

9 Smith Chandra. Surrogacy and India A Legal Perspective http://ssrn.com/abstract=1762401

189
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. 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
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.\textsuperscript{10}

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.\textsuperscript{11} This led to the government drafting a bill which is called the \textbf{Assisted Reproductive Technology (Regulation) Bill 2008}.\textsuperscript{12} 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.\textsuperscript{13} 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.

\textsuperscript{11} India’s Legislation of Commercial Surrogacy.[online]Available at: http://www.indiansurrogacy.com/item/india-legalisation-of-commercial-surrogacy.html [Accessed Date : 28th October, 2013]
\textsuperscript{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.\(^\text{14}\)

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.  

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.’

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,

17 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 (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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