

India's Assisted Reproduction Bill and the Maternal Surrogacy Industry

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Abstract

The latest version of India's assisted reproduction bill addresses many of the shortfalls of the previous draft. In this paper, we examine the latest draft's failure to address the most preponderant ethical issues affecting the burgeoning reproductive tourism industry.

Keywords: Assisted reproduction, surrogacy, ethics, law, epidemiology

1. Introduction

In 2010, the Ministry of Health & Family Welfare of the government of India put forward a bill meant to legally codify the use of assisted reproductive technologies (ARTs) [1]. In doing so, India joined a small group of countries, including Canada and the UK (but excluding such key service providers as the USA), which have federal ART laws. Given the dramatic expansion of India's reproductive tourism industry, which is worth hundreds of millions of dollars [2, 3], and the legal, ethical, commercial and technological challenges that such expansion has created, the bill was needed to help regulate that country's heavily market-driven fertility sector.

With respect to the industry's most famous and ethically sensitive aspect, that of the provision of maternal surrogacy services, the bill states [4] that:

1. Surrogacy shall not be available to "patients for whom it would normally be possible to carry a baby to term."
2. Surrogacy contracts shall be legally enforceable.
3. Married women need their husband's consent in order to become a surrogate.
4. Surrogates shall not undergo embryo transfer more than three times for the same couple.

5. Egg donor identities shall remain strictly confidential.
6. There shall be a detailed accreditation process for fertility clinics and gamete donor banks.
7. The Department of Health Research shall establish and manage a "national ART registry."
8. The only "couples" eligible for ART shall be those "having a sexual relationship that is legal in India."
9. Foreigners seeking surrogacy services must provide written proof that their home country "permits surrogacy, and the child born through surrogacy in India, will be permitted entry in the country."

With this brief paper, we will explore some of the implications and challenges of the bill, as it pertains to both the evolution of India's reproductive technologies industry, and in particular her maternal surrogacy services.

2. Same Sex Couples

In 2008, the Sama Resource Group for Women issued a letter of concern to the Minister, voicing concerns over an initial draft of the bill [5]. They pointed out that there is confusion regarding who is specifically responsible for compensating a surrogate, where and when medical screening of the surrogates should take place; and indicated the complete dearth of concern over health of the offspring. The ultimate draft of the bill addressed some of these concerns, but not to the full satisfaction of commentators.

With respect to the maternal surrogacy industry, two prominent features of the bill present themselves. First is the seeming disqualification of same-sex clientele from seeking commercial ART services, most notably lesbian couples. As per the first point above, by limiting surrogacy only to those physically incapable of maintaining a pregnancy, so-called "socially infertile" women are disqualified. While this does not necessarily exclude gay men, who, it can be argued, are physically incapable of childbirth, point #8 above is clearly targeted at that demographic. While steps are underway to decriminalize homosexual unions, there remains opposition to this development at the highest levels of government [6].

This interpretation is contradicted by Dr Samrit Sekhar, who insists that the phraseology of the bill is meant not to deny the reproductive access to homosexual individuals, but rather to protect the rights of ART-produced offspring in a system that might not acknowledge the legality of same-sex adoptive parents [7]. If this were truly the intent of the bill, however, one hopes that its phraseology would not be so misleading.

3. Rights of the Surrogate

In an earlier paper [8], we identified several ethical pitfalls associated with the Indian maternal surrogacy model. The two most glaring were: (a) the insufficiency of the medical informed consent model to take into consideration the social risks posed by maternal surrogacy; and (b) the lack of independent advocacy, for the purposes of contract negotiation and medical decision-making, on the part of the surrogate.

In its current form, the bill fails to address either of these concerns, thus allowing for the sustained, profound vulnerability of the surrogate and her family. Specifically, we argued that it is ethically incumbent upon the clinic to express the social and emotional risks posed to surrogate, such as the risk of her community's disapproval and the possibility of domestic tension with her husband. Indeed, the bill fails to mention any of the physical risks, such as those involved in egg retrieval, common in the ART process [9]. The commercial nature of the exchange represents a subtle motivator for the under-expression of such risks, such that they reduce the chances of an otherwise eligible surrogate from participating.

Independent advocacy is required to remove the conflict of interest inherent in the clinic's role as representative to both the paying client (putative parent of the produced offspring) and the surrogate. It is, after all, the commissioning parents (clients) and the clinician (provider) who decide which procedures the surrogate will undergo [10]. We argued [8] that formal provision must be made for guaranteed separate legal representation for the surrogate, such that her rights are not superseded by those of the paying client.

Failure to address these concerns gives the new draft of the bill a sense of favouring the needs of the client over the surrogate. Sama recapitulates this sentiment by observing that payment to the surrogate is now required in five installments instead of three, with the bulk of payment (75%) to be made after delivery of the child, allowing for greater financial risk on the part of the surrogate. This is in dire contrast to the 2008 version of the bill, which held that 75% of payment was to be made before the birth of the child [11].

The shifting of recompense from pre- to post-birth is also indicative of the industry's undervaluing of the role of the surrogate. While these women are the bedrock upon which the maternal surrogacy side of the ART industry is built, they are nevertheless only deemed valuable if they successfully produce children [11]. This is also reflected in the omission of codification of her counseling needs (in the event of medical misadventure or of such common occurrences as post-partum depression) or of her family's compensation in the event of her death [10].

Further indicative of the bill's devaluing of the role of the surrogate, *vis-à-vis* the client, is the failure to codify the usage of technologies and procedures more protective of her health and welfare [9, 10]. One commentator is critical of the bill's tendency to treat the surrogate essentially as a type of technology, legally indistinguishable from devices and procedures, and argues that what is needed is a separate bill focused solely on surrogate rights [9]. Reflective of this sentiment is the bill's authors' choice to limit the number of live births permitted over the course of the surrogate's life, rather than the number of ART cycles [11]. While both measures portend to protect the surrogate's health, only the latter properly distinguishes between her overall physical health and her health solely as it pertains to her ability to produce a child.

In our earlier paper [8], we identified the potential for "selective reduction", or abortion, as being an important ethically divisive medical possibility that does not enter into the informed consent process. Qadeer [10] links this observation with the aforementioned tendency to treat the surrogate as a technology, by pointing out that the contract between the clinic and the client allows for the request of an abortion in the event of a genetic abnormality, though this option is absent from the clinic's contract with the surrogate! With this omission, the surrogate's service moves from the provision of reproductive capacity to the complete temporary rental of her entire being and body, abandoning her most fundamental reproductive right.

4. Rights of the Child

The 2010 version of the bill differs from its 2008 incarnation in its focus on the rights of the child [12]. The industrial nature of the sector views children as a business product, the client as a customer, and the surrogate as a manufacturer. A ubiquitous criticism is that common respect for human dignity is missing in this equation.

In the wake of a handful of high profile cases [13] that almost led to child abandonment, there was clearly a need to institute measures for ensuring a good home for ART children. In response, the bill's current draft properly provides for clarity on the citizenship and disposition of the child.

However, Qadeer [10] argues that the child has an innate human right to bond with the surrogate, the first physical mother it has ever known. Denial of that right would, in such a view, constitute a sort of emotional abuse that is sustained by the requirement that all further contact between surrogate and child is denied, making impossible the creation of social ties. Qadeer's is a marginal viewpoint that nonetheless speaks to society's ongoing struggle with its evolving conceptualizations and definitions of motherhood. And while such a struggle correctly lies outside of the purview of law to define, it is unavoidable that any national ART law would be cited to help inform the discussion. Thus, it should be considered when drafting such a landmark bill.

5. Women's Rights

Any discussion of ART, especially as it concerns maternal surrogacy, is necessarily a meditation on the role and empowerment of women. India's reproductive tourism industry is built upon three important pillars: her extensive clinical infrastructure, her state-supported

medical tourism infrastructure, and her reliance upon the cooperation of economically and socially disadvantaged women. This is sadly a reality of economics, wherein the leveraging of poverty allows for the sustenance of low cost services attractive to an international clientele. Legislation seeking to manage this industry must not lose sight of this basic reality, and must strive to invest in the support and enrichment of women's social uplift wherever possible.

The threat of the commercialization of ART to the status of women is palpable to feminist theorists. "Acknowledging surrogacy as legitimate labour and permitting a market in surrogacy could push women back into their role as reproducers, thus endangering the hard-won gains that women have made to be more than mere reproducers" [9]. It is difficult to encode such a concern within an encompassing Act ostensibly meant to regulate a set of medical technologies. One approach, not taken by the current bill, would be to guarantee basic levels of autonomy and remuneration for the surrogate. One method of autonomy has already been discussed, that of requiring the presence of an independent advocate for the surrogate to represent her interests to both the client and clinician.

The idea of fair remuneration is a softer recommendation, dependent upon the definition of "fair." However, the concept of "fair trade international surrogacy" was introduced by Humbyrd [14] as a path for establishing less exploitative pricing standards for poor women at the disadvantaged end of the power spectrum. This points to the need for an eventual global consensus on the value and limits of such services.

6. The State's Responsibilities

On its face, the bill exists to protect the rights and welfare of all players in the ART industry. However, its focus appears to be the avoidance of legal disputes over parentage for the purposes of easing international adoption procedures and therefore lubricating the industry as a whole [9]. Such a perceived bias is disappointing, in that it exemplifies the state's abrogation of its primary role as defender of the rights of the people, in favour of its secondary role as manager of the nation's wealth. By some accounts, this is a systemic phenomenon, as "the priorities of the state in relation to health care have shifted from protecting the public good to promoting the interests of industry, thus creating the conditions for health care to be 'a site of corporate profit'" [15, 16].

This observation underlines the importance of the evolution of ART in India, or indeed in any democracy. How a nation conceptualizes its relationship with commerce and reproduction ultimately reflects that nation's understanding of its own values, and reflects the state's understanding of its role and responsibilities with respect to its people. The failure of the bill to properly reflect the needs and rights of the industry's most vulnerable actors is a generic failure of government to capitalize on an opportunity to better define itself in an historical moment of dramatic economic and cultural change.

One hopes that the next iteration of India's federal ART bill embraces these definitional concepts of fairness, autonomy, safety and investment in human uplift.

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