Editorial

Third party Reproduction in Recent Scenario

Present day advancement in assisted reproductive technology (ART) procedures has opened a new area known as surrogacy which can otherwise be called third party reproduction. Third party reproduction made it possible for a child to have 5 parents as following genetic mother, genetic father, gestational mother, rearing mother, rearing father. As the procedure is becoming popular now-a-days, the necessity of detailed information about social, psychological and legal aspects are of immense importance. A surrogate mother (SM) is a woman who carries pregnancy for another woman. The ethical, moral and legal issues have far lagged behind the technical development in the process of third party reproduction. The first in-vitro fertilization (IVF) surrogate pregnancy occurred in the United States in 1985. This is called gestational surrogacy where egg and sperm of two other individuals are used to create a pregnancy in the carried by using IVF technology. Gestational carrier arrangements have become more common in recent years, in part due to the availability of IVF, and in part due to their reduced legal risk. The few reported decisions reflect a general consensus that the couple providing the gametes and intending to parent the child are the child’s legal parents, overcoming any common law presumption of maternity based on giving birth. The other form of surrogacy is traditional surrogacy where IVF procedure is not required. In these cases the surrogate is inseminated with sperm of the male partner of infertile couple. In the former form of surrogacy the carrier is not genetically related to the child but in the later form the new born is genetically related to the surrogate and the male partner, but not the infertile female partner otherwise called rearing up mother. So in traditional surrogacy, the infertile couple should legally adopt this child after birth. A gestational carrier contract should be as comprehensive as possible, setting forth, for example, the parties’ intentions with respect to the parentage of the child, their financial arrangements, prenatal care, delivery plans, selective reduction, abortion, future contact among the parties, and co-operation on legal steps to establish parentage. Because of constitutional procreative rights and protections, specific performance of certain critical aspects of an agreement, such as selective reduction and abortion, is highly unlikely. Should a carrier breach that aspect of an agreement, provisions for damages may be appropriate and enforceable. Gestational surrogacy may be considered by a woman who has functioning ovaries but either absent or non-
functioning or malformed uterus. In certain situations where pregnancy may cause a threat to the life of the female partner, gestational surrogacy may be considered. Traditional surrogacy is called for when ovaries of a woman are non-functioning and classically where the uterus is also absent or non-functioning along with. This form of surrogacy may also be considered by a woman who has a transmissible genetic disease. Before selecting a surrogate, the screening procedures, psychological and legal issues are to be considered. The ethical, moral and social issues need careful consideration as well.

As the demand of surrogacy increasing in India along with ART procedures ICMR has come out with many guidelines about ART for surrogacy. The ICMR guidelines are as follows:

A child born through surrogacy should be adopted by genetic/rearing parents unless they can establish through genetic fingerprinting that the child is theirs (records should be available). Gestational surrogacy should be considered for indicated cases only. Payments to surrogate mothers should cover all genuine expenses (documents must be available).

ART centers should not to be involved in money matters. ART clinics not to advertise for surrogate mum. Search to be performed by the intended couple, semen banks or legal firms. SM should not be 45 years of age, ART clinics must ensure the health of a woman by standard screening procedures before accepting as SM.

A relative, a woman, known or unknown can serve as SM though the relative should be of same generation. A prospective SM should be seronegative for HIV even just before ET, SM to give in wiring that no intravenous drug abuse by shared syringe, no blood transfusion, she and her husband (to best of her knowledge) did not have any extramarital relation in last six months.

Declaration by SM for non-use of intravenous drugs and not accepting any blood transfusion except obtained from certified bank. No woman can be SM more than thrice in her lifetime. The outcome of surrogate pregnancies undertaken in our centre is encouraging. The procedure is still less popular in our country as compared to western world for social reasons but will be more acceptable in the near future. There is tremendous scope of research in this field. Creating a pregnancy in places other than uterus may be a good thought. Developing an embryo in natural or artificial container where a suitable surface for implantation and placental development can be provided is another way of achieving success. This procedure might be complete in-vitro pregnancy. Using stem cell technology to create artificial uterus may be the best solution in women having absent, removed or diseased uterus. This is still at a hypothetical level.

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