COMMENT

Social and ethical basis of legislation on surrogacy: need for debate

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As a public health priority assisted reproductive technologies (ARTs) are low on the epidemiological scale in India. Of the estimated 8-10% infertility in Indian women 98% have secondary sterility–they have been pregnant at least once before but are unable to conceive again. Their problems are due to untreated disease, poor health care practices or malnutrition. Most of these can be avoided through effective antenatal and postnatal care, and through good primary health care with basic facilities to diagnose and treat infertility. All this can be done without distorting public health priorities.

However, such services are not available to the majority of people in India. And women who are unable to have children face suffering and social ostracisation. Further, the desire for children is laced with the eugenic notion of genetic belonging in patriarchal societies. These conditions are used by the medical profession and medical market to promote ARTs.

ARTs are also used for surrogacy. In this case, an embryo is created with in vitro fertilisation (IVF) and implanted in the uterus of a "surrogate mother". (The sperm and ova used for IVF come from donors or the commissioning couple. Ova are "harvested" surgically following the administration of drugs.) The surrogate carries the pregnancy to term and hands over the baby to the couple or individual who has commissioned the pregnancy. She is paid a fee for carrying the pregnancy. Surrogates are almost always from poor and lower middle class backgrounds (1).

Surrogacy is becoming more common in India though it is the only option in just a fraction of IVF cases. One factor in this rise is reproductive tourism as people travel to India to commission a baby. Another is the economic compulsions of the not so well off. A third is the growing tribe of experts within the medical market who see profits in this procedure. The three factors have pushed surrogacy with ART beyond its legitimate place in priorities. They have allowed the medical profession to exploit the economically needy.

Every technology has a bias depending upon the context in which it evolves. However, its impact outside that context depends upon the manner in which it is used. It can be used to nurture traditional values and curtail the potential to create new ethical practices. Or it can be used to question existing retrograde practices and values. How do social forces shape the use of ARTs and their progressive potentials if any? To answer this we explore the way these technologies are used and their social impact.

Social processes and the introduction of ART and surrogacy

When a society changes rapidly, its ethical norms are challenged. They are challenged by the biases of new knowledge and by the conflicts created as new practices threaten these norms.

Ethics is the notion of what is good and right in society that guides human action. In periods of transition new understandings emerge of what is ethical practice. This emergence is not a linear process but a trajectory interspersed with conflicts of ideas and interests in various arenas of the technology-society interface. In medicine, for example, the principles of beneficence, non maleficence, consent, confidentiality and patient autonomy have guided clinical practice. The discipline of public health added social responsibility and justice to the ethics of medical practice and research. Here we explore the conflicts emerging out of the practice of ARTs and the extent to which the proposed legislation (2) contains them by reasserting ethical principles.

ART and the medical market

A significant percentage of babies in developed countries in the West are born through IVF. Some of these involve surrogacy, and reproductive tourism takes place within the US and in some parts of Europe. In that part of the world, the debate is focused on the ethics of surrogacy rather than on the economic advantage of any particular region.

On the other hand, such an economic advantage is seen in India, which is perceived as a hub of quality ART services that can be had for one-fourth of the price in the West. This explains the rush of foreign couples seeking surrogacy (most commissioning parents in Indian clinics are from outside the country) and ART, and the proliferating medical tourism market in ART.

There are two concerns about this trend in India. The first is the *misuse of technology* causing serious problems such as a declining sex ratio, rising caesarean sections and overdiagnosis leading to unnecessary medical procedures. The second is the *commodification of body parts* such as in the clandestine trade in kidneys, placentas and aborted foetuses. When these trends are combined as in reproductive technologies–the results are disturbing. There are reports of young women being used to harvest oocytes or ova without their informed consent on the risks and consequences of this procedure; of clinics promoting IVF without the necessary technical resources and human power; and of specialists organising surrogacy contracts for foreign clients without ensuring the security and rights of the surrogate mother or baby (3).

Most of these problems are a consequence of the unregulated ART industry–with varying prices, standards and procedures–that gives primacy to profits rather than the epidemiological needs of the majority in India. The state

ignores the need to prevent secondary infertility that is due to poor obstetric services and reproductive tract infections. It does not address the poor nutritional status of women which affects their ability to conceive and carry a pregnancy to term. And finally, it does not provide basic services to treat infertility. Instead, the private sector is given freedom to set up more ART clinics. This strategy is in line with its policy to encourage medical tourism to earn foreign exchange rather than protect the health of the majority. The ART industry is estimated to be worth $445 million (4).

Because the industry is so profitable, the limitations of this technology are not publicised. ARTs have relatively low success rates. They also pose risks to the gestational mother, the baby and the ovum donor. Among the complications are hyper-ovulation syndrome, multiple pregnancies and the risks of techniques such as foetal reduction. Babies from ARTs are more often of low birth weight and have a higher rate of birth abnormalities than babies born the conceived naturally. These facts are known to the profession but not made public.

The state is under pressure from users of these technologies to keep the public informed of these risks and to regulate surrogacy. However, it is unwilling to let go of the financial advantage of this industry. So it has responded by hurriedly putting together a few ill thought out ideas to draft legislation for ART (2). This draft Bill is likely to be placed before Parliament shortly.

It needs to be emphasised that legislation pertaining to only one aspect of health is not only insufficient but actually subversive, as it has the capacity to distract from the main thrust of policy. The ART Bill can be analysed only within the social context that we propose to explore.

Impact of technology on key definitions

Changing technologies influence not only the societies around them but also the very definitions of problems. For example, *surrogacy* changed its nature and definition with the evolution of ARTs.

In the mythological stories of Rohini in the Mahabharata who bore a child for Vasudev and Devaki, surrogacy would have involved sexual intercourse between the male partner and the surrogate. The technology of artificial insemination brought surrogacy into the domain of a more acceptable medical practice.

Still, with artificial insemination, the ova came from the surrogate mother, and the integrity of genetic and gestational aspects was retained. She was the biological mother and she chose to part with her baby and give it to another.

This changed with in vitro fertilisation. After the techniques of ova harvesting and IVF and embryo transfer became popular, it was no longer necessary to use the surrogate's ova. Technology thus explicitly distinguished between the social and gestational value of mothers and genetic material that was now available through donors. It weakened the ideology of motherhood and the most commonly held ethical and legal position that a mother is the one who gives birth and genetic parents alone provide identity.

At the same time, nurturing and bonding acquired a new meaning with knowledge of genetics and of intrauterine and early development. It was established that for the child's genetic potential to unfold fully, it should be nurtured in a biologically optimum and socially secure environment. For the development of a well adjusted baby, the importance of not separating it from the gestational mother too early was thus laid by modern scientific knowledge. It established the need to practise a more inclusive and intimate form of surrogacy where the two families participate, and separation is delayed for three to six months for the welfare of the baby.

In contrast to the area of child development, when we look at the medical definition of *infertility* (a couple's failure to conceive after one year of unprotected sexual intercourse), we find it inadequate, as it is based on social perception rather than a body of knowledge of pathology or of epidemiology. The definition is also undependable as it does not take into account the variation in social perceptions. Different communities accept different time gaps between marriage and conception. For example, this time gap is two years in rural Bangladesh (5). So there is a need for a *medically defined* standard or guideline for when couples need reassurance and when medical intervention is necessary. Many couples without any specific diagnosis are declared infertile by the current medical definition and are made vulnerable to the vices of the market.

The technologies of human organ donation and of surrogacy have shaped definitions differently. Human organ donation is restricted to a non-commercial transaction by the Human Organ Transplant Act, 1994. However, temporary lending of uterus on payment has not been objected to by the state. This irrational distinction between human body parts donated and those rented, and the *equating of goods and living beings* in commercial surrogacy, undermines the sacrifice made by surrogates, and their autonomy. Medical providers view it as an industry where the cheap "labour" of the Indian surrogate makes it a profitable venture for them.

Their logic obfuscates the distinction between the *product of social human labour* (consumable commodities) and *the product of woman's procreative labour* (a human baby). This distortion is the product of market liberalisation pushing profit-oriented, technocentric solutions for infertility instead of addressing its social determinants.

By using healthy women as means of reproduction for the infertile, on a commercial basis, the experts create the same inequality of power and control in ART clinics as in patriarchal society. Even when surrogacy is seen in the market framework a key issue is the definition of *compensation*. To understand this, the irrationality of blurring the definitions of production and procreation needs to be underlined. There is no way to put a value on the product of the latter (a baby), except arbitrarily. Therefore, its value has to be the same as anywhere else in the world even if the Third World provides cheap human labour and technological services such as ART.

In the US not only is surrogacy many times more expensive than it is in India, the surrogate is better provided for. In addition to medical expenses related to the pregnancy,

the surrogate is given health insurance for the period of involvement, medical insurance for her family as she is the caretaker for them and expenses including for maternity care and clothing. In addition expenses for the independent lawyer that she would employ are paid by the commissioning parents (6). As a country claiming to have "international standards" and "world class" institutions, India should strive for these norms and no less. The reality is that while in the US up to 50% of the cost of ART with a surrogate arrangement goes to the surrogate, in India most of the money is appropriated by the sperm banks, clinics and lawyers.

Social context of surrogacy and ART

New reproductive technologies claim to help human beings through creative interventions that reduce suffering and have the potential to transform society. The commercialisation of surrogacy, however, creates several social conflicts rather than resolving a few. It generates family pressure on poor women to offer their wombs for a price. Almost one third of Indian women are extremely vulnerable due to poverty, marginalisation in labour and job markets, patriarchal social and family structures and low educational levels. For them, in particular, the financial gain through surrogacy becomes a key push factor. It is well known that most surrogate mothers are from not so well-off sections and their primary motive to become surrogates is monetary. This makes their economic exploitation easy for the agents working for commissioning parents.

Procreation and infertility must be interpreted within constructs like patriarchy and within existing social and economic inequalities. The same is true for surrogacy. The use of ART to "help" infertile couples adds new conflicts. For example, the way ART is practised reduces parents into objects of medical experimentation and sanitises the mystique of biological evolution. Surrogates frankly accept monetary motives (treatment, education and housing for family members) but face the dilemma that being a surrogate is socially unacceptable. So rather than tell their neighbours that they gave away their child, they tell them that the baby died.

The government's view on this subject is a matter of concern. In a meeting convened by the Ministry of Women and Child Welfare in June 2008, a minister of the government stated that the fact that these women get amounts equalling two-three years of their wages can not be ignored. This is indicative of the mood in the government that sees surrogacy as a replacement for employment guarantee and adequate subsistence.

Another area of concern in the use of ARTs is for the disability and women's movement. This is around the narrowing of choices for couples in the name of expanding choices. Gender, disability and infertility are social constructs. Yet, the Pre-conception and Pre-natal Diagnostic Techniques (regulation and prevention of misuse) Act gives parents the absolute right to abort a disabled foetus. The use of preimplantational genetic diagnosis in ART gives the option to eliminate disability without defining any limits to this option. Thus, the selective exclusion of the disabled and of girls has become possible through ART (7).

There are cases of the surrogate refusing to part with the baby, but being unable to pay back the sum received. There are also instances of the surrogate changing her mind about the pregnancy and opting for abortion. Such actions conflict with the interests of the commissioning parents and the reputation and profits of the providers. They therefore seek regulation through legislation. These interests are well represented on the drafting committee of the ART Bill.

Surrogacy can also affect older children's perception of the values and integrity of their family unless there is transparency and involvement of the commissioning/social mother right through the pregnancy. Secrecy and anonymity create a negative environment that affects human relations within and outside families.

Yet another issue that emerges is children's right to information about the identity of their parents. At present this right may be exercised in adulthood, though the sense of belonging and socialisation begins very early. The global experience of adoption teaches us that the urge to know one's roots brings young adults back to unknown people. Why then fit surrogacy in the old patriarchal mould of secrecy and anonymity, instead of changing norms and making the process more transparent? For the commissioning mother, being involved with baby care right from the beginning while it is breastfed, and knowing the surrogate through the pregnancy, might be a step forward. It might make adaptation less difficult for all concerned. These questions need to be examined and not set aside simply to push the surrogacy markets. Secrecy and anonymity are rooted in the social value of the primacy of "blood relations". This itself derives from notions of exclusivity and superiority–the very essence of eugenics. The present practices, instead of openly questioning these values, harm children by letting them grow up with false notions of belonging and then pushing them into a search for identity, a sense of shame and anger against their social parents (8). An open and frank environment could be much more conducive to accepting their status.

Again, the present restrictive policy towards the sexuality of same sex couples denies them open access to ART despite sufficient scientific basis establishing the biological validity of their distinct sexualities. The legislation chooses to remain silent on their need for a family, reflecting a lack of initiative to question obsolete social mores.

Surrogacy as it is practised is heavily biased against the baby. It requires the surrogate mother not to get too involved with the growing baby in her body. The baby has no say in the matter and has to live the consequences of the social process. The baby's right to bonding and breast feeding for a minimum period of three to six months is denied. Also the very right to survival of all babies born out of ART–whether disabled or one of a multiple pregnancy–is undermined as they are not treated at par with other babies but depend upon the whims of their commissioning parents for survival.

These emerging social practices protect the interests of the market and negate almost all the principles of medical ethics enunciated earlier. Is the draft Bill any different?

The draft ART (Regulation) Bill, 2008

A huge infrastructure is proposed for registration and standardisation of clinics and sperm banks. However, there will

be little effort to regularly monitor the success rates of different techniques. The focus is on research in and popularisation of ART rather than on stopping the misuse of technology and the exploitation of donors and surrogates. This is illustrated in the following examples.

An extremely inadequate and open format for a private contract between surrogates and commissioning parents permits the continued exploitation of surrogates. It does not address concerns such as issues of health, informed consent, compensation and legal assistance. This is despite the fact that the Bill recognises surrogacy as "pregnancy achieved in furtherance of ART", and therefore acknowledges its imperfection.

The Bill also propagates the patriarchal and eugenic values of exclusivity by giving primacy to genetic parenthood. It goes to the extent of denying the right of the surrogate to be registered as the birthing mother and directly transfers parentage to protect the right of the buyer at the cost of the baby. At the same time the interests of clinics and sperm banks are fully protected. All risks are transferred to the surrogate–be it her death, complications during foetal reduction or the transfer of infections such as HIV.

The Bill denies the critical developmental needs of the baby and in order to make separation easy and quick for a commercial surrogate, ensures fast separation. It also bans the donation of ova by her. It goes to the extent of permitting three surrogate births to a woman and three cycles of ova transfer for a single couple without any reference to the health risks to the surrogate. At the same time the right to demand abortion and pregnancy reduction is given to the commissioning parents and the surrogate is bound to oblige. No attention is paid to the right of the surrogate to keep the baby if she changes her mind early or due to the death of her own child.

Similarly, same sex parents do not get any recognition by the draft though single parents can access the technology.

The question of the identity of a parent is clouded by secrecy and anonymity. No effort is made to bring about a degree of openness and co-operation between the two families to secure the welfare of the baby.

The Bill not only openly protects and promotes unregulated commercial surrogacy, it also contradicts existing national policies on health and family welfare. These contradictions are:

a) The state has a two-child policy to ensure stable populations and women's health. Those opting for surrogacy cannot be exceptions.

b) Maternal mortality, which is a matter of great concern for the government, will by no means decline if surrogacy practices permit nine possible cycles of transplant of ova (a maximum of three cycles for a single commissioning couple and three surrogate babies in a lifetime irrespective of the number of her own children).

c) The state's public policy is against gender exploitation, but gender-based economic and social exploitation is built into present surrogacy practice.

d) The sale of children, human trafficking and sale of body parts are illegal activities as is evident in the laws for trafficking and human organ transplant. Yet commercial surrogacy is being promoted.

e) India is a party to the UN Convention on the Rights of the Child and committed to the protection of children before and after their birth. Yet the present legislation does not ensure that child rights are fully protected.

The fact that the drafting committee was not concerned about these contradictions is reason enough to demand that these questions be thrown open to a public debate to find how best the interests of the baby, the surrogate mother or the adopting parents could be looked after within an ethical frame.

Such a move will help evolve a more widely accepted legislation, particularly as the social complexity in this country gives rise to many views regarding infertility and surrogacy. Accordingly, there are those who are completely against surrogacy on ethical and ideological grounds, those who fully support it even as a commercial venture, those who accept it but oppose its commercialisation and those who on the very basis of ideology say that commercial surrogacy - if well regulated - is a way to question patriarchal notions of family and society. It is interesting that within feminists, one set encourages adoption and questions the eugenic tendencies of genetic manipulation that reinforce patriarchal notions of paternity and the other uses genetic manipulation to attack the traditional family. These counter currents raise significant challenges for law and policy makers genuinely interested in the regulation of ART and surrogacy. It would therefore be in their interest to listen carefully.

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