

Teaching Notes

COMMERCIAL SURROGACY AND FERTILITY TOURISM IN INDIA

The Case of Baby Manji

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Japanese couple Ikufumi and Yuki Yamada traveled to India in late 2007 to discuss with fertility specialist Dr. Nayna Patel their desire to hire a surrogate mother to bear a child for them. The doctor arranged a surrogacy contract with Pritiben Mehta, a married Indian woman with children. Dr. Patel supervised the creation of an embryo from Ikufumi Yamada's sperm and an egg harvested from an anonymous Indian woman. The embryo was then implanted into Mehta's womb. In June 2008, the Yamadas divorced, and a month later Baby Manji was born to the surrogate mother. Although Ikufumi wanted to raise the child, his ex-wife did not. Suddenly, Baby Manji had three mothers—the intended mother who had contracted for the surrogacy, the egg donor, and the gestational surrogate—yet legally she had none.

The surrogacy contract did not cover a situation such as this. Nor did any existing laws help to clarify the matter. Both the parentage and the nationality of Baby Manji were impossible to determine under existing definitions of family and citizenship under Indian and Japanese law. The situation soon grew into a legal and diplomatic crisis. The case of Baby Manji illustrates the complexity and challenges faced by institutions in the face of emerging technologies.

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1. Open class with reactions to the case:

- a. What do you know about commercial surrogacy and fertility tourism?
- b. Does anyone have personal or family experience with commercial surrogacy, or with traveling to another country for medical treatment? Does this case resonate in any way with your experiences or those you've heard about?

2. What triggered the crisis in this case? When did it occur?

In the most general terms, a “crisis” may be defined as a moment when understandings of “what should be” can no longer be applied to the situation at hand. Participants in the Baby Manji case experienced a sense of crisis on a personal level, but the crisis was also experienced at the institutional level when both the available understandings of family and the existing legal structures related to family and citizenship were unable to accommodate the phenomena of commercial surrogacy. Having two countries involved exacerbated the sense of crisis.

An important point to emphasize in the discussion is that institutional crises are complex, with multiple actors, causes and factors contributing to their development. We may limit our understanding of the case when we try to identify a single person or moment in time as the key to the crisis. A better approach may be to allow the layered complexity of the case to stand as it is.

Possible responses:

- a. The moment the contract was signed
- b. The Yamadas' divorce
- c. Baby Manji's birth
- d. When Mr. Yamada applied unsuccessfully for identity and travel documents for the baby
- e. When the case started to attract international media attention
- f. When the NGO Satya accused Akanksha of child trafficking
- g. When Dr. Patel refused to acknowledge Akanksha's role

3. For whom was this case a crisis? What was at stake for the different institutions, groups, and individuals involved?

Possible responses:

- a. **Akanksha Infertility Clinic and other such clinics**
 - i. Contestation over the Baby Manji situation threatened the legitimacy of infertility clinics in India. With a loss of legitimacy clinics would lose credibility with foreign clients and likely be more heavily regulated by the government. Both of these events could result in lost income for the clinics.

b. Medical tourism companies

- i. Medical tourism companies have made significant profits from commercial surrogacy by using sophisticated Internet-based strategies to market comprehensive services to prospective fertility patients. Designed to bridge the distance between healthcare consumers in developed countries on the one hand and healthcare providers and surrogates in developing and transitional-economy countries on the other, these services depend on low prices and lack of regulation in India to keep costs and hassles to a minimum.

c. Intended parents

- i. Fertility tourists now come to India in search of surrogates from a wide range of countries, including Britain, France, the United States, Canada, Singapore¹, Japan², Australia³, the Middle East⁴ and Israel⁵. The discrepancy between access to treatment at home and access abroad is perhaps the most significant contributor to the growth of fertility tourism in general and commercial surrogacy in particular.
- ii. Infertility patients are motivated to seek treatment abroad because costs are substantially lower. Many patients have exhausted their domestic options by the time they consider traveling abroad because of high treatment costs at home, often stemming from little or no insurance coverage for infertility procedures. Commercial surrogacy in India (US \$5,000-\$12,000) costs significantly less than in the United States (\$40,000-\$100,000).⁶
- iii. Another motivation is the ability to circumvent legislation in their home countries that precludes patients from receiving desired services. For example, eight US states (AZ, IN, KY, LA, MI, ND, NE and NY) and Washington, DC, and all but six European nations ban surrogacy outright, and many other states and countries discourage it.⁷
- iv. Going abroad can also allow patients to skirt restrictions such as bans on services for lesbians, gay men, older women or single people, and caps on the number of embryos that can be implanted in surrogates at one time. Fertility tourism can also help patients surmount administrative hurdles: Britain currently has a seven-year waiting list for donated eggs.⁸

d. Surrogates and egg donors

- i. Surrogates and egg donors earn significant fees from their services, and they consent to the procedures by signing contracts.
- ii. However, they also undergo invasive medical procedures such as intensive hormone treatments and multiple-embryo implantation without access to legal protection of their health and human rights. And the significant disparity in economic and social capital between fertility patients on the one hand and surrogates and egg donors on the other brings into question whether such consent can truly be considered fully informed.

¹ Mukherjee, Kritivas. "Rent-a-womb in India Fuels Surrogate Motherhood Debate." (Reuters, February 12, 2007). <http://geneticsandsociety.org/article.php?id=3386>.

² "Surrogacy a \$445 mn Business in India." *The Economic Times* (August 25, 2008).

³ Haworth, Abigail. August 2007. "Surrogate Mothers: Womb for Rent." *Marie Claire*. http://www.marieclaire.com/world/articles/surrogate-mothers-india_

⁴ Gupta, Jyotsna Agnihotri. 2006. "Towards Transnational Feminisms: Some Reflections and Concerns in Relation to the Globalization of Reproductive Technologies." *European Journal of Women's Studies* 13(1): 30.

⁵ Gentleman, Amelia. "India Nurtures Business of Surrogate Motherhood." *New York Times* (March 10, 2008).

⁶ Galpern, op. cit., pages 11-12.

⁷ Ibid, 17.

⁸ Higgins, op. cit.

e. People born via surrogacy

- i. Fundamental questions about the identity, parentage and nationality of people currently born via commercial surrogacy remain unanswered. Even if these questions are addressed in new legislation, the deeper issues that surrogacy raises remain. How does surrogacy complicate the identities of such people, and what tradeoffs are involved for them in permitting surrogacy contracts? How can their rights be protected when contracts are signed prior to their conception? What access to birth, medical and legal records should people born via surrogacy be entitled to over the course of their lives?

f. Indian government

- i. A key factor complicating reform of the commercial surrogacy industry is the lack of capacity in current Indian law to address emerging issues. This is an outgrowth of the government's enthusiastic promotion of a business climate that is friendly to the medical tourism industry, which was founded on the outsourcing model pioneered in other industries in India. At both the national and the state level, the Indian government promotes the country's reputation as a premier destination for medical tourism,⁹ because the industry serves as a driver of economic growth as well as an income generator for the state in the form of tax revenue. The absence of industry regulations attracts patients and keeps fertility treatment costs low.
- ii. "The legitimising of reproductive processes, like surrogacy, means legitimising its outcome too. Therefore, the law not only has to adapt to the new technology, but has to meet the challenge of marrying the old with the new without unsettling what we hold dear."¹⁰

g. Indian civil society

- i. Satya, an Indian social justice NGO, filed for custody of the baby, claiming she had been abandoned, a public gesture designed to draw attention to complex conflicting values about family, technology and commodification of children. What investment does civil society have in seeing these questions aired?
- ii. Tension exists in industrializing nations between economic growth and human rights. Of equal concern is the diversion of primary healthcare resources—including fertility treatment—away from low-income women and families in favor of the tertiary care offered to wealthier patients from India and abroad.¹¹

4. Can we envision this case unfolding differently if other structures had been in place, or is this just inevitably messy terrain?

- a. The case brought to light the inadequacy of the voluntary guidelines to address the family structures made possible by emerging biotechnology. The draft legislation would address the concerns of a broader array of stakeholders and expand the social contract beyond the gestation period. In what ways would this address the complex questions the case raises about family, parenthood and citizenship? In what ways would it fail to do so? Is it possible to redefine family under the law in such a way that accounts for the new relationships this case creates?

⁹ Mulay and Gibson, op. cit., page 85.

¹⁰ Makhija, Sonal. "New born challenges." *Daily News & Analysis* (October 12, 2008).

¹¹ Mulay and Gibson, op. cit., pages 91-92.

- b. Is the legal ambiguity of parentage in cases such as this only resolved by banning commercial surrogacy, as many other countries have? What are the risks and benefits of such a ban?
- c. What about disputes between the surrogate and the intended parents? Can the law ever adequately respond to the question about which parents have the larger claim to the child?