CHAPTER - 6, PART - II

THE LEGAL IMPLICATIONS AND COMPLICATIONS OF DONOR INSEMINATION (DI) AND SURROGACY IN INDIA; BREEDING LEGAL ISSUES YET TO BE SOLVED AND SETTLED BY THE LEGISLATURE AND JUDICIARY : SOLUTION TO DI AND SURROGACY IN INDIA.

6.1 Background :-

As we have seen in chapter 6 of part-I of this thesis that the technique of DI has been developed from the technique of artificial insemination which was performed in the USA in 1866 by Marion Sims but abandoned on religious and ethical considerations terming it immoral. Thereafter Robert Dickinson of the USA used the technique of artificial insemination during the 1890s using sperm of non-husband, that is donor sperm which caused an uproar and was called a technological form of adultery for which Dickinson was castigated by many. The system used by Dickinson for artificial insemination using non-husband (donor sperm) subsequently acquired the name of donor insemination (DI) and in 1953, frozen donor sperm was used for the first time.¹

The system of DI though not recognised in 19th Century in the USA and other world nations, subtilely paved its way in some of the countries particularly in the USA and UK, after the development of IVF and production of first test tube baby in the year 1978. Likewise the concept of surrogacy arrangements also developed. Both the DI as well as the surrogacy arrangements have been legalised in some countries, and the DI as such is not considered an adultery in those countries. Likewise surrogacy has also been accepted. At present DI and surrogacy is being
Simultaneously with the increasing use and application of DI and surrogacy after the production of world's first TTB, many legal complications also came up on those countries. Therefore some countries have regulated and controlled the use of DI and surrogacy imposing various restrictions. Even some countries have banned DI altogether and surrogacy made a criminal offence punishable under the law if carried on as profit earning business. However in India the use and application of DI and surrogacy is in its very initial stage but if the same continues it would lead to multifarious complications in view of the social pattern and structure of our country. Before discussing these implications and their solution in India, we may have a look at some of the problems faced by other world nations on account of the use and application of DI and surrogacy which compelled them to ban or restrict the use and application of DI and surrogacy as follows.

6.2 Donor insemination: Complications and legal checks in the world around:

After the invention and development of IVF and production of first TTB the technique of DI has been widely used to give relief to infertile couple suffering from male side infertility. The intensive use and application of DI in USA has given rise to many legal complications in addition to the psychological and emotional impact. The use and application of DI from fresh semen has even posed danger to the health of the women so inseminated as the semen was affected with AIDS. It is, therefore, implied that in the absence of any guidelines, rules and regulations with regard to the use and application of DI, the IVF clinics were operating without any control of the government by way of registration, licence etc and further that some of them
have inseminated the fresh semen without screening of the donors. Apprehending danger to the health of the people on account of increased use of artificial insemination using donor sperm and the deep concern with respect to the sharp increase in sexually transmitted disease particularly AIDS, the American Fertility Society was compelled to appoint an Adhoc Committee to suggest and draft the Guidelines in the use of fresh and frozen semen for donor insemination in the year 1986 and the Committee so appointed drafted New Guidelines for the Use of Semen Donor Insemination: 1986 under the chairmanship of Edwin P. Peterson. ²

These guidelines, inter-alia, provide for insemination procedure; indications (artificial insemination-donor); evaluation of the couple; evaluation of husband; evaluation of female recipient for medical reproduction history, physical examination, laboratory test, documentation and timing of ovulation and evaluation of possible tubal or peritoneal abnormalities; donors, for selection of donors, screening of donors for semen's screening, genetic screening, medical history, physical examination and laboratory screening for sexually transmitted diseases; management of donors for monitoring health status payment to donors, limitation to donor use, consent and record keeping; use of fresh-verses-frozen semen and discussion of techniques for match between couple and donor, the sperm for artificial insemination of donors, insemination procedure. All these aspects of donor insemination has been dealt with in detail in Section-II to VIII of the Guidelines referred to above. However we may discuss these guidelines in brief as follows:

Section-II provides that artificial insemination using either fresh or thawed frozen semen from a suitable donor may be employed to effect a pregnancy in a women of reproductive age where appropriate indication exist. These indications are to take into account the age and status of the female recipient. Careful consideration
to be given for possible psychological evaluation and counselling.

Section - III provides for indications (artificial insemination donor) so as to find out whether the husband is sterile, has seminal fluid abnormalities associated with male factors infertility, has a known hereditary or genetic disorder, etc.

Section - IV provides for evaluation of the couple so as to make the couple aware of the adverse emotional and psychological consequences to the procedure of AID and get consent form signed by the couple.

Section - V provides for evaluation of the husband for a through male factor evaluation, to evaluate the husband's health, status and about sexually transmitted diseases, etc.

Section - VI provides for evaluation of the female recipient to find out medical and reproductive history according to standard that are applied to woman anticipating pregnancy, physical examination including pelvic examination, laboratory tests as recommended for any women attempting conception, documentation and timing of ovulation which may include basal body temperature, cervical mucus changes, ultrasound monitoring of follicular maturation, etc. and evaluation of possible tubal or peritoneal abnormalities and tests to detect other possible causes of persistent in fertility.

Section-VII deals with donors, for selection of donor. The main features are assurance of good health, status and absence of genetic abnormalities and that donors should be younger than 50 years of age, screening of donors for semen's screening suggesting that several samples be examined before proceeding with extensive procedures, the sample should be examined within one to two hours after
ejaculation into a clean container; genetic screening of potential donors for any possible genetic disorder; medical history of the donors to ensure that the donors are generally healthy and give no history to suggest hereditary and familial disease containing complete sexual history so as to exclude the donors having high risks for AIDS or should have multiple sexual partners; physical examination by either the physician group that performs the insemination procedure or one of their associates completely as a routine laboratory screening including blood typing and RH testing; laboratory screening for sexually transmitted diseases for syphilis and other diseases; managing of the donors to monitor health status so as to diminish the risk of transmitting infectious identities to women during insemination, payment to donors varying from area to area but should not be such that the monitor and incentive is the primary factor in donating sperm, limitation to donor use for which institutions and clinics should maintain sufficient records so that they set a limit to the number of pregnancies for which an egg donor is responsible and suggested 10 pregnancies per donor, for consent of donors it may be desirable for the donor to sign the consent form, keeping and maintaining of permanent confidential records of donors including genetic work-up and other non-identifying information and making them available on request on an anonymous basis to the recipient and any resulting of offspring; and uses of fresh-versus-frozen semen, it is generally recognised that pregnancy rates using fresh semen are significantly higher than that of frozen semen. Sexually transmitted diseases are a risk with both fresh and frozen semen. If fresh semen is to be utilised, there should be screening of donors as outlined.

Section-VIII provides for discussion of techniques for match between couple and donor, there are several ways to match the couple with donor. Some clinics take picture of each donor and place them in the confidential file along with donor's
vital statistics. There are obvious hazards to that method. The couple should be encouraged to list the characteristics they desire in prospective donors including height, body-build, complexion, hair-colour, eye-colour etc. The characteristics of husband and wife should be tabulated for reference. If the match is not possible the problem should be discussed to avoid misunderstandings; the sperm for artificial insemination donor, the donor should collect the seminal fluid under supervision. If multiple insemination are implied the clinic should use the same donor for any given cycle. The practice of mixing husband’s semen should be discouraged. The available data suggest that this practice may interfere with the fertilisation of ability to the donor sperm. Also, it confuses the issue. Any psychological uncertainty on the part of the couple should be dealt with before proceeding with insemination. And for insemination procedure, the semen specimen should be carefully examined to ensure that the sample is satisfactory.

Accordingly in the USA; Chapter containing RSA 168-B : 10 of an Act (Chapter-87, Laws 1990) relative to surrogacy, effective from First January 1990 provides, "Semen Donors. No semen shall be used in an insemination procedure unless the sperm donor has been medically evaluated and the results, documented in accordance with any rules adopted by the division of public health services, demonstrate the medical acceptability of the person as a sperm donor";

168-B : 12 provides, "Recipient of Insemination. No woman shall undergo an insemination procedure unless the woman has been medically evaluated and the results, documented in accordance with rules adopted by the division of public health services, demonstrate the medical acceptability of the woman to undergo the insemination".
168-B : 14 provides, "Gamete Donors. No gamete shall be used in an *in vitro* fertilisation or preembryo transfer procedure, unless the gamete donor has been medically evaluated and the results, documented in accordance with rules adopted by the division of public health service, demonstrate the medical acceptability of the person as a gamete donor; and

168-B : 15 provides, "Restrictions on use of Preembryos".

i) No preembryo shall be maintained ex utero in the noncryo-preserved state beyond 14 days' post-fertilization development;

ii) No preembryo that has been donated for use in research shall be transferred to an uterine cavity".

Warnock Report made as many as 64 recommendations.\(^3\) The recommendations have been made in view of the various problems which have arisen and also which were apprehended to arise in view of the new development of getting babies through the technique of IVF.

While dealing with artificial insemination by donor the committee reports that "Artificial insemination by donor (AID) may be used when investigations have shown the husband to be sterile or to have significantly reduced fertility, or it may be used for the avoidance of hereditary diseases when these are carried by the male".\(^4\) Regarding the transmission of hereditary disease, the committee reported, "The increased understanding of genetics and the availability of genetic counselling has meant that people are now aware of the principles that govern the inheritance of genetic diseases and the likelihood of transmitting an hereditary disease which may be severely handicapping in its effects to the next generation, either because
the individual has the condition or is a carrier. Couples who know of the possibility of such disorders in either or both families face a difficult choice. For some conditions, prenatal diagnostic screening already provides a means of detecting abnormalities or genetic disorders in the foetus. This may provide parents with an opportunity for termination of pregnancy if they want it. However there are people for whom a termination is unacceptable. For them, the choice at the moment is a harsh one, between the risk of having handicapped children, and having no children at all". It further reports, "For such people, the use of a technique involving donated eggs or semen which do not contain the genetic material associated with the hereditary disease offers real hope of giving birth to healthy children. Even though they do not require the donation as a treatment for infertility, it seems to us right that, in their circumstances, they should be offered, as part of the process of genetic counselling, the facility to use a technique which will help to prevent handicap in the next generation. We know that, where the hereditary condition may be transmitted by the male, AID is already quite often suggested. We hope that our proposals for the regulation of AID, and for making the child legitimate, will in the future make this a more acceptable option. We hope, too, that those involved in counselling couples at risk of transmitting an hereditary disease will now begin to consider the potential benefits of egg and, in rare circumstances, embryo donation to overcome problems where the woman is at risk of passing on the hereditary condition. We believe that the range of options for helping such couples should be made more widely known, so that the fears and unhappiness caused through the risk of transmitting an hereditary condition can be ceased. We recommend that it should be accepted practice to offer donated gametes and embryos to those at risk of transmitting hereditary disorders".6
Discussing the then prevailing position in U.K., in respect of the AIH and AID, the Committee reported, "Under existing law neither AIH nor AID is unlawful. A child born to a married couple as a result of AIH is the legitimate child of that couple. A child born as a result of AID, on the other hand, is illegitimate, and so is liable to suffer all the disadvantages associated with that status. In theory the husband of the woman who bears an AID child has no parental rights and duties in law with regard to that child; these in principle lie with the donor, who could be made liable to pay maintenance, and who could apply to a court for access or custody". After examination the arguments for and against AID, the Committee concluded, "We have concluded that AID should no longer be left in a legal vacuum but should be subject to certain conditions and safeguards, and receive the protection of the law. It is certain that, for some people, AID will always remain unacceptable. Nevertheless we cannot accept their objections as a reason for denying the opportunity for treatment to those infertile couples who do not share their beliefs. Moreover the practice of AID will continue to grow, with or without official sanction and its clandestine practice could be very harmful. It is, therefore, desirable that AID should be available as a treatment for the alleviation of infertility, in a form subject to all possible safeguards. We regard it as a legitimate form of treatment for those infertile couples for whom it might be appropriate. Therefore we recommend that AID should be available on a properly organised basis and subject to the licensing arrangements described in Chapter Thirteen, to those infertile couples for whom it might be appropriate. Consequently we recommend that the provision of AID services without a licence for the purpose should be an offence".

Further with regard to the AID, while making recommendations, the Committee reported: We recommend that --
"The establishment of a new statutory licensing authority to regulate both research and those infertility services which we have recommended should be subject to control".9

- "There should be substantial lay representation on the statutory authority to regulate research and infertility services and that the chairman must be a lay person".10

- "All practitioners offering the services that we have recommended should only be provided under licence, and all premises used as part of any such provision, including the provision of fresh semen and banks for the storage of frozen human eggs, semen and embryos should be licensed by the licensing body".11

- "The licencing body be asked to consider the need for follow-up studies of children born as a result of the new techniques, including consideration of the need for a centrally maintained register of such births".12

- "The sale or purchase of human gametes or embryos should be permitted only under licence from, and subject to, conditions prescribed by the licensing body and therefore unauthorised sale or purchase should be made a criminal offence".13

- With regard to principles of AID provisions and consequential legal changes, the Committee recommended that :-

- "The AID child should in law be treated as the legitimate child of its mother and her husband where they have both consented to the treatment. This will require legislation".14
-- "On reaching the age of eighteen the child should have access to the basic information about the donor's ethnic origin and genetic health and that legislation be enacted to provide the right of access to this. This legislation should not be retrospective".  

-- "A change in the law so that the semen donor will have no parental rights or duties in relation to the child".  

-- "The formal consent in writing by both partners should, as a matter of good practice, always be obtained before AID treatment begins. A consent form should be used and thoroughly explained to both partners").  

-- "Following the English Law Commission, that it should be presumed that the husband has consented to AID, unless the contrary is proved".  

-- "The law should be changed so as to permit the husband to be registered as the father".  

-- "For the present a limit of ten children who can be fathered by donations from any one donor. To prevent the possibility of the same donor being used unwittingly by different clinics, we recommend that the NHS numbers of all donors be checked by the clinics where they make their donations against a new centrally maintained list of NHS numbers of existing donors, which is to be held separately from the NHS central register".  

-- "There should be a gradual move towards a system where semen donors should be given only their expenses".
In Sweden, apprehending danger to the effect that the DI children may not be properly looked after by recipient parents or that the DI children may not grow up in favourable conditions and also that a woman who is less than marriageable age or unmarried may not get baby by DI, Sections 2 and 3 of Law No. 1140 of 20th December 1984 on insemination in Sweden provides as follows:

"S.2 Only a woman who is married to or cohabits with a man in circumstances resembling marriage may be inseminated. It shall be a condition of performing insemination that the written consent of the woman's husband or cohabitant is obtained in advance."

S.3. Inseminations with sperm from a man other than the husband or cohabitant of the woman may only be performed in a public hospital under the supervision of a specialist in gynaecology or obstetrics."22

"The physician shall verify, on the basis of the couple's particular medical, psychological, and social conditions, whether the performance of the insemination is appropriate. The insemination may only be performed if there are grounds for considering that the resultant child will grow up in favourable conditions. The couple may appeal to the National Board of Health and Welfare if their application for insemination is refused. No appeal shall lie from the decision of the Board. "The physician shall select an appropriate sperm donor. Information on the donor shall be entered in a special register, which shall be retained for at least 70 years".23

Further to avoid production of TTBs from the imported sperm Section 6 of the aforesaid law in Sweden provides, "Frozen sperm may not be imported into the country without the consent of the National Board of Health and Welfare".24
Section 7 of this law also provides for punishment of fine or imprisonment not exceeding six months for violating the provisions of law.25

Further, in Sweden, the National Board of Health and Welfare on insemination laid down Regulations and General Recommendations No. 6 of 27th March 1987, making provisions supplementing the provisions laid down in the aforesaid law No. 1140 of Sweden. Regulation-1 lays down that before carrying out an insemination, the physician in-charge must verify that the husband has in fact given his consent in writing and that he is still alive; sperm from different donors has not been mixed; and in the course of the same menstrual cycle, the woman is not inseminated with sperm from more than one donor; Regulation-2 lays down that the physician must verify that the donor is not suffering from any detectable disease liable to entail a risk to the health of the woman or the child to be born; in cases of insemination by donor, only frozen sperm may be employed; on the donation of sperm, the donor must undergo screening for HIV prior to freezing of the sperm; the frozen sperm from the first donation may not be employed until two sperm samples, taken at an interval of not less than six months, have been tested and found seronegative; the physician must inform the donor that the resultant child is entitled to learn who the donor is. The donor must also be informed that he may subsequently be required to provide blood specimens or to undergo examinations; and the colour of the donor's eyes and hair, and his weight and size, must be entered in the donor's case record; Regulation-3 lays down that sperm banks must be sited on lockfast premises; and sperm specimens must be so coded that the identity of the donor is not disclosed to unauthorized persons; Regulation-4 lays down that if the psychosocial examination contraindicates insemination, the reasons for the decision must be entered in the woman's individual insemination case record, and the parties informed.
of the decision and their right to have the case reviewed by the Board; Regulation-5 lays down that the husband's written consent to insemination must be retained in the woman's individual insemination case record; And Regulation-6 lays down that the hospital carrying out the insemination must keep two individual case records, one for the sperm donor and the other for the woman undergoing insemination; both records must be conserved for at least 70 years after the last entry; the donor's record must be marked with a code entered in the woman's record; and a coded entry must be made in the woman's records whenever an insemination is carried out. When insemination occurs, it must be clear which insemination treatment led to pregnancy.

In Spain, Section-1 of Order of 15th June 1988 on the coordination of activities relating to and the control of the human immuno-deficiency virus in medical interventions connected with the procurement and deposit of semen, lays down that in medical interventions involved in the withdrawal, use, and deposit of semen for human reproduction, appropriate tests with findings and certification, must be carried out to detect HIV markers; S.2 specifies that semen obtained from persons who prove to be seropositive must be destroyed, apart from that required for study, analysis, and research; S.3 requires the same testing, findings and certification in relation to the recipient woman; in the event of a confirmed positive result, the continuation of the medical intervention must be reconsidered and S.4 lays down technical and administrative provisions on the tests and their coordination.

In USSR; Decree No - 669 of 13th May 1987 of the USSR Ministry of Health on the extension of the experimental application of the method of artificial insemination by donor on medical indications provides for various aspects of AID in USSR including medical tests of the donors for AIDS.
In Bulgaria, Section 8 of Order No 12 of 30th May 1987 on artificial insemination in woman lays down, "Artificial insemination with genetic material from a third party may be performed, on the following medical indications:

1. there are permanent disorders of fertility or deterioration of basic indicators that control the possibility of fertilization by the husband's sperm;

2. treatment provided to the husband in order to restore his fertility has proved ineffective;

3. the husband is suffering from a hereditary disease that jeopardizes the viability of his progeny;

4. iso-immunization is present, in cases where there is a serious risk that the fetus would suffer from a haemolytic disease; or

5. there is a history of habitual abortions, that have been determined to be due to morphological or genetic anomalies in the husband's spermatozoa.29

In Austria, Decree of 23rd June 1988 of the Federal Chancellery on the testing of semen donors or, as appropriate, of semen for the purposes of artificial insemination indicates the conditions under which sperm donation is authorised; Section 1 lays down that donor must be clinically healthy and a non-smoker; S-2 provides that the donor must not be a carrier of disease pathogens (including negative results in testing for HIV antibodies); S-3 provides that an analysis should reveal no HIV antibodies or antigens; and S-4 lays down that the sperm must be frozen for at least six months and, before being used, the donor must undergo a test for HIV infection.30
Likewise some other countries have also made appropriate provisions regarding use and application of DI.

Regarding the health experience of single woman who have children through artificial donor insemination, an exploratory qualitative research study was conducted to investigate the same.

A case study design was used, consisting of two single women who had children through artificial donor insemination. Results suggested that the decision to have donor insemination was made after a lengthy process of considering multiple factors. The subjects' relationships and roles were affected as were future goals and aspirations. Personal perspectives of self enhancement were evident on vulnerability. Health care specialist were identified with emphasis on the decision counselling, direct care, educative and leadership aspects of this nursing role. Directions for future research were proposes".31

After going through the above we may conclude that the complications arising out of the use and application of DI in most of the countries in the world relate to the danger of sexually transmitted diseases especially AIDS and genetic disorders which are likely to affect the woman inseminated and the resultant TTB; Unregulated and uncontrolled clinics dealing with production of TTBs and creating problems; risk of getting twins or more TTBs from DI; exploitation and manipulation by not keeping proper records of DI couples and DI child; danger of getting DI child by the unmarried woman; danger of false claims against the doctors; the status of the DI child etc. etc.

Considering the multifarious problems arising out of the use and application
of DI, Sweden and Brazil have altogether forbidden DI.\textsuperscript{32}

Court in Celle (Germany) held that husband need not be forced into paternity of DI child :-

However the latest legal problem which arose in Germany is of a significant development in the legal field in respect of the pregnancy achieved through donor insemination. In this case the legal issue which came up for decision before a court in Celle, lower Saxony was, "can a husband withdraw his consent to the artificial insemination of his wife when the marriage is on the rocks after insemination?"

In this case after marriage the couple found they are unable to have children, therefore the couple decided to go for artificial insemination by donor (AID). The wife underwent AID for several years and eventually she became pregnant in September 1988 by donor insemination. By this time the marriage was on rocks. The husband who was then of 35 years old asked his wife to sign away her right of maintenance for the twins she was expecting. She did so while still in hospital. The twins were born in June 1989 and the couple was divorced in 1990. The twins were legitimate as the law stood. The husband contested the legitimacy and the court ruled that they were illegitimate since the husband was not bound to automatically accept the paternity. The German Tribune of June 10, 1992 states that the ruling is so fundamental that the court itself agreed to refer the case to the Federal Supreme Court in appeal. In the ruling given by the Court in Celle, the court had held, "even a husband who has consented to artificial insemination of his wife by a sperm donor need not be forced into paternity he is inwardly no longer prepare to accept".\textsuperscript{33}

In view of the above it is crystal clear that the technique of DI has created lot of legal problems and social complications in the countries world around and
even the TTBs obtained through the artificial insemination of donor sperm are likely to suffer a lot in comparison to the NBBs. One can very well imagine the fate of the woman in Germany with twins, who is left to struggle through out her life for bringing up the twins as well as maintaining herself, apart from the twins having lost the paternity in the above mentioned case.

6.3 Surrogacy : Complications and legal checks in the world around :-

To overcome the female infertility where the woman were incapable to bear the child, a system of surrogacy developed in most of the countries. This surrogacy arrangements led to many legal complications. Mostly the surrogate mother tangles come up because of the psychological and emotional attachments. Many surrogate mothers did not wish to return the child to the recipient parents. There has been a legal fight over the custody of TTB as discussed in detail in chapter-3 of part-II of this thesis, out of which the recent Baby M Case in the United States has raised numerous legal concerns causing many legislative bodies to consider possible status to regulate or prohibit surrogacy. The surrogacy arrangements has been misused by many of the agencies dealing in surrogacy arrangements for the purpose of making profit in many countries and particularly in U.K.; where upon the British Government was compelled to enact the Surrogacy Arrangements Act 1985 making the running of business of surrogacy for profit a criminal offence as we have discussed in chapter-1 of part -I of this thesis.

The Surrogacy Arrangements Act 1985 in U.K. was the result of immediate necessity arising out of the emerging situation due to the fact that many agencies from the USA had started operating in U.K. making the surrogacy a profitable business and there was a growing public concern about the import and export of
surrogate mothers whereby the surrogacy agencies had been earning huge profit. The innocent women were being exploited and the situation was demanding immediate curb on the activities of the profit oriented agencies dealing in the business of arranging surrogate mothers for the infertile couples. Under those circumstances the said Act was hurriedly enacted putting an end to the so called profit oriented activities of the agencies so operating in U.K. by making the act of arranging surrogate mothers for the purpose of making profit as a criminal offence punishable under the said Act. Section 3 of the said Act makes it an offence to publish or distribute advertisement in respect of surrogacy services and various penal provisions are laid down in Section-4 thereof.

Sub-section (4) of Section-1 of the said Act provides for consideration of the circumstances as a whole in order to determine whether an arrangement is made before the surrogate mother began to carry the child, and with a view to any child carried in pursuance of it being handed over to, and the parental rights being exercised (so far practicable) by, another person or other persons and in particular where there is a problem or understanding that any payment will or may be made to the woman or for her benefit in respect of the carrying of any child in pursuance of the arrangement, to that promise or understanding.

Sub-section - 9 of Section-1 of the said Act provides that this Act applies to arrangements whether or not they are lawful and whether or not they are enforceable by or against any of the persons making them.

Sub-section 1 of Section-2 lists the activities in relation to surrogacy that are prohibited by the Act if undertaken on a commercial basis. Under sub-section 2, surrogate mothers and commissioning parents are not guilty of an offence. Sub-
sections 5 and 6 make it an offence for a body of persons to receive payment for negotiating or facilitating the making of surrogate arrangements. Sub-sections 7-9 make it an offence for a person to take part in the management or control of a body which acts as a commercial surrogacy agency, unless he does not know and has no reason to suspect that it so acts.¹⁵

Likewise in the USA, as discussed in para-3. 10 of chapter-3 above, in September 1986, a Committee chaired by H.W. Jones published a monograph detailing the ethical consideration of the new production technologies and the report of this committee has been published in September 1986 issue of "Fertility and Sterility" from the American Fertility Society. This committee in its report stated that the committee opposes the use of surrogate gestational mothers for non-medical reasons. The committee recognises, however, that there could be a role for surrogate gestation in reproductive medicine. If surrogate gestational motherhood is used, it should be pursued as a clinical experiment. Therefore the general application of this procedure is considered to be premature. (Chapter 24 of the report).³⁶

Therefore we find an enactment in USA (New Hampshire) relative to surrogacy being an Act (Chapter-87, Laws 1990) which became effective with effect from first January 1990 regulating the procedures relating to surrogacy. Chapter containing RSA 168-B : 16, 168-B : 17, 168-B : 18 and 168-B : 19 are the relevant provisions which are quoted hereinbelow:

168-B : 16 Regulatory Procedures.

1. A surrogate arrangement is lawful only if it conforms to the requirements of this subdivision, and if, before the procedure to impregnate the surrogate:
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(a) The health care provider performing the procedure receives written certification that the parties successfully completed the medical and nonmedical evaluations and counseling pursuant to RSA 168-B:18 and 19;

(b) The surrogate arrangement has been judicially preauthorized pursuant to RSA 168-B:23; and

(c) All parties to the surrogacy contract provide the health care provider performing the procedure with written indication of their informed consent to the arrangement.

II. The procedure to impregnate a surrogate shall be performed only in accordance with rules adopted by the division of public health services.

III. No woman shall be a surrogate, unless the woman has been medically evaluated and the results, documented in accordance with rules adopted by the division of public health services, demonstrate the medical acceptability of the woman to be a surrogate.

IV. No person or entity shall promote or in any other way solicit or induce for a fee, commission or other valuable consideration, or with the intent or expectation or receiving the same, any party or parties to enter into a surrogacy arrangement.

168-B : 17 Eligibility.

I. All parties to a surrogacy contract shall be 21 years of age or older.

II. The intended mother shall be medically determined to be physiologically unable to bear a child without risk to her health or to the child's health.
III. The intended mother or the intended father shall provide a gamete to be used to impregnate the surrogate.

IV. The intended mother or surrogate shall provide the ovum.

V. No woman may be a surrogate, unless she has documented history of at least one pregnancy and viable delivery. The surrogate shall be in good health without recurrent conditions that may effect pregnancy.

168-B : 18 Nonmedical Evaluations.

I. A nonmedical evaluation shall be performed on each party by a psychiatrist, psychologist, pastoral counselor or social worker, who is licensed, certified, or authorized to practice under the laws and rules of the state of New Hampshire, who shall maintain a record of the findings and conclusions and make a copy available to the person evaluated. Each party shall waive any privilege against disclosure of confidential communications and disclose a copy of the findings to the other parties prior to entering the contract. A copy of the findings shall be filed with the court by each party, unless good cause is shown.

II. The person conducting the nonmedical evaluation shall determine the party's suitability to parent by considering:

a) The ability and disposition of the person being evaluated to give a child love, affection and guidance.

b) The ability of the person to adjust to and assume the inherent risks of the contract.
III. A home study of each party involved shall be conducted by a licensed child placing agency or the division for children and youth services to assess the ability and disposition of the person to provide the child with food, clothing, shelter, medical care and other basic necessities. A copy of the findings shall be filed with the court by each party.

168-B : 19 Medical Evaluation. General requirements for a medical evaluation shall include the following:

I. Gamete donors, recipients of insemination, participants in *in vitro* fertilisation and preembryo transfer shall be medically evaluated in accordance with RSA 168-B : 10 and 168-B : 12-14.

II. The surrogate and the intended parents shall receive genetic counseling, if the surrogate is 35 years of age or older.37

In Japan, it is reported from Tokyo that a growing number of infertile Japanese couples are seeking the service of surrogate mothers abroad but the practice is raising eye brows of many Doctor's and women's groups here who say it exploits women and violates human rights. In a society where traditions place great emphasis on preserving family bloodlines, women are under great pressure to produce children even though they may have problems of conceiving, says Turiko Ashino of the Family Planning Federation of Japan.38

In view of the above it is crystal clear that the arrangement of surrogacy has posed several legal complications compelling many countries either to ban the surrogacy altogether or put suitable restrictions in order to avoid misuse of the arrangements.
6.4 In India: Apprehended legal implications and social complications on account of DI and surrogacy:

From the above discussion we have seen that in other countries, lot of complications have developed because of DI and surrogacy out of which one is common in all the countries that is danger of genetic and sexually transmitted diseases, particularly AIDS. In India also all those problems are likely to come up and the chances of AIDS are more in India because there is hardly any properly maintained sperm bank and mostly DI cases are done from the fresh semen obtained mostly from the medical students as we have seen in the previous chapter. However in addition to the problems faced by other countries, the affairs of DI and surrogacy in India would cause several typical social complications and legal implications. Some of those have already been taken up in chapter-3 above, but requires little refreshing touch for the purpose of present discussion. Accordingly we may proceed further.

In Indian society the husband-wife ties are sacred. The blood relation and line of heritage for further generation is considered of high values. The family ties are strengthened with kith and kins of blood relations. The Indian society in fact is seeped in tradition and strong family values. Inheritance and succession of property to the next generation is based on the line of nearest blood relations. Religions and faiths have deep roots in Indian society. 70 to 80 percent of the people of Indian society live in villages and substantial percentage of Indian population forms a tribal belt mostly inhabitants of hilly areas and some of them still live in thick forest having their traditional way of living with bows and arrows to defend themselves. Illiteracy among them is the general rule and education is an exception. What to speak of tribal peoples, even the people in villages are not educated to the
required standard and even in
the city and town areas where
most of the educated
people live, even the concept of TTB; is not fully understood and DI or surrogacy
is too far from their perception. People still believe that the TTB is produced in
a test tube instead of taking birth from mother's womb. To them DI and surrogacy
is yet unheard of, what to speak of having awareness of the legal implications and
social complications of DI and surrogacy. To them parents are only those persons
who have married each other and produced the children of their own genes by way
of natural coitus. To them the father is the one out of whose biological origin they
are the outcome and mother is one from whose womb they have taken the birth.
Under such circumstances DI where the biological origin is underground and not
known to the child, on having learnt about the fact that he or she is the product
of DI technique, the psychological and emotional impact is likely to put them in
gear to run in search of their biological origin. This may not be true in all cases
but the possibility of such apprehension cannot be ruled out in majority of the cases
particularly where the TTB is a male baby because in Indian society females are
generally considered to be more moderate than males and having lot of patience
to face the odds in order to maintain their own dignity and the dignity of the family.
Also the female in Indian society is considered as a member of weaker section of
the society than the males, so to avoid the fear, humiliation and insult that is likely
to result because of ingress upon their own privacy and also the privacy of their
recipient parents, the female TTBs may not run in search of biological origin but
the male TTBs belonging to the dominating factor of the Indian society are likely
to do that. This would definitely create chaos and havoc in the society in India.
The fact that the people in India worship mother like God, the TTBs who are the
products of DI through surrogate mother, after knowing this fact are likely to
abandon the recipient mother and incline to go to surrogate mother who has given
birth to them. This is one aspect of the matter as to why DI and surrogacy must be banned in India.

Next aspect of the matter is that the Indian social pattern has strong traditional ties where the matrimonial relations are founded after great deal of investigations and deliberations in to the status and family background of the forefathers, taking care of their own gotras, pindas and sapindas particularly in Hindu society. While establishing the matrimonial ties, in some of the cases it is found that when the people searching match for marriage come to know that the person in question is an adopted son or daughter of the family; irrespective of the high status of the adopting family; the counterpart backs out and the matrimonial relations does not proceed to become a reality. In case of TTBs who are the outcome of DI or surrogacy where the biological father or mother is not known, can we expect the matrimonial relations to become a success? It is strongly apprehended that this will stand like a stumbling block for the purpose of marriage. This would result, as discussed earlier in chapter-3 of part-II of this thesis, into division of TTBs of DI or surrogacy products and the TTBs produced by the married couple out of their own biological origin and the NBBs who are the product of natural process. Thus there is strong apprehension that the DI and surrogacy would divide the Indian society into 2 to 3 groups for the purpose of establishing matrimonial relations. This would create a society altogether different and unheard of, totally shaking and shattering the very basic social structure of Indian society where the traditions, blood relations and family values are high which would wither away like a steam in the sky.

As we have seen in earlier discussion that in most of the countries, particularly in USA and U.K. the unmarried or single woman are begetting TTBs with DI without entering into matrimonial ties and though presently they are reporting that
they are not facing any problem and some of the nations also are in favour of them stating that the children so produced by them are adjusting as normally as other children, yet the possibilities of the complications in those countries cannot be overruled because at present the children are ignorant and innocent but when they will grow up and will be capable of distinguishing their arrival in this world departing from the normal process, the things are likely to become otherwise. At present also those innocent TTBs while observing other children calling their male parent "a Papa, a Papa"; they must also be desiring to call some one a Papa. But as we have seen herein above that there are cases where the single woman has had TTBs, not only the relationships and role of the TTBs but also their future goals and aspirations were affected. Any way their society may still be able to accept these children but in Indian society the result is likely to be other way around. Following the attitude and fashion of single woman in their countries to beget TTB; there is a possibility that in India also some women may go for TTBs through DI without entering into matrimonial relations. If that happens in India, it is apprehended that such children will be the worst sufferer. As discussed earlier in Indian society even the adopted children face lot of taunts and ridicule from their counterpart. What would be the conditions of the TTB who is born without any known father, can very well be imagined and what would be the condition when they grow up and find no match to marry them which is likely to happen in our society. Otherwise also how odd does it look to bring a child in this world without a father. As discussed earlier such child is likely to be looked down upon, teased, humiliated and discarded in Indian Society. Such children are likely to become a nuisance in the society, because under such kind of disrespect and humiliation which is likely to be in their case, they are likely to become depressed and desperate one. They are likely to do what they feel like, if they feel like to become calm and quiet, they will be so; and
if they feel like to become daciots or hardcore criminals perhaps there will be hardly anyone to stop them which is more likely to happen if they are neglected or abandoned for want of nourishment and necessities of life in this modern era where the people have become more self oriented and desired to be recognised and respected. Every individual wish to have respectable status in the society in which he live, but whether these TTBs shall have the same status as that of the NNBs in Indian society is very doubtful. The behaviour and conduct of such neglected TTBs, as discussed earlier, would create havoc in the society in India posing serious problems for the government to tackle, if they become beggars, the society has to bear the burden and the government has to rehabilitate them and if they become hardcore criminals then the society will have a tough time and the government will have to tackle the problem in order to provide peace and tranquillity in the society. In both the cases, the government shall be burdened and the expenses so incurred are likely to be collected by the government through various taxes imposed upon the members of the society. Thus other members of the society who have not even contributed to create such kind of situation shall also be burdened. This is how the TTBs obtained through DI or surrogacy are likely to affect the Indian society at grass root level implicating each and every member of the society.

For the last two-three years we have been hearing the news of exporting minor females from India to other countries, particularly in Saudi Arabia. Imagine a situation if an unscrupulous person goes on producing female TTBs with the help of newly developed sex selection technique of IVF through DI and surrogacy by collecting the semen at a cheap rate and arranging the surrogate mothers from the poor section of the society by making normal payments to them and with a view to run a Brothel or with a view to export the females to other countries or for both
the purposes. Can anybody in India in the absence of stern and deterrent prohibitory laws in this regard, stop such person from so doing? Of course, the laws for the time being in force can book the person under the provisions of law but if the ground taken is that the existing laws are only applicable to the individuals who are born by natural way and not by the technique of DI or surrogacy i.e. TTB. It is strongly apprehended that the mischief and lacuna is likely to go in favour of this ground of defence taken by such unscrupulous person. Also as discussed earlier in chapter-3 of part-II of this thesis if any person produces TTBs by this technique for the purpose of using them as cheap labourers in his own industry, the existing provisions of law may not be sufficient to deter him from so doing.

Another serious problem will arise where a female spouse coolly and stealthily goes to some IVF clinic and in collusion of some unscrupulous physician gets conceived through DI from the sperm of her choice or of a lover, will it not amount to cheating her husband and what will happen, if, somehow the husband comes to know about it? It is apprehended that there will be serious set back in their matrimonial relations in Indian society. Similarly if a husband arranges DI to hide his own infertility without letting his wife know about the same, would definitely be a cheating of his own wife and similarly if somehow the wife comes to know about the same the matrimonial relations are likely to end in smoke. Such kind of possibilities are very much there, as we have seen earlier in chapter-3 of part-II of this thesis, that even some of doctors dealing with the production of TTBs in India have admitted the fact that on many occasions either the husband or the wife or the father-in-law or the mother-in-law approached the doctor for keeping such secrecy in order to get TTB. The lust for begetting TTB is one thing and the welfare of the TTB is another thing. The production of TTB with DI and surrogacy cannot
fulfil both.

Moreover the tendency of the infertile couple in India to somehow beget a TTB is on the hike and as we have seen in earlier discussion that they are going to any length for begetting TTBs without understanding the complications and difficulties which they are likely to face in future. They are so desperate to have a baby that they bring any one along with them to become donor for them.

Further, for begetting TTB through the DI and surrogacy the maintenance of sperm bank is an essential requirement to preserve sperm, eggs or embryos, this would create additional problems of manipulations, mischiefs, thefts, dacoities, smugglings and exploitation as discussed in chapter-3 above. We have seen in chapter-4 above that there are only 3 to 4 sperm banks in India at present and we have also seen what is going on there. The way these sperm banks are operated there is hardly any government control and supervision thereon. The owners of the sperm banks are having a free hand to do whatever they like and the infertile couple seeking for DI are totally depending on the doctor through whom the treatment is sought. Maintenance of records and secrecy also involves lot of complications.

Apart from the above the conservative attitude of the Indian people is also likely to be fatal if the DI and surrogacy are allowed in India. The people those who are begetting TTB in India even do not desire to get any publicity in fact they want to hide this fact from others. Obviously because the society in India has not sanctioned the approval of TTBs specially through DI and surrogacy.

Let us now look at the surprising news headline "India's first test tube baby ready to reveal birth truths";\(^{39}\) which was flashed in the morning of 19th February,
1997 as a News items of Feb 18 from New Delhi (PTI) stating "India's first test tube baby girl whose identity had been kept secret for 18 years has at last decided to tell the world the secrets of her birth for the cause of science" provided, the Press did not invade the privacy of her own or that of her parents.

Durga (not her real name) was 'created' in the laboratory in 1978 by Subash Mukherjee and his team in Calcutta and is the world's second test tube baby after the birth of Louise Brown in a London hospital the previous year.

Mukherjee committed suicide in 1981 because his colleagues thought, he was a fraud and Durga's conservative parents refused their daughter to be identified in public.

But the parents apparently had a change of mind after listening to a moving tribute to Mukherjee by T. C. Anandkumar, a pioneer of *in vitro* fertilization (IVF) at the Third National Congress on Assisted Reproductive Technology and Advanced in Infertility Management held recently at Calcutta.

'Delivering the Subash Mukherjee Memorial Oration Anandkumar, who is president of the Hope Fertility Clinic in Bangalore, told the gathering that he would like to formally state that Mukherjee must be given the credit for having produced India's first test tube baby using ingenious methods'. All other achievements, he said, 'dwarf in comparison to what Dr Mukherjee achieved with so little support'.

Anandkumar told PTI that after hearing the lecture, Durga's parents met him to explain why they did not want Durga's identity to be revealed at that time when IVF was a novel procedure, and how they felt different now.
According to Anandkumar, Durga who is 'a delightful young lady of 18, well educated and articulate', did not have objection to revealing facts of her birth 'if it helped advancement of knowledge'. But she did not want the press to intrude on her or her parent's privacy.

The scientist from Calcutta who created history but died a dejected man, has at least been credited for what Anandkumar said, was an original contribution to reproductive research.

Describing Mukherjee as a biomedical scientist 'far ahead of his times', Anandkumar said, "His tragedy lies in that he did not publish most of his work in standard peer-reviewed journals". Consequently, much of his work never saw the light of the day, and he succumbed to social pressures taking "the only way out he could think of".

Mukherjee hanged himself because the medical community did not believe his achievement, and he could not produce Durga as a proof in difference to the wishes of her parents.

Mukherjee and his co-workers Sunit Mukherjee and S. K. Bhattacharya had claimed that they implanted into the uterus of Durga's mother an embryo which was kept frozen for 53 days resulting in the birth of a normal baby girl. The Calcutta team was the first in the world to have used frozen embryo to produce a test tube baby".40

Let us now analyse the intensity and implications of the conservative attitude of the people of our society in general and that of Durga's parents, who are also the members of our society, in particular. Its intensity particularly in context of
Durga's parents, is so high that it has not uprooted its roots even after the long gap of 18 (eighteen) years as we see that the news is revealed by the baby on the condition that "provided the press did not invade the privacy of her own or that of her parents" and that too it is revealed only "for the cause of the science" and that "if it helped advancement of knowledge" not otherwise as she did not want the press to intrude on her or her parent's privacy.

Its implications are not far to seek; firstly it deprived the young talented doctor and up coming scientist of the credit, name and fame he infact deserved by producing the first TTB of India by dint of his best efforts and struggle to achieve the feat he achieved, as the credit of producing India's first TTB is claimed and infact has gone to Dr Indira Hinduja of Bombay; secondly, it deprived our nation of her pride to have become the second country of the world to produce the second TTB of the world as Dr Indira produced Indira alias Harsha Chawla only on 6 August 1986 by which time many other countries like Austria, America and France have already produced many TTBs; thirdly, it ultimately resulted into death of a rising medical scientist by suicide committed under the impact and influence of depression circumvent by the selfish conservative attitude of Durga's parents which in fact is responsible for the suicide in question, which tantamounts to abetment of suicide punishable under the IPC if not a culpable homicide not amounting to murder; fourthly, it caused tremendous mental agony and personal irreparable loss to the family of the deceased doctor-cum-scientist as the aggrieved family not only got deprived of the name and fame but also lost the bread earner of the family; fifthly, it destroyed the national asset of which India could be proud of; sixthly, it caused tremendous mental agony to the colleagues of the deceased doctor-cum-scientist apart from rendering them helplessly deprived of their further research
work to advance the cause of medical science; seventhly, last but not the least, it created long vacuum in the further development of medical science in India in particular and in the world in general.

What an apathy? Had Durga's parents come out of the clutches of conservative attitude and done what Durga has now done, we would have certainly not lost the golden asset Dr Subash Mukherjee since deceased. Anyway it cannot be undone which has rightly or wrongly been already done.

In view of the above discussion it is crystal clear that the atmosphere in the Indian society is not yet congenial for DI and surrogacy, hence should not be allowed in India in order to save and preserve her existing social structure as well as to maintain peace and harmony in the society.

Breeding Legal Issues :-

There are several legal issues breeding out of DI and surrogacy which have not yet been solved but urgently required to be solved and settled. While considering DI in India an author name M. Habibulla, says, "Many questions loom large with regard to DI and remain unanswered. Sold sperm is processed, frozen and resold. The important question is, should sperm be sold as a commodity? Can it be exchanged? Can it legally be held as property? Is not donor insemination a form of adultery? Does it not violate the dignity and respect due to human procreation? Would it not destroy the sacred bonds of marriage? Should DI be made available to any woman irrespective of her marital status, criminal record mental state and genetic inadequacies? These and other ethical legal questions could DI : Should India rush headlong into the moral morass?". There are many more questions
which can be added in this list, i.e., Has every one a right to procreate a TTB in any manner? Has the unmarried women right to beget TTB without entering into matrimonial ties and deprive the TTB of fatherhood? Has the unmarried man right to procure the TTB through surrogate mother without entering into lawful wedlock? Does any one has a right to deprive TTB of his or her status at par with NBB? Should selfish end of begetting TTB be allowed to be fulfilled at the cost of or by infringing of the right of the TTB to enjoy his or her life at par with NBB? Should the concept of prohibited degree of relationship for marriage be done away with for begetting TTB?

6.5 Solution :-

The only solution of the problems arising out of DI and surrogacy in India is to completely stop the operation thereof. This can be achieved by two ways; firstly by making endeavour to bring general awareness in the minds of the people in India about the social complications and legal implications of begetting TTB by DI and surrogacy. At present in majority, the people in India are not fully aware about the concept of TTB even, therefore, complications and implications of DI and surrogacy is absolutely beyond their reach to perceive and to understand the future repercussions thereof. It is strongly believe that if the people are aware of all these problems, they would definitely not go for DI and surrogacy in India. The awareness can be achieved by pressing the services of various media, arranging debates and discussions, conferences and public meetings and discussing the problems with the people. We do not have any lack of communication in the present era. We have various effective media like Radios, TVs apart from newspapers, magazine etc. This can be achieved by giving full nation-wide coverage in the various TV programmes and also ensuring some programmes in the regional services of various TV channels operating in India.
at present; secondly it can also be achieved by making suitable enactment totally banning the operation of DI and surrogacy in India and providing for stern punishment for any violations thereof. Even the very act of going for DI and surrogacy must be made a serious criminal offence in India. Procedure for punishing such culprits should be made simple like a summary trial so that immediate action could be taken against the wrong doer. Likewise the institutions facilitating for DI and surrogacy should be closed down and the physicians helping to beget TTB by DI and surrogacy should also be made liable for punishment apart from cancelling their licences even for the normal practice as a doctor. Donation of sperm should be absolutely banned and the frozen sperm should not be allowed to be preserved for the purpose of DI but may be allowed if the same are intended to be used by the lawfully married couple to beget TTB in future or in case of a widow who could not beget a child during the life time of her husband due to some unavoidable circumstances but before the death of her husband his sperm could be preserved for the purpose of getting a child by his widow. Under no circumstances the single unmarried woman or man should be allowed to beget TTB. The stern punishment should also include the forfeiture of the properties of any person involved in the activities of begetting TTB through DI and surrogacy. By all these measures the impending danger can be averted and the Indian society can be saved from the destruction apprehended on account of DI and surrogacy operation.
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