The legal and moral debate leading to the ban of commercial surrogacy in India

El debate legal y moral que conduce a la prohibición de la subrogación comercial en India

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Abstract

Assisted Reproductive Technologies (ART) offer the possibility of unrelated surrogacy arrangements to infertile couples and childless human relationships. In the late 80s, qualified specialists in India took advantage of the availability of willing surrogates and the absence of regulations, to create a market in commercial surrogacy for clients from within the country and abroad. The Ministry of Health stepped in with guidelines only after strong protests from women's groups and citizens, following media stories of surrogate hostels, abandoned children and exploitation. Meanwhile, 'infertility' clinics mushroomed, offering donor gametes, in-vitro fertilization and surrogacy services at a fraction of the cost in western countries. By early 2000s, India had emerged as the most popular destination for commercial surrogacy arrangements. In response to protests from doctors, citizens and human rights groups, and mindful of

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the ban on commercial surrogacy arrangements in most developed countries, the Government issued ART guidelines that were progressively restrictive; but these did not *have the teeth to rein in* the lucrative business that commercial surrogacy had transformed into. Finally, in 2016, the Government proposed a Bill that would bring an end to commercial surrogacy. The Surrogacy (Regulation) Bill 2016 addressed surrogacy arrangements exclusively, taking it out of proposed ART Bill that was aimed at comprehensively regulating all other aspects of assisted reproduction and the clinics involved. The legislation was directed mainly at the social issues and exploitative elements specific to commercial surrogacy arrangements, rather than the technical process. If passed, the Surrogacy Bill will effectively ban commercial surrogacy in India.

Key words: surrogate maternity, India, commerce.

1. Introduction

It is widely acknowledged that India possesses world-class medical facilities available at significantly lower cost than many Western countries. The presence of highly qualified, English-speaking medical professionals and lower costs make India an attractive destination for medical tourism, enthusiastically supported by its government. With developmentts in the field of reproductive technology, reproductive tourism soon followed at the turn of the century. The last few years witnessed a tremendous growth in clinics and personnel working in the field of Assisted Reproductive Technology (ART) including In Vitro Fertilization (IVF), sperm and ovum donations and surrogate motherhood, placing India far ahead globally in the infertility industry, specifically in "commercial surrogacy". The terms surrogacy and commercial surrogacy were discussed in the Euro-American contexts since early 1980s. In the Eastern World, India was the first country to have a booming industry in both national and transnational surrogacy [1]. The recent

Surrogacy (Regulation) Bill, 2016 in India emerged from a host of concerns that arose from the perspectives of human rights, health policy, feminist ethnography, and bioethics [2]. The Bill seeks to bring an end to the commercial medical enterprise of surrogate baby production that flourished on the back of weak regulations and a vulnerable population in India. The Surrogacy Bill 2016 was the culmination of sustained civil protests from non-government organizations, religious groups, women's rights groups and the law commission.

2. Different types of surrogacy [3]

The term "surrogacy" comes from the Latin *surrogatus*, meaning someone who acts in the place of another, a substitute. The New Encyclopedia Britannica defines surrogacy as «a practice in which a woman (surrogate mother) bears a child for a couple unable to produce children in the usual way, usually because the wife is infertile or otherwise unable to undergo pregnancy» [4]. According to Warnock Report of the Committee of Inquiry into Human Fertilization and Embryology (1984), «surrogacy is the practice whereby one woman carries a child for another with the intension that the child should be handed over after birth» [5]. Among other "artificial reproductive techniques", surrogacy in particular invites social and ethical dilemmas due to the number of persons involved in human procreation, and concepts like "genetic mother", "biological mother", "legal mother" and "commissioning parents". We shall review these terms and the different types of surrogacy, as the legal system of India understands it.

2.1 Traditional surrogacy and gestational surrogacy

Traditional/natural surrogacy is called partial or genetically contracted motherhood, because the surrogate mother is also the

biological and genetic mother. She is impregnated with the sperm of the intended father, who contracts with the woman to bear the child. In gestational surrogacy, the embryo is formed "In Vitro" and implanted in the womb of the surrogate mother. The surrogate undergoes the pregnancy, and is the "biological mother" but is not genetically related to the child. The genetic mother in this case would be the ovum donor or the intended/commissioning mother herself. In most countries, the woman who gives birth to the child, the biological mother, is considered to be the child's "legal mother".

2.2 Commercial surrogacy and altruistic surrogacy

Surrogacy is commercial or altruistic depending on whether the surrogate mother receives financial reward for the pregnancy and relinquishment of the baby. If the contract includes financial payment, it is commercial surrogacy. If there is no financial incentive beyond reimbursement of medical and other reasonable expenses, it is termed altruistic surrogacy, and the surrogate agrees to bear the child out of a sense of compassion for the infertile couple.

3. The beginning: ART and surrogacy in India

The fact that the world's second IVF baby Kanupriya was born in Kolkata on 03 October 1978, just two months after Louise Brown, the world's first IVF baby in Britain, reveals the advanced state of medical technologies and innovations in India [6]. Unfortunately, the achievement of Dr. Subhash Mukhopadhyay and his team with Baby Kanupriya was not recognized for lack of proper documentation. The Government-appointed committee submitted a negative report, and Dr. Subhash committed suicide soon after. The second claim of the first "scientifically documented" test tube baby in India was made by Dr. Indira Hinduja and Dr. Kusum Zaveri in collaboration

with Institute for Research in Reproduction (IRR) with the birth of Harsha Chawda, on 06 August 1986 at King Edwards Memorial Hospital (KEM) in Mumbai. The Indian Council of Medical Research (ICMR) report confirmed that «in-vitro fertilization and embryo transfer technique, perfected and performed as a collaborative project between KEM Hospital and IRR, resulted in the birth of Harsha».[1]

A study of the growth of ART in India reveals that commercial surrogacy began around 1997, when a woman reportedly agreed to act as a "gestational carrier" and utilized the sum she received to pay the medical treatment for her paralyzed husband. In another case in 2003, a Gujarat clinic helped an older woman to carry a surrogate pregnancy for her own daughter. The woman gave birth to twins, who were also her own grandchildren [8-9]. From then on, commercial surrogacy developed as a lucrative possibility using ART [7]. The number of surrogacy contracts rose sharply over the next decade and it is now estimated that about 2,000 children are born through commercial surrogacy in India each year [10-11].

3.1 Reproductive tourism in India

Technical expertise, absence of regulations and willing surrogates who were mostly indigent women, drew clients to India for infertility treatments. The country became a *global health destination* second only to Thailand in the number of foreigners arriving for medical assistance [12-14]. Clinics like Akanskha Infertility Clinic in Anand, Gujarat, shot to fame with stories of its success with commercial surrogacy featured nationwide [15]. Later the surrogacy map of India came to include the metros like Mumbai, Delhi, Hyderabad and smaller towns.

Commercial surrogacy got indirect legal sanction in 2002, when the Assisted Reproductive Techniques guidelines addressed surrogacy contracts and conditions. India joined the very few countries that allowed commercial surrogacy, while it was banned in most countries

of the world [16]. The commercial enterprise built on supply of surrogate babies to infertile couples and foreigners brought huge financial profits. A 2008 study valued the assisted reproduction industry in India at $450 million a year [17], while a World Bank study in 2012 estimated surrogacy to be a business worth $400 million a year, across 3,000 fertility clinics across India[2] [18-20].

The cost of a single IVF and implantation cycle in India was initially $18,000 to $30,000, roughly half of the cost in Thailand, and a third of the cost in the US. This caused a boom in the industry that topped at almost $2 billion per year [3] [19; 21], 80% from international clients. The official estimate even in 2016, was around $140 million [22]. Still other reports pegged the business at $1 Medicina y ética 2019 Número 3 - 6 esp.13-abril-19billion (£690 million) per year [15; 23]. A BBC News report estimated the business to be worth $2.3 billion annually, with 5,000 babies born in India each year through this process [24-25]. There is no authoritat-ive government audit of these clinics in India, and confusion exists over whether reproduction tourism alone accounted for $2.3 billion, or medical tourism as a whole [1; 26]. Approximately 12,000 foreigners sought help from these fertility clinics every year [15], mainly from United States, United Kingdom, Australia and Europe.

When the government of India imposed a ban prohibiting gay couples, single parents and non Indian citizens from opting for surrogacy in India (2012-2015), there was an expected fall in clientele. Dr. Anoop Gupta, director and infertility specialist at Delhi IVF & Fertility Centre commented on the "drop in busines", «India has been a brisk market for surrogacy due to cheaper services and easy availability of poor women. India is a country of English-speaking people, fair complexion, outstanding medical expertise and technology. This was the reason why foreigners were attracted to this country. But since the Home Ministry put restrictions on foreigners, it led to a slump in surrogacy». He predicted a 80% decline in surrogate pregnancies in the years following the ban [27].

4. Scandals that shocked the nation and the world

As expected, Commercial Surrogacy in India was mired in controversy from the beginning. The identity of the baby, relationship with genetic parents, rights of the surrogate mother and those of the commissioning parents, had always been the subject of discussion. In many cases commissioning parents were the genetic parents, while in other cases gamete donors were used. Issues arose regarding citizenship of the child, and commissioning parents faced hurdles to transport their babies home.

4.1 The case of Baby Manji

Similar to the *Baby* M case in New Jersey, United States,[4] India too witnessed a complicated legal case in surrogacy.[5] A Japanese couple contracted an Indian surrogate to carry an embryo formed from the father's sperm and anonymous Indian egg donor. Unfortunately, the Japanese couple got divorced a month before Baby Manji was born. The father wanted the child but his ex-wife was uninterested, and this created a dilemma regarding the parentage and the nationality of the child, under the existing Indian and Japanese citizenship laws. Adoption of a girl child by an unmarried man was not allowed by Indian law, and under Japanese law the child could not be Japanese because the birth mother was Indian [28]. Baby Manji's case created a sensation in the media, and was finally resolved as a special case, when the Japanese paternal grandmother agreed to receive the baby in India, and the Japanese authorities agreed to assign citizenship based on genetic testing in Japan [29].

4.2 The Australian twins

In 2012 an Australian couple arbitrarily rejected one of twin surrogate babies. The couple informed the Australian High Commission that they would take only the female child leaving her twin

brother behind, as they already had a boy child and could not afford to care for both children.[6]

The Couple was aware that the child would be stateless and at risk, as there was no safety net in place for surrogate babies who were abandoned. The Australian High Commissioner in New Delhi informed Canberra of these risks, but did not insist on the parents accepting the boy child. After social outcry in the media, the matter subsided when a childless Indian couple stepped up to adopt the rejected boy.

4.3 Jan Balaz vs *Union of India*

In the case of a German parent, once again citizenship of the babies was in question. Though the birth of the twin boys was registered in Gujarat, the passport and visa for the babies were withheld, and a legal battle ensued. Germany would not accept surrogate children as its citizens, and neither would India, since the parents of the children were German. In a further complication, the German couple applied for Indian passports for the babies, as they worked in UK and wanted to take the babies there; this landed the case in the courts. After considering the legal, moral and ethical issues involved, the court prioritized the rights of the innocent babies over the rights of the biological parent, surrogate mother and ovum donor. Since the surrogate mother and the ovum donor were Indian citizens, the court granted Indian passport to the babies.[7]

The Supreme Court later stayed this High Court decision, but permitted the children to leave the country [30].

4.4 The Israeli couple in 2010

In 2010, an Israeli father was denied both passport and visa by the Jerusalem Family Court for his twin sons born through surrogacy in India. The twin surrogate babies had to wait for months until a

paternity test proved that the Israeli citizen was the biological father [31-32].

Similarly, in the case of an Israeli homosexual couple, there were challenges in acquiring an Israeli passport due to incongruous country immigration laws [32].

4.5 The earthquake of Nepal in April 2015

The tragic events in the aftermath of the earthquake in Nepal exposed the risks and injustice linked to commercial surrogacy. It is reported that restrictions by the Indian government led to the transport of surrogate mothers across the border to neighboring Nepal, a country that allowed surrogacy arrangements, in this case for Israeli nationals, as long as the surrogate was not a Nepali citizen [33-34].

When the earthquake struck in April 2015, these surrogate mothers were abandoned in Nepal, while the Israelis airlifted their citizens and babies to safety. Pregnant surrogates were brought back to India or left behind to deliver their babies. News report revealed the inhuman conditions that prevailed in the apartments and temporary shelters of the surrogate mothers [35].

4.6 Other issues reported in the media

There was a case filed in Gujarat in 2012, when a surrogate mother died tragically after giving birth to a premature baby (for an American parent) [19]. It raised the issue of safety of the surrogate mother in an enterprise centred on the baby, with the surrogate mother viewed as merely a rented womb.

In other cases, clinics focussed more on profits and neglected the duty towards the surrogate and the commissioning parents. There were reports of babies being mixed up, when DNA tests revealed that the baby was not genetically related. There were also reports of excessive payouts for unnecessary medical bills and over

charging by clinics [36]. In the case of twins born to a Canadian couple through surrogacy, after the DNA tests failed, the children had to be sent to an orphanage as the clinic could not locate the children's genetic parents [37].

Australian journalist Julia Medew described the story of Sam Everingham, who contracted for surrogacy in 2009. He never imagined he would lose two baby boys in a Delhi hospital, or be responsible for termination of multiple pregnancies in the surrogate. Along with his partner, he carries memories of four painful years navigating India's unregulated surrogacy system. One problem was transfer of large numbers of embryos by Indian doctors to increase the chance of a successful pregnancy. This resulted in four babies when parents only wanted one or two. It also meant difficult decisions had to be made about fetal reduction in surrogate mothers [36].

5. Official regulations on surrogacy in India

Diverse groups in society sought proper regulation of ART in India, out of concern for surrogacy arrangements. A survey conducted in Mumbai and New Delhi by the Centre for Social Research reported inadequate safeguards in terms of legal provisions or health insurance for surrogate mothers involved, most of whom were poor and uneducated. There were no fixed payment structures, nor provisions for post-pregnancy health care [38].

5.1 Indian Council of Medical Research Guidelines, 2005

The National Guidelines for Accreditation, Supervision and Regulation of ART Clinics in India, published in 2005, were the earliest guidelines by the Ministry of Health and Family Welfare Government of India (MoHFW), ICMR and the National Academy of Medical Sciences (NAMS), that contained permissive references to surrogacy arrangements. It deemed the surrogate mother to be the

legal mother (until delivery), but allowed the birth certificate to be made in the name of the genetic parents. Third party donors and the surrogate mother were expected to relinquish all parental rights over the offspring (p. 63).

On reaching adulthood, the child had the right to information about his/her genetic parents and the surrogate mother, except personal identity i.e., name and address. A single woman too could seek to become a parent through ART and surrogacy (p. 62).

According to these guidelines, all the expenses of the surrogate mother during the period of pregnancy and post-natal care relating to pregnancy would be borne by the couple seeking surrogacy (commissioning/intended parents). The surrogate mother would also be entitled to monetary compensation from the couple, the exact value decided by a *discussion between the couple and the proposed surrogate mother* (p. 63).

Article 3.10.2 of the guidelines said that surrogacy by assisted conception should normally be considered only in patients for whom it would be physically or medically impossible/*undesirable* to carry a baby to term. The surrogate mother should not be over 45 years of age and could not act as surrogate more than thrice in her lifetime (p. 69).

5.2 ICMR Statement of specific principles for assisted reproductive technologies, 2006

This document added details to the 2005 guidelines regarding surrogacy arrangements. It allowed the intended parents' preferential right of adoption of the child, subject to six-week postpartum delay for maternal consent. Here it mentioned that surrogacy should be resorted to *only if medically certified as the sole solution to infertility or there is any other medical bar on pregnancy*. The document also confirmed the right to seek abortion under the MTP Act as inviolable right of the surrogate and the genetic/intended parents would have no claim over the fees already paid [39].

5.3 The Assisted Reproductive Technology (Regulation) Act, 2008

Responding to the call for enforcement of the 2005 guidelines, the Government decided to enact a law to protect the rights of stakeholders and punish transgressors in this area. Chapter VII of this legislation dealt with the right and duties of patients, donors and surrogates. It allowed the surrogate mother to receive compensation from the intended parents, after relinquishing all parental rights over the child.

In case of failure of pregnancy, the surrogate mother would not undergo embryo transfer for the same couple more than three times. Intending parents would be legally bound to take custody of the surrogate child irrespective of any physical abnormality, and refusal to do so would constitute an offence under this Act. Foreigners or non-resident Indians seeking surrogacy in India would have to appoint a local guardian who would be legally responsible for the surrogate during and after the pregnancy until the child is delivered to the intended parents [40].

5.4 228th Report of the Law Commission of India, 2009

Despite efforts to legislate surrogacy, there was pressure from Women's rights groups and civil society, following media reports of exploitation and injustice. The 228th Report of the Law Commission of India on the "Need for Legislation to Regulate Assisted Reproductive Technology Clinics as well as Rights and Obligations of Parties to a Surrogacy" was the beginning of a serious re-evaluation of surrogacy contracts.[8] It suggested a pragmatic approach to legalize altruistic surrogacy arrangements and prohibit commercial ones.[9]

5.5 The Assisted Reproductive Technologies (Regulation) Bill, 2010

The ART (Regulation) Bill of 2010 expanded on the legislation of 2008. The recommended age limits of surrogates were 21 and 35,

and the surrogate was limited to five live births, including her own children.

Foreigners seeking surrogacy in India required documentation that their country accepted surrogacy arrangements, and would permit the surrogate child to enter that country as the biological child of the commissioning parents. The Bill also insisted on appropriate insurance for both the child and surrogate mother until the child was handed over to the commissioning parent(s) or any other person as per the agreement, and until the surrogate mother was free of all health complications arising out of surrogacy.

The Bill stated that a surrogate child commissioned by a foreigner to be born in India, would not be an Indian citizen. At 18 years of age, the surrogate child could seek information related to the donor or surrogate mother, except personal identification. Only in life threatening conditions of a minor child, to assist treatment, would it be possible to release identification of the genetic parent or surrogate mother, with prior informed consent [41].[10]

5.6 Letters from the Ministry of External Affairs and the Ministry of Home Affairs in 2012

Responding to the issue of citizenship of surrogate babies, the Ministry of External Affairs had clarified in a letter dated July 2012, that intended parents needed to obtain a *letter from the Embassy of the foreign country in India or the Foreign Ministry of the country* stating that 1) their country recognized surrogacy, and 2) the child/children would be permitted to enter the country as *a biological child/children of the couple commissioning surrogacy*. It added that a couple seeking surrogacy in India should be *heterosexual, married for at least two years, and should obtain a medical visa* for the purpose of seeking surrogacy arrangements in India.

The same year, in response to rumors that single and homosexual couples would continue to avail surrogacy services in India while

on a tourist visa, a letter dated December 2012 from the Ministry of Home Affairs, restricted surrogacy for foreign nationals to heterosexual couples only, who had to be married for at least two years, holding permission for a medical visa to contract surrogacy in India. It clarified that gay couples would not be issued medical visas for surrogacy, as India did not recognize gay marriage [42-43].

5.7 Assisted Reproductive Technology Bill 2013

When it became clear that surrogacy contracts involved legal issues beyond health, like birth certification, parentage, immigration and citizenship, beyond just the Ministry of Health and Family Welfare, a modification was made to the existing Assisted Reproductive Technology (Regulation) Bill in 2013. It now included the Home Ministry's decision that a medical visa was required for foreigners, and commissioning parents could only be heterosexuals couples married for at least two years. It also expressed the need to protect the rights of the surrogate mother [44-45].

5.8 Commissioning of Surrogacy Instructions, 4 November 2015

When all efforts to address the legal and social dilemmas through legislation failed, the Government of India, Ministry of Health and Family Welfare finally published its surrogacy instructions in Nov 2015 stating its intention of ending commercial surrogacy through enactment of the Surrogacy (Regulation) Bill.[11]

The letter prohibited import of human embryos for purposes other than regulated research under the ICMR guidelines. This applied to ART clinics importing embryos for infertility treatments in India. The letter closed the door on medical visas for foreign citizens and Overseas Citizens of India (OCI) seeking surrogacy, as well as exit visa for children born in India through surrogacy. However, it allowed surrogate arrangements already in progress to

continue under controls and permissions by the State Health Authorities.

5.9 The Surrogacy (Regulation) Bill, 2016

The Union Cabinet of India approved the Surrogacy (Regulation) Bill on August 24, 2016.[12] The new bill placed a complete ban on commercial surrogacy in the country, permitting access to surrogacy only to legally wedded Indian couples. Surrogacy arrangements for foreigners, NRIs and PIOs were prohibited, as well as for unmarried or single parents, live-in partners and homosexuals [42]. Minister Sushma Swaraj defended the Bill, stressing the need to regulate the huge numbers of surrogacy clinics that would now offer only altruistic surrogacy according to the bill [46]. Commercial surrogacy was deemed a punishable offence that could attract a penalty of 10 years imprisonment.

Clauses arranged in the Bill of 8 chapters describe the terms of eligibility for couples seeking altruistic surrogacy arrangements and their responsibilities. Chapters 3 and 7 focus on the rights of the child born through surrogacy, they also specify the age, rights and protection of the surrogate and relationship to the intending parents. In chapters 4, 5 and 6, the Bill describes the appropriate authorities with whom fertility clinics need to register at central and state levels, their composition and their powers. In chapters 2, 3 and 7, regarding Clinics, Hospitals and laboratories, the Bill cautions against illegal activities related to commercial surrogacy and the punishment they would attract.

6. Legal and ethical arguments raised against commercial surrogacy

As the number of infertility clinics offering commercial surrogacy grew, news reports began to circulate about exploitation of ovum

donors and surrogates. These women from urban slums were typically economically disadvantaged, in circumstances that forced them to seek monetary help through surrogacy arrangements. International press, TV shows like Oprah Winphry, media interviews and local magazines dissected this new avocation and opinion was divided on the individual right to decide, versus the right not to be exploited. Women's groups raised the call to protect vulnerable Indian women from exploitation by wealthy clients from the West. High-profile Indian film stars like Amir Khan, Shah Rukh Khan and Tusshar Kapoor who opted for surrogacy, aggravated the social debate [47-48].

Later, scandals about abandoned babies, citizenship tangles and neglected women fuelled protests to the Health Ministry and the Government of India against commercial surrogacy. The Law Commission and special committees sought reform in this unregulated sector in response to public interest litigation. Films like *Filhaal, Chori Chori Chupke Chupke, Made in India, Vicky Donor, Doosri Dulhan, I am Afia, Google Baby* and *Mala Aai Vhhaychy* highlighted social angst around surrogacy, while books like "Baby Makers" by Gita Aravamudan and "Politics of the Womb" by Pinki Irani unveiled underlying moral dilemmas and social injustice. It was this backlash from society that moved the Government to tighten regulations and finally ban Commercial Surrogacy altogether. The arguments raised by diverse groups were confluent, and the section below highlights the main concerns.

6.1 The child-a saleable commodity?

In commercial surrogacy, the child is not a *gift* as portrayed, but rather the most vulnerable entity, devoid of choices and completely at the mercy of contracting parties, regulations and social uncertainties. The human right to procreate is a negative right, which means this right cannot be denied to a human being. However, an individual cannot demand to have a child as an absolute right. Infertility is a

human condition that can be reversed by medical treatment in some cases. Where it is irreversible, adoption has been the only option until ART became available. Using ART, a well-to-do couple can contract to have a genetically unrelated child, born through a third party surrogate specially commissioned for the purpose. Would such a child be perceived as a commodity or acquisition? This view diminishes the preciousness and dignity of a human child.

A child born to its natural parents receives acceptance in a way that is obfuscated by surrogacy arrangements. While every child has the right to be accepted, loved and cared for irrespective of imperfections, will only an unblemished child be acceptable in surrogacy?

Every orphaned child is a responsibility of society, deserving of nurturing parents and a home, just as much as genetically related children or children conceived at a high price through surrogacy. When children wait to be adopted, commercial surrogacy appears a self-indulgent pursuit, uncaring of social need. There is also the perception that children born through surrogacy arrangements can be trafficked because they are taken across country borders, and assigned non-genetic parentage and citizenship.

6.2 Exploitation of women

In a country where millions of women lack education and empowerment, with discrimination against women at every stage of life, commercial surrogacy presents one more way to exploit Indian women [49]. Data linked to female feticide, girl infanticide, child marriage, rape, abuse, dowry deaths and abandonment of widows clearly indicate that women are vulnerable and must be protected by the state and the law.[13] In commercial surrogacy, women can be pressured to "volunteer" their bodies and wombs in return for money, to repay family debt, school fees or cost of building a home.

The demographic profile of surrogacy *volunteers* in India is suggestive of possible exploitation. Mostly from lower income groups and slum dwellers, these women are removed from their homes and incarcerated in hostels until the child is born. In interviews, many admit their decision was linked to financial need and would not be surrogates if their situation were different. In news photographs, they wear facemasks that conceal identity, as though ashamed of their situation. Indian law forbids solicitation and procurement of services in prostitution as it can lead to exploitation of women, and commercial surrogacy can be viewed through the same lens.

6.3 Dignity of the individual

Every human being has the right to a life of dignity linked to inherent value as an individual. This human dignity stems from religious or spiritual beliefs about human existence and purpose.[14] If a monetary value is placed on human life, and human child bearing becomes a financial contract, the dignity of human beings is severely compromised.

The abolition of slavery happened in response to the clamor for human rights; that a human being, or his body and body parts, cannot be a commodity for sale [50-51]. In surrogacy, poverty drives women to risk mental and physical health, even their bodies for financial return. Just as commercial organ transaction was prohibited in India through legislation, the Transplantation of Human Organs Act 1994,[15] commercial surrogacy too should not be allowed; as such contracts are unconscionable, unenforceable and unethical.

6.4 Right to health and right to life

Though natural, human childbearing is a complex process, fraught with risks and complications right from ovulation and conception

to pregnancy and childbirth. Hormonal and physiological changes during this process can compromise the health of the mother. A young married couple may accept these risks in their desire to start a family. However, when financial pressures drive a woman to put her health and life at risk by undertaking unnatural embryo implantation procedures, hormonal manipulation and even surgery, to fulfill another person's desire for a child, her Right to Life and Health is clearly violated.

Risks of pregnancy and childbirth include pre-eclampsia, hyper emesis, miscarriage, placenta praevia, deep vein thrombosis, pulmonary embolism, fatty liver, cardiomyopathy, DIC syndrome, joint pains, sciatica, pelvic girdle pains, infections, indigestion and urinary tract infections, haemorrhage, amniotic fluid embolism and rupture uterus, among others. Surrogates are at risk from additional hormone injections given to prepare the uterus and prevent miscarriage. They may be implanted with multiple embryos to improve chances of success; multiple pregnancies pose a greater obstetric risk. In some cases, a surgical procedure called fetal reduction is performed on the mother. Finally, the doctor mostly advises elective caesarean section to reduce risk to the child.

Who cares for the surrogate when pregnancy has taken its toll on her, physically and mentally? Is the compensation fair? Insurance does not cover complications due to surrogacy and the surrogate could become infertile herself due to medical complications, or even lose her life. Can such high risk be justified? No compensation to the surrogate or her family would be deemed adequate in case of harm or death. Commercial surrogacy is a clear violation of the fundamental Right to Life and health.[16]

6.5 Unethical medical practice

The most disturbing aspect of the *rent-a womb* and *baby-outsourcing* boom in India was the complicity of medical professionals. Assisted Reproductive techniques provided huge monetary benefits to doctors

offering this option. The availability of willing surrogates and lure of profit appeared too attractive, leading to mushrooming clinics and advertisements in newspapers and online.[17] Claims of success were unsubstantiated and poor success rates of IVF were underplayed. The option to have a baby through a surrogate mother was extended to single women, same-sex couples and foreigners. While the actual medical indications for surrogacy were few, clinics extended this option to all manner of clients, for a variety of reasons. The money involved fuelled a powerful lobby that influenced government decisions and regulations. Client's demands were pandered to in the name of infertility treatments, while destitute women were exploited as surrogates in a shameful sell-out by the medical profession.

6.6 Identity of the child

The complex arrangements between commissioning parents, gamete donors and the surrogate, lead to confusion over the identity of the child and responsible parent. Most countries accept the birth mother as the legal mother, expecting the commissioning parents to adopt the child even when the child is genetically related. Other countries insist on genetic testing as proof of parentage for the birth certificate. Dissimilar laws led to distressing situations where the child could not be taken to the country to which the parents belong. (See cases above)

This situation is unfair and detrimental to the child. The UN Convention on the Rights of the Child says «every child has the right to a name, birth registration and nationality».[18] Commercial surrogacy across national borders can subject the innocent child to uncertainty, abandonment and insecurity at a vulnerable stage, its fate in the hands of strangers or the state. It is also unclear whether the child has a right to know about their genetic or surrogate parent. These issues regarding parentage, right to know, and confidentiality can harm the child.

6.7 International clients

Most countries have banned commercial surrogacy, and these citizens look to countries with lax regulations like India to pursue their desire for a child. The combination of lower costs, high quality medical facilities, and availability of surrogates attracts foreigners who may be single, unmarried couples, or same-sex couples. This raises the spectre of crossborder child trafficking and commoditization of children (Australian couple above). Developing countries have a duty to protect citizens from global exploitation by wealthy foreigners and unscrupulous touts, in a world driven by economic demand and supply.

6.8 Motherhood and childbearing

Maternal bonding and nurturing that begin from the early months of pregnancy are unique and undisputable. This important human affinity is vital to care and protect the vulnerable human child. Separation from the surrogate mother after birth is unnatural, cruel and inhuman, even when the surrogate is fully aware of this eventuality. What are rightful claims of a surrogate mother who has nurtured a child in her womb for nine months? Should she be allowed any option if she has a change of heart, or be forced to hand over the child? These disturbing scenarios require debate and discernment.

What rights do the commissioning parents have? Can they refuse a child that is physically imperfect? If the commissioning parents die before the child is born, who is responsible for the child and how can the child be protected?

6.9 Unenforceable contracts

Commercial surrogacy contracts containing monetary benefit to the surrogate in exchange for child-bearing services are unenforceable

and unconscionable. Under Section 23 of the Indian Contracts Act, a contract is *deemed unlawful if its enforcement could result in injury to one of the parties or if it is immoral or against public policy*.[19] The surrogate could clearly be harmed, her health and life at risk in fulfilling the contract terms. The notion of procuring the services of a woman for childbearing and childbirth can also be viewed as immoral. Commercial Surrogacy arrangements cannot be part of public policy in a developing country where women could be exploited in the guise of providing children to infertile couples. Such possibility of exploitation is injurious to public welfare.

Is it possible to put a price on human health or a human organ, or its use? For this reason, organ donation, blood donation and even human cadaver donation are always altruistic. Can such contracts be enforced? Can the surrogate be forced to part with the child? If the contracting couple refuses, should the child be forced on them? Would this be in the best interest of the child?

7. Conclusion

As signatory to the international charter of human rights, the Indian Government has a duty to ensure Human Rights and Constitutional Rights of every citizen. Women and children are vulnerable, and require protection from exploitation. Research in medical science and technology may lead to advances in health sciences and health care, but it is imperative that human applications of technology are evaluated in terms of the human, social, and ethical implications. Until such time, restricted use or even a complete moratorium should be imposed.

If a woman is moved by empathy to assist childless couples as a surrogate, in cases where medical indications exist, there can be no price placed on this altruistic act. Altruistic surrogacy can be allowed, as with altruistic organ donation in India, along the lines of the Transplantation of Human Organs Act 1994. The proposed

Surrogacy (Regulation) Act 2016 would allow altruistic surrogacy conditionally, under strict regulations in registered infertility clinics but firmly shuts the door on commercial surrogacy in India.

It is expected that there will be protests and lobbying from physicians, lawyers, surrogacy agencies, clients from India and abroad and surrogate mothers themselves, against the ban on commercial surrogacy in India. But considering the social, moral and legal aspects of the issues involved, the government's decisive step to ban commercial surrogacy in this country may prevail. It will be a commendable display of responsibility to preserve and protect human rights and dignity of the human person, especially in vulnerable populations.

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[2] We note that the article of Shilpa Kannan was published already in March 2009, and the figures in recent articles, are unbelievably the same for the figures she quotes the National Commission for Women.

[3] Presented by Soumya Swaminathan, Director General, Indian Council of Medical Research.

[4] Ref.: *Baby* M, 537 A.2d 1227, 109 N.J. 396. NJ; 1998.

[5] Ref.: *Baby Manji Yamada v. Union of India and ANR*, INSC 1656.2008 (29 September 2008).

[6] There are a lot of articles found on the issue a few to name: John Carney, *Baby Boy Abandoned in India by Parents Who Kept His Twin Sister But Left Him behind* "*as They Already Had a Boy and Couldn't Afford Twins*", Daily Mail Australia, 24 June 2015 accessed on 20.10.2016 at http://www.dailymail.co.uk/news/article-3137049/Baby-boy-abandoned-India-surrogateparents-kept-twin-sister-left-boy-couldn-t-affordtwins.html; Samantha Hawley, Suzanne Smith and Michael McKinnon, *India Surrogacy Case: Documents Show New South Wales Couple Abandoned Baby Boy Despite Warnings*, ABC News, 13 April 2015, accessed on 20.10.2016 at http://www.abc.net.au/news/2015-04-13/australiancouple-abandon-baby-boy-in-india-surrogacy-case/6387206.

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