INTERNATIONAL JOURNAL FOR LEGAL RESEARCH AND ANALYSIS

Open Access, Refereed JournalMulti Disciplinary
Peer Reviewed Edition :

www.ijlra.com

 ISSN: 2582-6433

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ISSN: 2582-6433

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ISSN: 2582-6433

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ISSN: 2582-6433

ASSISTED REPRODUCTIVE TECHNOLOGY AND WOMEN'S REPRODUCTIVE HEALTH

AUTHORED BY - SHUBHRANGANA PUNDIR

Introduction to the topic-

The body of a human is a great machine, the workings of which remain a mystery. The future of childbirth in the form of test tube babies and surrogate motherhood has introduced previously unimagined potentials in the sexual arena. When human procreation is separated from sexual relationships, spouses can rapidly become entities for sex. It becomes difficult to recognize the dignity in one another, particularly in the unborn child. Science and technology, on the other hand, have made huge contributions to society. However, it is not morally justifiable and is rather controversial.

Birth and family are considered the most fundamental roots of life, and infertility is one of humanity's most serious problems. Surrogacy is one of the assisted reproductive techniques that employ the use of a third party. Given the absence of a specific reproductive and sexual health care program for surrogate mothers in Iran, as well as the challenges that these women will face, the findings of this study are useful sources of information for the necessary interventions to promote their reproductive and sexual health.

Fertility is regarded as a significant value in most cultures, and the desire to have a child is regarded as one of the most basic motivators in humans. Humans have made numerous attempts to overcome infertility since ancient times. These techniques were developed in response to the needs of infertile couples. Where conditions or diseases make it impossible to carry a pregnancy, third-party reproduction may be considered. This is known as gestational surrogacy. Meanwhile, gestational surrogacy may be one of the infertility treatments. This method takes the form of an agreement in which the woman agrees to carry a pregnancy and then hand over the child to the intended couple at the time of birth.

Congenital absence or abnormal uterus, hysterectomy, Mullerian anomaly, unexplained recurrent

ISSN: 2582-6433

miscarriages, repeated failures in infertility treatments, inability in embryo implantation, prenatal medical conditions when pregnancy would increase the chances to her health, use of teratogenic drugs by the mother to treat the disease, and finally a poor obstetric history are the most common indicators necessitating gestational surrogacy (GS). Surrogate mothers face a variety of pregnancy and delivery issues that other women do not because of the peculiar characteristics of gestational surrogacy.

Women's health issues within the realm of Artificial Reproductive Technology-

Surrogate mother reproductive and sexual health care is not well covered in standard obstetric textbooks, and there are few clinical practice guidelines on the subject. Surrogacy is becoming increasingly common, so providers of reproductive health care must be aware of the related ethical, legal, and birth issues. This phenomenon has sparked public debate about the potential consequences of surrogacy, including economic oppression, ethical ambiguity, and psychological harm to the surrogate mother. Surrogacy raises more questions about healthcare, legitimate, and psychological screening, counseling, antenatal care and delivery, legal, breastfeeding, and psychological issues after birth. All of these issues necessitate a collaborative approach by all participants, including obstetricians, gynecologists, midwives, psychotherapists, lawyers, surrogate mothers and envisioned couples, infertility clinics, aid agencies, and hospitals.

Even though surrogacy has been practiced since the 1980s, it is still regarded as a novel method that necessitates evaluation, policy formulation, programming, and a comprehensive and in-depth introduction from various perspectives, and each field of science should contribute to illuminating its various aspects. When it comes to surrogacy, it is critical to consider not only the scientific, medical, and even legal aspects of the procedure, but also the feelings, experiences, and concerns of the women who use it.

With advancements in medical sciences and technology, especially in assisted reproductive techniques that have revolutionized the reproductive environment with techniques such as donor insemination, embryo transfer methods, and so on, methods such as surrogacy are also gaining popularity for a variety of reasons. A surrogate mother, as the term is commonly used, is a woman who is paid to bear a child for her employer and then returns the child at birth. The term 'surrogate'

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means substitute.[1]

Aside from surrogacy arrangements occurring within the family, community, state, and country as a result of low-cost medical facilities combined with advanced reproductive technological know-how, India is gradually but steadily becoming a great attraction forsurrogacy arrangements to several foreigners, particularly wealthy Westerners. When financialarrangements are made in exchange for the surrogate child, the child becomes a 'saleable commodity,' complications arise and issues such as the privileges of the surrogate mother, thechild, and the commissioning parents become involved. To address and regulate surrogacy arrangements the Government of India has taken certain steps such as the introduction and implementation of National Guidelines for Accreditation, Supervision and Regulation of Assisted Reproductive Technology (ART) Clinics in India, 2005 by the Indian Council of Medical Research (ICMR) under the Ministry of Health and Family Welfare, Government of India.[2]

Despite the growing popularity of surrogacy, this treatment method is fraught with complications. Surrogate mothers' reproductive and sexual health care is not well covered in obstetric textbooks, and there are few clinical practice guidelines on the subject.

The Feminist and Radical Viewpoint-

From their first use in the late 1970s until the mid-1990s, ART was a topic of serious concern for feminists internationally.[3] Issues ranged from assessing health risks to ethical and political issues raised by these technologies. Radical feminists addressed issues of choice as controversial: despite the assertions of preference surrounding ART, it has not increased women's reproductive freedom. Indeed, the healthcare, legal, and commercial advancements of ART, as well as the shift in social perception of motherhood brought about by the use of IVF and surrogacy, have set up forms of authority over female reproduction.

[1] Karkal M. Surrogacy from a feminist perspective. Issues med ethics. 1997 oct-dec;5(4):115-6. PMID: 16267915.

[2] *National Guidelines for Assisted Reproductive Technology: Ethical Issues in Surrogacy* - Paper presented by Dr. R.S. Sharma, DDG (SG), Division of RHN, Indian Council of Medical Research, New Delhi at the meeting-cumworkshop organized by the Ministry of Women and Child Development, Govt. of India on 25th June 2008 atIndia Islamic Centre, New Delhi.

[3] Corradi, Laura Maria (2021) "Assisted Reproductive Technologies and Health-Related Issues Among Women and Children: A Research Review," Dignity: A Journal of Analysis of Exploitation and Violence: Vol. 6: Iss. 2, Article 2.

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Over the last two decades, there has been a rapid increase in the number of technologies that aid reproduction, increasing the likelihood of conception and carrying a pregnancy through to term. The term "Assisted Reproductive Technologies" (ARTs) incorporates multiple procedures, ranging from the relatively simple intrauterine insemination (IUI) to variants\s of in-vitro fertilization and embryo transfer (IVF-ET), also referred \s to as IVF and more commonly known as "test-tube baby technology". These technologies have advanced at a rapid pace since the latter half of the twentieth century. They have also had an impact on how society views pregnancy, reproduction, and motherhood.

The first IVF baby in India may have been born just a few months after Louise Brown, the world's first IVF baby, was born in the UK in 1978. Dr. Subhas Mukherjee of Kolkata claimed responsibility for Durga, the world's second IVF baby. However, his claim was rejected because it was deemed insufficiently documented. 1 On August 6, 1986, India's first "scientifically documented" IVF baby was born. Harsha Chawla was born as a result of the collaborative scientific research of the Indian Council of Medical Research's (ICMR) Institute for Research in Reproduction and Mumbai's King Edward Memorial Hospital. [ICMR 2005].

As a result, the pull towards ART services is not the same for people all over the world. Infertility in the West is not subject to the oppression of social stigma that the infertile face in India. The contributory factors in this context are legal prohibitions or hassles, delays, and cost differential. Unlike overcoming the stigma associated with infertility, exercising choice in childbirth is important for Western couples seeking ARTs across national borders. The worth of children and having them raise and/or form families varies by culture.

While having one's child to raise and form a family may be a priority for gay and single people - married or unmarried - and couples from non-Asian societies, for NRIs and South Asian couples, eradicating the stigma of infertility and starting a family may be a bigger draw for ART.

India is quickly becoming a top location for reproductive tourism. The considerable number of ART clinics and fertility centers in company hospitals in the private health sector offer cutting-edge technology and expert medical care to those seeking to have their child. Infertility clinics displaying their services and achievements, particularly in terms of survival rates with pictures of babies born from ART procedures, are becoming more common.

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ARTs are used to treat infertility in women, such as blocked fallopian tubes and poor ovarian function. Even in cases of severe medical impairment, such as a lacking uterus or impaired egg production, ARTs attempt to treat female infertility through egg donation and/or surrogacy services. Since the first IVF baby was born in 1978, these services have grown exponentially. They have given hope to millions of aspiring adults, including those who are past reproductive age, to have their children. Many stories about the success of medical feats are widely publicized, and they inspire admiration for ART's achievements.

India's vantage point-

The Surrogacy (Regulation) Bill, which was introduced in the Lok Sabha on July 15, 2019, was referred to a select committee. The report was tabled before the standing committee on February 5, 2020, following a thorough revision of the Bill. The Bill was later passed by both houses of Parliament during the winter session of 2021. The President signed it, and it goes into effect in January 2022. Surrogacy is defined in the Act as a practice in which a woman bears a child for a commissioning couple to hand it over to them after the birth. It is only permitted for charitable purposes or for couples suffering from proven infertility or disease. Surrogacy for commercial purposes, including the sale, prostitution, or any other form of exploitation, is prohibited.

Furthermore, once the child is born, it will be considered the couple's biological child. Abortion of such a fetus is permitted only with the consent of the surrogate mother and by the provisions of the Medical Termination of Pregnancy Act.

Increased technological intervention in the processes by which women conceive strengthens the male-dominated medical profession's control over procreation, inevitably leading to greatersocial control of women by men. With discussions of "harvesting" eggs and "uterine environments," the language of reproductive technology already vividly illustrates the extent to which women's bodies are dehumanized. The development of the concept of a "surrogate mother" is linked to the rise of these technologies. The term itself is misleading. The woman isnot a surrogate; she is the child's biological mother. Business companies can more easilycontrol and exploit the woman's pregnancy by naming her as a surrogate and rejecting her biological relationship with her child. Surrogacy issues are too complex to discuss here, but insummary, surrogacy promotes women's economic, physical, and emotional exploitation. In exchange for money, a woman who engages her body as a "surrogate" mother concurs to giveup power over her pregnant body. She may face

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a future of grief similar to that of women whohave given up their children for adoption. It is acknowledged that some women experience emotional problems in handing over the baby or as a result of the reactions around them, thesefeelings appeared to lessen during the weeks following the birth.[4]

There is also a growing debate about the rights of the fetus to be regarded as a "patient," which arises from how reproductive technologies separate women from the embryo/fetus. The representation of women as merely capsules or packaging for the fetus in discussions of the fetus as a "patient" is horrifying. In debates over a coercive cesarian section, doctors have asserted the power to restrain a woman and perform the surgery under court order if the womanrefuses surgery and the fetus is said to be in danger.

Motherhood and Women's Reproductive Autonomy, through the lens of Artificial Reproductive Technology-

Surrogate motherhood as an arrangement, in which a woman takes no ownership of the child born, has raised moral, ethical social, and legal questions about both woman and the 'Commissioned baby'.[5] The commercialization of new reproductive technologies and surrogacy has promoted profit-driven research (as opposed to public health services). These technologies also attract significant federal money in Australia, diverting research and resources away from the less glamorous work of infertility prevention.

This scenario's problems include the verification of upper-middle-class definitions of the perfect baby, an inability to recognize infertility, mortality, and imperfection, and the consequences for human society of the split between sexuality and procreation. Because women have always had complete control over reproduction, even in patriarchal cultures, technological advances have disturbing ramifications for our lives.

For many women—past, present, and future—childbearing is the primary source of power from which to deal with the conditions of their existence. According to research, problems can arisein

[4] Jadva V, Murray C, Lycett E, MacCallum F, Golombok S. Surrogacy: The experiences of surrogate mothers.Hum Reprod 2003; 18:2196-204.
[5] A, Kumar P, Inder D, Sharma N. Surrogacy and women's right to health in India: Issues and perspective. Indian J Public Health 2013; 57:65-70.

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families where babies were created through "donation" of gametes or surrogacy. The lack ofa "bio-social connection" with the surrogate mother hurts children's psychological well-being.According to the researchers, the absence of a correlation with the surrogate mother (who givesbirth to them) is more troublesome for children than the absence of a link with the genetic donors. In other words, while the terms "paternity" and "maternity" are socially conditioned, nine months of a conceptual relationship cannot be dismissed as a purely biological issue. Thesurrogate mother is more than just a "carrier," she is one of two elements of a living dead, exchanging biological, emotional, and some genetic information with the developing child.

An intentional mother receiving a genetically unrelated HET embryo with donated gametes hasthe option of growing the child in her womb, forming a significant physiological tie with him/her during pregnancy, delivery, and nursing. In the case of gestational surrogacy, on the other hand, such elements of connection are completely absent. In the last decade, researchershave looked into the consequences of separating a newborn baby from the woman who just gave birth to him or her. The surrogate's breasts are full of milk after birth, and she must undergo hormonal treatments to stop the milk flow (lactogenesis). After delivery, the surrogatemother may feel psychologically attached to the child she conceived during pregnancy and to whom she gave birth.

Surrogacy is not a new concept in India. Commercial surrogacy, also known as "womb for rent," is a thriving industry in India. In India, an English-speaking environment and lower-costservices attract eager customers. Surrogacy practice's future projections range from the opportunity to exploitation - from rural women in India lifted out of poverty to a dystopian nightmare of developing country baby farms. In the case of surrogacy in India, it is difficult todetermine whether these women are exercising their rights or are coerced into becoming surrogate mothers by their mother-in-law or husband's desire to meet material and financial needs.

Surrogacy opponents argue that the practice is morally equal to prostitution and that, as such, it should be prohibited. Surrogacy contracts are "dehumanizing and alienating" because they deny the credibility of the surrogate's pregnancy perspective. The surrogate mother attempts toavoid developing a special bond with the child in her womb and views the pregnancy as merelya means of earning much-needed funds. Payment for bodily offerings dehumanizes the surrogate mother and misuses her reproductive organs and capacity for the wealthy's gain.

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Surrogacy outsourcing is a fraudulent practice. There is presently no law in place to safeguard surrogate mothers in the incident of birth complications, forced abortion, or other similar situations. Artificial insemination has been nearly legal in India since 2002, and the country has surfaced as a sort of pioneer in the field. This is why critics believe that the surrogacy industry utilizes poor women in countries like India, where maternal mortality is already high.

In India, the Ministry of Women and Child Development is investigating the issue of surrogate motherhood to draft comprehensive legislation. The Indian Council of Medical Research (ICMR) has proposed strict penalties for violators and tight regulation of Assisted Reproductive Techniques in draught legislation on surrogacy (ART). The proposed law limitsthe number of embryo transfers a mother can undergo for the same couple to three if the first two attempts fail, and it also states that no woman should behave as a surrogate for more thanthree live births in her lifetime. The ICMR and the Ministry of Health and Family Welfare issued only these guidelines in 2005. "A relative, a known person, or a person unknown to thecouple may act as a surrogate mother for the couple," according to ICMR guidelines. If a relative is acting as a surrogate, the relative must be of the same generation as the woman seeking the surrogate."

Before accepting a woman as a potential surrogate for a specific couple, the ART Clinic must ensure (and document) that the woman meets all testable criteria for a successful full-term pregnancy." These guidelines are lopsided and rash. The fragmented role of women insurrogate structures has prompted a reconsideration of the definition of motherhood and the classification of maternal rights. Surrogacy opponents argue that the practice is morally equalto prostitution and that, as such, it should be prohibited. Surrogacy contracts are "dehumanizing and alienating" because they deny the validity of the surrogate's pregnancy perspective. The surrogate mother attempts to avoid developing a special bond with the child in her womb and views the pregnancy as merely a means of earning much-needed funds. Compensation for bodily services dehumanizes the surrogate mother and misuses her reproductive organs and capacity for the wealthy's gain.

Conclusion-

In this paper, I discussed various physical and psychosocial issues affecting women who use IVF, egg suppliers, surrogate mothers, commissioning parents, and children conceived using these technologies. Much more research on all aspects of ART is required: We are witnessingthe emergence of a breeder category: women from poor countries or migrants, women of color,or

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women from the white lower classes—often in need of paying their mortgage debt or sendingtheir children to college—who are producing children for (economically better off) third parties. What a social process cannot be regarded as unproblematic or as a personal matter. Infeminist research and the social sciences, the interpretive task of creating a baby should be reconsidered through the lens of an intersectional approach. This is particularly important because, as analyzed in this paper, there is a long list of recorded serious short- and long-termhealth hazards in peer-reviewed journal articles for women and children born from ART, which should be discussed alongside the social and ethical issues I have raised. Other issues concernthe right of several subjects involved in ART to know and risk disclosure about potential harm.

Problems involved

Mothers are not fully briefed about the risks to their health as a result of current medical research studies. Should intended parents (whether infertile couples, single women, lesbians, gay men, intersexual or transsexual people) be denied the right to know about the negative health effects of ART on the children they pay for? Should children born through gamete donation and/or surrogacy not be aware of their biological origins and who gave birth to them?Do these children not have the right to a healthy birth? Fertility in both men and women is unquestionably declining in developed countries, and ART could become an even more widespread occurrence. We all know that environmental pollution and the widespread presenceof chemical and physical hazards. Chemical carcinogens hurt our genetic structure, reproductive potential, and the health of our progeny in the future. Today, sensitivity to chemical and physical carcinogens causes harm to future generations and reduces theirreproductive capacities. Answers may be found in ecologically based prevention policies, cultural shifts around the concept of maternity and parenting, and legislation that allows singlewomen, LGBT members, and alternative families to live together. Women's health has historically been a common ground for feminist activism; it should reclaim the center of the ART debate as a political priority and non-divisive goal.

It can be depressing to consider the barriers to reproductive justice, the backlash against women's rights movements' gains, the failure of public officials to enforce laws that guaranteewomen's rights, and the engrained traditions and political views that motivate politicians to deny funding for women's reproductive health and to enact laws that close clinics that provide necessary services.

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As a sad paradox, men run governments, train doctors, manufacture birth-control devices, distribute grant money, decide on the accessibility of abortion, and run the businesses that market the products and make money. As *Jalna Hanmer and Pat Allen* have said, women act as individual and social power agents.[6] We proceed to conspire against ourselves. The revived positive attitude toward motherhood discussed ordinarily supposes that all women canbecome pregnant voluntarily and easily through sexual intercourse. It existed before the emergence of the technologies discussed here. Ironically, this shift toward positively valuing women's reproductive roles has provided technopatriarchs in medical research with justification for maintaining control over and experimentation on women's bodies in the nameof mothering power.

We need to rethink what "choice" means for women in the context of biomedical and its complement, genetic engineering. *As Barbara Katz Rothman has commented, in gaining the choice to control the quality of our children, we may lose the choice not to control the quality,that is, the choice of simply accepting them as they are*. She points out that we also forfeit the right not to know some things, like the sex of the unborn child.[7] One of the fundamental elements of the women's movement has been to ensure and safeguard the right to choose sexuality and reproduction. We demanded the ability to choose whether or not to have childrenand gained access to both contraception and abortion.

[6] Jalna Hanmer and Pat Allen, "Reproductive Engineering: The Final Solution?" in Alice through the Microscope: The Power of Science in Women's Lives, ed. Brighton Women and Science Group (London: Virago, 1980).

7 Barbara Katz Rothman, "The Meanings of Choice in Reproductive Technology," in Arditti et al. (n. 22 above).