SURROGACY

Information Brief

Sama – Resource Group for Women and Health

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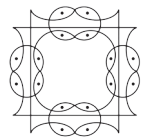

Sama Resource Group for Women and Health

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This Information Brief presents and discusses various facets and issues related to surrogacy in the country - the arrangement, players involved, health risks, citizenship issues of children born from surrogacy, etc. These and other key social and legal aspects related to surrogacy are included here.

The Brief will facilitate access to information and an understanding of issues related to surrogacy in India for a wide range of individuals and organizations – groups, networks working on public health, women's health and rights, human rights, law, etc.; as well as women who are in surrogacy arrangements or are exploring such a possibility.

This Brief is structured in a way that draws on Sama's engagement through research reflecting the documented ground reality vis-à-vis the practice of surrogacy, interspersed with relevant sections from the Assisted Reproductive Technology (Regulation) Bill and Rules - 2013 and Ministry of Home Affairs (MHA) Guidelines providing a useful and critical overview about surrogacy in the country.

What is surrogacy?

The word "surrogate" is derived from the Latin word "subrogare", which means "appointed to act in the place of". In simple terms, a surrogate woman is one who agrees to carry a pregnancy to term for a couple or individual, in case it is not possible for them/her to do so themselves/ herself. Surrogacy is generally placed under the umbrella term of Assisted Reproductive Technologies (ARTs), a group of technologies that assist in conception or carrying a pregnancy to term. Surrogacy, however, is an arrangement that involves the use of these technologies. According to the Assisted Reproductive Technology (Regulation) Bill and Rules - 2013,

> *"Surrogacy", means 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 and hand over the child to the person or persons for whom she is acting as a surrogate;*
>
> *"Surrogate mother", means a woman who is a citizen of India and is resident in India, 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 viability and deliver the child to the couple or individual that had asked for surrogacy;*
>
> *"Surrogacy agreement", means an agreement between the persons availing of assisted reproductive technology and the surrogate mother.*

What are the types of surrogacy arrangements?

The arrangement of surrogacy can be differentiated on two basis:

1. **Genetic and Gestational surrogacy:** Surrogacy can be defined on the basis of whether the surrogate's ovum (egg) has been used in developing the embryo and thus whether her genetic material will be transferred to the child.

    a. **Genetic Surrogacy or Traditional Surrogacy:** Is an arrangement when the surrogate provides the egg and carries the pregnancy. This is done through the process of Artificial Insemination (AI) or Intra Uterine Insemination (IUI). These procedures entail transferring semen/ sperm (whether commissioning parent's or donor's) into the surrogate's reproductive system and the process of fertilization happens within her body. Since the genetic material (egg) of the surrogate is being transferred, this kind of surrogacy is termed as Genetic Surrogacy.

    b. **Gestational Surrogacy:** When the surrogate conceives through Embryo Transfer (ET), following the procedure of in vitro fertilization (IVF). The fertilization of the ovum happens outside the body and the fertilized embryo is transferred to the uterus of the surrogate. The embryo might be a result of the fertilized gametes (egg and sperm) of the commissioning parents, or gametes (either sperm or egg or in some case both) obtained from the donors. Since the surrogate carries the pregnancy but does not provide the genetic material (i.e. her ova/egg), such an arrangement is known as Gestational Surrogacy.

What counts more?

The fact whether surrogate has contributed her ovum (egg) or not can be very significant as very often it is argued that it is the genetic link that is most important in establishing parentage and greater link to the child. However, how can we decide which bodily contribution is more important? Should genes matter more than bodily fluids and nutrition provided during pregnancy? This question did not arise before the IVF technology split the process of reproduction. But can there be a definite answer to this? Who decides?

The nature of the surrogacy arrangement has changed over time with advancements in the realm of reproductive technologies. With the more recent IVF-ET technology, and thus the possibility of gestational surrogacy, many permutations and combinations are now possible which involve the participation of multiple individuals in the arrangement.

> *The current Draft Bill Prohibits of genetic surrogacy. It makes genetic surrogacy illegal, i.e., a surrogacy arrangement that involve the woman bearing a child using her egg (oocyte) and the commissioning man's sperm/donor is illegal.*

The definition underlines the fact that the surrogate mother is not the biological parent thus emphasizing that only those that contribute the genetic material can be considered to be biological parents. The fact

that a human body nurtures the pregnancy has nothing to do with biology. Also less invasive and expensive procedure like Intra Uterine Insemination (IUI) cannot be used for surrogacy arrangements. Thus both genetic and gestational surrogacy should be allowed.

2. **Altruistic and Commercial Surrogacy:** Another way of identifying different types of surrogacy is on the basis of the motive behind entering into the surrogacy arrangement and the nature of the payment made to the surrogate.

    a. Commercial Surrogacy: It is a form of surrogacy in which the surrogate enters the arrangement primarily for financial reasons. In such instances, the surrogate is paid to carry a pregnancy to term.

    b. Altruistic Surrogacy: The surrogate receives no financial reward for her pregnancy and the relinquishment of the child. However, in such instances usually all expenses related to the pregnancy and birth are borne by the intended parents; these might include medical expenses, maternity clothing, and other related expenses. In altruistic surrogacy, it is mostly a member of the same family, or someone known to the couple who acts as the surrogate.

With no financial incentives, these arrangements often carry moralistic connotations, and the surrogate's contribution seen as a 'noble' deed for the 'greater good' or giving the 'greatest gift' of a child to an infertile couple.

The debate and pros and cons of commercial surrogacy and altruistic surrogacy needs to be discussed and understood further, before a law is made commercializing. Much caution needs to be taken before making this legal, as we know that in poverty ridden conditions, surrogate mothers will be available with no regard to their own safety and with no regard to any rules or standards that need to be followed. The government cannot pass a law that would put at risk their own people or that would take advantage of the vulnerability of the people due to their situations and circumstances.

Who can be a surrogate mother?

Sama's work revealed that a woman can choose to be a surrogate mother for various reasons. They may range from financial reasons to more personal reasons. Sama's research[1] revealed that most Indian surrogates entered the arrangement to fulfill a financial need.

[1] Birthing A Market: A study on Commercial Surrogacy', Sama (2012)

Surrogates described conditions of unemployment or nature of work available to them as insufficiently low-paying, casual work and struggle to run a household. Some women came from families that faced immediate needs and along with their husbands they bore the responsibility of paying off debts, children's education or buying a house.

The Altruistic trope

Even in cases of commercial surrogacy one often sees the use of altruistic language appealing to women to become surrogates. The 'noble' deed counters prevalent stigma surrogates might face for accepting money for child bearing.

Eligibility criteria: In our research findings, specific identity markers such as caste, class and physiological characteristics (complexion, facial features, height) were often sought by commissioning couples and ART clinics in choosing a surrogate mother. Some couples may express a preference for a surrogate belonging to a particular caste or religious community. This process of socio-medical screening, though not uniformly practiced, mirrors the existing social hierarchies and stereotypical notions.

Marital status: The marital status of the surrogate mother is more or less a uniform stipulation for participation as a surrogate. (There have been cases of divorced, widowed, separated or single women participating in the arrangement, but they are few in number). Spousal consent is often considered a necessary requirement for her to enter the arrangement. The contract requires the signatures of both the surrogate and the husband. In many cases they are also asked to refrain from engaging in sexual intercourse for the duration of the pregnancy. The involvement of the husband or the surrogate's family is considered necessary to avoid any conflict regarding the pregnancy (that is not conceived with the husband) given the existing stigma or misconceptions surrounding surrogacy.

Number of living children: In our research most surrogates had between 1 and 2 children before they entered the arrangement, but there is no impediment to the choice of a surrogate in case she has more than 2 children. Their fertility was necessarily measured through the number of living children a woman had, but her eligibility was bolstered if she had undergone the sterilization process after the birth of her children.

Medical history: The health history that is examined in the case of gestational surrogate mothers includes her obstetric health history such as the number of deliveries, number of abortions, etc. It also includes menstrual history, history of use of contraceptives, other medical history, family history, whether the she has been a surrogate before, history of blood transfusion, history of substance abuse, blood group and tests for blood status, blood-sugar tests, blood-urea, urine examinations, hepatitis C status, HIV status, hemoglobin status, etc.

The Draft Bill (Clause 46(14), states that "No ART procedure shall be performed on a woman below the age of twenty one". There seem to be an inherent contradiction about the age-cap as under Clause 60 (5) the Bill states that "No woman less than 21 yrs. and over 35 yrs. shall be eligible to act as a surrogate; provided that no woman shall act as a surrogate for more than three successful life births in her life, including her own children…"

There seems to be inherent assumption that a surrogate will have two children of her own and therefore more or less there is still possibility of three successful live births through IVF.

Who are the commissioning couple or intended parents?

The surrogacy arrangement is available as one of the options to couples and individuals seeking to have a child. While it is usually well off infertile couples who opt for this, given the high cost of the arrangement, there are couples from middle income level also seek for a surrogate in order to have a child.

The commissioning couples / individual or intended parents / parent who seek to have children through surrogacy are:

Heterosexual couples who are unable to conceive a child through sexual relations, or when the woman is unable to carry the pregnancy, may seek the services of the surrogate. Depending on whether the couple is able to produce viable gametes, an egg or sperm donor may also be involved.

Besides heterosexual couples, there may be single men and women (who are unable to carry a pregnancy) who may seek to have a child with the help of donor sperms or eggs, as may be applicable.

Surrogacy is also an option for same-sex couples who want to have a child. Gay couples require both an egg donor and a surrogate to realize a pregnancy. One partner may give the sperm, which may then be used to fertilize the donated egg.

The Draft ART bill defines "Couple" as a relationship between a male person and female person who live together in a shared household through a relationship in the nature of marriage.

This definition of couple effectively bars couples who are separated cannot access ARTs and is a severely restricted one or all people who are not in a heterosexual marital relationship. Therefore, as per the definition, gay couple(s) cannot access ARTs in India, once the Bill is implemented. This clause

in the draft bill is discriminatory, baseless, and a violation of rights to equality, freedom, and reproduction.

Who are the other key players in a surrogacy arrangement?

Surrogacy has now become a major component of the larger fertility industry, which also includes technologies for assisted conception such as embryo transfer. Surrogacy arrangements in India is no longer restricted to metro cities, but has percolated to smaller towns as well with a more prominent features of aggressive marketing through advertisements, websites, brochures, involving various actors. Apart from ART clinics, a range of other organizations have sprung up to provide diverse kinds of support services to further the growth of this industry. The networks that have emerged, with both formal and informal players, have links from the local to the national and international levels. These include private healthcare consultants, law firms, travel agencies, government tourism departments, agents for surrogacy arrangements, surrogacy homes, and Non-Governmental Organizations. It also includes the commissioning couple and the surrogates too.

a. **The IVF Clinic / Centre:** IVF clinic has a major role to play as those who administer the reproductive technologies used to achieve and monitor the pregnancy Clinics that provide surrogacy services may not necessarily be only IVF clinics. They may operate as IVF clinics/ Fertility centres: providing IVF, ICSI, IUI and other forms of infertility services, IVF wings in multispecialty hospitals.

There are very few ARTs clinics or hospitals that arrange only surrogacy services. Most often ARTs clinics combine their other services of providing IVF, IUI and ICSI with surrogacy as an additional option. Many clinics may organize the entire arrangement for the commissioning couple from hiring the surrogate, to administering the technology, to supervising the contract, to overseeing the pregnancy, to finally delivering the baby. But other clinics that may only participate in supervising the medical part of the arrangement, that is, the IVF, the embryo transfer, and monitoring the progress of the pregnancy. Variations exist in the way the arrangement is organized by and with different ARTs clinics and centres.

b. **ART Banks:** ART Banks are new features of the industry.

In the ICMR ARTs Bill, 2013, the closest reference to such a stakeholder is made in the formulation of an ART Bank: '"ART bank", means an organisation that is set up to supply sperm /semen, oocytes / oocyte

donors and surrogate mothers to assisted reproductive technology clinics or their patients'.

The Bill gives many powers to the ART Bank (including storage of information regarding donors, surrogates and couples) restricting the administration of the IVF to the clinic.

c. **Other third-party networks** within the surrogacy arrangement include a wide variety of actors excluding the primary participants, i.e. commissioning couples, surrogate mothers and IVF specialists. Also known as surrogacy agents, third party networks may include corporations and local recruiters who manage and create liaisons between the main participants in the commercial surrogacy arrangement.

Who oversees the intermediaries or agents?

Agents or intermediaries have become important component of the fertility industry. However, the intermediaries or brokers are also many a times potential source of exploitation for the donors and surrogates.

The current draft has added a clause in this context. It states: The use of individual brokers or paid intermediaries to obtain gamete donors or surrogates shall be an offence under this Act, punishable with imprisonment for a term which may extend to three years or fine which may extend to rupees five lakh or with both. [Clause 68]

Such a step will prohibit ART clinics and banks from engaging with intermediaries or brokers to obtain surrogates. However, at the same time, couples and individuals should be made aware of such a provision, and also discouraged from entering the arrangement through any intermediary. Role and responsibility of ART bank in sourcing of gamete donors and surrogates need to be streamlined and better regulated.

Is there any data base or registry of ART Clinics & ART Banks?

Currently there is a registry of ART clinics maintained by the ICMR, where the clinics can voluntarily register. The Draft Bill mentions a centralized database to be maintained by the 'National Registry of ART Clinics and Banks in India of the ICMR'. However, there is no proposed system to record the number of children born to Indian surrogates being taken out of the country and the number of foreign couples undergoing ART procedures in India. Serious steps therefore need to be taken to incorporate all these into a proper recording system and monitoring and updating. Moreover, a database, if properly maintained will be useful in giving a sex-desegregated data (in terms of male and female) with respect to children born through IVF and surrogacy that is not available till now.

Can Foreigners / NRIs access Surrogacy?

According to the Ministry of Home Affairs, Government of India, 2013 Guidelines, only a heterosexual, married couple (married for a minimum of two years) can access surrogacy in India. These guidelines also prohibit access to same-sex couples and single/unmarried individuals.

> *The foreign man and woman are duly married and the marriage should have sustained at least for two years." [1]*
>
> Addressing a context of vastly inconsistent laws in different states regarding access to these technologies and their legality that could result in a citizenship crisis for the child, this response is quite inadequate and downright discriminatory. By effectively putting a bar on same-sex couples and all single persons, the state has constructed a category of people who can become parents, in resonance with the larger patriarchal bias of the state.
>
> Additionally, the requirement of a two years long marital relationship, possibly presuming this time period to ascertain a stable relationship that will not result in a possibility of an unwanted child in case of separation or divorce, is completely arbitrary.
>
> *The Ministry of Home Affairs Guidelines state that Foreign nationals intending to visit India for the purpose of Commissioning Surrogacy shall be issued Medical Visa.*
>
> *The couple commissioning surrogacy should be in possession of a letter from the Embassy of the foreign country in India or the Foreign Ministry of the country stating clearly that:*
>
> - *The country recognizes surrogacy.*
> - *The child/children to be born to the commissioning couple through the Indian Surrogate will be permitted entry into their country as a biological child/children of the commissioning surrogacy.*
>
> *The couple commissioning surrogacy is required to furnish an undertaking that they would take care of the child/children born through surrogacy.*
>
> *The couple should produce a duly notarized agreement between the applicant couple and the prospective Indian surrogate mother.*
>
> *The surrogacy should be done only at one of the registered ART clinics recognized by ICMR.*

What about the citizenship of the child?

The foreign couple before leaving India for their return journey would require 'exit ' permission and should be carrying a certificate from the ART clinic concerned regarding the fact that the child/children have been duly taken custody of by the foreigner and he liabilities toward the Indian surrogate mother fully discharges as per the agreement. A copy of the birth certificate(s) of the surrogate child/children will be retained by the FRRO/FRO along with photocopies of the passport and visa of the foreign parents.

> *According to the ART Bill 2013, "A foreigner or foreign couple not resident in India, or a non-resident Indian individual or couple, seeking surrogacy in India shall-insure the child or children born through the surrogacy, at the time of signing the agreement, till the age of twenty-one years or till the time of custody of the child or children is taken, whichever is earlier, for wellbeing and maintenance of the child or children". [Clause, 17(a)(ii)]*
>
> There needs to be clarity regarding the details of the insurance and how this will be operationalized. In other words it is important to have clarity on what will be included in the insurance, and through whom the insurance will be channelized? Will it be the ART Bank, the local guardian or the adoption agency (in case the child(ren) is/are given for adoption? Further, in terms of monetary aspects will there be a standardized amount that will be decided as part of the insurance coverage? These aspects will be essential in maintaining greater transparency, accountability and well being of the child(ren). Therefore, the proposed Bill needs to specify such details for a better implementation. Also, if the custody of the child is not taken even after age of twenty-one what happens to the insurance, and the continued well being of the child(ren).
>
> *The same Clause further states that - use at least one gamete of their own in creation of the embryos. [Clause, 17(a)(iii)]*
>
> It seems that such a provision has been incorporated to maintain some kind of genetic connection/ linkage especially in case of trans-national surrogacy. Also, there seems to be a consideration that such a clause will increase the possibility of the commissioning couple or individual accepting the custody of the child. However, the exact reason or rationale for such a clause needs to be explained in the Bill. Does this mean that in cases where both donor sperm and donor oocyte need to be used because of medically indicated conditions, the couple cannot enter a surrogacy arrangement? Further, what will be the provision if the gamete of the gamete of the individual entering surrogacy arrangement is not viable to be used?

What kind of legal documents are required?

The present Draft clearly lays down the requirement of legal documents from the foreign couples regarding their respective countries permitting surrogacy and that the child born

out of such an arrangement will be the legal citizen of the country. This will be a much needed step towards addressing the issues of citizenship and other legal complexities. [Clause 60(17(b)]

The Surrogacy Contract

The surrogacy contract is the only form of legal document within the arrangement. It is primarily signed between the surrogate and the commissioning parents—but may also include the ART clinic conducting the arrangement. The contract maybe drawn up by the agent or a lawyer arranged through the ART clinic or by the commissioning couple themselves. The primary thrust of the contract is towards the relinquishment of the child on the part of the surrogate to the intended parents. There are varying templates and modalities of the surrogacy contract, which are followed by different clinics and agencies, but in essence the transference of the child on birth to the commissioning couple is the most important aspect.

In research findings the signatories to the contract were the surrogate and her husband, and the commissioning couple. In some cases where the husband is not present the surrogate and a relative may be co-signatories. However, the absence of a husband was not seen as a positive sign and research findings suggest that the ART clinic and the agent would insist on the presence and signature of the husband in order to take the arrangement forward. Research findings also suggested that there was no fixed juncture at which the contract was signed, and the surrogate had no role in deciding that either. The surrogate may not sign the contract until much later into the pregnancy, or after she has been tested positive for a pregnancy.

During the signing of the contract no legal counsel was made available to the surrogate and she was verbally explained the main terms of the contract. This was primarily because the contract is often written in English—a language most of the surrogates are not well-versed in. The contract was neither translated into Hindi or any vernacular language, nor read out fully, leaving the surrogates with no knowledge of what they had actually agreed to undertake or perform or deliver. The verbal explanation given by the agent, doctor or commissioning couple included a significant emphasis on the duty of the surrogate regarding the care of the pregnancy and the relinquishment of the child, and in some cases remuneration and the schedule of payment.

The contract in its current form was heavily biased towards the commissioning couples. Signing a contract is important for the process of acquiring citizenship for the child, of

the nationality of the commissioning parents in case they come from outside the country for the surrogacy arrangement. The contract turns into a tool to minimise any conflict or contestation against the commissioning parents' rights to the child, leaving out a whole range of crucial issues that need to be negotiated and settled as the terms of the arrangement. It becomes a security for the commissioning parents while the surrogates have none, with no control or say in the matter.

> The Draft Bill 2013 also falls short to mention the details of administration of the contract between the surrogate and the couple. Therefore questions like- 'who makes that contract and monitor that it is not breached?', 'How would the money transaction actually take place?' In case the surrogate is directly hired by the couple, 'how would the ART bank come into the picture and what would be the significance of the surrogate's contract with the ART bank?', remains unanswered. Since the Draft Bill allows known persons, friends and relatives to act as surrogate, it should also take into consideration such possible scenarios and clearly list down a mechanism for proper administration and monitoring of the contract drawn between the surrogate and the commissioning parent(s).

What are the health risks for women going / have gone through surrogacy?

The surrogacy arrangement entails many forms and kinds of risks. Most of the risks unfortunately are in relation to the surrogate. Medical risks on the surrogate's physical and emotional health are the most immediate cause of concern. Risks in case of the surrogate pregnancy are reportedly similar to those found in other IVF pregnancies—and are reported on a case-to-case basis than as an established finding. Yet, a recent study found that 2 out of 9 surrogates had a postpartum hysterectomy: 'the first for placenta accreta following delivery of triplets; the second following uterine rupture during the delivery of a macrosomic infant' (Bhatia et al. 2009: 52; Reilly 2007: 485). In our research we found that the practice to ensure a successful pregnancy; multiple embryo transfers; multiple pregnancies; foetal reductions and caesarean sections which had major implications on the health of the surrogates.

Most medical studies point towards the concern for the surrogate's psychological and emotional health, especially postpartum and during relinquishing the child. One of the studies suggests that without counseling, surrogacy should be treated as a 'high-risk psychological experience' (Reilly 2007: 485)—which is why counseling is mandatory in many parts of the world before a couple or surrogate can enter an arrangement. But no medical study has outlined any kind of adverse psychological effect on the surrogate during the pregnancy or after giving birth.

The process of gestational surrogacy involves repeated cycles of IVF, continued hormonal interventions into the surrogate' body leading to a routine of injections, medications and repeated embryo transfers. In order to ensure that there is no genetic connection between the surrogate and the foetus, IVF-ET or gestational surrogacy is preferred over traditional surrogacy in India. In case of traditional surrogacy the surrogate can be directly inseminated with the father's or donor's sperm through the IUI or intrauterine insemination and thereby significantly reduce the risks incurred through hormonal injections and constant medication required to prepare the uterus to receive the fertilized embryo.

The need to minimize the potential conflicts regarding claims over the child seems to trump over the concern for the health of the surrogates. Opting for gestational surrogacy as part of commercial surrogacy arrangements is not only the established and preferred practice but also features in the proposed law regarding the technologies.

ET impacts the surrogate's emotional and sexual health as well. Many of the surrogates interviewed mentioned that they felt depressed and/ or irritated during the process of repeated IVF and ET cycles. They may also be contractually asked to abstain from having sexual relationships with their partners during the ET and pregnancy.

> Though the present Draft does mention that ART procedure carry health risks both to the mother and child, there is no listing of the risks and adverse outcomes of these technologies for children. Also risks of multiple births and low birth weight that are most common with surrogacy and IVF does not feature in the Bill.

Is there any emphasis on counseling and mental health of surrogates?

Significance of counseling for people who opt for ARTs cannot be emphasized enough, provided the counseling is intended to help them make decisions which are truly 'best' for them.

Also if counseling is done by the ART clinic's own counselors, one may never be sure on whose interest the counseling is actually being done- the couple or the clinic. It is not difficult to fathom that the clinic may be inclined to further their own commercial interest and may not be able to provide an unbiased and unprejudiced counseling service.

> *The assisted reproductive technology clinics shall provide professional counseling to patients or individuals about all the implications and chances of success of assisted reproductive technology procedures in the clinic in India and internationally and shall also inform patients*

and individuals of the advantages, disadvantages and cost of the procedures, their medical side effects, risks including the risk of multiple pregnancy, the possibility of adoption, and any such other matter as may help the couple or individual arrive at a informed decision that would most likely to be the best for the couple or individual. [Clause 46 (6)]

The Draft seems to take a very narrow approach to counseling and nowhere looks at it as an ongoing and continuous process. This calls for provisions to arrange for counselors independent of the ART clinic and the Draft Bill must provide the guidance for accessing such independent counseling agencies. Independent, short and long-term counseling should be included in the Draft Bill for the infertile couples, surrogate and also for the commissioning parent(s). In surrogacy cases, the surrogate must be provided with adequate psycho-social counseling, and the implications of her decision on her and her family should be properly explained to her.

During the counseling for individuals who are providing gametes or embryos for donation, or wish to store their gametes or embryos, they should be given complete explanations about the medical, scientific, legal and psychosocial implications of their decision. The couples/individuals should be counseled regarding the other available options for infertility; possible variations, outcomes and limitations of the procedure (data provided in all relevant patient resources should be the clinic's own most recent live birth rate per treatment cycle and the national live birth rate per treatment cycle); the advantages and disadvantages of continued treatment center after failed attempts and the importance of informing the treatment center about any resulting birth.

Can the surrogate be forced to go for sex selection and Preimplantation Genetic Diagnosis (PGD) and sex selection?

The use of PGD for non-medical purposes is very controversial. Many moral and ethical issues are associated with PGD, such as the choice to be able to select the embryos of a particular sex, potential of parents to exercise excessive control over their children's characteristics, costs and availability dependent on the financial status of the parents, safety, accuracy, regulation and monitoring. The use of PGD should be strictly monitored and it should be made clear that PGD will be available only where there is a significant risk of serious genetic condition being present in the embryo.

No assisted reproductive technology clinic shall offer to provide a couple with a child of a pre-determined sex. [Clause 51 (1)]

It is prohibited for anyone to do any act, at any stage, to determine the sex of the child to be born through the process of assisted reproductive technology.

No assisted reproductive technology clinic shall carry out any assisted reproductive technology procedure to separate, or yield fractions enriched in sperm of X or Y variations.

The collection of blood samples from pregnant woman and subjecting the blood sample for sex selection in any form both within the country and outside the country shall be prohibited. [Clause 51(2)(4) (5)]

Though prohibition of sex-selection has been stated in its provisions, the Draft Bill should deal with the issue of sex selection very stringently.

What kind of payment schedule is followed in surrogacy arrangements?

The remuneration given for surrogacy such as the amount and the payment schedule is one of the main reasons why surrogate opt for surrogacy. In our study the bulk payment was made after the successful birth of the child. Over the course of the pregnancy the surrogate received monthly installments for her diet and medication. At the beginning of the surrogacy arrangement, the surrogate may receive a small amount for each embryo transfer she undergoes, irrespective of whether that leads to a pregnancy or not. Payment schedules however vary significantly from case to case and the clinic.

What kind of payment does the surrogacy agent ask for arranging a surrogate pregnancy? Does the agent take a share of the surrogate's remuneration?

Not all surrogacy arrangements are managed or mediated through agents. Those that are arranged by agents involve the commissioning couple paying the agent for the expenses of organizing, hiring and caring for the surrogate, even including surrogate's payment. This means that agents often disburse the monthly installments and the entire payment to the surrogate and have control over the remuneration given to the surrogate. Many of the surrogates interviewed in our study noted that they believed that the agent paid them only after he had taken his share or commission from their reimbursement. Surrogates did not how much agents were paid, but they surmised that the amount was significant considering the kind of reduced compensation that they were given.

Agents' commission was payment for overseeing the entire arrangement. Agents justified their commission by noting that they took better care of the surrogates and helped couples through an otherwise complicated arrangement. Surrogate who entered the arrangement without the intervention of an agent did not receive higher payment than

those who did, primarily because of their lack of experience and knowledge about how much remuneration a surrogacy arrangement entails.

Is there any Insurance provided for the surrogate?

> *The present Bill also states that "the commissioning parent(s) shall ensure that the surrogate mother and the child she delivers are appropriately insured until the time the child(ren) is handed over to the commissioning parent(s) ……till the surrogate is free of all health complications arising out of surrogacy." [Clause 60(22)]*

However, the Bill does not elaborate on the nature and kind of insurance and the different aspects that should be included under insurance. The Bill also does not clearly mention about post-delivery and follow-up care of the surrogate mother. The Bill should thus, explicitly and clearly state regarding the Health Insurance and Legal aid for the surrogate. The surrogate must be reimbursed all her expenses made owing to the pregnancy including those spent on travel to the doctors, medical check-ups etc. Since most of the surrogates belong to the vulnerable group, it is therefore important that she should be assured access to free legal aid in case any conflicts arise during the surrogacy arrangement.

Compensation

In case of death of the surrogate mother, either during pregnancy, or during delivery or soon thereafter due to complications relating to the pregnancy, adequate compensation should be given covering not only the medical costs of treatment (not only at a government hospital but also at a private hospital), and compensation due to loss of life of a young woman, to be given to her family or legal heirs or the person she may nominate in the contract of surrogacy.

If the surrogate mother develops some temporary or permanent ailment or health condition due to the pregnancy, her costs of treatment should be covered till the ailment exists medically, and compensation ought to be paid, for loss of job or labour or work that the women could have done prior to the pregnancy or thereafter, by the parents of the child and by the insurance companies (if they have such a coverage).

Birth Certificate of the child-in whose name?

The present Draft Bill has a provision of including the names of commissioning/genetic parents in the Birth Certificate of the child(ren).

The Draft Bill should, however, also consider granting a parental status to the surrogate mother. When a woman gives birth to a child, the birth must be officially documented and that women must be the natural parent of the child born to her. This can be followed by a transfer of parenthood, to the intended parents, either through adoption or another system devised for the purpose.

The Medical Termination of Pregnancy (MTP, 1971) Act guarantees women in India the right to abortion, while international human rights legislation guarantees physical integrity. The Draft Bill must therefore ensure that the intended parents understand and agree to the fact that the surrogate has a right to physical integrity and bodily autonomy, i.e. she cannot be forced to abort the foetus, go through foetal reduction or made to follow a certain diet. These decisions are for the surrogate, and no one else, to make.

Is there any law or guideline currently regulating surrogacy in the country?

Over the years there have been several attempts by various government agencies to regulate the industry. However, many of these proposals lead to further ambiguity regarding how they may be read together, inconsistent and contradictory recommendations, or are significantly inadequate to address several concerns and aspects of the arrangement and use of the technologies.

The Indian Council of Medical Research (ICMR) and the Ministry of Health and Family Welfare (MOHFW) first developed Guidelines (2005) which are non-enforceable and virtually not adopted in practice, and recently drafted The Assisted Reproductive Technology (Regulation) Bill and Rules-2010. Prior to this, the Bill was made available for public perusal in the year 2008 (with the same name). Even though this has been an important step, the document has not addressed the issues in a comprehensive manner from a women's rights perspective. Some clauses have been added and some changed from the previous draft.

The recent 2013 Draft Bill acknowledges the importance and significance of ethical practices in the context of ART services, in the present form, the Bill is inadequate in protecting and safeguarding the rights and health of women going for IVF techniques, recruited as surrogates and children born through commercial surrogacy. It also lacks setting the standards for medical practice and completely ignores the regulation of the third party agents who play pivotal role in arranging surrogates such as surrogacy agents, tourism operators and surrogacy homes operators, etc.

In 2013, the Ministry of Home Affairs (MHA) issued guidelines detailing the new requirements for the visa process for foreign nationals coming to India to enter into

these arrangements, while not addressing the practice or regulation in its entirety. This categorizes the visa as ‘medical’ and makes it permissible only for heterosexual married couples to opt for surrogacy. It also gives ART clinics a pivotal role in settling terms between the commissioning couple and the surrogate.

Further Readings/ Key Resources from Sama

1. **Birthing a Market: A Study on Commercial Surrogacy (2012a)**
   is a comprehensive report based on research in Delhi and Punjab on surrogacy and the experiences of surrogate mothers.

2. **Regulation of Surrogacy in Indian Context (2012)**
   consists of our critique and recommendations regarding surrogacy in the Indian Council Of Medical Research and Ministry of Health and Family Welfare, Government of India's draft guidelines on assisted reproductive technologies.

3. **The Assisted Reproductive Technology (Regulation) Bill & Rules (Draft)-2010 Policy Brief**
   Includes our recommendations on the proposed law.

4. **Constructing Conception: A Mapping of Assisted Reproductive Technologies in India (2010)**
   is our study in three states of India on the use of proliferation of assisted reproductive technologies.

5. **Unravelling the Fertility Industry: Challenges and Strategies for Movement Building (2010)**
   is based on our international consultation on commercial, economic and ethical aspects of assisted reproductive technologies.

6. **ARTs and Women: Assistance in Reproduction or Subjugation? (2006)**
   is our study of 12 districts in state of Madhya Pradesh on the health impact of injectable contraceptives, like Depo-Provera.

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