

Guardians of Care: Role of Nurses in Promotion of Legal and Ethical Rights of Women in Infertility Treatment

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Summary

Nurses are the largest health workforce in the healthcare delivery system. They use a human rights-based approach in delivering care. Women's right to health includes their sexual and reproductive health. Global decline in fertility is a social concern. Assisted reproductive technologies (ARTs) provide a range of solutions for couples, but they also raise critical ethical and legal challenges, particularly concerning the rights of women undergoing infertility treatment. This paper explores the legal and ethical aspects of infertility care, and highlights the nurses' role in upholding women's rights within. After literature search of online databases such as PubMed and Google Scholar, newspapers, policy documents and ethical published guidelines, Mendeley Reference Manager version, this paper identified the human rights violations in relation to reproductive health of women, like problems in affordability, accessibility, stigmatisation, and commercialisation of ART services. It also addressed the balance between reproductive autonomy vs welfare of the child; right of the child to know its origin; challenges in the upbringing of the child born out of ART; role of surrogacy and ART Act in overcoming these challenges. Nurses should be empowered and educated, and be made aware of relevant legal provisions. Nurses must be made strong enough to voice out and contribute to broader reproductive justice.

Key words: Infertility, Legal and Ethical Issues, Assisted reproductive technology

Nurses are the largest health workforce in the healthcare delivery system; they employ human rights-based approach in delivering care. So, they must know who the rights holders are. What rights do they have? And how nurses can ensure that the right holders enjoy their rights. The Indian Constitution upholds the right to health for every citizen, which is a fundamental right and not a privilege. Of all forms of inequality, inequality in healthcare is the most unjust and inhumane, said Martin Luther King. Unlike other forms of inequality, like social, educational and economic inequality, health inequality is associated with life and death. Gender inequality in health care is widespread. The bias and belief held by people, including nurses themselves, further influence the health care outcome of women.

The International Convention on Economic, Social and Cultural Rights (ICESCR) and the Convention on the Elimination of Discrimination against Women (CEDAW) indicate that women's right to health includes their sexual and reproductive health. The reproductive health of women is directly linked to fertility. The global decline in fertility rate is a social concern as it changes the demographic trend of a country. Fertility rate is the average number of children born to a woman in her lifetime. In India, the

Total Fertility Rate (TFR) was 2.0 in 2021 (2.1 in rural areas, 1.6 in urban areas); in Tamil Nadu, the TFR is 1.8 (1.9 in rural, 1.6 in urban areas). Almost all South Indian states have fertility rate comparable to those in developed countries (Chauhan Bala, 2024). Narayan P (2024), in an article in India Today, reported a finding published by The Lancet that the fertility rate in India was 6.18 in 1950 and it dropped to 1.91 in 2021. It will further reduce to 1.3 by 2050 and 1.04 by 2100.

The World Health Organisation recommended considering infertility as a disease, as it affects the well-being of the people who suffer from it (Del Rio A 2021, et al). It is said to be more than a health problem, as it is associated with social and public health issues, which need immediate attention (Chiwari et al, 2021). Infertility is the failure of a couple to conceive despite unprotected intercourse for a period of one year, which affects both men and women. The declining fertility rate globally resulted in the mushrooming of fertility centres and sperm banks. Infertility resulted due to various factors, and the treatment options range from regulation of menstrual cycle, lifestyle modification, treating the underlying causes of infertility, Assisted Reproductive Technology (ART) such as Intra Uterine Insemination (IUI), In Vitro Fertilisation (IVF), Intra Cytoplasmic Sperm Injection (ICSI), to surrogacy as the last resort (Anaman-Torgbor et al, 2021)

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The rights of a woman who seeks infertility treatment are in jeopardy at home, as she may have to go through guilt, shame, marital stress, intimate partner violence, social isolation, abandonment, loss of dignity, to divorce (Chen et al, 2025). The situation is further worsened at health care facilities when they face human rights violations in seeking treatment for their sexual and reproductive health. Nursing being a female-dominated profession, and nurses being more than 50 percent of the health workforce, they can understand the depth and extent of the problem. Nurses can identify the challenges and augment the human rights-based care for women.

Objectives

This study endeavoured to identifying the forms of human rights violations faced by women in infertility-related treatment, legal and ethical challenges faced by the nurses, identification of policies and regulations existing to prevent human rights violations and the nurse's role in promotion of human rights in the care of women in infertility treatment.

Literature review: The relevant literature was searched in online databases such as PubMed, Google Scholar, including newspapers, policy documents and ethical guidelines published.

Mendeley Reference Manager version 2.130.2 was used to organise the review. The concept was organised under four major headings.

Human Rights Violations Faced by Women seeking Infertility Treatment

Stigmatisation: Infertility is a social stigma, and childlessness is considered a shame for the couple. It is strongly believed that the life of human beings is incomplete without children (Goswami et al, 2021). A study reported that women undergo ART because of the strong desire to become pregnant and to escape from the social stigma of childlessness (Manvelyan et al, 2024)

Availability of treatment: The mushrooming ART centres in the private sector is dominating the infertility treatment. The Times of India (dt 3 Dec 2019) stated that there were 1846 ART centres across the country. As of 2021, no government hospitals could offer infertility treatment in Tamil Nadu. Only after October 2023, two governments hospitals established a facility to offer IVF services. Infertility treatment is given the least priority in the low- and middle-income countries due to overpopulation, limited health care budgets and other health care priorities. Moreover, the treatment is less successful due to a lack of advanced equipment (Bao Y et al, 2025).

Accessibility to treatment: Access to treatment depends on the socio-cultural and economic factors of couples (Wiersma M et al, 2022). Private sector dominates IVF treatment, and the services are concentrated in urban and metropolitan cities. Women from rural areas seeking IVF treatment have to travel to those cities, and large populations in smaller towns and villages remains underserved. High costs associated with ART prevent couples from accessing the infertility treatment. Lack of political initiatives for affordable ART treatment worsens the situation (Qian X et al, 2025). Even if the treatment is accessible, it would be an out-of-pocket expenditure for the couple. Higher utilisation of ART services is reported in countries where there are public and third-party reimbursement (Ghinea et al, 2022).

Affordability of treatment: Specialised treatment and advanced equipment with trained professionals are available in a private health care institution, where the charges are high. The Indian Society of Assisted Reproduction says 10-15 percent of couples face infertility issues. The cost of a single IVF cycle ranges between ₹1.2 lakh to ₹ 2.5 lakh. Given the low success rate of IVF (30-35%), multiple cycles are often needed that further escalate the costs. Not all health insurance plans cover infertility treatment, and even if so, it is limited. India has been a favourable destination for IVF procedures, attracting international patients. India was considered the surrogacy capital of the world, and the village of Anand in Gujarat, as the "cradle of the world".

The cost for single IVF includes drugs for ovulation induction, ovum retrieval and embryo freezing, implantation procedures, pre-implantation tests and other associated costs. It causes economic strain on the couples, and high costs keep them out of treatment (Kool et al, 2020). Many couples spend from the savings earmarked for other needs (Goswami et al, 2021).

Preservation of Oocytes: The question arises as to when to preserve and the number of oocytes to be preserved. There are no standard timelines, it depends on the conditions of the woman and sometimes her partner. It includes age and medical conditions of the woman, ovarian reserve, reproductive goal and paternal health. Preserving a low number of oocytes may lead to future need for retrieval, and preserving a greater number of oocytes results in a reduction of ovarian reserve. The younger the age of the woman during retrieval, lesser the cost, ovarian stimulation required and the less physical discomfort than the woman in advanced age. Also, the fewer the number of egg retrievals, lesser the discomfort and cost (Burrell et al, 2014).

Embryo transfer: The number of embryos to be transferred is associated with the out-of-pocket

expenditure. One common risk associated with the ART is multiple gestation with associated complications to the mother and the health of the babies, resulting in long long-term costs for both of them. It is also understood that the higher the maternal age over 40 years, the lower the pregnancy rate (Ghinea et al, 2022).

Surrogacy: Women living in certain poverty-stricken areas in India see surrogacy as an option for survival. Surrogate mothers are exploited and ill-informed about the legal process. In most cases, surrogate mothers are expected to live in the facilities provided by the surrogacy clinic where their needs are taken care by the health care worker and the intending parents. This might seriously impinge on the rights of the surrogate mother if the surrogacy is not strictly adhered to.

ART as second-rate service: Government facility for infertility treatment facility is already limited. During the COVID-19 era, with full focus on treating pandemic, all non-essential services were withheld which resulted in heightened stress among women who were on the treatment. Though strengthening the principle of social justice and prioritising societal needs over individual needs are considered valid at the time of the pandemic, the discussion on ART as essential vs non-essential services sparked valid ethical concerns (Lampic et al, 2021).

Commodification of services: Chains of ART centres in India offer high-quality, world-class services to the infertile couple. The sperm, egg, embryo and the human body and the entire process become marketable services and goods, resulting in new markets. Globalisation of ART services leads to fertility tourism and brings economic disadvantage to the home country. The buying and selling of services and products further bring harm to the women.

Legal and ethical challenges

Reproductive autonomy vs welfare of the child: In a positive sense, the woman seeking ART could enjoy reproductive autonomy by utilising these services, including surrogacy. In a negative sense, the welfare of a child born out of ART is at stake, especially when the child lacks a genetic link with their parents. The standard and quality of life of such children may be a serious concern.

Risk related to the right of the child to know its origin: A child born out of ART with surplus embryos and both gamete donation may face a future challenge when they come to know about their genetic link and the presence of siblings, and the nature of the complex family structure. There may even be a disappointment and distress for the child if their expectations of those involved are incompatible.

Right to parenthood: If we apply the principles of natural parenthood, children born out of ART and surrogacy services have more than one parent. These complexities are addressed by the ART and Surrogacy Act of 2021. It declares that the child born out of surrogacy is the biological child of the intending parents. The donor and surrogate mother relinquish the parental rights and the baby to the commissioning mother. A child born through artificial insemination with a deceased husband's sperm is considered the legitimate child of the couple. Moreover, the children born out of ART are granted coparcenary rights.

There are two types of surrogacies. In gestational surrogacy, the embryo is transferred to the surrogate mother's uterus, who is only a carrier and not genetically related to the child. In another type, the intended father's sperm or donor sperm is injected into the surrogate's uterus and or surrogate's own egg is used for fertilisation. Hence, the surrogate mother has a genetic link with the child.

Complexity of relationships: With the use of ART and surrogacy, the concept of genetic mother, gestational mother and social mother arises. Understanding, accepting and valuing these complex relationships may pose a great threat to the child (Chambers GM et al, 2020).

Risk of abandonment and upbringing challenges: The child born through ART may be abandoned, and task of ensuring a quality life, including education, lies with the intending parents.

Exploitation of women: Though ART is the solution for the infertile couple, the commodification of women and commercialisation of ART and surrogacy services, on the other hand, is intolerable and unacceptable. Wherever Legally permitted encourages women to rent their womb in exchange for money resulting in the exploitation of their poverty. Surrogate mothers' willingness to take part in such services may not be free from coercion, and participation may not be voluntary. In such cases, the decision of the surrogate mother may not be autonomous and influenced by external factors, at least by the family circumstances, which may be coercive, especially for women from developing countries (Piersanti V et al, 2021).

Rights of the individual vs the right of the child to have a traditional family structure: Surrogacy is also the solution for same sex couples and unmarried mothers who want to have their child. It may be disappointing to the child to know that it does not have parents of both genders. In a traditional family structure, the child is nurtured by parents of both genders, which is essential for the psychosexual development of the child.

Altruistic vs commercial surrogacy: In commercial surrogacy, the surrogate mother bears a child

in exchange for money, whereas in altruistic surrogacy, the surrogate mother accepts money only for treatment and insurance. Not all countries accept commercial surrogacy. Some countries even criminalise commercial surrogacy.

Legal Framework to Prevent Human Rights Violations in ART

The Assisted Reproductive Technology Act 2021 and (Regulation) Rules 2022, and the Surrogacy Act 2021 and (Regulation) Rules 2022 regulate the ART and Surrogacy services in India. These rules give details about the ART clinics/banks, registration of the clinic, grievance redressal, insurance coverage of the donor, duties of the clinic, staff requirements of the ART clinic, and various documentation required in the ART clinic, and various documentation required in ART. Surrogacy rules prescribe the eligibility for a surrogate mother, staffing requirements of the surrogacy clinic, sample application forms for couples opting for surrogacy services, consent and agreement form, medical indication for gestational surrogacy and registration of surrogacy clinics.

ART services can be availed by women age 21 - 50 years and men aged 21-55 years. It mandates the purchase of insurance coverage for a period of one year for the oocyte donor, and a woman shall not be treated with gametes or embryos derived from more than one man or woman during any one treatment cycle. It further mandates that a clinic shall never mix semen from two individuals. The age of the sperm donor must be between 21 to 55 years, and the ovum donor must be between 23 to 35 years. An oocyte donor can donate only once in her lifetime, and a maximum of 7 oocytes can be retrieved.

All unused gametes and embryos must only be used for the recipient and not be used for any other couple. It permits the cryopreservation of oocytes or sperm of persons suffering from cancer for more than 10 years, with the permission of the National Board. It prohibits any preimplantation genetic testing for gender selection, and demands that the information about the number of donors, both sperm and oocyte, screened, maintained and supplied to the clinics shall be maintained and provided to the National Registry regularly. It permits altruistic surrogacy and prevents commercial surrogacy. It demands the purchase of insurance coverage for 36 months for the surrogate mother to cover the pregnancy and postpartum medical expenses. It limits the number of attempts to surrogacy procedure to a maximum of three, and the number of embryos to be transferred is limited to one and to a maximum of three in special circumstances. The form to take consent of the surrogate mother and agreement for surrogacy states that the surrogate mother should relinquish

all her rights over the child. The mother can be a surrogate only once.

It mandates that a surrogate should be a close relative of the intending couple; a married woman having a child of her own; 25 to 35 years old; be a surrogate only once in her lifetime, and possess a certificate of medical and psychological fitness for surrogacy. Further, the surrogate mother cannot provide her own gametes for surrogacy. It ensures that the child born out of surrogacy is deemed to be a biological child of the intending couple, with entitlement to all the rights and privileges available to the natural child.

Nurse's Role in Promoting Rights-based Care of Women seeking Infertility Treatment

Ensuring the Rights: In the context of sexual, reproductive and maternal health, the patient's rights include a right to information, informed consent and refusal, right to privacy and confidentiality, right to be treated with dignity and respect, right to equality and non-discrimination, and a right to the highest attainable standard of health. The children's rights include right to: information, have their parents and guardians, to be listened to. Nurses are accountable for helping the end user to realise their rights. It is necessary that recipients of services are told about their rights, how to enjoy and what facilities are available to ensure these rights are realised.

Empowerment of women: Nurses must understand that indicators of health, such as availability, accessibility, acceptability and quality of health care services, should be available without discrimination. Nurses are in a position to empower women about the medical services and legal provisions. The following can be taught by the nurses: (a) Elective egg freezing, which is advocated for medical and non-medical reasons; the major medical reasons being conditions causing premature ovarian failure. Though controversy arises in advocating egg freezing for non-medical reasons, it is viewed as positive by women in developed countries due to delayed conception for various reasons. Social egg freezing is preferred by women where the egg is preserved for social reasons, such as career, studies or because the child cannot simply fit into their current life (Manvelyan et al, 2024).

Empowerment of surrogates and intended parents: Surrogates must be empowered on the contract conditions, procedures they need to undergo, risks involved, rights of the surrogate, intended parents, intended child and the legal provisions, etc, to make informed decisions with full awareness. Nurses can teach the mothers that informed consent can be given after obtaining clarification from the treating specialist (Piersanti et al, 2021). The intended parents need to be informed of their rights, the surrogate mother's rights, the intended parents' obligation

towards the surrogate mother, such as coverage for insurance, paying for treatment related to pregnancy in case of altruistic surrogacy (Signore et al, 2021).

Awareness about the legal framework: Wherever nurses work, they should first be aware of the existing legal framework in relation to the use of ART. Nurses must understand that medical tourism in ART results in a great challenge in legal registration of the child in the intended parent's country of origin, especially if the child is genetically unrelated, where the donor gametes are used for conception. The child may be denied legal parentage and citizenship. In such case, the child should neither be left in the lurch nor left with the custody of the surrogate mother (Del Rio et al, 2021).

Addressing psychosocial needs of the women: Nurses are in a position to reassure, encourage and be of support to the women in all stages of treatment, as it is painful, exhausting, and time-consuming. Women would be anxious about the outcome of the procedure, given that the success rate is influenced by many other factors. The laboratory investigations which they have to undergo frequently, injections which they have to take regularly, even discourage the women and may give up once and for all (Chen et al, 2025).

Disclosure to the child of their genetic origin: Nurses can provide opportunities for parents to discuss and reflect on disclosure of their child's genetic origin, especially for the donor-conceived child. The age at which the disclosure can be initiated and the risks of postponing can be explained. Nurses can encourage open communication and provide lifelong support to the family. In addition to routine care, nurses can ensure safe, couple-friendly and women-friendly spaces to promote a sense of well-being. Nurses should treat women and donors with dignity, respect and provide them with privacy. Nurses can address barriers to empowerment by providing information in the local language. They should also examine their attitude towards a certain group of patients and recipients of treatment.

Conclusion

Nurses form a major workforce in the reproductive healthcare sector. They have both professional and social responsibilities as citizens to ensure the rights of all concerned. Even though they are often not responsible for human rights violations that happen around reproductive health, they are in a position where they can safeguard the rights of all concerned and ensure measures to prevent any violations. Nurses should be educated and be made aware enough of all the legal provisions, and have courage and commitment to adhere to the same. They must be made strong enough to voice out and stand with the law.

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