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ARTICLES

# REPRODUCTIVE TOURISM AND THE QUEST FOR GLOBAL GENDER JUSTICE

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*reproductive tourism,*
*assisted reproductive technologies,*
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***ABSTRACT***
*Reproductive tourism is a manifestation of a larger, more inclusive trend toward globalization of capitalist cultural and material economies. This paper discusses the development of cross-border assisted reproduction within the globalized economy, transnational and local structural processes that influence the trade, social relations intersecting it, and implications for the healthcare systems affected. I focus on prevailing gender structures embedded in the cross-border trade and their intersection with other social and economic structures that reflect and impact globalization. I apply a social connection model of responsibility for unjust outcomes and consider strategies to counter structural injustices embedded in this industry. The concluding section discusses policy reforms and proposals for collaborative action to preclude further injustices and extend full human rights to all.*

## INTRODUCTION

Over the past two decades the global baby business has burgeoned into a multi-billion dollar industry.[1] Though cross-border reproductive services account for only a small fraction of this global industry, they exemplify some of the most disturbing features of an escalating trend in reproductive medicine. They utilize the reproductive capacities of poor women in transitional economies to complement the reproductive deficiencies of women in more affluent ones. They embody stereotypical conceptions of women's social role, extend the power and authority of the reproduction industry far beyond the treatment of individuals with fertility problems to presently fertile women, further the interests of other profit-oriented industries, bypass regulatory efforts of national governments, and exemplify self-serving Western attitudes toward less developed countries. My aim here is to examine gendered social structures embedded in the cross-border trade, their intersection with other structures in globalization processes, and strategies that might be developed to counter structural injustices in this industry.

I draw on a distinctive construction of structural processes and their outcomes that has been advanced by Iris Marion Young and several other feminist theorists.[2] In Young's analysis social structures are not limited to formal institutional rules of cooperation but also include interdependent processes of competition and cooperation – including interactive routines, the mobilization of resources, and the built environment – that link social positions with relations among individuals. These structures constrain or enable specific courses of action, thereby contracting or expanding opportunities open to individuals. By virtue of their social connection all who participate in these structures share responsibility for their outcomes. Those who have the most power and influence in a specific system or derive the greatest benefit from it bear the greater share of responsibility for unjust outcomes. Young calls this conception of responsibility a 'social connection model'. Here I consider the structural

[1] An estimated 20,000–25,000 cross-border fertility treatments are carried out in Europe alone each year. This year the industry is holding its own international conference. Details are available at http://www.icgrt.com [Accessed 3 Jan 2010].

[2] I.M. Young. 2007. *Global Challenges: War, Self-Determination and Responsibility for Justice*. Malden, MA: Polity Press: ch. 9.

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processes through which social connection operates in the reproductive tourism industry. In the concluding section, I suggest collaborative projects and alternative processes and policies to counter injustices bound up with reproductive tourism.

## THE DEVELOPMENT OF CROSS-BORDER REPRODUCTION

Cross-border reproduction was initially a low-profile phenomenon that eluded widespread public attention. It was subsumed under the broader category of 'medical tourism', which includes cross-border travel for any type of medical treatment. Initial mention of travel for reproductive services specifically is generally attributed to a 1991 paper by Bartha Knoppers.[3] However, one group of feminists had already condemned one type of reproductive travel, cross-border surrogacy, as 'reproductive trafficking'.[4] But few picked up on their concerns at the time. In those years assisted reproductive technologies (ART) were comparatively rudimentary and commercial marketing of them was not yet widespread. In the interim, however, assisted reproduction has grown into a transnational industry and the pace of globalization has accelerated considerably. Disparities between the circumstances of privileged Western women and women in less developed countries have magnified. Globalized economic and social structures are now intersecting the market for assisted reproductive services. Impoverished women in less developed countries are being solicited to compensate for the reproductive deficiencies of infertile women in the West. In this environment similarities between cross-border reproduction and sex trafficking are more conspicuous. Both play on asymmetrical constructions of the social roles of women and men and reinforce stereotypes about women as primarily sexual beings. Some feminists are now probing these commonalities more fully and identifying further connections among cross-border practices that trade on women's sexuality.[5] Their critiques are relevant to other cross-border reproductive transactions as well as surrogacy. They show how both prostitution and the surrogacy trade intersect structures of inequality and social subordination that exploit the vulnerabilities of participating women. They contest claims by supporters of this market that these women are free agents and the best judges of their own interests. Most can earn far more, supporters point out, by selling their reproductive capacities at market rates than they could possibly make by any other form of legitimate employment. Supporters extend this individualistic line of reasoning to the purchasing woman, too; she is entitled to enter into any arrangements she can negotiate with women offering their services.

Critics point out that the mere fact that a woman sees employment as, say, a prostitute or surrogate as a better option for her than no employment at all does not show that she has made this decision freely. Even if it is granted that women from abroad who employ these women are acting autonomously, it is far more difficult to make the case that impoverished women who offer their services are granting autonomous consent. Only those who are fully informed about the effects of an intervention on their wellbeing can act autonomously. Development scholars often call consent under such compromised conditions 'adaptive preferences'. Unfavorable circumstances can distort preferences so that people's subjective views are an unreliable measure of their wellbeing.[6] Martha Nussbaum, a leading proponent of this characterization, points out: '(t)he poor and deprived frequently adjust their expectations and aspirations to the low level of life they have known.'[7] Along with Amartya Sen, who initially applied the term 'adaptive preference' to consent under such constraining conditions, Nussbaum thinks that the impoverished often internalize their oppression and may actually come to prefer what is disadvantageous to them. Margaret Walker disagrees. She points out that this account casts these women as victims devoid of personal agency. In her view compliance under such severe circumstances is an effort to garner a measure of control under extremely difficult conditions. Citing Uma Narayan, she characterizes such conduct as a form of 'bargaining with patriarchy', an option that even privileged women cannot wholly avoid.[8] Her explanation conjoins these women's options with conditions that influence all women's choices in a world where male

[3] B.M. Knoppers & S. LeBris. Recent Advances in Medically Assisted Conception: Legal, Ethical and Social Issues. *Am J Law Med* 1991; 17: 329–361.

[4] G. Corea 1985. *The Mother Machine: Reproductive Technologies from Artificial Insemination to Artificial Wombs*. New York: Harper and Row; J. Raymond 1993. *Women as Wombs: Reproductive Technologies and the Battle over Women's Freedom.* New York: Harper Collins. Both discuss the use of surrogates in less developed countries by women in wealthier ones. They call the practice 'reproductive trafficking' but many now use more inclusive language: 'cross-border reproduction', 'fertility tourism', or 'travel ART'.

[5] Among them are Heather Widdows and Naomi Pfeffer. See H. Widdows, Border Disputes across Bodies: Exploitation in Trafficking for Prostitution and Egg Sale for Stem Cell Research. *Int J Fem Approaches Bioeth* 2009: 2(1); 5–24. Pfeffer's comments were delivered at the 21st Century Motherhood Conference, London, Sep. 2009.

[6] This concept has become a commonplace in the economics literature. Note M.C. Nussbaum 1995. Human Capabilities, Female Human Beings. In *Women, Culture, and Development: A Study of Human Capabilities.* M.C. Nussbaum & J. Glover, eds. Oxford: Clarendon Press: 61–104.

[7] bid: 259–273.

[8] M. Walker. 2003. Truth and Voice in Women's Rights. *Recognition, Responsibility, and Rights.* R.N. Fiore & H.L.Nelson, eds. Lanham, MA: Rowman and Littlefield Publishers: 169–180. The reference to Narayan is from her 1997 book, *Dislocating Cultures*. New York: Routledge.

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dominated social and economic structures still prevail. Women are simultaneously both victims and agents.

Of course, this characterization does not imply that women's power to grant legitimate consent is compromised to the same degree everywhere. The force of patriarchal institutions varies considerably across the globe. And gender-specific stereotypes and expectations affect women differently depending on other surrounding conditions. Nussbaum and Sen make a valid point in calling attention to severely constraining circumstances. Walker and Narayan are right to point out that women living under such conditions can still exercise agency. But the individualist supposition that all choices are comparably free is hollow and misleading. It presumes that individual actions can be detached from surrounding social conditions. As Onora O'Neill observes:

> Genuine, legitimizing consent is unfortunately often undermined by some of the institutions and practices which most readily secure an appearance of consent. The more relations with others are ones of structural dependence, the more the weak have to depend on trusting that the (relatively) strong will not exercise the advantages which proximity and superior status give them . . . This is not to say that (the) impoverished are irrational or wholly dependent or cannot consent. However, their effective capacities and their opportunities for action . . . constrain their possibilities for refusal and negotiation.[9]

Despite varying emphases, these objections to the individualistic stance share a common theme: the need to shift moral focus away from isolated acts of consent to evaluation of the full context surrounding such acts.

It is understandable that impoverished women in poor economies may accept offers to sell their bodily resources rather than sink further into poverty, but their consent can't turn a morally unacceptable offer into a morally fair purchase. Such offers exploit their vulnerabilities, expand the reach of market forces, and subvert efforts by the purchasers' home countries to reign in unfair reproductive practices. However, it is also important to be mindful of the vulnerabilities of infertile women travelers. Prevailing social structures affect them as well. Adequate assessment of the reproductive tourism industry calls for consideration of the entire range of social structures that shape arrangements between buyer and seller. A fully comprehensive appraisal would include noncommercial as well as commercial transactions. It would take into account a range of measures to alleviate involuntary infertility among women in both the more and less developed countries. Following a brief recapitulation of economic and social conditions constraining gender specific choices universally, I focus on specifics that shape reproductive choices and sustain the tourism industry.

## THE CYCLE OF GENDER SPECIFIC VULNERABILITY

In one of her final essays Iris Young revisits Susan Moller Okin's characterization of gendered social structures. Okin describes how gendered relations in the family interact with gendered workplace norms to reinforce women's vulnerability.[10] Women's family position restricts opportunities to participate in the paid workforce and these inequalities cycle back to reinforce gender inequality in the family. Though Okin's analysis focuses on women in the USA, Young argues that the basic structural logic of the gendered cycle of vulnerability extends to relations that condition and constrain the lives of women across many eras and localities. This cycle of vulnerability is situated within a complex of other social, economic, and cultural structures that interact in complex ways. Married women, some of the unmarried, and childless women are all vulnerable to domination, exploitation, and deprivation by structural processes tied to the gendered division of labor in the family.[11] The division of social relations into public and allegedly private spheres still prevails. Despite differences in historical context, women still do most of the domestic work in both more and less developed countries.

However, the situation of women in less developed countries is far more perilous. The reproductive tourism industry reflects and impacts the treatment of these women. Their situation is worsened by economic globalization.[12] Western dominated institutions champion market supremacy and privatize national economies, diminishing access to social benefits for women, children, and other disadvantaged groups.[13] Women are particularly vulnerable, for not only do they perform most of the housekeeping, cooking, and caring chores,

[9] O. O'Neill. 2000. *Bounds of Justice.* Cambridge, UK: Cambridge University Press: 166–167.

[10] S.M. Okin. 1989. *Justice, Gender, and the Family.* New York: Basic Books.

[11] Young, *op. cit.*, note 5, p. 223.

[12] A.M. Jaggar. 2003. Vulnerable Women and Neoliberal Globalization. In *Recognition, Responsibility, and Rights*. R.N. Fiore & H.L. Nelson, eds. Lanham, MD: Rowman and Littlefield: 195–209. See also her 2004. Globalizing Feminist Ethics in *Setting the Moral Compass: Essays by Women Philosophers*. C. Calhoun, ed. New York: Oxford University Press: 233–255. On the tendency to emphasize family as a local institution see also Thomas Pogge. 2002. *World Poverty and Human Rights*. Cambridge, UK: Polity Press.

[13] The World Economic Forum represents the dominant world players. The World Social Forum was organised to counter its influence. However, it does not focus explicitly on gender-specific injustices. For the latter see documents of the UN Commission on the Status of Women, particularly specific to the March 1–12, 2010 session at http://www.un.org/womenwatch/osagi/ [Accessed 8 Mar 2010] Also see Alison Jaggar's Transnational Cycles of Gendered Vulnerability: A Prologue to a Theory of Global Gender Justice. *Philosophical Topics* 2009; 37: 33–52.

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they also have to assume more responsibility to meet their family's economic needs. These circumstances contribute to growing disparities in health outcomes. Educational opportunities for girls suffer too because cash-strapped families often give priority to male children since their potential earning power is greater. Globalizing trends extend preexisting vulnerabilities of women and facilitate the influx of women into low-paying jobs, chiefly in industries that most closely resemble women's domestic role, which often further intensifies their poverty. Persistent male bias in the workforce contributes to the exploitation of women's comparatively cheap labor power. Poverty induces people to resort to work that separates them from their families or jeopardizes their health. These conditions put pressure on women to become sex workers, surrogates or ovum donors, thus perpetuating the gendered cycle of vulnerability.

## VULNERABILITIES OF WOMEN WHO DEPEND ON THIS MARKET

Women who provide reproductive assistance to those from abroad typically have very limited earning power, have little formal education, and have to provide for their own children. Accounts of these women's motivations stress their need to supplement the meager earnings of their husbands so their children can have an education or they can move to less crowded living quarters. When such women act as surrogates they are likely to be subject to extremely confining conditions. The venture of an enterprising Indian physician has been recounted in numerous news stories.[14] She runs a gestational surrogacy service that conscripts local married women who have already borne at least one child and isolates them in her house for the duration of their pregnancy, separating them from their husbands and children. Both the surrogate and the couple who hire her sign a contract stipulating the terms of agreement. But considering the limited reading ability of most surrogates, they are unlikely to understand the terms of the contract they are allegedly consenting to. As in most other surrogacy contracts, they promise that the commissioning couple will cover all medical expenses. But unlike normal pregnancy where the wellbeing of the pregnant woman is paramount, the focus of medical care in surrogacy cases is the production of a healthy child. Care ends with the birth of the child, but the woman who bears the child may have lasting effects. In more developed countries surrogates would have legal representation and independent counseling to explain the complexities of medical interventions.[15] But in poor countries assistance to protect the decision-making authority of surrogates is seldom available.

Egg donors who experience complications are seldom offered even this degree of medical care. Egg donation involves a lengthy and intrusive process lasting up to six weeks. In a natural fertility process, only one egg would typically ripen for ovulation but egg donors are stimulated to produce as many as thirty to fifty eggs. First, under medication their ovaries are shut down to disrupt their natural ovulation cycle so multiple eggs can be produced and matured in the laboratory. Next for up to ten days they must inject themselves daily with powerful hormones. Injections are followed by surgical intervention to retrieve the egg follicles from the ovaries. Possible side-effects range from psychological discomfort, bloating, cramps and headaches to kidney disease, blood clots, premature menopause, and in extreme cases, death. Ovarian hyperstimulation syndrome occurs in around 2% of cases and animal studies indicate that abnormalities may occur in offspring. Reliable data on the long-term effects of the hormones injected may not be available for decades. Without being told in advance that they might have difficulty conceiving in the future or might give birth to a child who develops a disability, donors cannot even weigh medical risks. Their vulnerability to mistreatment is greater than that of women who are undergoing treatment to circumvent their own infertility. For these women are being treated for another's benefit, and the treating clinic has a powerful incentive to maximize benefits to those who pay their fees.[16] Though both surrogacy and ovum donation take place in both more and less developed areas, lack of education and adverse economic conditions magnify their harmful effects on impoverished women.

Risks to traveling women seem negligible compared with those to the women who provide their bodily resources. However, prevailing social structures also influence the choices of Western women who seek out reproductive assistance in less developed countries. This market is now intertwined with the national policies of many states, which often prioritize the interests of medical institutions, brokers, and travel industries. The rapidly escalating reproductive tourism industry includes interlocking facets of both global and local markets that reflect and contribute to other structural injustices. To escape dependence on male wage earners and carve out a

[14] Note Abigail Haworth's widely cited *Marie Claire* article Surrogate Mothers: Womb for Rent. Available at http://www.marieclaire.com/world-reports/news/internationalsurrogate-mothers-india [Accessed 27 Feb 10].

[15] For additional details see Concerned, Confounded or Clueless: Are Women Considering the Risks Involved in Egg Donation? at http://www.corethics.org, various issues of Reproductive BioMedicine online at http://www.rbmonline.com [both accessed 3 Jan 2010]; and The Boston Women's Health Collective. 2005. *Our Bodies, Ourselves*. New York: Touchstone: Ch. 22.

[16] This point was suggested to me by L.C. Ikemoto. Reproductive Tourism: Equality Concerns in the Global Market for Fertility Services. *Journal of Law and Inequality* 2009; 27: 277–309.

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career in the workforce, many Western women are postponing reproduction until their careers are well established. But by then their peak childbearing years have passed and conception is more problematic. Rather than forego reproduction entirely, increasing numbers are now relying on this industry to satisfy their long postponed reproductive plans. Many more who cannot obtain ready services in their home country because of regulatory limitations, age restrictions, sexual preference, or waiting times go abroad where they can purchase faster or cheaper services, obtain surrogates, or undergo genetic or gender selection. Several Western countries now forbid ovum donation or ban payment to donors of sperm and ova.[17] Such restrictions tend to reduce the availability of gametes in the home country and induce the affluent infertile to shop in poorer countries where spare gametes are in more plentiful supply.

Where self-pay fertility care is available in the West, it tends to be very costly. Few jurisdictions have insurance plans that cover fertility treatment and those that do often impose restrictions on the type of procedure available. Some physicians in the UK (where there is a three year waiting list for ova) have reportedly suggested that their patients purchase ova by mail order from countries that permit payment. Other clinics in Western countries are taking direct action. They are setting up satellites in developing countries where paid ovum donors are in plentiful supply and labor is cheap. Would-be parents who cannot achieve or complete a pregnancy but still wish to have a biologically related child search the Internet for profiles of women who are willing to carry their fetus to term. They then travel abroad for embryo transfer and again to bring the infant home with them. Internet websites also claim that they can eliminate embryos that might carry a known disorder or are the 'wrong' sex. Some contend that donors are selected to accommodate the clients' preferred facial features and talents or that they are able to eliminate embryos with 'inferior' intelligence.[18] Customers utilize these websites to assemble a combination of services from several countries. A gay couple from Israel used a mail-order egg from Romania that after fertilization was shipped to India for transfer to a surrogate.

## HOW THE GLOBAL MARKET FACILITATES REPRODUCTIVE TOURISM

These industries depend on impoverished local women to supply ova, embryos, and surrogacy services. However, economic disparities alone would not be sufficient to create so robust a market if globalization were not accompanied by intermediate structures, most notably advances in medicine and embryology, cheap transportation, and communication technologies. Local women are often recruited by brokers who rely on communications technologies to publicize their services. Medical institutions set up domestic clinics abroad and physicians in destination countries set up their own clinics to capture the foreign trade. Infertile Western women pick up recommendations from multilingual websites or the popular media and scour books with titles like *The Complete Idiot's Guide to Medical Tourism* and *The Medical Tourism Travel Guide*. This literature applauds countries that are the prime destinations for overseas *in vitro* fertilization (IVF) treatment.[19] Websites sponsored by treatment centers in destination countries often read like travel brochures for luxury resorts. Some offer a full complement of services including interpreters and hotel room reservations for traveling patients.[20] These clinics may serve both overseas and local women with fertility problems but their primary focus is on more prosperous women from abroad.

Globalisation flows in multiple directions and impacts virtually all economies. But it has a disproportionate impact on developing economies. Reproductive travel is highly profitable to the tourism industries of poor countries and the indigenous people who organize the trade. New communication technologies facilitate collaboration among disadvantaged social groups in disparate locations and cheaper travel supports face-to-face projects among them. But such gains are dwarfed by the problematic aspects of globalized markets.

## VULNERABILITIES OF AFFECTED ECONOMIES

The costs of this 'free' trade are high for both the immediate parties and the healthcare institutions in the home countries of travelers. The interests of numerous parties are at stake in addition to the women seeking overseas services and the women providing the service or product. The brokers who benefit from the cross-border baby

[17] The UK prohibits payment for gametes and Italy has enacted some of the most restrictive regulations for ART use in Europe. Other countries that do not permit ovum donation include Germany, Norway, Austria, and Denmark. I speak of 'donors' only because this terminology has been so widely adopted. It is a misnomer, however, that disguises the nature of transactions that are largely commercial. 'Vendors' would be a more accurate term.

[18] Presently, there are no reliable genetic tests to determine such characteristics. The best that can be done is to try to match the physical characteristics of the biological parents with those of the intended social parents.

[19] Among these countries are Spain, the Czech Republic, Ukraine, Romania, India, the United Arab Emirates, and Thailand.

[20] Note online sites such as http://www.hospitalscout.com/, http://www.extendfertility.com/ and http://www.fertilityplus.org/ [All accessed 3 Jan 2010].

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business often reap handsome profits. In India, for instance, only about half the amount paid for reproductive services is actually transferred to the women undergoing the risk, a small fraction of what these travelers would pay in the West. The broker who negotiates the deal gets a sizable cut.[21] The healthcare systems of both the country offering services and the one providing subsequent care to returning travelers have much at stake in the trade. Health care of both the travelers and the children they bear falls on the returning country. I turn now to consider the effects of the trade on these parties.

Legal protections available to prospective mothers in the home country seldom apply abroad. Surrogacy contracts may not be upheld and national laws in countries providing treatment may not be adequate to determine the identity of the legal mother.[22] Adding to such complications are the difficulties of procuring the necessary immigration papers for foreign-born infants. The quality of medical treatment may be substandard. Infection rates are seldom available. Genetic tests may be unreliable. Donor sperm may not have been screened for viruses such as HIV. Reliable data on complication rates during pregnancy and pregnancy outcomes may not be available. Often more embryos are transferred than the home country would permit, risking higher rates of multiple pregnancy which endanger both woman and fetus, requiring very costly prenatal and postnatal care – which must then be borne by the parents or the healthcare system of the home country after the parents return there.

The healthcare systems of destination countries suffer too. Their ART services are often provided by indigenous medical professionals who have been trained in advanced industrialized countries under subsidies provided by their home country. However, after completing their medical training, instead of treating citizens of their own country, they often give preference to patients from the world's richest economies who are in a position to pay the highest fees. Governments in some developing countries favor such arrangements since they attract foreign money to the country. Though infertility rates among women in countries serving travelers are just as high, perhaps higher, than rates in the home countries of women seeking services, preference is given to those who can pay the most.[23]

Future children of these traveling women may also suffer. Their legal status may be unsettled when their parents return home with them. They may never be able to learn the identity of their biological parents or the woman who carried them; their birth certificate may include only the names of the social parents.

## EFFECTS OF TOURISM ON HEALTHCARE SYSTEMS

Globalization has made it possible for many institutions formally under the control of national governments to transcend the boundaries of their home countries, thereby evading effective regulation by national governments. They may still limit access to assisted reproduction within their borders, but communication and travel across borders offset their policies. Capital mobility, free trade, technological advances, cheap transportation, and rapid communication all spur the growth of this industry. They have exacerbated gulfs between rich and poor at the local as well as the global level and undermined the abilities of governmental units to regulate economic and social policy within their own jurisdictions.

Supporters of the cross-border trade often focus their arguments on the policies of countries that regulate fertility services.[24] Defenders of what is termed a 'safety valve' argument contend that home countries need to allow tourism to minimize protest against their own restrictive policies and avoid moral conflict arising from incompatible national policies. In their view reproductive travel has a stabilizing effect on restrictive policies since it allows women who feel oppressed by domestic limitations to bypass local restrictions. Admittedly, such practices may appease regulatory authorities and restrain domestic opposition in the short term, but this advantage is bought at the expense of longer term problems for both the home countries of travelers and the economies of impoverished countries. Legislation that restricts the options of infertile residents tends indirectly to support exploitation of women in poorer regions. It also adversely affects the healthcare system of the infertile woman's country.[25] Unless they shift costs onto travelers who are impregnated abroad, their home countries will ultimately need to assume the cost of their medical care and care of the infants they bring home. In the event of multiple pregnancy, expense to the home country for care of premature infants is likely to be very costly, much more than, say, several cycles of *in vitro* fertilization would have been at home.

Another consideration that supporters of this argument overlook is the injustice of giving foreigners privileged access to scarce medical resources when a country's own citizens suffer disproportionally high rates of maternal and infant mortality. To attract foreign fertility tourists, some developing countries divert resources to private facilities that serve only the elite. Despite data showing that infertility rates in developing countries are as high as

[21] http://www.msnbc.com/id/22441355 [Accessed 2 Aug 2009].

[22] http://www.thewip.net/ [Accessed 3 Jan 2010].

[23] M.A. Ryan. The Introduction of Assisted Reproductive Technologies in the 'Developing World': A Test Case for Evolving Methodologies in Feminist Bioethics. *Signs* 2009; 34: 805–825.

[24] G. Pennings. Legal Harmonization and Reproductive Tourism in Europe. *Hum Reprod* 2004; 19(12): 2689–2694.

[25] This point has also been noted by Gillian Crozier in an unpublished paper delivered at the First Invitational International Forum on Cross-border Reproductive Care in Ottawa, Canada, 2009.

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in the West, even feminists who are otherwise sensitive to social context tend to formulate their critiques of assisted reproduction through a Western lens.[26] True, pressures from the fertility industry, male partners, and national governments eager to boost their birthrates may push Western women to undergo intrusive bodily procedures that are arguably contrary to their interests. But circumstances are often very different for infertile women in impoverished areas of the world. Marcia Inhorn notes that infertility rates tend to be highest in areas of the world where fertility is also highest.[27] Teen childbirth, unsanitary birthing conditions, and untrained attendants all contribute to high morbidity rates during childbirth that drive up the incidence of secondary infertility.[28] Apart from a few 'hot-button' issues such as genital mutilation and fistula, few Western feminists have addressed local conditions in regions where infertility rates are comparable to industrialized countries. Yet 'barren' women in those regions pay a much higher price for infertility than in the West, for there, the gendered cycle of vulnerability is embedded in social contexts that are often far more constraining than those that affect Western women. Many infertile women are severely stigmatized and ostracized. In some societies they are at high risk for domestic violence, abandonment, divorce, and infidelity.[29]

Though commercial purveyors of reproductive ART have exploited opportunities to market their wares in these developing countries, the market-oriented approach is even less likely to have a substantial impact on infertility rates there than in the West. Interventions that focus on reversing the effects of infertility are far more costly to both individuals and their governments than preventive care that deals with factors that contribute to infertility, such as access to prenatal care, nutrition, and infectious disease control. Lack of preventive care, in developing countries particularly, intensifies inequalities among the world's women.

Unjust, as well, are the racial implications of cross-border fertility tourism. Media coverage of cross-border reproduction has concentrated heavily on the use of Indian women to bear children for Western women, lending support to the view that a key factor contributing to the cross-border trade is race. Racial preference is undoubtedly a significant component in the underlying market for those who seek out these services. Most are white and want a child who looks like them.[30] Some plan to keep the child's true origins secret. Though the preference for a racially matched child may seem natural, it harbors a persistent bias that has underlying eugenic overtones. Some commentators argue that the pursuit of a racially matched family within this commercial context turns race into a commodity.[31] By way of illustration, Lisa Ikemoto mentions a news story about a surrogacy client who said that part of the incentive to travel to India for gestational surrogacy was to help an impoverished woman there. Ikemoto points out the sense of *noblesse oblige* underlying this market narrative. She remarks:

> What these stories express is the persistence of a form of racial distancing that may make hiring a woman to gestate, give birth to, and give up a child psychologically comfortable. It is a post-industrial form of master-servant privilege.[32]

Ikemoto's observation is supported by Chandra Mohanty's work. Mohanty fleshes out links between the colonialization and racialization of subject peoples. Colonialization is a common rationalization for seeing subject people as inferior, fit only for the most menial labor.[33] The fertility tourist who uses this means to justify hiring a nonwhite woman to gestate a child for her perpetuates this kind of colonialist mindset. Governments that make their own domestic regulations palatable by indirectly encouraging their residents to travel abroad for reproductive care are behaving like the imperial powers that exploited the natural resources of dependent counties to the advantage of their home country. Whether this is an intentional policy of home countries or only an inadvertent side-effect, it perpetuates injustices to formerly subject peoples and imperils the long-term wellbeing of the impoverished women whose bodily resources are put at risk.

## REDUCING INJUSTICES

Before turning to proposals to reduce injustices generated by the cross-border reproductive traffic, I draw together my remarks about responsibility for unjust outcomes. Utilizing Young's broad interpretation of social structures to include interdependent processes of competition and cooperation, interactive routines, resources, and the built environment, I focus on the roles participating physicians, healthcare systems, media, employers and

[26] Ryan, *op.cit.* note 22.

[27] M.C. Inhorn. Global Infertility and the Globalization of New Reproductive Technologies: Illustrations from Egypt. *Soc Sci Med* 2003; 56: 1837–1851. The UN Human Rights Council recently adopted a resolution affirming preventable maternal morbidity and mortality as a human rights issue. It is available at: ap.ohchr.org/documents/E/HRC/resolutions/A_HRC_RES_11_8.pdf [Accessed 8 Mar 2010].

[28] That is, inability to become pregnant or carry a fetus to term following an initial pregnancy.

[29] Ryan, *op. cit*. note 23.

[30] This is true of many who shop for ova at home too. 'Fertile HOPE', an organization that provides fertility resources for cancer patients, states in its literature that: 'egg donation allows you to select an anonymous donor whose traits and characteristics closely match your own.'

[31] Ikemoto, *op. cit.* note 16.

[32] Ibid: 308.

[33] C.T. Mohanty. 2003. *Feminism without Borders: Decolonizing Theory, Practicing Solidarity.* Durham: NC: Duke University Press.

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governments have played in generating injustices in the industry. I bear in mind Young's stipulation that those who benefit disproportionally or have the most power and influence carry the greatest share of responsibility for unjust outcomes.

Many healthcare providers reap handsome profits from their infertility practices. Some exploit their authority by coaxing women patients to exhaust every available option to achieve pregnancy even to the point of financial insolvency. Some use strategies to improve their success rates that jeopardize their patients' wellbeing, such as overstimulating their ovaries to maximize egg production or transferring more embryos than good practice warrants, thereby risking the health of both mother and child.

Healthcare systems often price fertility care beyond the reach of many patients. Some countries that provide otherwise comprehensive national health insurance coverage control costs by imposing unreasonable limits on the number of IVF cycles they cover. Others exclude coverage for IVF altogether. And some provide no national insurance at all. Such practices induce women to search overseas for more affordable options. Pharmaceutical companies benefit handsomely, regardless of the locality providing treatment. They market fertility drugs worldwide, aggressively promoting their products through fertility clinics, physicians, advertisements, and websites that target infertile women. I have already discussed the short-term risks of drugs that hyperstimulate the ovaries so they produce multiple eggs. Researchers are still trying to understand their longer term effects. Safeguards against their excessive use are, at best, inadequate even in developed economies. No safeguards at all exist in many less developed countries where women are far less likely to be well informed about accompanying risks.

Globalization has also enormously expanded the reach of media outlets. Often they romanticize women's desires for children and exaggerate or mislead their audiences into believing that infertility treatment always ends happily. Employers also share responsibility for unjust outcomes. Women workers may be penalized for taking time off for childcare emergencies or giving priority to childbearing during their peak years of fertility. Governments often collude in such employment practices. Some erect barriers to the quest for children that few parents can surmount without considerable sacrifice. Social structures in most areas of the world fail to credit women for their contribution to collective wellbeing through childbearing and rearing. Often such structural impediments to parenting leap to the foreground.

Such impediments cannot be overcome without structural reforms by institutions that benefit disproportionally from global markets. They would need to assume a greater share of responsibility to protect the health and safety of all who take part in collaborative reproductive arrangements. Measures would also be needed to: equalize the playing field so institutions no longer have a bargaining advantage over individuals, safeguard the agency and wellbeing of individual participants both within their home countries and abroad, and protect individual and social interests by eliminating women's vulnerability to commodification. A number of commentators have offered provisional suggestions that go part way toward meeting these objectives. Some proposals deal with measures that individual countries might initiate. Others focus on cooperative projects among several states acting in concert. Of course, these general approaches presuppose that states are already motivated to reform current practices. However, without aggressive advocacy by politically astute groups intent on pursuing more just arrangements, prospects for far-reaching change are doubtful. I will briefly outline the several approaches that have been advanced, ruling out such excessively draconian measures as prohibitions against overseas travel for reproductive services.[34] Lastly, I will consider concerted action by groups seeking to reform the trade.

The first group of proposals is intended to counter the practices of countries that actively encourage reproductive travel. The Indian government promotes the trade which brings valuable tourist dollars into the country. It offers a special visa for medical tourists and has introduced legislation to ease access to surrogates by foreigners. Paradoxically, the USA, one of the world's richest countries, offers similar access and provides more fertility services to nonresidents than any other country. However, some other countries that currently offer comparable access to foreigners are now considering regulation to reduce access. Poland's treatment of reproductive tourists has recently come under local criticism and authorities are now debating possible regulation.[35] The governments of several other Eastern European destination countries are also having second thoughts about reproductive treatment of foreigners. Romanian police recently raided a clinic owned by two Israelis and arrested numerous people who were charged with buying human eggs from indigent local women for a few hundred euros and implanting them in Israeli women for thousands of euros, thereby violating Romanian law that prohibits payment for human ova and organs.[36] Thailand is in the process of formulating regulations that will impact on their reproductive travel industry. Better coordinated efforts are sorely needed before it can be known whether such approaches have an appreciable effect on unjust practices.

Some critics of reproductive tourism favor a different strategy. Rather than focusing on measures by destination countries to regulate trade within their borders, they emphasize steps home countries might take to liberalize

[34] I have in mind measures to prevent residents from traveling overseas for abortion instituted by the Irish and German governments.
[35] *European Journal* newscast, PBS, 15 Aug. 2009.
[36] *BMJ* 2009; 339: 3003.

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national laws. Since Canada passed restrictive legislation forbidding commercial payment for gametes and surrogacy services, many Canadians travel to US clinics where gametes are readily available for a hefty fee. To reduce this trade Assisted Human Reproduction Canada, the federal agency established in 2006 to regulate reproduction, is considering liberalization of their practice to allow compensation to gamete donors, thereby reducing incentives to travel outside Canada. Some observers of the European scene are advocating policy changes that are more extensive than those under consideration in Canada. Disparities among the reproductive regulations of European countries are even greater than in North America. Some observers contend that liberalizing measures should be given priority over other approaches to reducing injustices because they protect moral pluralism and preserve the moral autonomy of individuals.[37]

Granting the importance of these values, it is far from clear that liberalization alone would advance them considerably. That strategy might work as a partial device, say, to limit overseas travel for gametes, but its effect would be counterproductive unless it were coupled with measures to reduce exploitative practices domestically. Without complementary measures it might only increase incentives for young women to sell their ova, thereby expanding commercialization of women's reproductive capacities at home. Liberalization of surrogacy laws would have comparable consequences and be likely to meet vociferous resistance in many countries. Moreover, such an approach would have no effect on overseas travel to obtain cheaper services.

Another way around barriers to domestic access would be to even the playing field by subsidizing services so those who cannot afford expensive fertility services can access them locally in a cost-effective manner. However, such measures would require national governments to increase expenditures substantially. Even nations that provide universal healthcare often have lengthy waiting lists for IVF treatment. So cost-cutting strategies would need to focus on other measures, such as inducing physicians who specialize in fertility services to reduce fees that are now among the most highly compensated in the profession. Pharmaceutical firms would need to trim their costs too. Some NGOs and medical organizations, such as Physicians for Human Rights and the World Medical Association, might be enlisted in a cooperative effort to rein in exploitive reproductive practices. However, to be effective, programs would need to be coordinated across very diverse economies.

Other approaches have been suggested that circumvent restrictive regulation by applying existing international laws in novel ways. One extends to reproductive care a strategy used by feminist groups to provide abortion services to women from Ireland where abortion is still prohibited. It utilizes international shipping legislation to provide care from a ship in international waters where ships can evade laws in nearby countries since they are governed by the laws of their home nation.[38] Another approach targets existing international trade agreements to ensure fair treatment of vulnerable groups who might be adversely affected by the reproductive travel industry.[39] Still another aims to ease transfer of newborns following surrogate birth by changing immigration laws to follow established procedures in international adoption.[40]

Common to this entire group of proposals, though, is the presumption that injustices tied to prevailing open market arrangements apply only to individual parties and do not extend to social institutions. But the conditions that created the cross-border trade are not reducible to individuals one by one. They affect the interests and well-being of all parties including collectivities that are not reducible to the sum of individuals. None of these regulatory schemes speak directly to structural injustices that motivate cross-border traffic.

A more effective way to lay the groundwork for just arrangements would be to harmonize regulation among jurisdictions in a manner that maximizes the long-term interests of all affected parties. Some commentators think barriers to this approach are insurmountable, that cultural differences among countries make cross-border regulation impractical. If that were the case, however, it would preclude regulation *within* many countries too, for cultural differences within countries are accelerating as people migrate from poorer regions to more prosperous ones. Another objection speaks to a more serious barrier to reform: the broad variation in national regulatory schemes. Among EU countries alone, there is considerable regulatory disparity. The UK has comprehensive regulation but Spain still has very little. Reproductive tourism is now a growth industry there, attracting women from countries with tight regulation including the UK and Germany.

More promising as an initial step might be an approach that aims for international certification and accreditation of fertility clinics and laboratories administered, possibly, by the World Health Organization. To be effective, of course, such certification would need enforcement measures more stringent than presently obtain, say, under the US Laboratory Certification Act. But at the very least women seeking services abroad would have safety

[37] G. Pennings, G. De West et al. European Society of Human Reproduction and Embryology, Task Force on Ethics and Law 15: Cross-Border Reproductive Care. *Hum Reprod* 2008; 23(10): 2182–2184.

[38] D. Hunter. The Challenge of 'Sperm Ships': The Need for the Global Regulation of Medical Technology. *J Med Ethics* 2008; 34: 552–556.

[39] Crozier, *op. cit.* note 25.

[40] C. Humbyrd. Fair Trade International Surrogacy. *Dev World Bioeth* 2009; 9(3): 111–118.

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protections and reliable data to compare the success rates of reporting clinics. And women in destination countries would be protected from at least some of the unjust practices that endanger their health.

Feminist activists in some of these countries are campaigning for more extensive reforms including elimination of commercial surrogacy transactions. A resource group for women and health in India that goes by the acronym SAMA has raised a complex set of issues regarding both internal and external factors contributing to the reproductive tourism industry. The agenda for their forthcoming conference in New Delhi includes pressures on the apathetic Indian government to add enforcement measures to presently voluntary guidelines for the regulation of ART clinics. SAMA is also seeking to develop a framework for ethical norms and regulations and situate debate on ARTs within the context of women's health, human rights and social justice.[41]

Effective implementation of a social connection model of responsibility would require application of several approaches. Needed are both transnational programs to address the effects of existing injustices and measures to preclude future ones. Indirect measures to forestall further injustices to women who presently participate in these practices are also required. Though groups in destination countries such as SAMA are alert to local injustices engendered by the trade, there is little evidence of comparable efforts among women's groups in the home countries of infertile travelers. Women's groups in departure countries need to campaign to sensitize Western women to the circumstances that motivate impoverished women to lend their bodies to the reproductive goals of others. Programs need to be accelerated to provide alternative options to women who cannot presently earn a decent livelihood without compromising their own health and wellbeing.

Enduring relief from the burdens the trade imposes on participating women is likely to come about only by dismantling incentives to exploit unjust access to reproductive services. In transitional economies dismantling will require expansion of economic opportunities for presently marginalized women. In advanced industrialized regions changes will require cooperation and coordination across disparate jurisdictions. Halfway measures won't accomplish the job since globalization has bound the economies of transitional and industrialized economies so tightly together. Because they are so interdependent it is vital that they all participate in programs to lift marginalized women out of poverty and provide alternative options to involuntarily childless women at home. Ironically, the latter might prove to be the more difficult to accomplish. This will require greater self-restraint by both the fertility and the pharmaceutical industries as well as other institutional structures which benefit under current arrangements. Only concerted cooperative action by voluntary groups, national governments, and global institutions can reign in the exploitive use of women's bodies, remove reproductive functions from market norms, and preclude further injustices in this global industry. Even such measures might not be sufficient, however. A program structured around the social connection model of responsibility would concentrate on avoiding further injustices. But positive measures are also needed to alleviate the social conditions that pull impoverished women into the reproductive tourism industry.

Committed groups like SAMA are working to marshal the support of UN agencies to implement human rights policies that impact the cross-border reproductive trade. Some are specific to the work of a particular agency. Others are comprehensive and seek a framework for ethical norms reminiscent of the proposal put forth by Mary Robinson, the former UN High Commissioner for Human Rights. She pressed for 'ethical globalization' to replace the dominant neoliberal economic agenda with UN standards directed to improved health and elimination of poverty.[42] Emphasizing the 2000 UN Millennium Conference resolution calling for 'shared responsibility', her program aims to establish economic, social, and political institutions that will make it possible for everyone to fulfill their human rights. She stresses the positive obligations of wealthy countries to undo the damages of globalization by redistributing the world's resources in a more morally responsible way. Her approach complements the social connection model's emphasis on responsibility to avoid future harms. Several recent UN human rights initiatives point the way toward shared responsibility to transform global governance programs from the prevailing 'benevolent charity' approach to a focus on human rights that recognizes the injustice of current economic and social structures. Coupled with Young's framework, Robinson's proposal would address the negative moral effects of globalization by extending full human rights to all. Finally, impoverished women who presently have no choice but to offer their reproductive capacities to affluent tourists to meet their family's needs would be able to reclaim their bodily integrity and secure genuine options to provide decent lives for their children.

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[41] They can be contacted at http://www.samawomenshealth.org/ [Accessed 3 Jan 2010].

[42] M. Robinson. 2006. *A Voice for Human Rights.* Philadelphia: University of Pennsylvania Press.

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