ARTICLES

The ART of marketing babies

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Abstract

New legislation can be oppressive for a significant population depending upon the politics of its drafters. The current upsurge of the surrogacy trade in India, and the label of a "win-win" situation that it has acquired, points towards an unfettered commercialisation of assisted reproductive technology and the practice of surrogacy that is blinding its middle class users as well as providers, policy makers and law makers, and charging an imagination that is already caught up in spiralling consumerism. This paper analyses the Draft Assisted Reproductive Technology (Regulation) Bill and Rules, 2008, in the Indian socioeconomic context. It identifies the interests of the affected women, and examines the contradictions of the proposed Bill with their interests, as well as with current health and population policies, confining itself to the handling of surrogacy and not the entire content of the Bill. The bases of the analytical perspective used are: the context of poverty and the health needs of the Indian population; the need to locate surrogacy services within the overall public health service context and its epidemiological basis; the need to restrain direct human experimentation for the advancement of any technology; the use of safer methods; and, finally, the rights of surrogate mothers and their babies, in India, as opposed to the compulsion or dynamics of the medical market and reproductive tourism.

According to a report of the 18th Law Commission of India,"Law is to act as ardent defender of human liberty and an instrument of distribution of positive entitlements." (1: 7) Nelson Mandela addressing the special convocation held in his honour in 1990 at the Jawaharlal Nehru University,made a deep impression on us when he questioned the sanctity of law and said it must be challenged when it becomes oppressive. This wisdom coming from a lawyer with a difference highlights the role legislation plays in a society riddled with conflicts; liberating for some and oppressive for others. Notwithstanding the Law Commission's idealism, new legislation too could be oppressive for a significant population depending upon the politics of its drafters. The current upsurge of the surrogacy trade in India, and the label of a "win-win" situation that it has acquired, points towards an unfettered commercialisation of Assisted Reproductive Technology (ART) and the practice of surrogacy that is blinding its middle class users as well as providers, policy makers and law makers, and charging an imagination that is already caught up in spiralling consumerism.

The aura of the high-tech has overshadowed the exploitation of less-privileged women. There was, thus, little public dissent to the several regressive proposals regarding surrogacy in the Draft Assisted Reproductive Technology Regulation Bill, 2008 (2), and it was proclaimed that women accepted it out of their own free will. Stories abound of this free will: economic pressures forcing women into surrogacy; a relative needing a kidney transplant; buying a taxi to run the household; or the decision to give schooling or a house to her children (3). She is 'fed up of her poverty', becomes the rationale for providers who argue that, just as medical technology is cheap in the Third World, so too are surrogacy arrangements that help families to overcome financial constraints (3). There are also stories of surrogates clinging on to the commissioning parents, demanding more and more, and even refusing to part with the baby. This disturbs the clients and their providers whose business and reputation is at stake. These so called dirty workers are then unable to fight discrimination, not only because they are dependent (4), but also because the State itself is not concerned about exploitation, false promises, misuse of techniques, and, above all, about the loss of ethical principles in the present practices as well as in its law - the proposed Draft Assisted Reproductive Technology (Regulation) Bill and Rules, 2008 - that lacks even a preamble.

This paper identifies the interests of the affected women, and examines the contradictions of the proposed Bill with their interests, as well as with current health and population policies. The critique is confined to the handling of surrogacy and does not discuss the entire content of the Bill. The bases of the analytical perspective (5) used are: the context of poverty and the health needs of the Indian population; the need to locate surrogacy services within the overall public health service context and its epidemiological basis (6); the need to restrain direct human experimentation for the advancement of any technology; the use of safer methods; and, finally, the rights of surrogate mothers and their babies, in India, as opposed to the compulsion or dynamics of the medical market and reproductive tourism.

The practice of surrogacy can be ethical only if the interests of the baby, the gestational mother, the commissioning parents, and science itself are located within this framework. The proposed Bill not only disregards these but also negates a number of important state policies. If legislated, it could make these policies irrelevant. The central issue, therefore, is: what perspective must guide the practice of surrogacy?

The concerns of the affected

The newborn baby

The vulnerability of the baby can be enhanced if the surrogacy process is not sensitive to the issues of child rights. These rights

are: i) the right to bonding, breast feeding for a minimum period of three to six months, and early psychological and immunological development while prescribing the time of separation; ii) the right to survival like any other baby, including a baby with disability or born of a multiple pregnancy; this cannot be undermined by the whims of the commissioning parents; iii) the right to a safe home as an obligation of a state that permits surrogacy in cases where both sets of parents refuse to accept the baby, and iv) the right of babies to know their identity; as an early acceptance of their status helps their socialisation and acquisition of a sense of belonging. Discovering parentage late or accidentally is more damaging than knowing the truth in an open and frank environment. Secrecy and misinformation are born out of the notion of priority of biological associations over socio-psychological ones.

The surrogate mother

Voluntary acceptance of surrogacy requires that women have self respect and social status born out of equal opportunities, adequate wages, and freedom of decision making. It should not be an alternate employment generation scheme. It would be a mistake to evolve legislation on the basis of systemic weaknesses and failures, or for lawmakers to assume that volunteerism under conditions of poverty is genuine. In the present context, surrogacy is rarely voluntary. Hence, one needs to know what payments have been made for, and to articulate the difference between commercial and voluntary surrogacy.

In the best traditions of liberal thought, the concepts of minimum *wages* and *compensation* were understood separately. One was: money payment during the period of employment that would provide a family unit a level of survival that is socially acceptable; and the other was payment for permanent or temporary disability and for death (7). A third kind of money exchange, that is now included, is *coverage* of expenses for an altruistic act of humanism, as in organ transplants, where expenses of donors are born by the family receiving help. But normal pregnancy is neither a disease nor a disability; hence the issue of 'compensation' for pregnancy does not arise.

The compensation can only be for the handing over of - or separation from - the baby, for damage caused to the mother in case of complications and medical negligence, and in the event of the mother's death. This should include compensation to the family, which is denied her care while contributing to mother and baby care during the period of surrogacy. Women are, in fact, being forced to become captives of clinics in the name of their protection and care. In addition, for nurturing the baby, the surrogate should earn wages[ss1] for the time and energy invested in pregnancy and baby care. Coverage of expenses for surrogacy would mean all services for the surrogate. Apart from all medical expenses, it should include, as in the West, her life insurance, counselling and legal expenses, travel charges, psychological evaluation, adequate food, and health insurance for the family that is involved in providing care while the baby is with them (8). In voluntary surrogacy then, at most, coverage of expenses and part of compensation could be paid, while in commercial surrogacy all of these are the surrogate's due.

We now examine the notion of wages for, and products' of, surrogacy. The global market has made Third World labour a resource for its growth as it is cheap. This principle has been thoughtlessly transferred to surrogacy where the procreative labour of the surrogate woman is equated to social labour of human beings. The product is a commodity or a service in one case, and a human baby - the future of mankind - in the other. To compare these forms of labour and product is untenable as the latter is a biological process linked to human, biological, psychological, and emotional energies continuously invested over a period of time, that affects the whole being. This cannot be put at par with skill-based physical labour of the former. Similarly, while an Indian commodity may have lower value as a product of low-cost raw material, technology, and human labour, the value of life of a surrogate baby cannot be lower in India as its human potential - and the maternal energies that nurture it - are the same globally. The value of surrogate motherhood (as wages) and the surrogate baby (as compensation) is thus universal. It cannot be measured regionally. At best it can be given a universal arbitrary value, as there is no way that the human potential of a baby can be assessed at birth, nor can gestation be different in different countries.

This obfuscation of the difference between a commodity and a human baby, and between social and procreative labour, has provided the rationale for justifying two assumptions. First, the priority of the rights of owners of genetic material over the surrogate's gestational rights in the true eugenic tradition; second, the undermining of surrogate gestation as 'services provided' and labelling it as cheap labour. This logic is unacceptable and unethical as it denies the universal value of life for all babies, and the value of gestation, which is labour extraordinaire.

While ARTs have transformed genetic material - so critical within the eugenic perspective of parenthood - into an acquirable commodity, the key dimensions of motherhood remain gestational and social mothering. The modern understanding of foetal and infant growth has also shown the importance of early bonding (9) that in fact begins in the uterus, and of breast feeding (10), both critical for emotional and physical development and immunological protection of the baby. This need for biological continuity in baby care places responsibility not only on the mother but, more so, on the doctors who advise her.

It is the state's ethical responsibility, then, to come clean about definitions, valuations and payments if it is promoting commercial surrogacy. To use the language of voluntarism and hence deny payments is to cover up its own business interests and its neo-liberal paradigm.

The infertile and same sex couples

If one of the sexual partners is infertile, that couple is called infertile. However, this malaise is generally assumed to afflict

women alone, even though in India, according to the president of Indian society of ART, it is estimated that 40-50% of infertility afflicts the male and about 15% remains unexplained (11). The problem of female infertility in India arises primarily out of poor health and health services as, of the estimated 8-10% infertile women, 98% have secondary sterility caused by infections such as post-partum infections, tubercular infections, reproductive tract infections, complications of delivery, and poor nutritional status. Most of these can be avoided through effective primary healthcare with basic services for diagnosing and treating conditions causing infertility. Reproductive tourism distorts these priorities.

Women requiring the help of a surrogate mother should have the right as well as the responsibility of participating in the care of the surrogate mother and the custody of the baby to ensure the smooth transfer and socio-psychological preparedness of the second mother. The veil of secrecy and separation of the two mothers will be antithetical to this desirable mode of transition. Also, the right of couples of the same sex needs to be protected.

Couples of the same sex - despite their fertility - need donors or surrogates; their primary problem therefore is to be legally recognised as couples, to seek ART or surrogacy services. To force them to lie by calling themselves single parents is to treat them differently, a travesty of their constitutional rights to equality and justice.

Last but not least, the adoption laws need to be improved and streamlined to encourage adoption. Access to adoption services for all religious groups should be made possible.

Surrogacy and the proposed ART Bill, 2008

The Draft ART Bill, 2008 is reviewed in the light of the above understanding of ethical and social concerns. Its Drafting Committee was constituted of three lawyers from the Public Interest Legal Support and Research Centre (PILSARC) including its trustee; four representatives of service providers including the famous ART clinic, Rotunda; three government representatives; an eminent molecular biologist as its chairperson, and an Indian Council of Medical Research (ICMR)officer as member-secretary. Representatives of women's organisations, consumers' groups, public sector obstetric and paediatric service providers, and experts in ethics, child development and child psychology, were conspicuous by their absence.

The Draft Bill helps the state abdicate its responsibilities and protect and promote providers' and commissioning parents' interests in the free market by giving extraordinary powers to private sperm banks and clinics as against the surrogate mother. It does not ensure that all social groups within the country have equal access to this service and is actually geared to promote reproductive tourism and further open medical markets. Even the role of the proposed State Boards in providing the necessary counselling and legal assistance to surrogate women for a fair deal is not defined. As a consequence, the Draft bill neglects the interests of the baby and the surrogate mother and shrouds the challenge that ART poses to archaic social structures by conforming to traditional norms of a patriarchal society. It promotes and pushes ART as a desirable intervention, rather than trying to effectively regulate and monitor it. Its discrepancies, contradictions and directions can be gauged by the following observations around these two sets of issues.

Receding state and expanding markets

1. The regulatory authorities are the national and state advisory boards. The former is more focused on developing the field of ART, popularising it, and counselling patients, rather than setting up regulatory mechanisms. The state boards are the registering, monitoring, and enforcing authorities but, strangely enough, the clinics and the semen banks are to keep the records for 10 years only, after which, for some reason, these will be transferred to a central database of the Indian Council of Medical Research. How the monitoring of success rates of different technologies would be possible without a regular annual data supply is anybody's guess. In developed countries these data are collected on a continuous basis and published annually as national reports for ART performance, assessment, and monitoring - as in the USA (12). The national advisory board, instead of focusing on data monitoring, analysing for trends and publishing for open public debate, is to promote training and research in ART. Systematic data need to be collected annually and published by the national/state boards to report on types of sterility, the number of surrogacy arrangements, the reasons, success and complications for each type of ART used, the profile of the surrogate volunteer, the contract conditions with the commissioning couple, the clinic and the sperm bank, medical check-ups, the site and nature of registration of births, any complications and their management, sex of the baby, its follow-up, and the papers for nationality and migration in cases of foreign parents. However, like the drafting committee, the boards too are dominated by experts in ART and private ART providers, with a lack of representation of the other relevant experts and concerned sections of society.
2. The Bill prescribes a legally enforceable surrogacy agreement between the parties in which the State plays no role after preparing the rules and the forms for this. By providing a vague and open template for rules and contracts for what is, in fact, a private undertaking, it leaves huge gaps for the commissioning parents and providers to take advantage of the surrogate mother who is given no legal help by the State. The commissioning couple has the right to demand abortion and pregnancy reduction in congenital anomalies (not specified) and multiple pregnancies, if they so desire according to the surrogacy contract (Form J). This condition however is not stated in the contract between the provider and the surrogate (Form U). Hence, nobody, not even the clinic, has any responsibility

towards any risks (even death) to the surrogate mother arising out of these interventions.

3. The Bill ensures that both the private institutions (sperm banks and clinics) exploit the two parties and donors to their advantage and do not suffer monetarily. Both institutions have the right to full information on the surrogate's private contract with the commissioning couple and on the outcome of her pregnancy, and have control over her actions during pregnancy. But they have no financial or medical obligations. The sperm bank alone gives the green signal to the surrogate after the tests are done. Yet, neither the sperm bank nor the clinic is responsible for any damages, even though the contract form forces the surrogate to sign that the choice of clinics and doctors will not be hers but of the commissioning couple. Also, no monetary benefit is given to the surrogate for remaining on the bank's waiting list.

4. The clinic even acts as her legal representative with the bank (Form R (2) of Rule 1.5). This is illegal as the clinic is not supposed to be a party to the identification of the surrogates at all. Its counselling too will be biased given the conflict of interest! While the surrogate signs a form that she has fully understood what was explained (without any specific details of it), the doctor only signs that she has explained everything to the "extent humanly possible"(2:94) . There is no way to assess from these Forms if the effects of the drugs and procedures used and their risks are adequately explained. The agreement with the surrogate and the clinic (Form J) puts in all the safety clauses for the clinic which is not held responsible for its failures. The implications of surrogacy (2:91) (social, psychological, emotional) and risks (to surrogate mother and baby) have not been listed adequately. The statements use clinical language with assurances that are likely to escape the woman's attention. For example, she is informed of the drug administration necessary but not of the side effects. Similarly, she signs on the dotted lines: "I have been assured that the genetic mother and father have been screened for---. However I have also been informed that there is a small risk of the mother or/and father becoming seropositive for HIV during the window period" (2:92).

   Thus, instead of testing the donors twice, this simple transfer of risk burden reduces the cost for the dominant controlling parties.

   What is said to the surrogate remains unrecorded. The agreement for surrogacy (Form J) makes the woman accept that she will agree to foetal reduction if asked for by the party seeking surrogacy but makes no mention of the risks involved.

5. When it comes to monetary transactions, the draft bill ignores available legal definitions and mixes up compensation with wages by stating that, "the surrogate may receive monetary compensation ... for agreeing to act as a surrogate" (2: Clause 34.3) or for "services provided" (2: Clause 34.17). Damage to the surrogate's health or her possible death is simply ignored. The draft proposes that the surrogate's expenses for insurance, "all expenses, including those related to a pregnancy achieved in furtherance of ART shall, during the period of pregnancy ... and after delivery as per medical advice, and till the child is ready to be delivered as per medical advice to the biological parents shall be borne by the couple or individual seeking surrogacy ..."(2: Clause 34.2). It is thus able to skirt the complexity of the issue of wages, compensation, and coverage of expenses altogether. All of it is transformed into payment for pregnancy achieved in furtherance of ART and service, as if the surrogate is being awarded for her contribution to science and society. Thus, the draft twists and turns terminologies and language to circumvent the issues of definitional clarity, and appropriation is artfully woven into the legislation. It is noteworthy that, while the legal definition of surrogacy that the draft bill sets for itself makes no mention of payment, the legal practice of surrogacy proposed makes payments necessary,laying the basis for commercialisation without actually pronouncing it. It clouds the ethical issues around compensation, wages and motherhood, rationalising it all by giving genetic material priority over gestation and calling commissioning parents 'biological' parents. By ignoring the eventuality of death no liabilities are fixed, leaving the children of the surrogate vulnerable. Even in terms of coverage for expenses, apart from counselling, legal expenses, travel and her dietary needs, payments even for medical coverage for a fixed period are not clearly spelt out. The lowest rates in the western market economies' range are US$13,000-25,000, so if Indian costs of labour and technology have to be lower, it should be through lowering the shares of clinics and gamete banks where the logic of low-cost labour and technology applies and the legislation must make the State responsible for fixing the lower limits. Standard knowledge of obstetrics and paediatrics is also not used to define critical newborn care (up to six months of life), but leaves the time of separation to be individually decided by the clinic doctor. This also reveals the keenness of the drafters to make commercial surrogacy easy.

6. The role of effective counselling to women and full information about the vulnerability of the baby, psychological, physical, and social consequences for her family cannot be over emphasised. Counselling must be done by an independent agency, with the help of the State and not the clinics. Clause 20.6 makes ART clinics responsible for this and ignores the obvious clash of interests. Even though single women are free to opt as surrogates, their need for intensive counselling is ignored.

Patriarchal biases and undermining of rights of surrogate mothers

1. This draft bill mixes up service with human experimentation for the advancement of science. Through its confounding logic it kills more than two birds with one stone. According to experts, patients needing the help of a surrogate are too few if proper selection criteria are used (13). The draft sets up

no criteria for the selection of 'patients' for surrogacy services. At the same time, it is well known that IVF results are better in healthy women as compared to women with problems in carrying a pregnancy to term and under stress (45% against 30%). Lack of stringent selection criteria has the potential for overuse of surrogacy for better results. In the process, surrogacy becomes a way to sustain a not-so-successful ART clinic and the profits that ensue. Vulnerable women become guinea pigs for promoting ART instead of being dissuaded through conditions that provide only for very genuine surrogacy needs, such as full payments, stringent selection of patients, and meticulous monitoring. According to the bill, not only is a woman permitted to undergo three surrogate births in her life time, she can also go in for repeated embryo transfers for a maximum of three times for a single contracting couple. Clause 34.9, in fact, says that if a transplant fails, the surrogate on mutually agreed financial terms prescribed in the contracts - as 50 % of the original agreement - can accept two more successful transplants. She is, however, not to have more than two surrogate babies and three embryo transplants for the same couple.

This means that a woman can attempt nine embryo transplants for three different couples. Her health and rational evidence, no doubt, is the last concern.

2. The draft prefers to give the surrogate the responsibility of providing the names of those who "have availed of her services" to the hospital, where she registers for delivery, but it does not require that she provide the hospital a copy of her private contract with them (Clause 34.8). The vague Clauses 34.2 and 34.3 of Chapter VII of the bill, as well as the contract between the commissioning parents and the surrogate mother (Form U), do not mention any details of the liabilities for which the commissioning couple would be responsible, except for the financial transactions for pregnancy and a mutually agreed upon compensation for 'services'.

3. Though punishment is envisaged (without any specification) for the commissioning couple if they refuse to accept the baby, in the case of foreigners there is no compulsion for them to be in India at or before birth as they can appoint a guardian for the infant. If they refuse to accept the baby, this guardian will be held legally responsible. Thus the legislation makes light of the punishment of the real culprits and makes no effort to hold them responsible. Even the handing over of the baby in such cases is mysterious. Form U requires two names of alternative guardians without any surety that they will be held legally responsible for the full care and upbringing of the baby. Again the role of the State in this eventuality is left out of the legal domain. This is a matter of concern as the draft is proposing laws within which it is not ensuring constitutional propriety and its own responsibilities.

4. The surrogate woman is denied the right to be an oocyte donor, in order to eliminate her genetic claim; in the process it does away with the use of intrauterine insemination - a much simpler and safer technique. The gamete bank is given the nomenclature of 'sperm bank', creating an illusion of a virile male population with no infertility. This undermining of the surrogate mother at all levels makes her just a "compensated surrogate worker" whose integrity, autonomy, and rights are an impediment to the profits of the medical industry. Her separation from the commissioning parents kills the potential of ART to create space for new social relations.

5. While the donors can refuse the use of their gametes before they are used and the surrogate has the right to abort and return the compensation, according to Clauses 34.4 and 34.10 of the Draft Bill the surrogate is required to "relinquish all parental rights" and permit the commissioning parents' names to be added to the birth certificate itself. Only when a woman's integrity as a person and her status as a nurturer are recognised will her right to the baby under given circumstances be respected and entered into the contract as is the case in many other countries Australia (14), the United States, the United Kingdom (15), France and the Netherlands are among those who give the surrogate a right to change her mind, and some extend it to even a week after the birth of the baby (Israel) (16).The Indian bill chooses to grant total security to the commissioning parents, ignoring that the surrogate's name on the birth certificate is important for ensuring the right to parental identity of a child born through surrogacy. This responsibility/right was later identified by the Law Commission 2009 but not granted (1:26).

6. The draft also does away with adoption of the surrogate baby. In the interest of the baby and the surrogate mother, transfer of parentage should be made easier but through fast-track courts as practised in South Africa. This will make surrogacy accessible to those communities that are not permitted adoption (17). This process of transfer must be included in the contract between the surrogate and the commissioning couple (Form U, Rule 15.1, p. 131-3) as it guards the right of the baby to breastfeeding and healthy growth.

7. The draft continues to operate within the patriarchal family framework wherein any form of family other than heterosexual is discouraged. Hence anonymity of the surrogate and the donor has to be maintained unless some life-threatening medical condition affects the child or, after s/he reaches 18 years of age, she/he demands this knowledge. This secrecy is contrary to the long-term interests of the child and the future possibility of an open society, and contrary to the spirit of justice and equality in the eyes of law. Similarly, a couple is defined as "persons having a sexual relationship that is legal in the country of which they are citizens or they are living in" (2:3). This excludes same sex couples in most Indian states that do not give legitimacy to them, forcing them to seek surrogacy as single parents.

8. The oocyte donor is also neglected. The contract she signs with the bank and the consent she gives to the clinic mention no side effects of ova retrieval procedures such as hyper-ovulation syndrome, the harmful impact of six possible repeated retrievals at intervals of three months on her reproductive health, or compensation for any damage to her health.

Conflicts with State policies

The principles of existing social and population policy (18) are negated by the draft ART Regulation Bill. The key areas of this negation are:

a) The State has a two-child policy to ensure stable population and the mother's health. It would be illogical to say that this is incumbent on all except for those who opt for surrogacy. This amounts to legally promoting ill-health in the surrogate women.

b) Maternal mortality, which is a matter of great concern for the government, will by no means decline among surrogates if surrogacy is promoted as a part of legalised reproductive tourism. High risks with commissioned abortions, pregnancy reduction, transplanting three or more embryos (fertilised in-vitro) in one cycle that increases the prevalence of multiple pregnancies - all these are well known, and may add to mortality.

c) The State's public policy is against gender exploitation. Surrogacy (commercial) on the other hand, is based on exploitation of needs - both economic and social.

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

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

The bill ignores both the ethical and conceptual issues raised in the earlier sections as well as the contradictions it generates vis- a-vis national policies. This reflects its ideological moorings in the neo-liberal developmental shifts of the post 1980s era. It underlines the historical truth that legislations are not guided by ethical principles alone; they are primarily a product of changing socio-political balances. The dominant interests use their own rationality to redefine concepts, reinterpret ethics, and deal with social conflicts. In the case of surrogacy itself, the draft bill defines it as "a pregnancy achieved through ART, in which neither of the gametes belong to her or her husband." (2:3) Thus, a woman can now either donate eggs or be a surrogate but not both as was the case earlier. In this change of definition, advanced technologies have replaced simpler pre-existing modes of surrogacy, and removed conflicts of interest around high-tech ART. That surrogacy has been clubbed with ART in itself reveals that it is seen more as an instrument for advancement of high-tech ART rather than as a means of fulfilling the wishes of commissioning couples from all strata. We argue therefore that this draft is reflective of the dominant ideological push that thrives on the inequities of the social system. For the draft to be reworked in a way that does not compromise the interests of the majority of Indians, it requires an alternate ideological push from within its makers or pressure from civil society.

Coming into being of the Act

The draft ART Regulation Bill 2008 was critiqued by women activists (19) for its weaknesses, for not locating ART within the priorities of public health, and for using the suffering of infertile couples in India to expand surrogacy markets for international clients without addressing social and medical causes of infertility and its solution (7). But there was no response from the authorities. This strange marriage of high-tech medicine and legislation focused on exclusive tourists and clients, ignoring the need to provide effective and safe technologies with the widest possible coverage to prevent secondary sterility -- a primary concern of the majority.

Inevitably, the draft bill does not realise the creative potential of surrogacy which opens new social spaces, such as the concept of 'family' for the surrogate child - the family could be more than a pair of parents. It ignores the need for altered definitions and construction of family and parentage and prefers anonymity and secrecy -- pretending that nothing unusual is happening. Instead of being celebrated for her act of generosity and humanness, the surrogate is treated by this piece of legislation as a contract worker available for exploitation --both monetarily and psychologically. The value of her gestational motherhood is denied, and weight is given to the commissioning parents as owners of the genetic material. This negation of the potential of a humane relationship between the two mothers and their families that can generate an open environment around surrogacy reflects the fears of a patriarchal society and its inability to address new challenges with a new vision.

The law makers are reluctant to accept that law in societies at the crossroads has to respond to new situations, and not contain and hide change -- even if it is the notion of parentage, motherhood, fatherhood, or family itself.

The 18th Law Commission that reviewed this bill had a mixed reaction. It pronounced infertility "a huge impediment in the overall wellbeing of couples" and "a major problem" (1:9), but without basing this statement on any objective assessment. Though prohibition of surrogacy was considered undesirable, it was realised that the complexity of the issues called for a comprehensive legislation. It stated that the draft prepared by the ICMR was full of lacunae and was incomplete, and proposed that, "while all reasonable expenses should be met" (1:25) by the contract, surrogacy must not be commercial. Second, the surrogate should be given life insurance, and financial support for the surrogate baby should be ensured in case of death of the commissioning parents. Third, it involved the husband and the family of the surrogate in the consent process and accepted artificial insemination and, therefore,

donation of ova, by surrogate mothers. At the same time, the Law Commission accepted the contention that parentage is determined by genetic relationship. It proclaimed: "the bond of love and affection with a child primarily emanates from biological relationship."(1:26) The child, according to the commission, should be registered as that of the commissioning parents, as perhaps gestation is not sufficient to generate love and affection. Essentially, then, the commission's review is only a slightly amended version of the Draft Bill with which it shares a eugenic, patriarchal philosophical base.

PILSARC, in the meantime, has allowed one of its members to go public about its disagreements with the draft bill. Gayatri Sharma claims that the bill was sent to them in 2006 for comments, and they reviewed and put in their bit in 2006. There have been many changes since then and the present Bill is different from the 2006 version according to Sharma. It is "conservative ... reinforces heterosexual and patriarchal assumptions" (20). There are, however, two problems with this dissent. Firstly, it bravely points out that though there is a criticism that surrogacy has been commercialised, "PILSARC and the Draft Bill are silent on commercial surrogacy." (20). As we have argued, it is their silence on ill-defined compensation and medical coverage that lends a hand in transforming surrogacy into a commercial contract. Second, the full PILSARC team might not have been a party to the outcome of the drafting committee but three of its members were.

After being on the ICMR and the health ministry's website for some time, the Draft has now resurfaced. One hopes that in its new avatar, a preamble will make its perspective explicit. The lawmakers have the onerous task of retaining collective respect for life, equality, justice and humanness that must guide all sciences and legislation. Such a task calls for political conviction and strong ethical moorings, as yet feeble in the Draft. It needs to address the issues highlighted above, and not just provide for the right to access ART services in the market without ensuring responsive primary healthcare services by the state.

References

1. Law Commission of India. Government of India. Need for legislation to regulate Assisted Reproductive Technology clinics as well as rights and obligations of parties to a surrogacy. Report 228 [Internet]. New Delhi: government of India; 2009 Aug 5 [cited 2010 Sep 26]. 54 p. Available from: http://lawcommissionofindia.nic.in/reports/report228.pdf
2. Ministry of Health and Family Welfare, Government of India, Indian Council of Medical Research. The Assisted Reproductive Technologies (Regulation) Bill & Rules - 2008 [Draft] [Internet]. New Delhi: MOH&FW, ICMR; 2008 [cited 2010 Sep 26]. Available from: http://www.prsindia.org/uploads/media/vikas_doc/docs/1241500084~~DraftARTBill.pdf
3. Mahurkar U. Donating a womb. *India Today* [Internet]. 2007 Sep 13 [cited 2010 Sep 26]. Available from: http://indiatoday.intoday.in/content_mail.php?option=com_content&name=print&id=1174
4. Pande A. Not an 'angel' not a 'whore': surrogates as 'dirty' workers in India. *Indian J Gend Stud*. 2009;16(2):141-73.
5. Qadeer I. Social and ethical basis of surrogacy in India, *Indian J Med Ethics*. 2009 Jan-Mar;6(1):28-31
6. Qadeer I. New Reproductive Technologies. In: Srinivasan S, editor. *Making Babies: Birth Markets and Assisted Reproductive Technologies in India*. New Delhi: Zubaan; 2010. p.1-21,
7. Law Commission of India. Sixty-Second Report on the Workman's Compensation Act, 1923 [Internet]. New Delhi: Ministry of Law, Justice and Company Affairs; 1974 Oct [cited 2010 Sep 26]. p.1-5. Available from:
8. International Assisted Reproduction Centre [Internet]. Minnesota: IARC; (c) 2010. Frequently asked questions; [cited 2010 Oct 4]; [about 3 screens]. Available from: http://www.fertilityhelp.com/index.php/Surrogacy/Frequently-Asked-Questions.html
9. Broad KD, Curley JP, Keverne EB. Maternal-infant bonding and the evolution of mammalian social relationships. *Philos Trans R Soc Lond B Biol Sci* [Internet]. 2006 Dec 29 [cited 2010 Sep 26]; 361(1476):2199-14. Available from: http://www.ukpmc.ac.uk/articlerender.cgi?artid=1183261
10. UNICEF- Unite for Children [Internet]. Geneva: UNICEF. Nutrition; [updated 2009 Nov 13, cited 2010 Oct 4]; [about 3 screens]. Available from: http://www.unicef.org/nutrition/index_breastfeeding.html [acited 2010, sept30th
11. Express News Service. 30 million couples in India suffer from infertility. *Indian Express* [Internet]. 2010 Mar 10 [cited 2010 Sep 26]. Available from:http://www.indianexpress.com/news/30-million-couples-in-india-suffer-from-inf/588934
12. Adamson D. Regulation of ART. In: Shannon TA, editor. *Reproductive technologies*: a reader. Maryland: Rowman and Littlefield Publishers, Inc; 2006. p. 1-9.
13. Malpani Infertility Clinic [Internet]. Surrogacy in India, Mumbai [cited 2010 Sep 26]. Available from: http://www.drmalpani.com/surrogacy-in-india.htm
14. Human Fertilisation & Embryology Authority [Internet]. Legal issues around surrogacy [last updated 2009 Apr 14; cited 2010 Sep 26]. Available from: http://www.hfea.gov.uk/1424.html
15. Stuhmcke A. For love of money: the legislative regulation of surrogate motherhood. *E Law Journal: Murdoch University Electronic Journal of Law* [Internet]. 1995 Dec [cited 2010 Sep 26]; 2(3). Available from: http://www.murdoch.edu.au/elaw/issues/v2n3/stuhmcke23.html
16. Schenker JG. Assisted reproductive practice in Europe: legal and ethical aspects.*Human Reproduction Update*. 1997;3(2):173-84. http://humupd.oxfordjournals.org/cgi/reprint/3/2/173.pdf
17. www.lawyerscollective.org/magazine/aug-sept-2008/feature-2 [cited 2010 Oct 4
18. National Commission on Population (Government of India). National Population Policy 2000 [Internet]. 2000 [cited 2010 Sep 26]. Available from: http://populationcommission.nic.in/npp.htm.
19. Sarojini NB, Sharma A. The Draft ART (Regulation) Bill: in whose interest?. *Indian J Med Ethics*. 2009 Jan-Mar;(6)1:36-7.
20. Sharma G. Without prejudice: regulation of surrogacy in India. Public Interest Legal Support and Research Centre Blog [Internet]. 2009 Jul 21 [cited 2010 Sep 26]. Available from:http://PILSARC.blogspot.com/2009/07/without-prejudice.html