

TOWARDS A KENYAN LEGAL AND ETHICAL FRAMEWORK ON SURROGACY

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DECLARATION OF WORK

I, Robai Ayieta Lumbasyo (Student Number: 778951) am a student registered for MSc Med (Bioethics & Health Law) in the year 2014.

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DEDICATION

For my mother Joy L Noreh, my friend, my mentor, my hero and my role model, the wind beneath my wings, without whom none of this would have been possible

My father Joshua L Noreh, who taught me by example that the brain if put to good use, is a great asset and breaking into new frontiers is not a preserve of a select few.

My brothers Gaynor and Robin Noreh, my best friends, my greatest fans and my study partners whose valuable support, constant debates and positive criticism made this research a worthwhile venture. I could not have done it without you and I hope this inspires you to greater heights.

ABSTRACT

Surrogacy motherhood, an arrangement involving one woman gestating a baby to be raised by another, is still a relatively ‘new’ technology in Kenya seeing as the first surrogate birth in Kenya happened in August 2007. Being a new technology therefore, the practice is still stifled in uncertainty thereby raising a complex web of legal and ethical issues. The fact that there is no legal and ethical framework to regulate surrogacy arrangements in Kenya, exposes the practice to corruption and other exploitative activities. Lapses and lacuna in the legal framework makes it hard to standardize the practice of surrogacy in Kenya, leaving the consumers of the service (technology) at the mercy of personal interpretation of the service providers. It is therefore essential that a legal and ethical framework is formulated to not only curb the rising incidences of exploitation but to also safeguard the interests of all parties involved. It is under this background that I intend to normatively assess the current practices of surrogacy in Kenya and make recommendations based on best practices internationally to guide the development of a legal and ethical framework on surrogacy in Kenya.

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‘Behold, children are a heritage from the Lord, the fruit of the womb a reward.

Like arrows in the hand of a warrior are the children of one’s youth.

Blessed is the man who fills his quiver with them!’

-Psalms 127: 3-4

CHAPTER 1

BACKGROUND

1.1 Introduction

The birth of Louise Brown on the 25th day of July 1978 through *in vitro* fertilization, changed the tide in reproductive health, taking it to a whole new scientific level and bringing about new hope to couples suffering from infertility (Gillon 1985). The emergence of the practice of surrogacy a few years later¹ made the situation even better since now women who were not in a position to carry pregnancies due to medical conditions were now hopeful if not assured of having children with their own genetic material.

In vitro fertilization is one of the many assisted reproductive technologies (ART) that is currently being used to treat or alleviate infertility. IVF is now a well-known technique, and does not require defining, however, in basic terms, it involves manually combining a harvested egg and sperm in a medical laboratory and thereafter transferring the resultant embryo to a woman's uterus (Fishel 1986). IVF has been effectively used to treat or alleviate infertility that is brought about by tubal blockage, immunological problems, oligospermia and idiopathic infertility. (Fishel 1986, Kimber 1994). Other methods used to treat infertility include gamete intra-fallopian Transfer (GIFT), Zygote Intra-fallopian transfer (ZIFT), Intra-cytoplasmic sperm injection (ICSI) Intrauterine insemination (IUI) and now surrogacy (Guzick *et al* 1998). Surrogacy is mainly used for treatment of infertility in cases where the woman whose womb cannot, for some medical reason such as hysterectomy, carry a baby. Ideally, surrogacy is a by-

¹ The first known case of a successful gestational surrogate birth was recorded in 1985.

product of IVF, meaning it stems from or is occasioned by IVF. In simple terms, surrogacy is whereby a woman agrees to carry a pregnancy for another with the intention of handing over the child once it is born.

The first case of surrogacy dates back to the bible in the Old Testament, where Sarah, unable to conceive after numerous trials, arranges for her Husband Abraham to impregnate her handmaiden Hagar who goes on to conceive Ishmael.² This type of surrogacy is termed as traditional surrogacy and was usually practiced at family level since it requires / required no regulating. In some African cultures, a barren wife was replaced by a fertile sister, a practice that is referred to as levirate marriage (Oboler 1986)

1.1.1 Types of surrogacy

As seen above, there are two types of surrogacy, traditional surrogacy and gestational surrogacy.

Traditional surrogacy is where a woman who carries the baby (the surrogate) is also the provider of the oocytes (eggs), that is, the surrogate is also the biological mother of the child. This type may be achieved either through direct physical contact with the provider of the sperm or through artificial fertilization / insemination as the case may necessitate. This type of surrogacy is very uncommon as it is hard to regulate. It most likely happens in a family set up and is guided by a ‘gentleman’s agreement’ that does not require enforcing (English 1991).

Gestational surrogacy is where a woman carries and bears a child on behalf of someone else. The potential mother or donor provides an egg, which is fertilized by the sperm of the potential

² Genesis Chapter 16 verses 1 – 4.

father (or donor) and the resulting embryo is implanted in the surrogate's womb. The surrogate in a gestational surrogacy arrangement has no biological links with the child whatsoever (Runzheimer & Larsen 2011). This is the most common type of surrogacy and due to its nature, it is prone to abuse hence the need for regulating the practice.

1.1.2 Definition of key terms

Section 1 of the Children's Act of the Republic of South Africa defines the following terms as hereunder;

Artificial fertilization: - In our case, artificial fertilization entails 'the placing of the product of a union of male and female gametes which have been brought together outside the woman body, in the womb of a female person'. (Children's Act No. 38 of 2005 of RSA).

Commissioning parents: - According to the Children's Act, a commissioning parent is a person who enters into a surrogate motherhood agreement with a surrogate mother. Commissioning parents therefore are the people who decide to enter into a surrogacy arrangement with the intention of bringing up the child once the child has been born by the surrogate host. [SA Children's Act No. 38 of 2005]

Usually one of the commissioning parents is unable to produce eggs or sperms as the case may be and even if they are able, the female partner may be unable to carry and sustain a pregnancy hence necessitating a surrogacy arrangement.

Gamete: - It denotes either of the two generative cells that are used for human reproduction. This is the male sperm and/or the female eggs also known as oocyte. The resultant product after fertilization is known as a zygote or embryo. [RSA Children's Act].

Surrogate mother / host: - A woman who enters into a surrogate agreement with the commissioning parents with a view of carrying and bearing a child and then hands the child over to the commissioning parents for upbringing. [RSA Children's Act].

Surrogacy motherhood agreement: - An arrangement / agreement where a surrogate mother agrees to be artificially fertilized for the purpose of bearing a child for the commissioning parents. Usually, the child born is not genetically related to the surrogate. The child becomes the legitimate child of the commissioning parents for all purposes and intent. [RSA Children's Act].

1.2 Contextualizing Current Kenyan Situation

Despite the fact that assisted reproductive technologies (ART) like IVF, GIFT, ZIFT, IUI and others have been in existence and in use around the world for a while, they are still relatively 'new' technologies in Kenya, seeing as the first IVF babies (twins) in Kenya were born on the 8th of May 2006 (Okwemba 2006). The first surrogacy babies in Kenya were born in August 2007 as per the records of the Nairobi IVF Centre. Currently there have been seventeen (18) surrogate births with a total of Twenty Eight (29) children born courtesy of the Nairobi IVF Centre, the leading IVF center in the country.³

³ There are currently five fertility centers in Kenya but only one center the Nairobi IVF center currently practices surrogacy. The other medical centres that offer fertility treatment are; The Aga Khan Hospital, Nairobi Hospital, Mediheal Fertility centre in Nairobi and Eldoret fertility centre

Being a new technology therefore, the practice of surrogacy has raised a complex web of legal and ethical issues it is therefore essential that a legal and ethical framework is formulated to regulate the practice. Even though a bill⁴ is currently being drafted to address this lacuna, the bill as it is does not cover all the aspects of surrogacy like registration of children born out of surrogacy, issues of international surrogacy and matters related to surrogacy for single parents and/or same sex couples⁵. Lack of regulatory framework may and has led to abuse of the process making it a hub for “renting wombs” and other exploitative practices (Gathura 2008). Lack of laws has also opened up uncontrolled medical tourism (Okwemba 2012), especially from countries with stringent surrogacy laws hence international standards are evidently not being met. The current practice of adoption⁶ which requires commissioning parents to legally adopt the child borne out of a surrogacy arrangement is lengthy and open to abuse. Since there are no codes of practice for the practitioners there is likelihood that one may exploit it to their advantage and in the process violate the rights of the ‘service users’. In the end, it is the rights of the patients that remain unprotected. When all is said and done; *Kenya is in URGENT need of a Legal and Ethical framework on Surrogacy.*

1.3 Research Purpose

This research therefore seeks to understand the current practices of surrogacy in Kenya in light of lack of legal and ethical framework, and thereafter make recommendations on best practices from other countries to guide the development of a legal and ethical framework on surrogacy in

⁴ The Reproductive Health Care Bill, 2014 (Senate Bill No. 14) has already been presented before the Kenyan parliament for first reading. It mainly deals with other issues of reproductive health like contraceptives, abortion *et al* and affords a chapter or two to surrogate motherhood arrangements.

⁵ Kenya does not recognize same sex marriages and / or unions and as such ART treatment including surrogacy for this group is non – existent.

⁶ An adoption process in Kenya usually takes between 3 to 6 years as per the practice on the ground

Kenya. I shall be relying on international and national legal instruments of various countries mainly from the United Kingdom and South Africa to guide me in the legal sphere whilst at the same time appreciating the place of ethical and moral theories in the law making process. This is because Kenya is a deeply religious and culturally oriented society and since surrogacy touches on the reproductive capabilities of people, it is important that their cultural, religious practices and moral opinions are incorporated in the law making process. Besides, it is assumed, and rightly so, that laws and policies are ideally social contracts made between a state and its populace and if they have to mirror the opinions of the society if they are to be observed and respected (Rachels & Rachels 2012).

1.3.1 Study Objectives

My study objectives are as follows;

1. To normatively evaluate the current practises, proposed laws, regulations and guidelines on surrogacy in Kenya.
2. To normatively evaluate the existing international and regional instruments and country specific laws (United Kingdom and South Africa) on surrogacy.
3. To normatively evaluate the opinions of the people of Kenya on surrogacy basing the same on the moral theories of utilitarianism, deontology, Principlism and social contract.
4. To formulate and make recommendations aimed at contributing to the development of laws, regulations and professional guidelines with respect to surrogacy in Kenya.

1.3.2 Outcomes

This study is intended to have two primary outcomes as follows;

Develop regulatory framework: - To make contribution to the development of laws, policies and professional guidelines on surrogacy in Kenya.

Scholarly contribution: - To contribute to the existing scholarly knowledge on surrogacy in Kenya.

1.3.3 Methodology

As this is a non-empirical ethical - legal study with no new data collected or analyzed, it will primarily take the form of desktop and library based research. I shall employ the typical research methods applicable to a pure normative study as follows; First, I shall critically analyze the laws and regulations that are related to the matter at hand, contextualizing them as needed, thus making them relevant and applicable to the current situation.

Secondly, in regard to moral and cultural based theories, I shall employ the typical research methods and standards applicable to philosophical research. This will involve interpretation and critical analysis of appropriate texts. This critical analysis will include definition of concepts, development and defense of arguments in relation to my research objectives, the use of counter-examples and articulation of the most plausible interpretation of significant concepts.

1.3.4 Argumentative strategy

I shall argue that Kenya has no legal and ethical framework on surrogacy, even though a bill is currently being drafted, hence surrogacy, a new phenomenon is highly exploitable. Secondly, I shall argue that, although Kenya is currently using some bits of English law as it is our common law, it does not fit into the country's structure, system, beliefs, cultural practices and technological state of advancement. I shall then further argue that since Kenya has heavily

borrowed on the South African Law in other areas with success (The Children's Act, The National Health Act and The Constitution), it would be reasonable to "borrow" the related laws et cetera relating to surrogacy. Being a deeply rooted religious and cultural country, and this research having an ethical (moral) component, it is only natural that the Kenyan peoples' beliefs are put in context as well. On this note, I shall argue that various theories, including but not limited to utilitarianism, Kant's deontology, Principlism and theory of social contract influence the beliefs or rather are the cornerstones of the people's beliefs and practices on surrogacy. Finally, I shall compare, contrast and thereafter merge the best practices of reviewed laws, regulations and professional practice guidelines, bearing in mind the place of the beliefs of the Kenyan people and the formulate recommendations to guide the development of legal and ethical regulatory framework on surrogacy in Kenya.

1.4 Chapter layout

In chapter one (1) herein, I look at the background information on ART, surrogacy and the current situation in Kenya. I have then defined basic concepts and terms relating to surrogacy. I have further given an overview of how I intend to address my research proposal including my study objectives, outcomes and the argumentative strategy. This is followed by my chapter layout herein.

Chapter two (2) deals with the current ongoing practice of surrogacy in Kenya and why there is a need for a regulatory framework. I also delve into issues of right to reproduce and the importance (if any) of children to parents and the society at large.

In *chapter three (3)* I look at some moral theories that may have bearing on surrogacy in Kenya. I have mentioned before that Kenya is a culturally rooted and religious country and as such people may feel the need to base reasons on why (or not) surrogacy should be practiced and if so, how it should be practiced. The moral theories act as a guiding rod towards the reasons arrived at.

Chapter four (4) deals with review of laws, policies and professional guidelines on surrogacy of two countries being the United Kingdom (UK) and the Republic of South Africa (RSA). I chose these two countries because of their relevance to Kenyan laws. The English laws serve as the common laws for Kenya. As for South Africa, Kenya has previously borrowed from South African laws before and with much success at that. Besides, South Africa resonates with Kenya as to cultural and economic development unlike the UK which is more technologically advanced.

In *Chapter five (5)* I merge the best practices of reviewed laws, regulations and professional guidelines and come up with recommendations on a regulatory framework for surrogacy in Kenya. I then offer my opinion on why the practice of surrogacy should be regulated or not.

CHAPTER 2

RATIONALE FOR A LEGAL AND ETHICAL FRAMEWORK ON SURROGACY IN KENYA

2.1 Introduction

In the previous chapter, it was acknowledged that ART, which includes surrogacy, is now a widely practiced mode of treatment for persons with infertility issues who have the desire to have children of their own. However, widely practiced does not necessarily denote widely accepted. The practice is still looked at with suspicion especially by people from the developing world, Kenya included. Being a relatively “new” technology in Kenya, the practice of Surrogacy raises a complex of legal and ethical issues in the country and the fact that there is currently no legal and/or ethical framework to regulate the practice makes the situation even dire. The reason for non-acceptance of the practice vary between communities, social- economical classes⁷ and even religious affiliations (Olingo 2011)

In addition to non-acceptance, some scholars have speculated that infertility is not a ‘disease’ in need of treatment as such and therefore Assisted Reproductive Technologies including surrogacy are not necessary (Kass 1971). However, there is dissenting opinion like that of Warnock’s who claims that infertility in human beings is a malfunction which if not properly taken care of, would lead to diseases like depression and other more serious mental disorders and as such is a

⁷ A basic analysis in Kenya shows that the upper economic class readily accepts the practice of surrogacy – perhaps due to exposure, while the lower class does not care for it at all though they are usually the providers of the “womb”. The middle class however is divided even though they form a bulk of the consumers of surrogacy services.

condition that warrants treatment (Warnock 1984). This begs the question, do human beings have the right to use whatever means available to satisfy their 'right' to beget children? As in, do we have the right to reproduce? Is it a human right to reproduce and if so, do we have corresponding duties and or obligations to (or not) reproduce? I intend to look at the possible answers to this question in this chapter. I shall also be looking at the current practices of surrogacy in Kenya and why, if necessary, laws regulating the practice of surrogacy should be enacted (or not) and the pros and cons of the practice of surrogacy to various classes of people in the society. But before that, let us examine the place of the family unit and its importance in the society particularly the African society.

2.2 African society, family and children

In the cultural traditional African community, which Kenya is a part of, people are interdependent and commune together as a society. A person's worth is determined through the eyes of his peers and community at large (Tangwa 2000). This interdependence is such that one's well-being is tied with the wellbeing of others hence people are obliged to cooperate and seek circumstances that not only make one happy but ideally resonate with the whole society (Wiredu 2008). This of course is tied up with the idea of a family; it being a basic and extremely important unit of the society; and as such what constitutes a family is as is defined by a society (Behrens 2014). Most African societies define a family as that which constitutes both adults and children. A family is thus incomplete if there is absence of children. A person who came of age was required to get a suitor and thereafter it was expected that children should follow from such a union. Children therefore were and still are considered to be of importance, not just for the continuity of the lineage of the parents but also of the society in general (Ankeny 2006). In fact,

some communities believed that sexual intercourse was (and is) intended for procreation purposes only and that a woman's role in the family and society at large was to bear children. (Qui 2002) This inference puts pressure on women to ensure that they beget children so as to be acceptable before the society as those who for some reason are unable to bear children are seen as of lesser value in the society.⁸(Kimani & Olenja 2001)

This perception of a woman being “incomplete” if a woman cannot have children of her own has not changed much over the centuries. The only difference is that in the modern society, the said perception is silent unlike in the earlier years. The stigma, however, remains. The desire to have one's own child is still as strong as it was in the days of old and it is not only affected by personal circumstances but also by social inference (Chadwick 2001 p.27). The circumstances and various cultural practices and beliefs have conditioned and even pressured the woman into feeling that without a child of your own, one's value diminishes before the eyes of the community. This same pressure applies to men as well but not as much as to the woman. In the African traditional set up for instance, a man and woman are considered complete family wise once they have children of their own. In the Judaism and Christian faiths, ‘reproduction represents the culmination of one's fulfillment of marriage vows as captured in popular religious dictum “be fruitful and multiply” ‘(Ankeny, 2006) .

2.2.1 Importance of children in an African / Kenyan family set -up

As seen above, children are an important aspect in most indigenous African communities. A woman without children is looked down upon and regarded as inferior. In fact, in some African

⁸ Cases abound of women being driven away from their matrimonial homes because they are not begetting children (Kimani & Olenja 2001)

communities, such women cannot hold any important positions in the society as they are regarded as being incomplete and as such incapable of managing society affairs.⁹ Actually, the more children one had, the higher her status in the society. It is with this background that a woman would go to great lengths and in the process, do everything and anything in her power to get children of her own (Kimani & Olenja 2001)

In Kenya, infertility in women has really cost the woman her place in her house and the society at large. Cases are rife of women who have been divorced and sent back to their parents since they are incapable of conceiving. Often time, the decision to “expel” these non-child bearing women from the house is arrived at without consideration of whether the infertility stems from the man or the woman. Other times, the man whose wife has not borne him children “goes out of the marriage” in search of a child (Kimani & Olenja 2001). Being a paternalistic society, such infidelity is welcome as it is seen as a “cure” for childlessness in the home. It is generally assumed that lack of children in the home is as a result of the woman’s fault and as such it is acceptable if the man gets the children out of his matrimonial home. Cases have been heard of where the woman herself, gets another woman to bear children with her husband on her behalf.¹⁰ This is termed as traditional surrogacy and the children borne out of such union are usually considered to be the children of the woman who sought the services of the surrogate. Such practice is mostly found among the Kalenjin and Abagusii tribes in Kenya.¹¹

⁹ In some churches and society set ups in Kenya, most positions of leadership are reserved only for married women who have children (Kimani & Olenja 2001).

¹⁰ As was the case with Sarah and Hagar in the bible (Genesis 16:2-4).

¹¹ In the Abagusii and Kalenjin sub tribes in Kenya an infertile woman was allowed to “marry” another woman who would bear children with her husband on her behalf.

Naturally, adopting of one's relatives children would be considered as a viable option. However, since people are more prone to want to have children of their own, with their own genetic matter and with no question of whom the real mother and father are, this option is not usually adopted. (Chadwick 2001). In this case then, surrogacy is the better or perhaps the only option as one can actually have children with their own genetic matter. However, as mentioned above, surrogacy is still not so widely accepted in Kenya. Besides, to be seen and be accepted as a mother, the society wants to journey with the woman throughout her pregnancy; that is; see the pregnancy, experience the progression of the pregnancy with the woman, and even celebrate the birth of the child as a family and as a society. So the fact that another woman will bear the child on her behalf, renders the whole surrogacy process unacceptable (Chadwick 2001)

2.2.2 Societal alternatives to Surrogacy (ART)

As cited earlier, adoption is the most preferred alternative of having children for couples who suffer from infertility or same sex couples (more on this to be discussed later). However, adopting a child does not solve the need or desire to have and or beget children as opposed to rearing children. Begetting implies passing on one's genetic material to their offspring while rearing is all about bring up, that is, tending to the needs of the particular child (Chadwick 2001).

Adoption may satisfy the "mothering role" of a woman (Chadwick 2001 p.24), but it does not quench her desire to beget and bear; that is, to bring forth a life into the world. Besides, everyone, both man and woman have the inherent desire to have children of their own blood and flesh that will carry on their name and genetic materials for generations. According to Plato, this desire is as natural as a desire for immortality (Chadwick 2001 p.25) as hereunder;

‘there is a sense in which nature has not only somehow endowed the human race with a degree of immortality, but also implanted in us all a longing to achieve it...One expression of that longing is...the wish not to lie nameless in the grave. Mankind is immortal because it always leaves later generations behind to preserve its unity and identity for all time: it gets its share of immortality by means of *PROCREATION*.’
(Emphasis my own)

In light of the above, adoption, though a noble process, does not fully address the issue of childlessness and the desire of one to bear a child. Besides, opportunities to adopt a child in Kenya have become fewer, expensive and time consuming. The rigidity of the Kenyan Children’s Act does not make matters any easier.¹²

Finally, allow me to speculate that in as much as child bearing is considered a natural process, an intrinsic desire of human beings, it does not confer a natural right to reproduce. Or does it? Allow me to examine this further as herein below.

2.3 Right to reproduce

Arguments abound on whether human beings have the right to reproduce. Some scholars are of the opinion that since giving birth is a God given natural process then it follows that there is an intrinsic right to reproduce (Ankeny 2006). Decisions on whether to reproduce (procreate) or not are linked to our self being and identity as human beings and as such are bound to arouse personal opinions. Some consider such decisions to be so personal and inherent such that they do not require legislating upon and/or regulating. Besides, as Immanuel Kant’s observed, human

¹² Adoption in Kenya is regulated by the Children’s Act Chapter 141 of 2007 (Rev.2010) of the Laws of Kenya.

beings have an intrinsic worth and dignity hence the ability to make decisions and choices on matters that determine their well-being. (Kant & Sullivan 1996, Rachels & Rachels 2012 p.136). However, this has not stopped international and national bodies from recognizing, providing for and regulating the right (or not) to reproduce. For instance, the United Nations Declarations on Human Rights – UDHR (1948), the International Covenant on Economic, Social and Cultural Right – ICESCR (1966) and International Covenant on Civil and Political Rights – ICCPR (1966)¹³ all support the notion that everyone has the right to marry and found a family. Regionally, this notion is echoed by article 18 of the African Charter on Human Rights (1981) and supported by article 6 of the African Charter on the Rights and Welfare of the Child (1990).

It should be noted that all these international and regional instruments are premised on the assumption that marriage is essential for founding of families. That children are begotten and borne out of a marital union since they fall under “right to marry and found a family” I want to however propose that married or not, every sane human being of sound mind should have the right to reproduce.

2.4 Current practices of surrogacy in Kenya

2.4.1 *Current clinical practice*

Surrogacy being a relatively ‘new’ technology in Kenya, has no laid down uniform code of practice. The few fertility centers that offer the surrogacy option of treatment by IVF are forced to rely on their own personal interpretation of how the process is to be administered¹⁴. At the

¹³ Right to reproduce is provided for under articles 16, 10 and 23 of the UNDR, ICESCR and ICCPR respectively.

¹⁴ As stated earlier, five clinics offer IVF treatment in Kenya but currently only one (1) center has successfully offered the surrogacy option.

Nairobi IVF Center, the pioneer and leading IVF facility in the country and my current employer, the practice is as follows:¹⁵

Upon establishing that a couple are a prime candidate for a surrogate, the couple is taken through in-house counseling process and advised of the option of the surrogacy, that is; it's benefits, procedure, risks and potential problems both now and in the future. The couple is then shown a database of potential surrogates and advised to choose a surrogate of their choice based on the bio-data indicated. Once a potential surrogate host is identified, she is contacted and advised to report to the Center where she also undergoes an in-house counseling on the surrogacy process. The surrogate and the intended commissioning parents are then introduced to each other and allowed to get to know each other before they are taken through a group counseling session.

After the group counseling session, the parties are allowed to discuss their expectations in private and if they have a 'working' consensus, then they are taken through legal counseling by the in-house lawyer, who informs them of their legal rights, responsibilities and/or expectations. The lawyer then drafts a surrogacy agreement in line with what the parties have agreed which they both sign and it is commissioned or notarized accordingly and then and only then, can the whole surrogacy process begin.¹⁶ It should be noted that before one is entered into the surrogates' database, one is subjected to medical, psychosocial and physical exam.

For one to be a surrogate she must be 1) At least 21 years old, 2) Must have at least one living child 3) Must be of sound mind 4) Should be physically healthy and free from specified diseases

¹⁵ I am the legal / ethics officer at the center so I am reporting from first-hand experience and / or observation.

¹⁶ I have annexed copies of the agreements (as Appendix 1-3) that clients sign before start of surrogacy process

and 5) Must hold a valid certificate of good conduct issued by the Kenya police indicating that she has no criminal record. I must admit that for a country with no laws and regulatory framework, this is a step in the right direction, however, it is not adequate and more needs to be done to ensure not only uniformity is achieved but also protection of all the parties involved is provided.

2.4.2 *Registration of children born out of surrogacy in Kenya*

According to Kenyan hospitals and apparently most hospitals world over, the person who carries and bears the child is considered as the real mother of the child. In fact the Human Fertilization and Embryology Act (HFEA) 2008 of the United Kingdom defines the term mother under sec. 33 (1) as follows;

33 ‘Meaning of “mother”

- (1) The woman who is carrying or has carried a child as a result of the placing in her of an embryo or of sperm and eggs, and no other woman, is to be treated as the mother of the child’

This therefore means that legally, the surrogate mother is to be treated by law as the mother of the child until such parental responsibilities are legally transferred to the commissioning couple

In Kenya, before the official registration of a child is done, a notice of birth is issued by a medical practitioner at time and place of birth indicating the name of the mother (the host) and sometimes the name of the father, place of birth (usually a medical center), sex of child and date of birth. This notice of birth is then used by the relevant authorities being the Department of registration of Births and deaths to issue a birth certificate (Births and Registration Act No. 2 of

1928 (as amended) Of Kenya). Since the name of the mother on the notice of birth is that of the surrogate, it follows that that is what will appear on the birth certificate. The current practice then is for the commissioning parents to legally “adopt” the child from the surrogate and then have the changes made on the birth certificate after an adoption order has been issued. This process of adoption is the legal and only recognizable process currently in Kenya of registering children born out of surrogacy. One or both commissioning parents have to undergo a DNA test to show relation to the child before the adoption process is complete. However, this process is very lengthy and stringent and as such is prone to corruption – to speed up the process.

2.4.2.1 *Cutting corners – Behind the scenes illegal practices*

Since the adoption process in Kenya, like in many other African countries is laden with bureaucracy, some commissioning parents and their host surrogates look for “other ways” – which most often are illegal - in which to go bend the system in one’s favor. The most common ‘back street’ route used in Kenya is identity forgery. This is where the surrogate mother uses the identity of the commissioning mother throughout her pregnancy including birth, so that the name of the commissioning mother is entered on the notification of birth and thereafter on the certificate of birth at registration. This is illegal and attracts a severe penalty under the criminal laws but due to desperation, some couples opt to take the risk.

The second practice, which is equally unlawful, is that of acquiring a forged birth notification letter from a medical facility. This practice, as it turns out, is rampant as persons do not wish to go through the long, tedious and corruption prone process of adopting¹⁷ the child once it has

¹⁷ Adoption in Kenya is guided by part XI of the Children Act, CAP 141 of the Laws of Kenya.

been born. Even though cases have not been reported, claims have been made on national televisions and print media.

Lastly, some couples decide to use family members with same surnames as theirs as surrogates, so that whatever is registered on the notification of birth and consequently birth certificate, will have little, if any consequences on the name changes. The first and middle names are usually omitted or abbreviated. This is the least common practice used but surprisingly, the less illegal one since no fraud per se has been committed.

2.5 Regulating surrogacy

Before I can adequately arrive at an opinion whether surrogacy should be regulated or not, I would like to look at instances both in support and against surrogacy as follows:-

2.5.1 *A case in support for surrogacy*

Surrogacy is one way of ensuring that infertile couples who desire to have children of their own, with their genetic material are able to do so (Ankley 2006)¹⁸. The role the surrogate mother/host is important in fulfilling the inherent desire of the commissioning parents of passing their genetic material to their offspring and hence ensuring the continuity of their bloodline (Chadwick 2001).

Secondly, by giving the infertile couple a chance to have children that they call their own, surrogacy alleviates the pain that comes with being judged by the society as being inferior due to childlessness. Granted, some scholars as mentioned before have argued that infertility is not a

¹⁸ Often times, the oocyte and sperm of the genetic parent is used to create the embryo to be carried to term by the gestational surrogate hence the genetic relation stated.

disease and should thus not be treated as such. However, in an African set up where children are the expected outcome of any union of spouses and without which one is ridiculed to an extent of developing stress related ailments, childlessness could easily lead to mental illness and other related disorders and should thus be treated as a disease. Surrogacy is therefore one way of ‘curing’ this so called ‘infertility disease’ (Chadwick 2001).

Thirdly, the practice of surrogacy may provide material gain (including monetary gain in some instances) for the surrogates. As noted earlier, most women who choose become surrogate hosts are usually from income challenged backgrounds and the belief that there shall be some material and /or monetary gain is may motivate them into becoming surrogate mothers (Okwemba 2012). There are however cases where some women become surrogates from the goodness of their hearts with the singular aim of helping infertile couples realize their dream of having children. This kind of surrogacy is referred to as altruistic surrogacy. That notwithstanding, many women become surrogates because of the intended financial gain (Runzheimer & Larsen 2011). Altruistic surrogacy, which is where the surrogate does not receive any compensation, in monetary or any other material gain, is mostly common among family members and very close friends, while commercial surrogacy is the most popular type among strangers. Some countries have banned commercial surrogacy, although some form of compensation is encouraged. These countries include Germany, France, Italy and Latvia.

Fourthly, the practice of surrogacy ensures that the clandestine practice of “selling and/or buying of children” is put in check. Cases have been reported where kidnapping and selling of children to childless couples in Kenya are rife. Childlessness is a big issue among communities in Kenya

and couples who find themselves without children go out of their way to ensure that they get children regardless of how those children are acquired. If surrogacy is allowed, as it is, and practiced in open without stringent rules and hindrances, then there would be no market to sell these children hence preventing the kidnapping of children. However, it should be noted that there might be other incentives for child trafficking which include provision of child labor and slavery; incentives that are far removed from our case at hand.

Finally, the practice of surrogacy in Kenya has opened doors for other reproduction non-related money making / income generating activities like general tourism. Since IVF in general and Surrogacy in particular is more easily and cheaply accessible in Kenya due to non-regulation, wealthy clients are taking advantage of the opportunity to travel not only for the treatment but also for tourism purposes. This then brings about income both to the nation and to the people working in the tourism industry. (Okwemba 2012).

2.5.2 A case against Surrogacy – *why surrogacy should be banned / regulated*

The following are some of the arguments and / or reason advanced on why the practice of surrogacy should be regulated and in the worst case scenario be banned.

2.5.2.1 *Exploitation*

Exploitation is the first cause of worry for the practice of surrogacy in Kenya and beyond. In fact this is the singular major reason why calls for the regulation of the practice have been made¹⁹. As noted earlier, most women who choose to be surrogates come from fairly poor economic

¹⁹ Law makers, service providers and service users are all united in the call for regulation of the practice of surrogacy.

backgrounds and are motivated by the monetary and material gain that comes with being a surrogate (Runzheimer & Larsen 2011). The fact that there is a pronounced difference economically, socially and in most cases educationally between the service “womb renters” providers (surrogates) and service seekers (intended parents) makes this practice a breeding ground for exploitation. Usually it is hard for the surrogates to negotiate for reasonable compensation as they are desperately in of money and would easily accept whatever is offered. Regulation of the practice would ensure that fair and reasonable compensation is made regardless of the economic status of the surrogate

2.5.2.2 *Failing international standards*

Kenya is a member of both regional and international bodies which have set certain minimal requirements on the practice of surrogacy by different bodies like the World Health Organization (WHO) and European Union. The fact that patients from countries especially Europe,²⁰ with stringent laws come to Kenya where there are no laws and policies to regulate the practice emphasizes the fact that international standards are not being met. (Okwemba 2012, Gathura 2008).

2.5.2.3 *Harm to the Woman*

As much as pregnancy is not a disease, it takes a toll on one’s body. Carrying a fetus/baby for nine months is not an easy feat. During this period, a woman undergoes a lot of changes; physically, hormonal, emotionally and in some cases spiritually. In some instances, complications such as high blood pressure may arise during pregnancy hence putting the woman at risk of sickness or even death. This is more prevalent in this kind of arrangement as chances of

²⁰ European countries such as Germany and Switzerland do not recognize surrogacy arrangements.

multiple pregnancies are high, which take an even higher toll on the woman. Cases have also been reported where death during child birth has occurred or complications arising during and after child birth.

The knowledge that all these risks are to be taken by a woman who shall not ultimately get to enjoy the 'bundle of joy' afterwards aggravates the condition. (Runzheimer & Larsen 2011).

Surrogacy has also been known to put psychological pressure on the family of the surrogate especially if she has a partner and children of her own. This is why pre and post surrogacy counseling are important components of the process. Parting with the child immediately upon delivery can lead postpartum depression (Runzheimer & Larsen 2011), which if not managed on time can lead to a more severe kind of depression, being clinical depression.

2.5.2.4 *Interferes with privacy, marriage and promotes homosexuality*

Surrogacy, IVF and ART in general are by nature, intrusive procedures. This then implies that privacy, an essential requirement in personal rights like right to reproduce shall then be infringed upon (although essentially privacy is not infringed if and when the subject of the infringement consents to it being infringed). Further, the introduction of a third party to the whole equation such as gamete donors and surrogates threatens the very core of an African and Christian/religious marriage institution. (Chadwick 2001). Procreation is viewed as a natural process that should ideally stick to being between man and woman (Ankley 2006) without interference from outside parties. The family, it has been argued, provides a solid social

foundation and any interference to its foundation may result in breakdown of social norms. Perhaps it may be under this background that Sir David Napley recommended that ‘fertilization outside marriage should be a criminal offence “in the interests of society’ (Chadwick 2001 p.22).

Secondly, with the emergence of these new technologies, it is now possible to cure the ‘social’ infertility especially among couples of the same sex. This, it can be argued is encouraging the ‘western’ ways as traditional African beliefs only recognized the heterosexual kind of family. On the other hand however, one could argue as Sheila Maclean does, that since such facilities like IVF and surrogacy programs are available, ‘to deny access on grounds of sexuality is to infringe the right on a discriminatory basis’ (Maclean 1986). A right that is secured and recognized both by constitutions of both the Republic South Africa²¹ and the Republic of Kenya.²²

Thirdly, fears abound that IVF and surrogacy may be used for ‘vanity’ purposes for well off women who do not want to subject their bodies through pregnancy may opt to use this technology for their own selfish and vain purposes.²³

Currently, same sex marriages are not recognized in Kenya and as such, people of same sex cannot by law have children, be it through adoption²⁴ or assisted reproductive technology, including surrogacy. In fact having carnal knowledge or relations with a person of the same sex

²¹ Article 9 of the Constitution of South Africa prohibits discrimination on access and enjoyment of rights on various grounds including sexual orientation.

²² Article 27 of the Constitution of Kenya prohibits discrimination on grounds of marital status.

²³ Some women, in pursuit of vanity, may use surrogacy as a way of avoiding growing fat and experiencing bodily change that is brought about by pregnancy and giving birth.

²⁴ The Children’s Act of Kenya prohibits homosexuals from adopting children of either gender.

is considered a criminal offence punishable by law.²⁵ So as it stands, the practice of surrogacy is currently restricted to heterosexual couples. Also, single persons are not being considered for surrogacy. One must either be married or have a partner in the traditional sense. This is not a legal requirement since there are no laws to that effect but rather an institutional preference and practice.

2.5.2.5 *Medical tourism and its harm*

Lack of laws, policies and regulatory framework has also opened up uncontrolled medical tourism from the western world (Okwemba 2012). This has come with other non-treatment related vices like price hiking and/or fluctuation on the costs of treatment as medical centers compete to entice as many patients as possible (Ligami 2014). The standard of treatment may also be compromised seeing as the numbers of service seekers is larger than that of the service providers. This also puts the would be surrogate at risk of being exploited as many surrogates are turning up, and to meet the demands, complete testing and / or counselling may be overlooked (Mosongo 20130). For instance, India has been turned into a surrogacy tourist industry with clients arriving from destinations that have either banned surrogacy, are expensive or have long waiting lists (Runzheimer & Larsen 2011). This practice is slowly creeping up on the Kenyan surrogacy market thereby necessitating laws, policies and guidelines to be put in place to regulate the practice.

2.6 Conclusion

As seen above therefore, Surrogacy, regulated or not, is a beneficial practice not only to the individuals directly involved but to the whole society/nation at large. However, like all things,

²⁵ Section 162, 163 and 165 of the Kenyan Penal Code criminalizes sex or carnal knowledge between male persons.

there are two sides to the surrogacy coin. The disadvantages cited of the practice of surrogacy make it a not so desirable and/or acceptable practice and the magnitude of the risks of the practice is heightened by the fact that it is unregulated hence prone to abuse and misuse. It is with this in mind that I propose the practice of surrogacy in Kenya to be regulated by a legal and ethical framework.

I intend to propose some recommendations on a regulatory framework for the practice of surrogacy in Kenya and to do so, I shall look at some relevant laws, policies and professional practices from two jurisdictions being the United Kingdom and the Republic of South Africa, giving reasons why the said jurisdictions have been considered in a much later chapter. But before that, let me look at some of the moral theories that may influence the acceptability (or lack of) of the practice of surrogacy in Kenya in my next chapter.

CHAPTER 3

MORAL THEORIES

3.1 Introduction

For centuries, ethics, morality and religion were closely interlinked hence morality was defined according to personal and societal religious beliefs. Religion provided a way out of what was considered morally right or wrong. God or a Supreme Being was seen as the divine law giver and authority on ‘moral codes’ and His word was considered final. However, this is no longer viable as religion itself is no longer universally accepted (Singer 1981). This has prompted man to go in search of the definition and provision of ethics and morality in science and thereafter in various moral theories. Even though the terms ‘Ethics’ and ‘Morality’ have been frequently used interchangeably, ethics involves ‘a careful systematic reflection on and analysis of actions and behavior (Dhai & McQuoid – Mason 2011), while morality refers to ‘norms about right and wrong human conduct that are so widely shared that they form a stable social compact’ (Beauchamp & Childress 2013).

Ethics therefore, is the study of morality. Since morality involves character, virtues and the use of words such as ‘right’ or ‘wrong’, it is not possible to pinpoint a specific course of action and declare it to be the standard unit of morality (Rachels & Rachels 2012). Different cultures have different practices and as such morality differs across board (Rachels & Rachels 2012). There is no clear definition of what ‘right’ or ‘wrong’ entails and what is fair, just and acceptable varies

depending on opinions, beliefs and practices of a particular cultural community.²⁶ It is therefore proper to assume that there is no ‘universal moral truths’ (Rachels & Rachels 2012). However, there is that minimum standard(s) of practice that is acceptable across board and these work as the guiding points in determining on what is right or wrong. Different moral theories have been used in a bid to describe and ascertain what morality entails as seen hereunder;

3.2 Moral theories

3.2.1 Utilitarianism²⁷

This is the most common and well known form of consequentialism which is usually referred to as the ‘greatest happiness’ theory (Dhai & McQuoid-Mason 2011). It proposes that an action should be considered right or wrong, good or bad, just or unjust depending on the resulting outcome. Utilitarianism upholds that the outcome of an action is the most important element as it is what is used to determine the moral value of a thing/action. Utilitarianism proposes that that which brings about the most happiness to the most people is what is to be seen as good and/or just.

This theory can be traced back to Jeremy Bentham and Stuart Mill. According to Mill ‘an act is right if it produces the greatest amount of happiness (good/pleasure) for the greatest number of people’ (Mill 1962). In fact Bentham was so passionate about this theory that he proposed that even laws made should conform to this theory. Laws scrutinized and found not to observe the

²⁶ Cultural relativism claims that morality differs from culture to culture depending on the habits of a particular society. That morality is basically acceptable habits within a particular community (Rachels & Rachels 2012)

²⁷ There exist various types of utilitarianism including Act and Rule utilitarianism but I shall be limiting myself to general and basic overview of utilitarianism.

principles of the theory, according to Bentham, were to be thrown away, amended or completely done away with (Mill & Bentham 1987).

In our case herein, a utilitarian would argue that the practice of surrogacy yields to more happiness for most people in the following ways. *Firstly*, couples/persons can have children of their own with their own genetic material hence able to pass down their genes and ensure continuity of their bloodline. This brings about happiness, fulfilment and psychological satisfaction. *Secondly*, the society is enriched by an additional member(s) hence strengthening the community both physically and psychologically. *Thirdly*, the surrogate host benefits monetarily or with other material gain due to the compensation given. Even if the surrogate agrees to be a surrogate without any monetary benefit, there is psychological satisfaction gained in knowing that one has helped a needy couple to acquire children. *Finally*, the medical facility where the surrogacy is carried out benefits both materially (payment for procedure) and in earning extra experience. The act of Surrogacy therefore, brings about a lot of happiness to a large group of people and as such, according to the utilitarian view, is a good thing.

Arguing from a utilitarian view therefore, I submit that surrogacy not only be allowed because it provides greater happiness for more people involved but that also if laws, policies and regulations to regulate the practice were to be formulated, the same should not be so stringent and inflexible as to render the practice un-ideal (Drivers 2007). Rigid regulation framework will do more harm than good as it will encourage the mushrooming of illegal practices as is the case currently. One may argue that not regulating the practice would be the ideal state as then parties will be free to decide for themselves, if, how and why to enter into such arrangements. However,

this would expose the practice to non-ethical practices for example negotiating of surrogacy fee to be paid which may lead to exploitation of the surrogate host. Rigid laws as seen above are also not the best option. Laws, policies and other regulatory framework should thus be as flexible as possible to ensure that the ultimate goal of bringing happiness to the majority of people is fulfilled.

However, this kind of thinking is challenged by questions like what is good? Is there a standardized and widely acceptable definition of good? What is happiness? What is good or just to one person may not necessarily be good to another. Besides, it is not possible to have a standardized unit of determining happiness as people do perceive happiness differently. Therefore, we cannot uniformly point at a certain event or particular outcome and proclaim it as the ultimate measure of happiness or good. For instance, in matters to do with surrogacy, the mere possibility of having a child with one's own genetic material may be deemed to bring happiness to the intending parents but this does not necessarily translate to happiness to the other members of the community. In fact, chances are that some people would rather that the intended parents adopt a child from the already readily available children in orphanages and redirect the resources that would otherwise have been spent going through a surrogacy procedure into taking care of an adopted child.²⁸ This, it may be argued will bring more happiness to greater number of people in the society than the surrogacy process.

It is important to note that happiness is not only measured on material benefits but also involves the emotional, psychological and physical satisfaction that a certain outcome brings to people. The satisfaction of having a child, of fulfilling the society's expectations, of helping someone

²⁸ As pointed earlier, adoption is not only lengthy and tedious, it is also a very expensive and stringent affair.

fulfill their desires of having a child, the satisfaction of being called a mother or father, of passing on your genetic material, enjoying your child, enjoying the status that comes with being called a parent, ability of fulfilling one's apparent God given command of "be fruitful and multiply",²⁹ these coupled with material benefits that come with surrogacy, in my view, form a solid case for surrogacy from a utilitarian angle. Besides a pleasure that can be attained now is to be preferred to pleasure that will be obtained in the future and that pleasures that are likely to be more fruitful in the future should be preferred (Drivers 2007). Surrogacy ensures that the intended parents not only get a chance of having a child of their own within a specified period of time but also guarantees a continuity of their bloodline, unlike adoption which is lengthy, tedious, and rigid and with no guarantee that an adoption orders shall be made.

Utilitarianism has received certain criticism, key among them being that as human beings, we are egoistic in nature and we would ideally champion causes that benefit us as individuals rather than those which add more value to the society at large. Surrogacy, since it touches on very personal issues related to reproduction, is a clear example of self-centered happiness as claimed. However, we have seen other benefits that may be derived from such arrangements that outweigh personal happiness.

In conclusion, a utilitarian therefore would be of the view that surrogacy should not only be allowed as it consequently leads to more happiness for more people, but it should also be regulated to ensure that this 'greater happiness' is not exploited. The regulatory framework however, should be flexible and lenient in order to bring about greater happiness to a greater number of people.

²⁹ The Bible in Genesis 1: 22, 28 and Genesis 9:1, 7.

3.2.2 *Kantian Deontology*

This is a duty based theory. The word Deontology is derived from the Greek word '*Deon*' which means '*Duty*'. Proponents of this theory argue that one ought to morally do a certain action not because it brings happiness but because it is their natural duty to do so. For instance doctors are to treat patients because it is their duty to do so. In short, it follows the process of 'Do X because it is your duty to do X' (Beauchamp & Childress 2013).

This theory is generally associated with Immanuel Kant and according to him 'a good will is good not because of what it accomplishes nor because of fitness to attain some proposed end; it is good only through its willing, i.e. good in itself' (Kant & Sullivan 1996). According to deontologists, consequences or outcomes of the action do not matter in fact 'deontologists should not be bothered about the outcomes of their actions, rather, they should seek to act in ways that are right in itself, irrespective of the consequences' (Rosenstand, 2009). Therefore, it is right to say that deontology is not concerned with or rather does not focus on outcome of actions but rather the motive or intention of the action (Dhai & McQuoid-Mason 2011). That one should aim at doing 'good' not because it will bring about greater happiness but because it is matter of doing one's duty and as such is expected of him.

Kant believed that in as much as human beings are rational beings hence capable of making reasoned decisions and choices affecting their wellbeing (Kant & Sullivan 1996, Rachels & Rachels 2012), it is important to have some laid down guidelines to help people come up with such decisions. These guidelines or principles take the form of maxims and were expressed by Kant in the form of categorical imperatives.

One of such categorical imperatives is ‘Act in a manner so as to treat humanity, whether in your own person or that of any other person, never solely as a means but always also as an end’ (Kant & Sullivan 1996) According to this maxim, we are expected to treat others well, in a manner that would not only benefit us but also benefit them as well. One is not supposed to use other human beings merely to achieve their selfish goals but rather ensure that there is mutual reciprocity. In line with the above categorical imperative, it may seem on the face of it that surrogacy goes against this maxim as its main purpose is to help intending parents bear a child ‘through’ the womb of another. This ‘another’ will eventually not be party to the benefits, joy and satisfaction that comes with begetting this child, as it’s only their womb that will be required and used. This it can be assumed, is a clear example of using another as a means rather than as also an end. However, if the surrogate host was to be compensated either monetarily or through any other material gain, this would amount to treating her not merely as a means but also as an end, the end being mutual benefit to both the surrogate and commissioning parent. This maxim therefore supports the notion of compensation in surrogacy without which, it leaves most, except the altruist surrogates, as merely means to an end.

The other two categorical imperatives; ‘Act in a manner as if the maxim of your action were to become by your will a universal law of nature’ (Kant & Sullivan 1996, Rachels & Rachels 2012) and ‘Act in a manner as if you were by your maxims in every case a legislating member in the universal kingdom of ends’ (Kant & Sullivan 1996) touch on our very core of taking steps to ensure that our actions resonate not only with us but also with humanity as a whole (Rachels & Rachels 2012). Our duty as human beings is to respect other human beings and acknowledge that

human beings have intrinsic dignity and worth. Our actions should therefore be guided by personal maxims that would make the act not only permissible to ourselves but also acceptable to humanity as a whole. Laws, should be formulated in such a manner that would be permissible and acceptable by all. In the case of surrogacy as per the two categorical imperatives above, it would be prudent to 1) Set up practices including laws that are fair both to the surrogate host and commissioning parents, 2) The practices should be permissible and acceptable to all and 3) The practices should be such that it wouldn't matter what end you are on, as the regulatory framework would be just to all

Both the utilitarian and Kantian Deontology theories are rooted in autonomy; which is the right one holds to make informed decisions on matters that directly affect their lives. This brings us to the third moral theory which comes in the form of principles and usually referred to as Principlism.

3.2.3 Principlism

According to Clouser, Principlism is the 'the practice of using "principles" to replace both moral theories and particular moral rules and ideals in dealing with the moral problems that arise in medical practice' (Clouser & Gert 1990). Principlism therefore is the use of known and universally accepted and recognized principles to analyze ethical and or moral dilemmas. It may be argued however that there are no 'universally accepted' values and principles as morality depends on different cultures and their practices, but Beauchamp and Childress, the key supporters of Principlism, claim that indeed there are certain standards and practices that are

acceptable by many as being just and fair. These four Principles are 1) Respect for Autonomy, 2) Non-maleficence, 3) Beneficence and 4) Justice (Beauchamp & Childress 2013).

Respect for autonomy is the first and probably the most common principle under Principlism. The word autonomy is derived from the Greek words *Autos* and *nomos* which means *self* and *rule* respectively. According to Gillon, ‘autonomy is the capacity to think, decide, and act on the basis of such thought and decision freely and independently without let or hindrance’ (Gillon 1985). Respect for Autonomy requires that no treatment or procedure should be done, including IVF and in extension surrogacy without obtaining an informed consent from both the surrogate host and the commissioning parents. Consent is deemed to be informed if it arrived at by 1) Persons with full capacity, both legally and mentally, 2) Voluntarily without any coercion or duress, 3) After full disclosure of both risks and benefits and 4) After full understanding of all material facts (Beauchamp & Childress 2013). Informed consent therefore is a voluntary, unforced decision/choice made by a competent person on the basis of adequate information that has been fully understood, to take part in certain procedure or accept certain treatment when fully aware of the benefits, consequences and risks of the procedure (Gillon 1985). Both the surrogate and the commissioning parents should therefore be availed of all the information concerning the procedure. The surrogate for instance, should be informed of what to expect before and after the surrogacy process. Support groups, if available, the costs involved, and the likely risks like multiple pregnancies which may lead to a difficult pregnancy *et cetera* are to be disclosed. Disclosure should be of material facts and includes disclosure of potential risks now and in the future. A case may easily be made of coercion seeing as there is likely to be an incentive of the

material gain, but as long as the said has been fully disclosed among other things then the consent shall be deemed to be informed.³⁰

This being said, it remains that the choice to have a child through surrogacy is a right that should be acknowledged and respected by others; and so is the choice to carry someone else's child as a surrogate. However, like all other rights, there should be guidelines and regulatory framework in place to ensure that one does not trample on another's rights in the exercise of their own.

Principles of *non-maleficence* and *beneficence* go hand in hand and are usually referred to as opposite sides of the same coin. Non-maleficence obligates us to avoid causing harm to others and is loosely translated from the *Hippocratic Oath*³¹ (Edelstein 1967) as '*Above all, do no harm*' while the principle of beneficence requires one to 'actively' do that which promotes the wellbeing of another (Beauchamp & Childress 2013). Obligation not to harm would demand that an otherwise healthy woman should not be taken through the process of fertility treatment just so as to act as a 'rented womb' to the commissioning parents. Pregnancy comes with its challenges, some of which may lead to physical, emotional and psychological harm. To put one through these risks and task them with bringing a baby to term and then give it up would 'loosely' amount to doing harm.

On the other hand, the principle of beneficence encourages one to actively go out of their way to help others. Infertility by itself is not a disease per se, but when it becomes a cause of other diseases like depression, anxiety and other disorders, then we may argue that it is in one's

³⁰ As cited before, surrogate hosts are mostly drawn from women in the lower economic bracket

³¹ An Oath taken by medical practitioners / physicians to obey its provisions in the practice of medicine (Edelstein 1967).

interest that ‘treatment’ which includes surrogacy is administered hence actively avoiding those ‘diseased’ disorders.

Beneficence require acting in the best interest of the patient, but in the case of surrogacy, it is hard to clearly determine who the patient is. Is it the commissioning parents who are infertile or unable to have children of their own without help or is it the surrogate who has to undergo unnecessary treatment to enable her carry a pregnancy whose benefits she will not get to enjoy. There has to be a clear balance between what harm should and can be done and the resulting benefits expected not just for the commissioning parents but for the surrogate as well.

Lastly, the fourth principle under Principlism is that of *Justice*; more specifically *Distributive Justice*. Beauchamp defines distributive justice as ‘fair, equitable and appropriate distribution of benefits and burdens...’ (Beauchamp & Childress 2013). This principle calls for equitable (fair) as opposed to equal distribution and/or allocation of health returns which includes benefits and harms (risks).³²

ART and in extension surrogacy are by nature expensive and as such, a reserve for the few who can afford it. Usually the middle and upper class hire the surrogates while the poor and lower class become the surrogates. This kind of relationship does not provide a balance as there is no ‘meeting of minds’ financially and the burdens, risks and harm of pregnancy falls on the woman who is less likely to afford it (Runzheimer & Larsen 2011 p.185). It is therefore important that risks and benefits are justified and distributed in such a way that these less privileged do not end up being more disadvantaged.

³² Benefits and risks should be so distributed as not to benefit one party at the expense of another.

3.2.4 *Social Contract Theory*

The social contract theory is attributed to Thomas Hobbes, a leading British philosopher of the seventeenth century. Social theory puts forth that morality or ethics is a set of basic rules mutually agreed upon by rational individuals and that agreement or contract is what is considered as the source of their authority (Drivers 2007). This theory is borne out of the fact that human beings are inherently selfish and self-centered and are apt to act in ways and manner that would promote their personal selfish interests. However, this would lead to a clash in the society since there would be no uniformity or guidelines on how to live harmoniously as each would be interested in self perseverance and enrichment, a state that would make life not only dreadful but also ‘*solitary, poor, nasty, brutish and short*’ (Hobbes & Curley 1994). To avoid this, it is then necessary to establish laws and social contracts that are mutually binding and protect the interests of everyone (Rachels & Rachels p.88). In the case of surrogacy, if the practice is left open and everyone permitted to follow whatever rules, laws or process that they deem fit, then there would be chaos which would not only lead to misunderstanding of the surrogacy intervention but also promote the exploitation of the whole arrangement.³³ The surrogacy process should not only be regulated but also the regulations should be such that the people will agree and adhere to. This is why when making laws and policies, one should put themselves in a situation whereby no matter what station or status in the society one occupies, such laws and guidelines would be considered fair. The laws should be such that it wouldn’t matter if one were to find themselves as the commissioning parent or surrogate host as what is stipulated would fair to both parties.

³³ As in the case in India, where the practices are so liberal and hence commercial surrogacy practiced which has seen poor women getting exploited.

3.3 Conclusion

In conclusion, all moral theories seen above seem to support the idea of surrogacy to varying degree and for different reasons. However, they are all riddled with ethical egoism; a state which supposes that human beings are driven to do something not out of their kindness or to help others but for their own personal benefit. In short, egoism is connected to doing that which promotes personal interest. This however should not be seen as a 'negative' because most personal interests coincide with helping others to induce a greater sense of personal gain. In the case of surrogacy, more often than not, each party has personal reasons and incentives of why they decide to take part in the arrangement. For instance; the interest of the surrogate is to get some monetary or material compensation. In cases of altruistic surrogacy, the satisfaction of doing 'good' for another is egoistic in nature and is considered incentive enough. The interest of the commissioning parents is to have a child with their genetic material while the interest of the doctor/practitioner is to further their business and skills. So all in all, from whatever angle and from whatever moral theory, everyone gets to further their interests in one way or the other.

There may however be some tug of war on whose interests comes before whose and what share of responsibility should be apportioned to whom. This is where a regulatory framework comes in play to clearly stipulate what is expected from each and to what degree and under what guiding principles (Olingo 2011). Seeing as Kenya has no such framework, it is of essence that laws, policies and guidelines are formulated to guide the practice of surrogacy (Olingo 2011). This is why in my next chapter i shall proceed to look at some laws, policies and professional guidelines of two countries being United Kingdom and South Africa, in line with what the moral theories

have provided above and thereafter come up with recommendations for a regulatory framework for Kenya.

CHAPTER 4

REVIEW OF REGULATORY FRAMEWORK OF THE UNITED KINGDOM AND THE REPUBLIC OF SOUTH AFRICA

4.1 Introduction

Currently, Kenya has no laws, policies, regulations and professional guidelines to regulate the practice of surrogacy. However, a bill³⁴ has been drafted and presented before a parliamentary committee to incorporate the same. However, the bill as it is, does not give a comprehensive guideline to the regulation of surrogacy. Being a member of various international bodies, Kenya is under the guidance of various international statutes, and one such statute is the Universal Declaration on Bioethics and Human Rights (2005), which, though it provides a general view on bioethics, the ethics on the practice of surrogacy can be inferred from it.

Kenya is a commonwealth country and as such, derive its common laws from the United Kingdom (UK). At the moment, the definition and practice of surrogacy as stipulated in the Human Fertilization and Embryology Act 1990, (amended in 2008), guide the practice of surrogacy in Kenya. This is supplemented with relevant provisions in the Surrogacy Arrangements Act (1985), the British Nationality Act (1981) and the British Nationality (Proof of Paternity) Regulations 2006 where relevant. These provisions act merely as guidelines as the laws are not enforceable in the Kenyan courts. Besides, seeing as there are wide differences in

³⁴ The Reproductive Health Care Bill 2014 deals mainly with other aspects of reproductive health and devotes a very small and therefore non-comprehensive paragraph on surrogate motherhood.

the two countries legal structure,³⁵ system, beliefs, cultural practices and most importantly technological state of advancement, it is important to establish a middle ground.

This middle ground, I believe, is the South African statutes, regulations and professional guidelines related to surrogacy. This is due to the fact that being a fellow African country, with relatively similar beliefs and practices, it would appear reasonable to adopt the relevant regulatory framework from South Africa. After all, one may say, Kenya has heavily borrowed, with success on other South African laws including the Constitution, The Children's Act (2005) and the National Health Act (2003). The South Africa Health Act provides for the regulation of Assisted Reproductive Technology, through its regulations relating to artificial fertilization of persons which surrogacy is but one piece to it. The Children's Act provides for the registration and care of children born out of a surrogacy arrangement, and there are ethical guidelines that guide the professionals in their practice. However, be as it may be, the progressive laws from the United Kingdom may also be relevant seeing as Kenya is progressively adopting new technologies as they come. This is why I shall look at regulatory frameworks from both countries before I make any recommendations, which shall be based on the best practices of the two countries (UK and SA). I shall start with the regulatory framework of the UK as hereunder;

4.2 Regulatory Framework on Surrogacy in the United Kingdom

4.2.1 Human Fertilization and Embryology Act 1990 (as amended in 2008)

The Human Fertilization and Embryology Act (HFEA) 1990 is an Act of parliament of the United Kingdom whose purpose among others is to 'establish a regulatory authority, make

³⁵ The Kenyan courts are known to be slow, expensive and complicated.

provisions for who in certain circumstances is to be treated in law as the parents of a child; and to amend the Surrogacy Arrangements Act 1985' (HFEA) The Act of 1990 was amended in 2008 to include making provisions for 'connected purposes'

The HFEA is the main regulatory framework for cases of assisted reproduction in the United Kingdom and its provisions provide for the following;

4.2.1.1 Parental orders

One of the key reasons for the enactment of the Act was to 'make provision about the persons who in certain circumstances are to be treated in law as the parents of a child'³⁶ (HFEA). This is an important section of the Act as it provides for the registration and recognition of parentage for children born out of arrangements such as surrogacy and same sex partnerships.³⁷ Section 54 part two (2) of the HFE Act of 2008 this section reads as follows;

54 (1) On application made by two people ('the applicants')/ the court may make an order providing for a child to be treated in law as the child of the applicants if –

- (a) The child has been carried by a woman who is not one of the applicants, as a result of the placing in her of an embryo or sperm and eggs or her artificial insemination
- (b) The gametes of at least one of the applicants were used to bring about the creation of the embryo, and
- (c) The conditions in subsections (2) to (8) are satisfied

The conditions to be satisfied under Section 54 (2-8) are;

³⁶ This is an important provision since the person who brings forth a child is legally considered as the mother of the child. (Children's Act of RSA)

³⁷ Unlike in Kenya, the UK allows for same sex unions. (HFE Act 2008 (as amended))

- (i) Applicants should be husband and wife or civil partners of each other
- (ii) At least one of the applicants must be genetically related to the child
- (iii) Both applicants must be 18 years and above
- (iv) The surrogate and her partner/husband (if applicable) must have freely and without any undue influence, consented to the making of the parental order.
- (v) The application is made within six (6) months after the birth of the child
- (vi) The child should be living with the applicant(s) at the time of application and either one or both of the applicants should be domiciled in the United Kingdom, the Channel Islands or the Isle of Man
- (vii) No money other than reasonably incurred expenses has been paid in respect of the surrogacy arrangement, unless that payment has been authorized by the court

If and when all the conditions of this section are met, then the court is able to order that commissioning parents/couple of a child born out of a surrogate arrangement are to be treated as the parents of the child without having to go through an adoption process. A report from a social worker may be required by the court before making a parental order.³⁸ A parental order transfers all parental rights to whoever it is given to and confers on the commissioning couple all duties and responsibilities of a parent whilst in the same breath putting an end to any such rights of the surrogate mother/parents.

4.2.1.2 Amendment of the Surrogacy Arrangements Act 1985

Part of the reasons for enactment of the HFE Act of 1990 and subsequently 2008, was to 'amend the Surrogacy Arrangement Act 1985',³⁹

³⁸ A visit by a social worker may be conducted to determine the suitability of the couple.

³⁹ Chapter 22 and 37 of the HFE Act amends the Surrogacy Arrangement Act of 1985

The provisions amended in the Surrogacy Arrangement Act 1985 (c.49) fall under section 36 of the HFE Act 1990 (c.37) and Section 59 of the HFE Act 2008 (c.22).

Section 36 (1) of the HFE Act 1990 provides for non-enforceability of surrogate arrangement by inserting Sec. 1A in the Surrogacy Arrangement Act as follows;

36 (1) after section 1 of the Surrogacy Arrangements Act 1985 there is inserted-

1A) No surrogacy arrangement is enforceable by or against any of the persons making it.

This provision basically means that the surrogate mother cannot be compelled by court or the commissioning parents to hand over the child, neither can the commissioning couple be compelled to pay any monies to the surrogate or recover monies paid to her. The agreement also cannot require either of the parties to take up or relinquish any parental responsibilities. This can only be done through a parental order. A surrogacy arrangement therefore, is akin to a “gentleman’s agreement.”⁴⁰

Sec. 59 of the HFE Act 2008 (c.22) amends the provisions of chapters 2 and 3 of the Surrogacy Arrangement Act 1985 (c.49) to allow a nonprofit making body (agency) charge facilitation fees for surrogacy arrangements.⁴¹ The agency may also compile necessary information as regards their services and this shall not be penalized⁴². Lastly, under this amendment, the agency is allowed to advertise their services and charge for them⁴³. (Human Fertilization and Embryology Act 2008 (as amended)

⁴⁰ A gentleman’s agreement is one which you entrust someone to keep his word – it is akin to saying ‘*my word is my honor*’.

⁴¹ Section 59 (4) and (5)

⁴² Section 59 (4)

⁴³ Section 59 (7)

4.2.1.3 Establishing a regulatory authority

Section 5 of The HFEA provides for the establishment of the Human Fertilization and Embryology Authority which is a body corporate, a legal entity with powers to sue and be sued - and reports to the secretary of the state. The membership of the authority includes a chairman, deputy chairman and other members as the secretary of the state shall deem fit and who have the necessary qualifications required to hold such post (s). The Act further provides for their appointment, tenure, responsibilities and remuneration

Functions of the authority

The authority is charged with the following functions among others;

a) Issuance of Licenses

The authority is charged with issuing of licenses for fertility clinics in the United Kingdom.⁴⁴

The HEA Authority not only issues licenses to facilities wishing to provide fertility treatment in the country but also monitors the medical facilities to ensure that the provisions of the license are followed. If not, the HFE Authority has the powers to suspend, revoke or withdraw the license of a facility and recommend appropriate punishment for the offending party. This is done through licensing committees that are set up by the Authority.

Licenses to conduct appropriate research are also issued by the Authority.

⁴⁴ The fertility clinics have to conform to some basic laid down standards before they can be licenced

b) Management duties

The authority is also charged with general management functions that include; keeping proper accounts of the body corporate, preparing annual reports of activities undertaken and developing professional codes of conduct for its members.⁴⁵

c) General functions

Other functions under section 8 of the Act include; reviewing of information about embryos and other services as stipulated by the Act, making public services provided to the public by the Authority and providing appropriate information and advice to the public as need arises.

4.2.2 The Surrogacy Arrangements Act 1985⁴⁶

The Surrogacy Arrangement Act Chapter 49 of 1985 of the United Kingdom⁴⁷ was enacted to regulate the practice of Surrogacy in the United Kingdom. It is a very small and short statute with only 5 sections (paragraphs).

Section 1 of the Act gives the definition of key terms like surrogate mother, surrogacy arrangement and payment. Under the Act, a surrogate mother means a woman who enters into an arrangement to carry such a child with the intention of handing the child over to another person(s) who shall then exercise parental rights over the child. The agreement to do so must be made before the woman begins to carry the child.

⁴⁵ Provided under Section 6 of the Act.

⁴⁶ Chapter (CAP) 49 of the laws of the United Kingdom.

⁴⁷ This is the main Act that provides for surrogacy arrangements in the United Kingdom.

Section 2 of the Act criminalizes commercial surrogacy and forbids payment to third parties for aiding in negotiating of any surrogacy arrangements. However the HFE Act 2008 allows under section 59 (4) for non-profit making agencies to make a not for profit charge for facilitating surrogacy arrangements.

Section 3 of the Act criminalizes any sort of advertisement and distribution of such adverts in any public media like newspapers, television and internet. This was however repealed by section 59 subsection (7) of the HFE Act 2008 which allows such adverts to be made and distributed but only by or on behalf of a non-profit making body and as long as it shall not be an advert calling for commercial surrogacy.

Section 4 of the Act deals with offences prescribing sentences and fines to be meted out to persons who go against the provisions of the Act.⁴⁸

4.2.3 The British Nationality Act 1981⁴⁹

The British Nationality Act Chapter 61 of 1981 of the United Kingdom was enacted ‘to make provision about citizenship and nationality...as regards the right of abode in the United Kingdom’.

Surrogacy arrangements, especially those conducted outside the United Kingdom, may raise issues about the nationality of the child⁵⁰. *Section 2* of the Act recognizes that a child born

⁴⁸ Punishment includes imprisonment, payment of fine or both.

⁴⁹ Chapter 61 of the Laws of the United kingdom.

⁵⁰ Kenya has seen an influx of patients from Europe including the UK. This is because it is cheaper in Kenya than in UK and services are faster since there are no waiting periods to be observed (Ligami 2014)

outside the UK shall automatically acquire British nationality if either of the parents is a British citizen. There has to be solid proof however of the parentage before nationality is conferred.⁵¹

Section 50 of the Act read in conjunction with the British Nationality (Proof of Paternity) Regulations 2006) defines who is a parent for children born after 1st July 2006 as follows. A parent is;

- i) The mother is the woman who gives birth to the child (this applies to a surrogate as well),
- ii) The father is either 1) the husband of the mother, 2) a person treated as a father under HFE Act 2008 or 3) any other person who meets certain requirements to proof paternity.

The requirements under (ii) above include; provision of a birth certificate issued by the relevant authority identifying him as the father of the child (certificate should have been issued within 12 months of the birth of the child. Any other evidence that may certify the Secretary of the state like DNA test report.

4.2.4 Conclusion

In conclusion, the UK laws allow for surrogacy as long as one of the commissioning parents is genetically/biologically related to the resulting child, all parties are adults of sound mind and have entered into the arrangement with their full informed consent, the practice is not for commercial purposes and commissioning parties should either be husband and wife or legal partners at the time of the arrangement. The commissioning parties have to obtain a parental order within three months of the birth of the child to transfer any or all parental rights from the

⁵¹ In some cases, DNA testing may be done to ascertain and/or proof parentage. (British Nationality Act)

surrogate mother to themselves. The UK laws also recognize that not for profit organization may act as surrogacy agencies.

4.3 Regulatory Framework on Surrogacy in the Republic of South African

4.3.1 The Children's Act of 2005

The Children's Act of 2005 was assented to on 8th day of June 2006 but became fully operation from the 1st day of April 2010.⁵²

This Act among other purposes was enacted to provide for surrogate motherhood and other matters connected therewith. The Act gives definition of key terms related to the practice of surrogacy which terms include, artificial fertilization, commissioning parent, gamete, parental responsibilities, surrogate mother and surrogate motherhood agreement.⁵³

4.3.1.1 Surrogacy motherhood agreement.

The Children's Act provides for a surrogacy motherhood agreement and lays down the conditions of its validity, confirmation by court, termination and its effect on the status of the child. No artificial fertilization on the surrogate mother can take place before a surrogacy motherhood agreement has been confirmed by the court. The fertilization has to take place within 18 months of the court's confirmation.⁵⁴

⁵² This is known as the date of commencement (Children's Act No. 38 of 2005 of RSA).

⁵³ Section 1 of the Children's Act of South Africa

⁵⁴ Section 296 of the Act.

Conditions of surrogacy

According to the Act, the following conditions must be fulfilled before parties enter into a surrogacy motherhood agreement;

- (a) Consent of the husband, wife or partner (if applicable) of both the commissioning parent and the surrogate mother to be must be sought and given. (However court may waive this provision in respect of surrogate mother),⁵⁵
- (b) At least one of the commissioning parties must be genetically / biologically related to the child,⁵⁶
- (c) A valid agreement must be entered into and confirmed by the court before fertilization of the surrogate mother. For this agreement to be valid, it must meet the following conditions as enshrined under section 292 of the Act. That is;
 - i. It must be in writing and signed by all the parties,
 - ii. At least one of the commissioning parents must be residing in the country,
 - iii. The surrogate mother and her partner (if any) must be residing in the country. The court may dispose of this condition if it chooses to,
 - iv. It must be entered into in the Republic of South Africa and
 - v. It must be confirmed by the relevant authority where the commissioning parents reside
- (d) The commissioning parent(s) must be in a state of permanent and irreversible infertility⁵⁷ and,
- (e) All the parties involved must be adults of sound mind and capable of entering into an agreement by law.

⁵⁵ Section 293.

⁵⁶ Section 294.

⁵⁷ Section 295 (a).

- (f) The surrogate mother must fulfill the following additional conditions
- i. Has a documented history of at least one pregnancy and viable delivery,
 - ii. Has a living child of her own and
 - iii. Is not using the surrogacy as a source of income.
- (g) A surrogacy arrangement may not be terminated after artificial fertilization of surrogate mother has taken place.

Prohibition of commercial surrogacy

The Act prohibits commercial surrogacy and forbids the surrogate mother from using the surrogacy as a source of income.⁵⁸

Effect of Surrogacy Agreement;

The Act provides that;

‘Any child born of a surrogate mother and in accordance with the agreement is for all purposes the child of the commissioning parent or parents from the moment of the birth of the child concerned.’⁵⁹

The agreement therefore confers parental responsibilities to the commissioning parents and as such infers or rather provides that;

- (a) The surrogate mother is obligated to hand over the child to the commissioning parents after its birth.
- (b) The surrogate mother has no parental rights to the child, either by herself or through her partner and/or relatives.

⁵⁸ Section 295 (c) (iv-v).

⁵⁹ Section 297 (1).

(c) Surrogate motherhood may not be terminated after artificial fertilization has occurred.

(d) The child has no claims either of maintenance or inheritance towards the surrogate mother, her husband/partner or relatives.

Children born out of a surrogacy arrangement whose surrogacy agreement does not conform to the provisions in the Act are deemed to be the child of the surrogate mother for all purposes.⁶⁰

Termination of the surrogate motherhood agreement

According to sections 298 and 299 of the Act, a surrogacy motherhood agreement may only be terminated;

(a) By the genetic mother of the child concerned as long as it is within sixty (60) days after the birth of the child as long as;

- i. The termination has to be in writing and notice filed with the court,
- ii. A court must be satisfied that the termination has been done voluntarily and that the genetic mother understands the effects of the termination of the agreement,
- iii. The termination is done in the best interest of the child and
- iv. Surrogate mother shall not incur liability to the commissioning parents for the termination of the agreement.

(b) Termination of a surrogate motherhood agreement has the effect of terminating any parental rights that may have already been invested in the commission parents and vests them in the surrogate parents. It also terminates any and all claims that the child may have to the commissioning parents or their relatives.⁶¹

⁶⁰ Section 297 (2).

⁶¹ Section 299.

(c) Termination of pregnancy as prescribed under terms of the Choice on Termination of Pregnancy Act, (1996)⁶² brings the surrogate motherhood agreement to an end.

Termination of surrogacy agreement does not necessarily mean that the surrogate mother terminates the pregnancy. She may carry it to term and take parental responsibilities over the born child(ren).

Payments in respect to surrogacy

The Children's Act (2005)⁶³ expressly outlaws commercial surrogacy and criminalizes any form of material payment that is made either as a reward or as compensation. However the following payments are allowed;⁶⁴

(a) Payments related directly to;

- i. Artificial fertilization,
- ii. Direct pregnancy expenses,
- iii. Payments related to the birth (delivery) of the child and
- iv. Payments made for the purposes (process) of confirmation of the surrogate motherhood agreement.

Payments made towards insurance of the surrogate mother and loss of earnings occasioned by the surrogacy is acceptable.

The Act prohibits publishing of names of the parties and advertisement of surrogacy services.⁶⁵

⁶² Act 92 of 1996

⁶³ Act 38 of 2005

⁶⁴ Section 301.

⁶⁵ Sections 302 and 303 respectively.

4.3.2 National Health Act 61 of 2003

Regulations relating to artificial fertilization of persons.

The National Health (2003)⁶⁶ provides for rules and processes for artificial fertilization of persons under the regulations relating to artificial fertilization of persons.⁶⁷ Even though the regulations do not touch on surrogacy directly, the fact that surrogacy is mainly achieved through artificial fertilization and more specifically IVF, makes the regulations relevant.

The regulations provide definitions of key relevant terms like artificial fertilization, embryo transfer, gamete donor, *in vitro* fertilization, oocyte and surrogate.⁶⁸

Under the regulations, artificial fertilization includes *in vitro* fertilization and embryo intra-fallopian transfer, procedures that are used when undertaking gestational surrogacy.

Provisions that touch on artificial fertilization and in extension surrogacy under the regulations include the following;

- (a) The full informed consent from parties involved before any procedure of artificial fertilization is undertaken.⁶⁹
- (b) Establishment of a central data bank where all information on gamete and embryo donation is stored. Information should be properly kept and updated and should be protected from the public.⁷⁰
- (c) Only competent and licensed person may effect artificial insemination including embryo transfer and that may only be effected at an authorized institution.⁷¹

⁶⁶ Act 61 of 2003

⁶⁷ The National Health Act provides for making of such regulations as may be necessary to regulate areas / provisions under its mandate. (National Health Act 2003)

⁶⁸ Schedule 1 of the regulations.

⁶⁹ Schedule 7 (e) and 11 (b)

⁷⁰ Schedule 5

⁷¹ Schedule 3 and 15(1-6)

- (d) Ownership of a zygote or embryo after fertilization is vested in the recipient. The regulations define a recipient to include ‘a female person in whose uterus/womb a zygote or embryo is to be placed for the purpose of human reproduction’ and a surrogate as ‘a voluntary recipient of an embryo who will carry such embryo to birth for contractual parents.’⁷²
- (e) All births delivered as a result of artificial fertilization should be recorded by person in-charge of the facility and thereafter into central data bank within 3 months of such birth.⁷³
- (f) Disclosing of facts resulting from artificial fertilization is prohibited except where law provides otherwise or where court so orders.⁷⁴
- (g) Persons going against any provision in the regulations are liable to a fine or imprisonment not exceeding 10 years or both.⁷⁵

4.3.3 Professional guidelines

The Health Professions Council of South Africa (HPCSA) is the main regulatory authority which deals with general matters concerns medical practitioners in South Africa. It has a list of guidelines that relate to different health related areas among them ethical guidelines for reproductive health among health care practitioners in South Africa.⁷⁶ These guidelines provide that surrogacy should only be applied in very limited cases⁷⁷ and under strict medical supervision⁷⁸. The autonomy of the surrogate mother has to be respected⁷⁹ and she should at all

⁷² Schedule 18 (1&2)

⁷³ Schedule 16

⁷⁴ Schedule 19

⁷⁵ Schedule 21

⁷⁶ Also known as HPCSA Booklet 13 (General Ethical guidelines for Reproductive Health)

⁷⁷ Guideline 8.1

⁷⁸ Guideline 8.4

⁷⁹ Guideline 8.3

costs be protected from exploitation, considering she is most likely from a lower socio-economic background from that of the commissioning parents⁸⁰. The guidelines prohibit the practice of commercial surrogacy⁸¹ and all cases of artificial fertilization should only be effected by competent, qualified and licensed practitioners.

4.4 Conclusion

In conclusion, it is apparent that South Africa does allow for the practice of surrogacy as long as the arrangement is entered into by adults of sound mind under a valid surrogate motherhood agreement, the agreement is registered and confirmed by the court before artificial fertilization is done, it is not for commercial purposes, surrogate mother/host meets certain laid out conditions, the commissioning parents suffer from permanent and irreversible infertility and the resultant child is genetically/biologically related to at least one of the commissioning parents. The resultant child is considered for all intent and purposes as the child of the commissioning parents.

Having looked at relevant statutes and moral theories, I now shall proceed to make recommendations on a regulatory framework on surrogacy in Kenya in my next chapter. These recommendations are based on what I perceive to be the best practices of both countries.

⁸⁰ Guideline 8.2

⁸¹ Guideline 8.3

CHAPTER 5

RECOMMENDATIONS

5.1 Introduction

In my opinion, the practice of surrogacy is a noble and essential service that allows couples suffering from infertility to have children of their own. However, surrogacy should only be practiced in a regulated environment. In as much as the practice can run without any regulations in a sort of “free for all and everyone for himself” kind of way, regulating the practice would not only put an end or rather curb any potential exploitation but would also ensure the provision of standardized services. One may argue that regulating the practice of surrogacy would be taking away the autonomy of people and denying them their right to make decisions on matters affecting their reproductive capabilities (Chadwick 2001, Ankley 2006), that regulating matters on reproduction is akin to inviting the state ‘to bed’ with couples and thereby infringing on privacy that is associated with the act of reproduction. (Chadwick 2001, Ankley 2006). These sort of arguments, I believe, are based or brought up by the fear of the “unknown”, Besides, I believe regulation would not only give parties more options in their decision making process but would also ensure that their decisions are protected by law.

As seen in previous chapters, usually women from the poor income bracket are the ones who become surrogates while the middle and upper class are commissioning parents. This makes it hard and even impossible to find a common ground seeing as the negotiating power is

unbalanced between the two parties. Regulation is the only way that would ensure that both parties are served justly without prejudice based on to social-economic standing.

Having said that, I make the following recommendations on a possible regulatory framework on surrogacy in Kenya. I shall heavily draw from the frameworks from the United Kingdom and South Africa and incorporate the findings from the moral theories that I have discussed in a previous chapter.

5.2 Specific Recommendations

I draw the recommendations from the regulatory frameworks of both the United Kingdom and Republic of South Africa, bearing in mind the norms and practices of the people of Kenya, the legal system and the technological advancement. The recommendations are as hereunder;

5.2.1 *Commissioning parents*

For parties to be considered as commissioning parents, they should meet the following requirements;

Capacity: - The commissioning parents should be adults that is be above 18 years of age at time of the arrangement. They should also be legally and mentally competent as per the laws of the Republic of Kenya.⁸²⁸³

⁸² In Kenya, the age of majority is 18 years old (Children's Act No. 8 of 2001 of the Laws of Kenya)

⁸³ Recommendations drawn from both UK and SA laws

Medical condition: - Surrogacy services should only be limited and offered to couples where the woman is incapable of carrying a pregnancy. Surrogacy for “vanity” purposes like avoidance to gain weight and other cosmetic and/or inconvenience purposes should be prohibited and even penalized.⁸⁴ Proof of infertility should be required from a qualified medical practitioner before parties can enter into a surrogacy arrangement agreement. Use of surrogacy for other reasons other than to treat infertility amounts to violating the principle of non-maleficence (Runzheimer & Larsen 2011).

Domicile: - Both or at least one of the commissioning parents should be domiciled in Kenya at time the arrangement. The relevant authority may however choose to waive this requirement so as to cater for patients from foreign countries as long as their country has no objection to this.⁸⁵

Marital status: - The commissioning parents should be married (either legally or traditionally) or be in a civil union, or be together in such a way that people around them consider them married before entering into a surrogacy arrangement.⁸⁶ Same sex marriages are currently not recognized in Kenya but the same should be reviewed in future. This provision also applies to single parent(s).

Genetic relation: - At least one of the commissioning parents should be genetically/biologically related to the child. Surrogacy arrangements for persons who are not genetically related to the

⁸⁴ Women have been known to want a surrogate so as not to interfere with their job responsibilities and social life.

⁸⁵ This is to discourage commercialized medical tourism.

⁸⁶ This includes traditional African weddings / marriages that are conducted according to various traditional cultures in Kenya (Kimani & Olenja 2001)

resulting child should be banned and even penalized.⁸⁷ Proof of relation may be done by carrying out DNA testing at least six weeks after the birth of the child which is paid for by the commissioning parents. This testing should be done in a registered and licensed laboratory.

5.2.2 *Requirements of surrogate mother/host*

For a woman to be considered as a surrogate host, she should fulfill the following requirements;

Capacity: - A surrogate mother/host to be should be 21 years and above at the time of the surrogacy arrangement.⁸⁸ However a lower age of 18 years may be considered depending on the maturity of the surrogate mother/host. The surrogate mother/host to be should be mentally competent at the time of entering the surrogacy agreement. A psychological analysis should be undertaken by a qualified practitioner to determine the mental and psychological capacity of the surrogate mother/host before a surrogacy arrangement can be entered into.

Proof of fertility: - The surrogate mother/host to be should have a documented history of at least one pregnancy which resulted to a viable birth. This in addition to medical records is evidence enough that she is capable of carrying a pregnancy to term.

Living child: - The surrogate mother/host to be should have a living child of her own at the time of the surrogacy arrangement agreement. This is because there is psychological attachment to

⁸⁷ This ensures that the welfare of the resultant child is protected at all times, as they have genetic links to either of the parent.

⁸⁸ I have considered age 21 instead of the usual age of majority of 18 years since pregnancy comes with a lot of responsibilities and requires a more mature mind and body.

bearing a child and the surrogate mother should have gone through that to understand what she is getting herself into.⁸⁹

Consent: - The surrogate/host mother should enter into the arrangement freely, without any coercion, duress or undue influence.⁹⁰ The consent given should be informed, that is it is given voluntarily, with full understanding of material facts which include risks, explained in a language that the surrogate understands. If the surrogate mother/host has a husband or partner, their consent should be sought as well. However, that can be done away with in certain special circumstances.

Domicile: - The surrogate mother/host should be domiciled in the Republic of Kenya at the time of the arrangement. This provision would serve to avoid medical tourists who are in search of “cheaper treatment” while at the same time not using “direct services” from the locals.

Purpose: - A surrogate mother should not enter into a surrogacy arrangement for commercial purposes. She should not be in it for the money. However, reasonable compensation for loss of earnings while she is pregnant should be allowed and given.⁹¹ Monies for direct expenses towards the artificial fertilization, birth of the baby, medical cover and immediate care for the child after birth should be provided for.

⁸⁹ For medical reasons, the living child should be at least two years and above at the time of entering into the surrogacy arrangement (Petitti 1985).

⁹⁰ Undue influence is usually seen and / or inferred from surrogacy between family members especially if the surrogate host is indebted to the commissioning parent(s) in one way or another.

⁹¹ This provision should be clear in the agreement and amount stipulated should be constant regardless of whether it is a single or multiple birth.

5.2.3 *Provisions of surrogacy agreement*

Before artificial fertilization and transfer of embryos into the surrogate mother's uterus is done, the parties must enter into a surrogacy arrangement and sign a surrogacy agreement beforehand.

The surrogacy agreement should have the following provisions;

Execution: - The surrogacy agreement should be in writing and should be signed by both parties. Verbal arrangements and / or agreements should not be allowed. The writing should be in either of the two national languages of Kenya being English or Swahili.⁹²

Jurisdiction: - The agreement should be entered into in the Republic of Kenya under the relevant law.⁹³ The said agreement should be notarized or commissioned by a notary public or a commissioner of oaths as the case may be.⁹⁴ Agreements entered into in other jurisdictions should first be approved by the Kenyan courts and addendums made to that effect before artificial fertilization can be done.⁹⁵ All such agreements should be drawn by qualified persons and notarized and / or commissioned before the parties to the agreement.⁹⁶

Commencement clause: - There should be a commencement clause in the agreement will start taking effect only after it has been approved by the court or whichever comes first. No artificial fertilization of the surrogate woman may happen before the agreement is in effect. Such fertilization will be considered as breach of law.

⁹² Agreements written in other languages should have official translations attached thereto before execution.

⁹³ The law on Contracts.

⁹⁴ Commissioning is done for Kenyan Nationals while notarizing is done in cases where one or more of the parties are foreigners (Advocates Act 1989 of the Laws of Kenya)

⁹⁵ A note from the respective embassy may be needed to prove credibility of the agreement.

⁹⁶ Only Advocates of the High Court of Kenya can draw such agreements (Advocates Act 1989 of the Laws of Kenya)

Compensation limits: - There should be a specified, directly and clearly written compensation limit to loss of earnings for the surrogate mother.⁹⁷ A birth should be treated as birth irrespective if it results into multiple babies or one child. No haggling or negotiations should be tolerated once artificial fertilization has occurred.

Provision for welfare of the child: - The agreement should provide for the contact, care, upbringing and general welfare of the child to be born. It should also provide for the child's position in the event of the death of one or both of the commissioning parents or their divorce/separation before the birth of the child. A guardian to the child should be named in the agreement in writing before artificial fertilization takes place.⁹⁸ This is to ensure that the surrogate mother is not left with the parental responsibilities should death or disappearance of both commissioning parents occurs.

Validity dates: - The artificial fertilization of the surrogate must take place within six months from the execution of the agreement.⁹⁹ In case pregnancy does not occur within the six months then a new agreement should be entered into. If there is a change of surrogate mother /host, a new agreement should be drawn.

⁹⁷ Perhaps a loss of income schedule should be drawn up.

⁹⁸ The proposed guardian should sign by his/her name to signify knowledge and acceptance of the appointment.

⁹⁹ Extension may be granted by court if there is difficulty in retrieval, fertilization or implantation. But such extension should not exceed three months.

Termination of agreement after fertilization: - The arrangement and agreement shall not be terminated after artificial fertilization has occurred unless under special circumstances which includes termination of pregnancy under advice from the medical doctor

5.2.4 *Effects of surrogacy arrangement*

The surrogacy agreement and arrangement should have the following effect;

Status of the child: - A child born of surrogacy shall be considered for all intent and purposes as the child of the commissioning parents and shall be registered as such under the births and deaths registration in the department of registration of persons.¹⁰⁰ This is only applicable if there was a valid surrogacy agreement entered and filed before artificial fertilization of the surrogate occurred.

Parental responsibilities: - All parental responsibilities are and should be vested in the commissioning parents. A child born of surrogacy shall have no claims for succession, maintenance or related child responsibilities claims towards the surrogate mother and her husband/civil partner and their relatives.

5.2.5 *Termination of surrogacy agreement*

The following are the provisions that are to be adhered to in termination of surrogacy arrangements agreements

¹⁰⁰ The department charged with registering of persons in Kenya (both births and deaths) (Births and Deaths Registration Act)

Termination of surrogacy agreement: - No surrogacy may be terminated after artificial fertilization has occurred. However, a surrogate mother who is also the genetic mother of the child may terminate a surrogacy agreement within sixty days after the child has been born.¹⁰¹ This should be done in writing and the notice filed in court.

Liability on termination of surrogacy agreement: - A surrogate mother should not incur any liability in exercising her right to terminate the surrogacy agreement except payments made as direct expenses towards the artificial fertilization of the surrogate mother, birth, immediate care of the child, medical cover and related incidentals thereto.¹⁰²

Effects of termination of agreement: - Termination of the surrogacy agreement should also serve to terminate all parental responsibilities that may have been given to the commissioning parents. The same responsibilities are now vested in the surrogate mother and the child may make no claims as to maintenance or succession on the commissioning parents.

5.2.6 *Payments for surrogacy*

Commercial surrogacy should be strictly forbidden and payment for surrogacy arrangements should be criminalized except payments for the following;¹⁰³

- (1) Compensations related directly to the artificial fertilization and pregnancy of the surrogate,
- (2) Expenses related directly to the birth of the child and immediate after care,

¹⁰¹ This type of surrogacy, which it is traditional surrogacy should not be encouraged as it is hard to regulate.

¹⁰² This provision is to avoid exploitation through punitive compensation for terminating surrogacy.

¹⁰³ Adopted from both the UK and SA regulatory frameworks.

- (3) Expenses related to confirmation of surrogate motherhood agreement,
- (4) Insurance cover for surrogate mother to cater for medical costs and other incidentals and
- (5) *Bona fide* professional services rendered like legal and medical services from qualified and licensed professionals.

5.2.7 ***Professional and institutional guidelines and policies***

Competence of practitioner: - Artificial fertilization should only be done by qualified and licensed practitioners.¹⁰⁴ A register of such qualified and licensed practitioners should be kept by the relevant professional body and be updated as need arises.

Licensed institution: -The artificial fertilization of a woman should only be conducted at a licensed institution which institution should be inspected frequently by relevant authorities. Certain standards for such institutions should be laid out and relevant authorities should ensure that they are met.

Continuous education: - Qualified professional practitioners should be required to attend continuous educational programs to update their skills and keep up with changing trends.¹⁰⁵

Self-regulation / professional code: - The practitioners in this field should be allowed to come up with self-regulatory rules and professional standards codes that govern their practice and provide for penalties for breach of the same.

¹⁰⁴ Qualified in the sense of both education and skill / practice.

¹⁰⁵ There should be a point system where practitioners are given points annually for attending various refresher skills. This should count towards renewal of their annual practicing license.

Creation of regulatory authority: - Further to the recommendation above, a professional body / authority should be created to regulate and register IVF and other ART centers. This authority should also prescribe mechanisms for dispute resolutions in cases of disputes in ART.¹⁰⁶

5.2.8 *General provisions (recommendations)*

Other recommendations for general provisions include the following;-

Databank: - A databank should be maintained by relevant body / authority of all pregnancies and births that have resulted by virtue of surrogacy.¹⁰⁷ This database should be updated frequently and a trend analysis done every year to determine the way forward. This may require the setting up of a regulatory authority / body to take care of these elements.

Surrogacy frequency: - A limit on how many times a surrogate can be a surrogate mother should be set. This is to not only avoid cases of turning surrogacy into a money making full time job but also safeguarding the health of the surrogate mother as many pregnancies within a specified period may be detrimental to the health of the surrogate.¹⁰⁸

¹⁰⁶ These ADR should be enforceable in a court of law.

¹⁰⁷ A databank would come in handy in case a follow up is ever needed.

¹⁰⁸ I recommend that a woman should not be a surrogate more than three times if she has only one child of her own and not more than twice if she has two or more children of her own.

Counseling services: - Pre and post surrogacy counseling should be offered free of charge before parties enter into a surrogacy arrangement.¹⁰⁹ Surrogate mothers can form support groups, if they so desire, where they get to share their surrogacy process.

Miscarriage clause: - There should be a provision for miscarriages such that if the surrogate miscarries through a fault not of her own then she should be entitled to a percentage of the loss of earnings justifiable with the number of months she has successfully carried the pregnancy.

Surrogacy agency: - A not for profit surrogacy agency may be set up to help connect the potential surrogates with potential commissioning parents.¹¹⁰ These agencies may charge a little fee for that and may advertise their services, however running an agency for profit making should be prohibited.

The institution / fertility center performing the artificial fertilization should not be the one to provide and / or recommend a surrogate mother / host.¹¹¹

Penalties: - Penalties for breach of provisions should be provided and should be severe enough to deter persons from breaching the provisions.

Surrogacy for same sex couples and single persons: - The current Kenyan law does not recognize same sex unions and as such ART treatment is not available to such couples. I

¹⁰⁹ This may be done through a surrogacy agency to avoid biasness and / or conflict of interest.

¹¹⁰ This will really reduce incidences of exploitation.

¹¹¹ To avoid cases of conflict of interest.

recommend that this treatment be availed to the same sex couples¹¹² and singles as long as they meet the other requirements.

5.3 Conclusion

These recommendations if accepted and implemented, will go a long way in ensuring that the practice of surrogacy in Kenya is safeguarded from corruption and exploitation. A regulatory framework would also ensure that services are standardized and made not only easy but also accessible.

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¹¹² This may require changing and / or enacting other laws to provide for recognition of same sex couples.

CHAPTER 6

CONCLUSION

6.1 CONCLUSION

I began my paper with acknowledging that assisted reproductive technologies and in extension surrogacy is a still a new technology in Kenya and as such there are still no laws, policies, and professional guidelines on its practice.¹¹³ I reiterated that the fact that since there is no regulatory framework for the practice, surrogacy arrangements were susceptible to exploitation and other vices and as such there was / is need for a regulatory framework.

I then looked at the Kenyan society and its perception on children and concluded that children are an integral part of the society and as such there is strong expectations and even pressure for women to bear children.¹¹⁴ Without children, a family unit is considered incomplete and the woman who cannot bear children is seen as a lesser member of the society. There may be suggestions that one adopt a child but the inherent need in humans to pass on their genetic material makes people yearn for their own genetically related children.

I have briefly touched on the right to reproduce for all, which right is linked to the fundamental right of life and right to health including reproductive health, although this right may not be accessible to all especially same sex partners as such unions remain unrecognized in Kenya.

¹¹³ Chapter 1 and 2

¹¹⁴ Chapter 2

However, I have recommended that same sex unions be acknowledged under the appropriate statutes and changes be made to the said statutes reflect the same.

I then looked at some moral theories and their ‘interpretation’ of surrogacy arrangement and came to the conclusion that they all seemed to support surrogacy arrangements albeit for different reasons and in varying degrees.¹¹⁵ For instance, in the utilitarian view, the arrangement is acceptable as long as it results in greater happiness for more people while the four principles under Principlism require one to weigh the benefits and effect of the practice and it is acceptable as long as it does not violate but rather conforms to the principles of respect for autonomy, beneficence, non-maleficence and justice.

Seeing as we have no laws and policies regulating the practice of surrogacy in Kenya, I looked at some legal frameworks from two countries being the United Kingdom and South Africa to get some insight on how the practice is regulated in those two countries. The reason for the choice of the two countries is that Kenya derives its common laws from the United Kingdom by virtue of it having been our colonial masters during the scramble for East Africa while South Africa brings about the prospect of having laws that resonate with the African culture and practices and are as such much more practical to the Kenyan context.¹¹⁶

¹¹⁵ Chapter 3

¹¹⁶ Chapter 4

I then made some recommendations based on the good practices from the two countries¹¹⁷, taking into consideration the role and opinions of the society in the law making process as looked into under the chapter on moral theories.¹¹⁸

In conclusion I am of the view that surrogacy is a worthwhile technology that has helped and continues to help alleviate infertility especially in women who cannot carry and bear children. It however needs to be regulated to avoid abuse and other exploitative practices.

¹¹⁷ Chapter 5

¹¹⁸ Chapter 3

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APPENDIX 1

MODEL USED AT THE NAIROBI IVF CENTRE, A FERTILITY CENTRE IN NAIROBI, KENYA

AGREEMENT FOR IVF (HOST) SURROGACY CONSENT FORM FOR HOST

I,(the “woman”)
with the consent of my husband/partner

of(address)
.....
.

Have agreed to act as a HOST mother for the GENETIC couple:-

..... (wife) &
(husband)

Both of:
.....
.....
.

who are unable to have a child by any other means.

1. I/We have had a full discussion onwith:
..... (name of medical practitioner)

2. I/We have been counselled on
by: (name of counsellor)

I/We understand that further counselling may be necessary, and is available for as long as we or the Clinic feel necessary.

3. I/We have taken independent legal advice from:

..... (solicitors)

4. I/We understand that the methods of treatment may include:

- a. Stimulation of the GENETIC mother for follicular recruitment.
- b. The recovery of one or more oocytes from the GENETIC mother by ultrasound guided egg recovery.
- c. The fertilisation of the oocytes from the GENETIC mother with the sperm of her husband/partner.
- d. That the GENETIC mother and GENETIC father will be screened for HIV (AIDS) and hepatitis B Hepatitis C and VDRL for Syphilis before involving me, the HOST.
- e. A maximum of three embryos will be transferred to me, the HOST.

5. I/We consent to the above procedures and to the administration of such drugs which may be necessary to assist in preparing the uterus for embryo transfer, and for support in the luteal phase.

6. I/We understand and accept that there is no certainty that a pregnancy will result from these procedures, since the success rate is uncertain even where an egg is recovered and embryo transfer carried out. I/We further understand and accept that the medical and scientific staff can give no assurance that any pregnancy will result in the delivery of a normal and living child.

7. I/We accept that the decision on the suitability and number of embryos for transfer to me, the HOST, will be that of the medical and scientific staff of Nairobi IVF Centre.

8. I/We shall have the right to terminate the pregnancy if the physician believes the pregnancy poses a serious risk of damage to health.

9. I/We agree to that at delivery, a birth certificate will name the GENETIC parents as parents of the born baby and will hand over the born baby to the GENETIC parents at child birth.

10. I/We have been given at least 24 hours to consider the contents of this document and we have been told that we might make such further enquiry as we wish before signing.

Dated, the _____ day of _____ 200_____

Signed Host / Woman _____

Husband / Partner _____

Solicitor _____ Date _____

Signed _____

Address _____

For and on behalf of the Clinic _____
Date _____

APPENDIX 2

MODEL USED AT THE NAIROBI IVF CENTRE, A FERTILITY CENTRE IN NAIROBI, KENYA

AGREEMENT FOR IVF (HOST) SURROGACY CONSENT FORM FOR GENETIC PARENTS

We, (the “husband”) and
..... (the ‘wife’), both of
..... (address)

being unable to have a child by other means, have requested The Nairobi IVF Centre, through their medical and scientific staff, to assist us (the GENETIC PARENTS) to have a child by IVF (HOST) Surrogacy.

1. We have had a full discussion on with
.....(name of medical practitioner)

2. We have been counselled on
by
.....

We understand that further counselling may be necessary, and is available for as long as either we or the Clinic feel necessary.

3. We have taken independent legal advice from:

.....
(Solicitors)

4. We understand that the methods of treatment may include:
- a. Screening for HIV (AIDS), hepatitis B, Hepatitis C, and VDRL for Syphilis.
 - b. Preparation of the woman by the administration of hormones and other drugs.
 - c. The operation by ultrasound guided egg recovery for the recovery of one or more oocytes (eggs) from the woman.
 - d. Fertilisation with the sperm of the husband of any oocyte or oocytes so recovered.

The Nairobi IVF Centre will use the sperm sample provided by

..... Signed

The Nairobi IVF Centre cannot guarantee authenticity of the sperm provided for the procedure. Therefore The Nairobi IVF Centre shall not be responsible for any variations in the sample sourcing.

- e. The maintenance and storage by cryopreservation of the embryo(s) resulting from such fertilisation until, in the view of the medical and scientific staff, they are ready for transfer to the HOST.
5. The HOST referred to above is
- (name)
-(address)
6. We consent to the above procedures and to the administration of such drugs and anaesthetics to the woman which may be necessary. We also consent to any further operative measures which may be found to be necessary in the course of such procedures.
7. We understand and accept that there is no certainty that a pregnancy will result from these procedures, since the success rate is uncertain even where an egg is recovered and embryo transfer carried out. We further understand and accept that the medical and scientific staff can give no assurance that any pregnancy will result in the delivery of a normal living child.
8. a. We request that any embryos not transferred to the HOST be stored by cryopreservation for a period of not more than five years.

- b. We understand that no extension of the storage is possible after five years if the intention is for the embryos to be used in a surrogacy treatment cycle.
 - c. We understand that, if we so wish, any suitable embryos so stored may be used for transfer to the HOST named above, at the discretion of the medical and scientific staff. We further understand that no assurance can be given to us that any such embryos will survive the thawing process or be suitable for transfer to the HOST.
 - d. We agree that no embryo so stored shall be removed from the custody of the Clinic without the written consent of both of us (or the survivor), such consent to be given within 28 days before such removal.
 - e. We agree that if we have no further need for the embryo(s), we shall decide whether we wish the embryo(s) to be donated to another couple, donated for research, or allowed to perish.
9. We accept that the decision on the suitability and number of embryos for transfer to the HOST, will be that of the medical and scientific staff of Nairobi IVF Centre Limited.
 10. We consent to the right of the surrogate host to terminate the pregnancy if her physician believes the pregnancy poses a serious risk of damage to her health.
 11. We hereby undertake to receive the born baby from the surrogate HOST for registration at birth as our own and subsequent parental care.
 12. We have been given at least 24 hours to consider the contents of this document and we have been told that we might make such further enquiry as we wish before signing.

Dated, the _____ day of _____ 200_____

Signed Husband _____

Wife _____

Witnessed by
(Solicitor) _____ Date _____

Address _____

For and on behalf of the
Clinic

Date

APPENDIX 3

MODEL USED AT THE NAIROBI IVF CENTRE, A FERTILITY CENTRE IN NAIROBI, KENYA

SURROGACY AGREEMENT

This Agreement is entered between..... and
..... ofandcitizenry respectively
and bearer(s) of ID/PASSPORT No..... andrespectively and of P.O Box
..... (Hereinafter referred to as "SURROGACY GENETIC COUPLE")
on one part and and
.....ofandcitizenry respectively and bearer(s) of ID/PASSPORT
No..... andrespectively and of P.O Box (He
reinafter referred to as "SURROGACY HOST COUPLE") and who may also be jointly referred to
herein as the "PARTIES."

THE Parties aforementioned herein do swear and affirm as follows;

1. **THAT** we are adults of sound mind, fully aware of the matters contained herein hence duly qualified to sign this agreement
2. **THAT** the SURROGATE HOST COUPLE has agreed to act as surrogate couple to the SURROGATE GENETIC COUPLE, who desire to have children through the IVF Procedure for the ensuing period
3. **THAT** the SURROGATE GENETIC COUPLE shall give the SURROGATE HOST COUPLE a sum of Kenya shillings 1,000,000/= as total surrogacy fee, paid in two instalments of Kenya shillings 300,000/= on pregnancy test turning positive and the balance of Kenya shillings 700,000/= on child delivery.

4. **THAT** the SURROGATE GENETIC COUPLE shall ensure that all the medical expenses and incidentals related to the pregnancy thereto arising from the surrogacy on the SURROGATE HOST WOMAN shall be covered and be fully paid for during the surrogacy period
5. **THAT** the SURROGATE HOST COUPLE has the right to terminate the pregnancy if her physician believes the pregnancy poses a serious risk of damage to her health
6. **THAT** immediately upon birth of the baby(ies) the SURROGATE GENETIC COUPLE shall receive the baby(ies) as their own from the SURROGATE HOST COUPLE and provide subsequent parental care
7. **THAT** in case of the death, mental incapacity or disappearance of either of the SURROGATE GENETIC COUPLE, the surviving partner shall have the responsibility of receiving and subsequently providing parental care for the baby(ies) born
8. **THAT** in the event of the death, mental incapacity or disappearance of both the SURROGATE GENETIC COUPLE, the baby(ies) born shall be given to a guardian to be named beforehand by the surrogate genetic couple

Name of guardian..... Sign

9. **THAT** in the event of divorce or separation of the SURROGATE GENETIC COUPLE, the baby(ies) born shall be given to the surrogate genetic woman or as may be decided by the surrogate genetic couple
10. **THAT** after the term of the surrogacy has lapsed the SURROGATE HOST COUPLE shall have no rights towards the baby(ies) born unless the surrogate Genetic couple says so in writing

11. **THAT** the SURROGATE HOST COUPLE shall take all the necessary precautions to ensure that no harm is done to the baby(ies) before, during and immediately after the delivery
12. **THAT** the SURROGATE HOST WOMAN shall not make unnecessary travels and visits within and outside the country without the express knowledge and permission of the Surrogate Genetic Couple
13. **THAT** at birth of the baby(ies) the Surrogate Host Couple shall notify the medical centre where the birth has occurred who the Genetic Parents of the baby are
14. **THAT** this agreement is valid for the period of surrogacy only and shall be deemed to lapse when the baby(ies) are born or in the event of the death of the Surrogate Host Woman, whichever comes first
15. **THAT** we have read and understood the contents of this agreement and have had the opportunity to be counselled by both a medical and legal person of our choice
16. **THAT** this agreement has been entered into voluntarily and freely, without any coercion, duress or undue influence of any kind whatsoever.
17. **THAT** what is herein is true to the best of our knowledge and understanding

Executed this day of in the year..... atby;

.....	)	
Surrogate Genetic Woman	)	Sign
	)	
	)	
.....	)	
Surrogate Genetic Man	)	Sign
	)	
	)	
.....	)	
Surrogate Host Woman	)	Sign
	)	
	)	

.....	)	
Surrogate Host Man	)	Sign
	)	
	)	
Before;	)	
	)	
	)	
	)	
Commissioner of oaths	)	
<u>Name, Sign & Stamp</u>	)	