



Institutions in Crisis

COMMERCIAL SURROGACY AND FERTILITY TOURISM IN INDIA

The Case of Baby Manji

Kari Points

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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Introduction

Gynecologist Nayna Patel is the medical director of the Akanksha Infertility Clinic. Located in the small city of Anand in the northwestern Indian state of Gujarat, Akanksha has made a name for itself as the global hub of the commercial surrogacy industry. In November 2007, Japanese couple Ikufumi and Yuki Yamada discussed with Dr. Patel their desire to hire a surrogate mother to bear a child for them. The doctor arranged a surrogacy contract with Pritiben Mehta,² a married Indian woman with children. Under Dr. Patel's supervision, the clinic staff created an embryo from Ikufumi Yamada's sperm and an egg harvested from an anonymous Indian woman.³ They then implanted the embryo into Mehta's womb.

In June 2008, the Yamadas divorced. A month later, on July 25, 2008, Baby Manji was born to the surrogate mother. Although Ikufumi Yamada wanted to raise the child, his ex-wife, Yuki, did not. The way she saw it, she was unrelated to the baby biologically, genetically and legally. Under the terms of the agreement with the clinic, the egg donor's responsibility had ended once she provided the egg, and the surrogate's job was finished as soon as she gave birth. 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. Was she Indian? Was she Japanese? Could she have an identity and a nationality without having a mother?

The surrogacy contract did not cover a situation such as this. Nor did any existing laws help to clarify the matter. In fact, no binding regulations on the surrogacy industry existed in India at all. As far as Dr. Patel was concerned, the clinic had fulfilled its promise to produce a baby. The situation soon grew into a legal and diplomatic crisis. Both the parentage and the nationality of Baby Manji were impossible to determine under existing definitions of family and citizenship in Indian and Japanese law. Yamada and his elderly mother launched a months-long campaign to secure the paperwork needed to bring the baby to Japan. The story of Baby Manji generated intense media coverage and public debate in India.⁴ It also obliged clinics like Akanksha to reexamine their purpose and practices in light of evolving beliefs around commercial surrogacy in India.

The Development of Fertility Tourism in India

When the Yamadas traveled to India to find a surrogate, they joined a growing line of hopeful infertility patients from around the world. They were the latest participants in a phenomenon known as fertility tourism, which works as follows: Patients with fertility problems go abroad to receive medical services—surrogacy, third-party gamete (egg and sperm) transfer, and in-vitro fertilization—in order to have a baby. In the late 1970s, these treatments (known collectively as *assisted reproductive technologies*, or ARTs) became commercially available in industrialized countries for the first time. Soon the demand for ARTs started to rise. Over time, in response to emerging ethical, religious, and health concerns, some governments in industrialized countries moved toward regulating the services. Stricter legislation limited patients' access to treatment in various ways: It banned or limited certain procedures

¹ This case generated nearly 100 articles in the newspapers I surveyed: *The Hindustan Times*, *Daily News & Analysis*, and the *Times of India* (India's papers of record), as well as *The Economic Times*, *Japan Times*, *Daily Yomiuri* (Tokyo), the *Straits Times* (Singapore), *The New Zealand Herald*, *South China Morning Post*, *The Australian*, *The Advertiser* (Australia), *London Times*, the *Daily Mail*, BBC News, CNN, and *The New York Times*. My media survey spanned mid-July 2008 to mid-May 2009. I ascertained the timeline of events and facts of the case from these accounts. Although to the best of my knowledge what I have presented here is an accurate representation of what happened, the articles often provided conflicting details.

² Initially the surrogate mother was anonymous, per the terms of the contract. Eventually her name and some biographical details became public.

³ One report identifies the egg donor as a Nepali woman living in India. See Brasor, Philip. "Surrogate path for dads not always as easy as for Ricky." *The Japan Times* (August 31, 2008).

⁴ Jayaram, P. "OK to Rent Womb in India: Court Ruling and New Bill Will Legalise an Industry Worth About US\$445m." *The Straits Times* (October 6, 2008)

(such as the implantation of multiple embryos), excluded some patients from treatment (older women, lesbians and gay men, single women), and caused long delays (due to limited supply of donated eggs stemming from restrictions on payments to donors, for example).⁵

ART clinics based in India and other developing countries emerged in part in response to these barriers. The niche marketing of fertility tourism to infertile couples from abroad gained traction particularly in India, which became the world's top destination for commercial surrogacy. Key reasons for India's dominance include its much lower costs, the large number of women willing to engage in surrogacy, top-notch private healthcare, English-speaking providers, a business climate that encourages the outsourcing of Indian labor, world-famous tourist destinations, and the total absence of government regulation. It is also one of just a handful of countries around the world in which commercial surrogacy is legal. One estimate calculates India's rapidly growing commercial surrogacy industry is worth U.S. \$445 million per year.⁶ Infertility clinics, healthcare providers, medical tourism companies, the broader tourism industry, the Indian government, and the women who provide surrogacy services all profit from this industry. However, whether the interests and rights of infertility patients, surrogates, egg donors, and the resulting children are protected—particularly once those children are born—is an open question. Dr. Sadhana Arya, one of the doctors who cared for Manji at Arya Hospital in Jaipur, said, “You have treated the surrogate mother like an object, used her as a factory, produced something, given money for it.” But the result is “a live child.” She added, “I think this should end. There should be stricter laws.”⁷ Although the Indian Council of Medical Research (ICMR), under the auspices of the Indian Ministry of Health, issued voluntary guidelines for ART clinics in 2002 and updated them in 2005, these guidelines are not binding.⁸ Vagueness on key issues such as surrogates' rights, surrogates' minimum age, contract specifics, informed consent, and requirements regarding adoption has made the voluntary guidelines a target of considerable criticism in India.⁹

History & Mission of the Akanksha Infertility Clinic

Akanksha Infertility Clinic was founded in 2002 in Anand, Gujarat, as a private medical clinic under the auspices of Kaival Hospital, a maternity hospital. Akanksha's broadly defined goal is “to give a helping hand with modern techniques to many infertile couples.”¹⁰ Dr. Patel started to specialize in commercial surrogacy services after a Gujarati woman gave birth to her own British daughter's twins at Akanksha in January 2004. Dr. Patel capitalized on the extensive media attention the case generated, and soon Akanksha had become the epicenter of the commercial surrogacy industry in India.¹¹

In the beginning, most consumers of commercial surrogacy services in India were a mix of non-resident Indians living abroad and local elites. As international media attention grew, the client balance shifted away from Indians and toward foreign nationals.¹² This same shift took place at Akanksha: “At first, the couples we helped were Indian, but now they come from all over the world,” said Dr. Patel in late 2007. “They are just ordinary, middle-class

⁵ Storrow, Richard F. 2006. “Quests for Conception: Fertility Tourists, Globalization and Feminist Legal Theory.” *Hastings Law Journal*, 57: 302-303.

⁶ “Surrogacy a \$445 mn Business in India.” *The Economic Times* (August 25, 2008).

⁷ Sidner, Sara. “Surrogate Baby Stuck in Legal Limbo.” CNN Online (August 12, 2008). Accessed May 22, 2009: www.cnn.com/2008/WORLD/asiapcf/08/12/surrogate.baby/index.html.

⁸ *National Guidelines for Accreditation, Supervision, and Regulation of ART Clinics in India*. 2005. Indian Council of Medical Research, New Dehli.

⁹ Sarojini, N.B., and Aastha Sharma. “Guidelines not enough, enact surrogacy laws.” *Hindustan Times* (August 7, 2008).

¹⁰ Akanksha Infertility Clinic website. http://ivfcharotar.com/about_us.html. Accessed December 2, 2008.

¹¹ Dunbar, Polly. “Wombs to Rent: Childless British Couples Pay Indian Women to Carry Their Babies.” *Daily Mail*, (December 8, 2007).

¹² Mulay, Shree, and Emily Gibson. 2006. “Marketing of Assisted Human Reproduction and the Indian State.” *Development*, 49(4): 84.

couples who feel they have run out of options in their own country.”¹³ In 2008, Akanksha reportedly was receiving 40 to 50 requests each month from couples around the world interested in hiring a surrogate¹⁴ and had 30 pregnant surrogates at any given time.¹⁵ According to Dr. Patel, “The service we provide is a big relief to the couples we treat because it is not only cheaper, but Indian law makes it much more straightforward for everyone.”¹⁶

Public information about the inner workings of the clinic is hard to come by. In addition to Dr. Patel, who is Akanksha’s medical director, the clinic staff includes nine doctors—mostly infertility specialists—and several lab technicians. It appears from media accounts of Baby Manji’s story that Dr. Patel is the sole staff member who represents the clinic to the media, government and general public. Although the clinic claims in recent years to have “achieved some of the best results,”¹⁷ it is unclear who the competitors are or what the criteria are for this distinction. Nor does the clinic provide information regarding its staff’s training or professional experience, or statistical data on its success rates.

From Dr. Patel’s perspective, everyone involved benefits from commercial surrogacy:

A woman who becomes a surrogate is paid more money than she could earn in her entire lifetime. She is doing something that she believes is good and makes her proud—bearing a child for a couple desperate to start a family, while at the same time providing for her own family. . . . It is easy for people in India and abroad who have never experienced infertility or poverty to say this is exploitation. But we are providing a service that profoundly changes people’s lives for the better. ¹⁸

Yet she acknowledges the potential for abuse: “It is sad if [the surrogates] are going into it purely because they need the money and there is also the risk that the children are being treated as commodities, which would be totally wrong.”¹⁹ Dr Patel says she makes sure surrogates freely consent to the contracts and are not pressured by their husbands or families. She admits the growing business in India may warrant government oversight, stating, “There is little regulation by the Indian Medical Council. Rules do need to be tighter to ensure women are not exploited in the future.”²⁰ There is no evidence in Akanksha’s publicity materials that the clinic adheres to ICMR’s voluntary guidelines for infertility clinics.

Contracting for Baby Manji

In late November 2007, at the Akanksha Infertility Clinic, Dr. Patel arranged a contract between Japanese couple Ikufumi and Yuki Yamada and surrogate mother Pritiben Mehta. As a hint of problems to come, the couple included a clause that the husband would care for the child in case the couple separated. According to Akanksha’s standard procedure, the surrogate signed away all rights to the baby. While the Yamadas waited, the clinic created an embryo from Yamada’s sperm and an egg from an anonymous donor and implanted it in Mehta. The Yamadas then returned to Japan to await the birth of the baby. In exchange for her services, Mehta received a house worth 325,000 rupees

¹³ Dunbar, op cit.

¹⁴ Sehgal, Priti. October 7, 2008. “Reproductive Tourism Soars in India: Adoption and Surrogacy Laws Have Yet to Catch Up.” *The Women’s International Perspective*.

¹⁵ Blakely, Rhys. “Surrogacy Orphan Trapped in Red Tape after Mothers Abandon Her.” *The London Times*, (August 7, 2008).

¹⁶ Dunbar, op cit.

¹⁷ Akanksha Infertility Clinic website: www.ivfcharotar.com/contactus.html.

¹⁸ Dunbar, op. cit.

¹⁹ Ibid.

²⁰ Ibid.

(US \$6,825), a payment of 50,000 rupees (US \$1,050), and 5,000 rupees (US \$105) per month for living expenses while pregnant. The monthly total was equal to “the salary of a well-paid blue-collar job” in India.²¹

The Birth

Eight months later, just a month before the baby was born, the Yamadas divorced. On July 25, 2008, Manji was born in a private hospital in Ahmedabad, Gujarat. When Yamada’s ex-wife (the intended mother) refused to travel with him to take possession of Manji, he flew to India alone. The anonymous egg donor (the genetic mother) had neither rights nor responsibilities toward the baby. The responsibility of Mehta (the gestational mother) had ended when the baby was born. It turned out none of the three mothers was legally responsible for Baby Manji, because the contract was not legally binding with regard to parental responsibilities.

The day after her birth, 17 explosions rocked Ahmedabad, killing 49 people and injuring over 200.²² An Indian friend of the Yamada family, Kamal Vijayvargiya, saw that Manji was moved to Arya Hospital in Jaipur, Rajasthan, 657 kilometers (408 miles) to the northeast, for her safety. Having contracted septicemia and viral infections, Manji stayed there for an extended time. Vijayvargiya’s wife, Shweta, who had given birth to her own baby the day before Manji arrived, breastfed her while she was in the hospital. Manji stayed on in the hospital once her health had improved because it was unclear who would receive custody.

Determining Baby Manji’s Identity, Family & Nationality

At first Yamada tried to secure documents to take the baby to Japan. But the Japanese Embassy in India refused to grant Manji a Japanese passport or visa. The Japanese Civil Code recognizes as the mother only the woman who gives birth to a baby. The code does not recognize surrogate children.²³ In this case, the woman who birthed Manji was Indian, not Japanese, which meant Manji was not entitled to a Japanese passport.

Yamada’s next stop was the Indian government. For a time, even though he was her genetic father, it looked as though he would have to adopt Manji. Because Indian laws don’t address commercial surrogacy, the genetic parents of babies born via surrogacy are required to adopt them. Again Yamada hit a legal snag: A 120-year-old law (Guardians and Wards Act 1890) does not allow single men to adopt baby girls. When approached by the press, Dr. Patel insisted that Yamada did not need to adopt the baby, because he was the biological father.²⁴ Despite this fact, Manji was not allowed to leave the hospital with Yamada.

Yamada then tried to file for an Indian passport for Manji, a document that requires a birth certificate before it can be issued. According to Indian law, a birth certificate requires the names of both mother and father. Although Akanksha Infertility Clinic certified that Yamada was Manji’s genetic father, the vital records registrar was uncertain which mother should appear on the document: Yuki Yamada, Pritiben Mehta, or the anonymous egg donor. On these grounds, the Municipal Council of Anand refused to grant Manji a birth certificate and referred the case to the national level for advice. Since Yamada is not Indian, and it was unclear whether Manji’s mother should be considered Indian, national offices also refused to issue a passport.

²¹ Blakely, op. cit.

²² Sengupta, Somini. “Terrorist Attacks Unsettling India.” *The New York Times* (July 29, 2008).

²³ Although surrogacy is not legally banned in Japan, the Japan Society of Obstetrics and Gynecology has issued nonbinding guidelines prohibiting the practice. See “Surrogacy baby awarded normal status.” *The Japan Times* (April 23, 2009). <http://search.japantimes.co.jp/print/nn20090423a7.html>. Nor does the practice enjoy popular acceptance, according to Brasor: . See Brasor, Philip. “Surrogate Path for Dads Not Always as Easy as for Ricky.” *The Japan Times* (August 31, 2008).

²⁴ Blakely, op. cit.

It was becoming clear that Yamada and his daughter were caught between two legal systems, neither of which was prepared to handle a case like theirs. He hired noted attorney Indira Jaisingh, who took the position that Manji had the right to live with her Japanese family and should receive Japanese nationality. She filed an appeal with the Indian government to issue documents for Manji and claimed the records made clear that Yamada was her father. Two days later, on August 8, the Anand municipality issued a birth certificate to Manji Yamada. The president of the Anand City Council said, “The issue was complicated as the baby technically has three mothers...and we had no experience of issuing a birth certificate in such cases. But now the certificate has been issued stating only her father’s name.”²⁵ Finally the official process for the application for a travel document to Japan could proceed.

In the meantime, Manji’s paternal grandmother, Emiko Yamada, had traveled to India to care for Manji in the hospital because her son had returned to Japan upon the expiration of his visa. She was reported to be “very emotional” regarding the authorities’ refusal to allow her son to take Manji out of India.²⁶ As soon as the vital records office granted the birth certificate, she filed a petition in Rajasthan High Court for temporary custody as Manji’s closest blood relative in India, until custody could be transferred to her son. “From deep inside my heart, I want to return immediately to my own country with my grandchild,” she said.²⁷

A Local NGO Accuses Dr. Patel of Child Trafficking

At this point, the story took an unexpected turn. In mid-August, Satya, a Jaipur-based social justice and child welfare organization,²⁸ filed a habeas corpus petition with the Rajasthan High Court. The petition claimed that Manji was a victim of a “child-trafficking racket” organized by Dr. Patel through her for-profit infertility clinic. Satya alleged that Akanskha’s aim was “furthering the illegal trade in infants and selling them to foreigners by taking advantage of the lack of proper surrogacy laws.” The petition stated that in the absence of such laws, which would clarify who Manji’s parents really are, Yamada should not be allowed to claim custody of Manji. The petition called the Yamadas’ arrangement “illegitimate conception for money on a commercial basis” and sought custody of the child for Satya on the grounds that she had been abandoned. Dr. Patel responded: “What evidence does the NGO have to make such wild allegations? I will sue it for defamation.”²⁹

What had begun as a routine contract between a couple and a surrogate thus reached the highest court in the land. India’s Supreme Court stayed the request for Manji’s appearance in court, dismissed Satya’s accusations that the baby had been abandoned, and granted temporary custody to her grandmother, Emiko Yamada.³⁰ However, it could not so easily dismiss the larger questions Satya’s petition raised about the parentage and nationality of children born via surrogacy. The court asked India’s Solicitor General, G.E. Vahanvati, to appear at the next hearing to clarify India’s stance on Manji’s parentage and citizenship.

The (Partial, Temporary) Resolution

On September 15, the Solicitor General told the Supreme Court that the decision about Manji’s passport was up to the Union government.³¹ Yamada’s attorney, Jaisingh, insisted that the ICMR’s voluntary guidelines intended babies born via surrogacy to be considered the legitimate children of their biological fathers. A month later, the Rajasthan regional passport office issued Manji an identity certificate as part of a transit document, paving the way for a travel

²⁵ “Japanese Baby Finally Gets Birth Certificate.” *The Times of India* (August 10, 2008).

²⁶ Blakely, *op. cit.*

²⁷ Sidner, *op. cit.*

²⁸ “Child Welfare.” (n.d.) Satya. <http://satyaanngo.org/satya%20doc/child%20welfare/childwf.pdf>. Accessed December 2, 2008.

²⁹ Pratap Singh, Bhanu. “Trafficking Cloud Over Baby Manji.” *Daily News & Analysis*, (August 13, 2008).

³⁰ See *Baby Manji Yamada v. Union of India & Anr.* (2008) INSC 1656 (29 September 2008). Judgement in the Supreme Court of India Civil Original Jurisdiction Writ Petition (C) No. 369 of 2008. <http://www.commonlii.org/in/cases/INSC/2008/1656.html>.

³¹ The Union Government is the official name of the federal Government of India.

visa for Japan. It was the first such identity certificate issued by the Indian government to a surrogate child born in India.³² The certificate did not mention nationality, mother's name or religion, and it was valid only for Japan, according to the passport office.³³ On October 27, the Japanese Embassy issued the three-month-old a one-year visa on humanitarian grounds. Less than a week later, Manji Yamada and her grandmother, Emiko, flew to Osaka. Japanese authorities stated at that time that Manji could become a Japanese citizen "once a parent-child relationship has been established, either by the man recognizing his paternity or through his adopting her."³⁴ However, nearly a year after her birth, no evidence had surfaced that Baby Manji's still-precarious legal status in Japan had changed. Her one-year humanitarian visa was set to expire in October 2009.

Growing Public Concern in India

Before the Baby Manji case, public pressure in India for national comprehensive regulation of commercial surrogacy had gained some momentum. The ICMR issued National Guidelines for Accreditation, Supervision and Regulation of ART Clinics in India in 2005 in response to this pressure. At a June 2006 national consultation, leading activists, academics, researchers, healthcare professionals and attorneys working on women's health and human rights met to scrutinize the guidelines. Their review strongly criticized the voluntary nature of the guidelines, asserted that the sections on clinic accreditation and key medical procedures were inadequate, and condemned the lack of an explicit human rights framework. Public concern was building about the effects of ARTs on women's lives and the wide-ranging issues arising from new reproductive biotechnologies.³⁵ Two years later, the Baby Manji case upped the ante. In August 2008, Rizvi Law College in Bandra chose surrogacy as the theme of its four-day national moot court competition for 24 law colleges from around the country, a sign of the intensifying public debate regarding the absence of laws regulating surrogate births in India.³⁶

A New Draft Surrogacy Bill

In September 2008, citing the upswing in surrogacy agreements, the potential for commercial exploitation, and the issues raised in the Baby Manji case, India's health minister, Anbumani Ramadoss, called for national surrogacy legislation. A week later, the ICMR presented a draft bill of binding national regulations³⁷ and invited public comments. The bill addresses commercial surrogacy as well as other emerging reproductive technologies.³⁸ Ramadoss said, "In light of the recent controversy (involving a Japanese couple and an Indian surrogate mother), I think it's time we had a law on surrogacy. It's become more than sporadic and is lending itself to commercial exploitation like the kidney (transplant)."³⁹ Interestingly, several highly visible medical providers involved in commercial surrogacy (although not Dr. Patel) stepped forward to express their support for the legislation. The

³² Bhandari, Prakash. "'Identity' for Little Manji." *The Times of India* (October 18, 2008).

³³ "Identity Certificate Issued to Surrogate Japanese Baby." *The Times of India* (October 17, 2008).

³⁴ "Surrogate Baby Born in India Arrives in Japan." *Hindustan Times* (November 3, 2008).

³⁵ Mulay and Gibson, op cit., pages 90-91.

³⁶ Misra, Anshika. "Rizvi Law College to Host Moot Court on Surrogacy." *Daily News & Analysis* (August 21, 2008).

³⁷ The bill's formal title is the Draft Assisted Reproductive Technologies (Regulation) Bill & Rules 2008.

³⁸ Sama-Resource Group for Women and Health. September 13-14, 2008. Press release. "National Consultation on Assisted Reproductive Technologies (ARTs): Emerging Concerns and Future Strategies." New Delhi, India. Personal communication with Sarojini, N.B. Executive Director of Sama Resource Group for Women and Health, October 30, 2008. E-mail correspondence.

³⁹ Singh, Seema. "Draft Regulation on Surrogacy in Two Months for Public Debate." *The Wall Street Journal Online*, Livemint.com. (September 7, 2008). <http://www.livemint.com/articles/2008/09/08000257/Draft-regulation-on-surrogacy.html>. India bans the selling of human organs, an industry that raises similar health and human rights concerns as commercial surrogacy. The 1994 Transplantation of Human Organs Act allows only organ donation by relatives. Public debate around commercial surrogacy often draws parallels with this act, since permitting commercial surrogacy contradicts the spirit of the act. Additionally, the act has done little to halt organ sales; indeed it fueled the growth of a wide-scale black market for kidneys and other organs replete with human rights abuses and negative health outcomes for people who sold their organs. This recent history is one factor shaping the commercial surrogacy debate.

director of Mumbai's well-known Malpani Infertility Clinic, Dr. Aniruddha Malpani, was an early supporter of regulation, saying that it would counteract the problem of the "international black market" in commercial surrogacy. "The surrogacy laws will give confidence to those who come to India for fertility treatment that they are well within the laws of the country and at the same time protect the rights of the surrogate mother and baby."⁴⁰

The Debate Continues

Because Indian law has been silent on commercial surrogacy, the legal struggle to clarify Baby Manji's parentage and nationality that ensued remained unresolved a year after the birth. This case appears to undermine Dr. Patel's assertion in December 2007 that "Indian law makes [commercial surrogacy] much more straightforward for everyone."⁴¹ The rapid growth of the industry has outpaced advances in the legal system. The case of Baby Manji also raised significant issues for international relations and for private-sector clinics such as Akanksha that provide surrogacy services.

In addition, the Indian public, led by the sizable and dynamic independent NGO sector in India, is engaged in a far-reaching debate about whether commercial surrogacy is a good idea at all.⁴² The Baby Manji case has brought many key questions to the fore: What is a mother? What is a father? What does it mean to be a human? A citizen? How do we recognize and validate the identities of people and families formed through emerging technologies? And if, in doing so, we change our core definitions of family, have we made progress?

Other institutional stakeholders, both in India and around the globe, have started to weigh in on the ethical issues raised by commercial surrogacy and fertility tourism. The September 2008 ruling of the Supreme Court regarding Baby Manji was the first national court decision regarding commercial surrogacy and surrogacy tourism in India.⁴³ Legal scholars and advocacy groups in India have begun to provide expanded analysis of the case and the broader concerns it raises.⁴⁴ On the global level, the International Federation of Social Workers recently issued a groundbreaking policy statement expressing their concerns about the complex social and ethical issues raised by cross-border reproductive services.⁴⁵ Calls are also growing from professional organizations in industrialized countries, such as the European Society of Human Reproduction and Embryology, for a reduction in cross-border reproductive care referrals and more aggressive measures to ensure safety and quality when patients do seek treatment abroad.⁴⁶ And in what may be an effort to position itself as consumer friendly and to control the tenor and content of proposed regulations, the fertility tourism industry itself has launched online forums with the stated goal

⁴⁰ Jayaram, op cit.

⁴¹ Dunbar, op. cit.

⁴² See, for example, Sama-Resource Group for Women and Health. 2008. "Assisted Reproductive Technologies: Autonomy or Subjugation? A Case Study from India." *Women's Studies International Forum*. 31(1): 319-325. doi:10.1016/j.wsif.2008.05.004. See also Sama-Resource Group for Women and Health. December 4, 2008. Letter to Dr. A. Ramadoss, "Comments and Suggestions on the Assisted Reproductive Technology (Regulation) Bill and Rules—2008 (Draft) and request to incorporate suggestions." http://www.samawomenshealth.org/downloads/ART%20Bill%20Critique_Sama.pdf.

⁴³ *Baby Manji Yamada v. Union of India & Anr.* (2008) INSC 1656 (29 September 2008). Judgment in the Supreme Court of India Civil Original Jurisdiction Writ Petition (C) No. 369 of 2008. <http://www.commonlii.org/in/cases/INSC/2008/1656.html>.

⁴⁴ See, for example, Malhotra, Anil, and Ranjit Malhotra. "Commercial Surrogacy in India—Bane or Boon?" *Law Gazette* (March 2009). Law Society of Singapore. <http://www.lawgazette.com.sg/2009-3/regnews.htm>. See also Anuradha Nayak. (n.d.) "Manjhi Yamada: Where Does She Belong? The Trials and Tribulations of Commercial Surrogacy in India." <https://sisterinlaw.murdoch.edu.au/index.php/sisterinlaw/article/view/12/35>.

⁴⁵ See "Cross-Border Reproductive Services." September 25, 2008. International Federation of Social Workers. <http://www.ifsw.org/p38001484.html>.

⁴⁶ See Pennings, G., et al. 2008. "ESHRE Task Force on Ethics and Law 15: Cross-border reproductive care." *Human Reproduction* 23(10): 2182-2184. doi:10.1093/humrep/den184.

of engaging prospective consumers in the policy debates around access to cross-border fertility services.⁴⁷ A group identifying itself as International Consumer Support for Infertility, funded by the pharmaceutical company Merck-Serono (unaffiliated with Merck & Co.), recently published an online brochure that provides guidance and warns consumers of fraud and other pitfalls in fertility tourism.⁴⁸

⁴⁷ According to the International Consumer Support for Infertility's mission statement, "The vision for the International Consumer Support for Infertility (iCSi) is to empower patients to become full partners in ART healthcare and public policy by building effective relationships with providers, governments and media world-wide." http://www.icsi.ws/about_icsi. Accessed June 15, 2009.

⁴⁸ "Traveling abroad for assisted reproductive technology (ART) treatment." 2008. International Consumer Support for Infertility (iCSi). http://www.icsi.ws/_data/page/948/Abroad4ART.pdf. The brochure was funded by Merck-Serono, which describes itself as the "global leader in infertility treatment, with over 60% market share and the most widely prescribed gonadotropin in the world." http://www.fertility.com/about/History_of_Serono_in_Fertility.jsp.

Appendix

Key Participants

Dr. Ikufumi Yamada	Japanese genetic and intended father of Manji, orthopedic surgeon, age 45, from Tokyo
Dr. Yuki Yamada	Japanese intended mother of Manji, age 41, from Tokyo
Anonymous egg donor	Biological mother of Manji, variously reported to be Indian or Nepali
Pritiben Mehta	Indian gestational surrogate mother, from Ahmedabad, married with two young children, in her 20s
Manji Yamada	Baby girl, born via surrogacy
Emiko Yamada	Ikufumi Yamada's mother and Manji's grandmother, speaks only Japanese, in her 70s
Dr. Nayna Patel	Gynecologist and medical director of the Akanksha Infertility Clinic in Anand, Gujarat
Kamal & Shweta Vijayvargiya	Tokyo-based Indian jeweler and his wife, friends to the Yamada family, their hosts and intermediaries during their time in Jaipur
Indira Jaisingh	Ikufumi Yamada's lawyer, Senior Supreme Court attorney from Mumbai, member of the UN Panel on the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)
Anbumani Ramadoss	India's health minister, introduced draft bill on commercial surrogacy

Map of India



Source: <http://www.askasia.org/images/teachers/display/48.jpg>