

**Outsourcing embryos:  
An examination of the maternal surrogacy market**

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**Abstract.** The word “market” brings to mind a grocery shop or perhaps the financial markets. However, with the advancements in reproductive technologies in the last thirty years, there is now an established market for sperm, eggs, fertilization techniques and even wombs. Surrogacy is a topic that most Americans are unfamiliar with; only a small percentage of American couples are infertile. However, surrogacy has made its popular culture debut with Kim Kardashian announcing her use of a maternal surrogate for her third child. I seek to provide an analysis for commercial surrogacy contracts and the gestational surrogacy market. Despite the lack of official statistics on the gestational surrogacy market, it is estimated to grow to a \$4 billion global market by 2020, which makes it an interesting market to examine.

**Keywords.** Embryos, In vitro fertilization, Maternal surrogacy, Commercial surrogacy.

**JEL.** I11, I18.

## 1. Introduction

**M**aternal surrogacy is a concept that, interestingly, originates in the Bible; specifically, Genesis records the story of Abraham and Sarah asking their slave Hagar to conceive their child Ishmael since Sarah was infertile. Since biblical times, it is highly likely there have been many unrecorded surrogate pregnancies of the traditional nature. The 1970s is the period in which maternal surrogacy and reproductive technologies experienced a series of revolutionary breakthroughs. Louise Brown was the first baby conceived through in vitro fertilization (IVF) and was born on July 25, 1978 (Pence, 2017). In the context of maternal surrogacy, her birth has relatively little importance. Far more important is the first successful use of IVF to create an embryo. In New Jersey in 1985, Mary Beth Whitehead entered into a contract with Elizabeth and William Stern to carry a baby to term for the couple and hand over the baby after delivery. Ms. Whitehead received \$10,000 in compensation and agreed to be inseminated with Mr. Stern’s sperm. However, after the birth of Melissa Stern, Ms. Whitehead refused to yield parental rights to the Sterns, so the Sterns sued. The Sterns did win in a lower state court, but the New Jersey Supreme Court ruled against the Sterns, stating the compensation as well as the surrogacy contract were “illegal, perhaps criminal, and potentially degrading to women.” Ironically, the Sterns did receive custody of the child, “Baby M” as the media called her, since the court believed it was in the best interest of the infant to award custody to the Sterns instead of to Ms. Whitehead (Haberma, 2014). This was the first case of modern, medically assisted traditional surrogacy. Additionally, the first case of gestational surrogacy was also recorded in the same year. A surrogate carried the biological child of a woman who underwent a hysterectomy but still retained her ovaries (Brinsden, 2003). From 1976 to 1988,

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approximately 600 babies were born via surrogacy. Between 1988 and 1992, more than 5,000 babies were born through surrogate methods.

## **2. Assisted reproductive technologies**

Maternal surrogacy is part of a subset of medical technologies known as assisted reproductive technologies (ART). ART involves the manipulation of sperm or ova outside the male or female body for the purposes of a pregnancy. Three common subsets of ART are IVF, assisted insemination, and gestational carriers. IVF extracts sperm and ova (eggs of a female) and combines them in a culture dish (hence “in vitro,” Latin for “in glass”) to create a pre-embryo, which is implanted into a woman’s uterus. Assisted insemination is the transfer of sperm to a woman’s cervix or uterus, usually without sexual intercourse (Knaplund, 2014).

Maternal surrogacy can be split into two categories: traditional and gestational. The only similarity is that both utilize women who choose to carry a pregnancy to term for a parent who cannot for medical or other reasons. Traditional surrogates are females who use their own ova and are artificially inseminated by the father or donor sperm. The traditional surrogate mother carries the baby to term, delivers the baby, and the baby is raised by the parents. In this case, the surrogate mother is the biological mother. Gestational surrogacy only uses the surrogate’s capability to carry a baby to term. The ovum comes from the intended mother or an egg donor; through IVF, the ovum is combined with the sperm of the intended father or a donor, and then the pre-embryo is implanted into the uterus of a gestational surrogate.

Surrogacy can either be commercial or altruistic. Commercial surrogacy involves the exchange of money between the intended parents and the surrogate. In altruistic surrogacy, the surrogate receives no financial gain for carrying the child. Often, altruistic surrogacies are carried out by people who have a close relationship with the intended parents. For the purposes of this examination, commercial surrogacy will be the focus since altruistic surrogacy is essentially unregulated, so the market is mainly in the shadows.

## **3. The Surrogacy Process**

Peter Nicolas, a professor of constitutional law, has provided a most edifying description of the surrogacy process since he himself was a participant in the process (Nicolas, 2014). First, intended parents must determine the laws that govern commercial surrogacy in their home state. If the laws are favorable, the next step is to select a surrogate agency. If not, the next step is to go to a state that is favorable to commercial surrogacy. The surrogacy agency often questions the intended parents on their perspectives such as whether they want traditional or gestational surrogacy, if they prefer a first-time surrogate or an experienced surrogate, what type of relationship they expect with the surrogate both pre-birth and post-birth, and if they would abort the baby if it were discovered to have birth defects. Additionally, the surrogate is screened psychologically in a similar fashion to the intended parents. This allows for compatibility between the intended parents and the surrogate. From then on, the intended parents, if not donating their own sperm and egg, must find an egg or sperm donor. IVF clinics are usually the intermediate party between the donors and intended parents.

Upon selection of the surrogate and with the source of ova and sperm confirmed, the intended parents hire a lawyer to represent them and often pay the legal fees of the attorneys for the donors, if any, and the surrogate. If a donor for sperm or egg is being used, a contract is drafted that states three key aspects: (1) the donor does not have parental rights or any responsibility for the child; (2) the donor must keep the intended parents updated in regard to his or her medical history; and if a child resulting from the donor’s sperm or ova were to suffer from any genetic medical condition, that information would be provided to the donor via the clinic. The surrogate’s contract is drafted with similar provisions. The

surrogacy contract is mainly designed to protect the wellbeing of the embryo and to govern what behaviors the surrogate mother can undertake. A contract could restrict her from consuming raw seafood products, drinking alcohol, etc. In Prof. Nicolas's opinion, the most important clause deals with the agreement that the surrogate will undergo an abortion if there is a medical defect with the baby or if continuing to carry the baby could damage the surrogate mother's health.

Specifically, for the case of surrogacy that Prof. Nicolas relates, the surrogacy contract was drawn up to circumvent Washington State criminal and civil law regarding surrogacy. As such, Prof. Nicolas assigned the surrogacy contract in Oregon to avoid criminal liability. However, avoiding civil liability would be a bit more challenging. Washington civil law deals with the enforcement of surrogate contracts, not their formation, and the law applied to contracts, "executed in the state of Washington or in another jurisdiction." As a result, the surrogate mother had to be born in Oregon, and a surrogate mother in Washington who could relocate to Oregon would not suffice. Prof. Nicolas notes that upon completion of the surrogacy process in Oregon, Washington would legally recognize the parent-child relationship if the parentage was defined by a judicial proceeding in Oregon because of the Full Faith and Credit Clause of the U.S. Constitution. Prof. Nicolas or his partner could identify as the genetic father of the baby, and if that parent signed an acknowledgement of paternity in Oregon, Washington law would fully recognize that acknowledgement.

#### 4. Legality of surrogacy

There exists no national regulation that governs the situations of commercial surrogacy in America. The issue is left to the states. The diagram on the next page provides an overview of the legality of surrogacy.

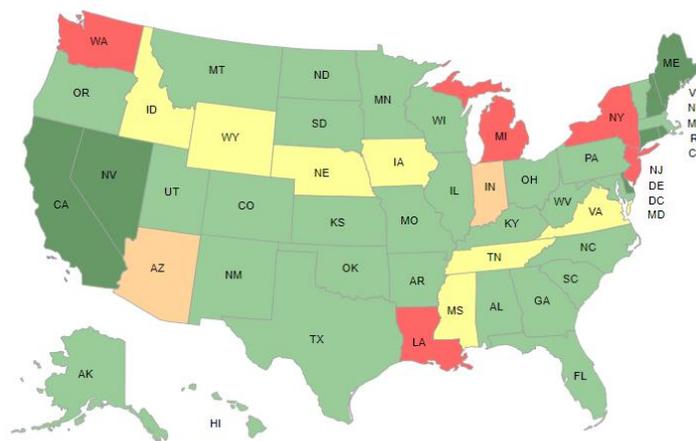


Figure 1. Legal Status of Commercial Surrogacy in the United States  
Source: [Retrieved from].

The *dark green* states (California, Connecticut, District of Columbia, Delaware, Maine, New Hampshire, Nevada, Oregon, and Rhode Island) permit commercial surrogacy and grant pre-birth orders. The *light green* states (Alabama, Arkansas, Colorado, Florida, Georgia, Hawaii, Illinois, Kansas, Kentucky, Massachusetts, Maryland, Minnesota, Missouri, North Carolina, North Dakota, New Mexico, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Vermont, Wisconsin, and West Virginia) permit surrogacy, but there may be additional post-birth legal procedures dependent on state and municipal laws. The *yellow* states (Alaska, Iowa, Idaho, Mississippi, Montana, Nebraska, Tennessee, Virginia, and Wyoming) practice surrogacy, but have different regulations for

married/unmarried and heterosexual/homosexual couples. The *peach-colored* states (Arizona and Indiana) permit surrogacy but declare gestational surrogacy contracts void and prohibit their enforcement. The *red* states (Louisiana, Michigan, New Jersey, New York and Washington) ban commercial surrogacy outright. New York bans commercial surrogacy outright but allows altruistic surrogacy. Overall, California and Oregon are the two most surrogate-friendly states. Indeed, these two states are very appealing to not only Americans, but also foreigners who seek a baby.

Prior to April 7, 2017, commercial surrogacy and altruistic surrogacy were illegal in the District of Columbia. A new law legalized surrogacy parenting and established a legal framework for surrogacy contracts. Before the law, gay and heterosexual couples who wanted to utilize the services of a gestational surrogate would cross state lines and go to states that are surrogate-friendly such as Oregon and California. With the new laws, the District of Columbia streamlines the surrogacy process by allowing intended parents to receive parenting rights during pregnancy, so they can essentially preorder birth certificates (Chandler, 2017).

### 5. The typical surrogate mother and clients

To date, there are no legal regulations that govern who can or cannot be a surrogate mother. Despite this, the industry has its own list of standards established by experts who agree on the criteria needed to qualify as a gestational surrogate.

The American Society of Reproductive Medicine (ASRM) has set some baseline criteria it wishes for the industry to follow. According to the ASRM, all surrogate mothers should be at least 21 years old; have at least one child; be healthy both physically and mentally; pass a psychological examination by a medical health professional; reveal their pregnancy history; undergo screening for sexually transmitted diseases and other viruses such as cytomegalovirus, HIV, hepatitis B, and hepatitis C; submit to examination of the uterus and cervix to ensure the pregnancy will be safe; and have their own gynecologists (Finkelstein *et al.*, 2016).

To find the typical characteristics of gestational surrogate mothers, I examined several popular surrogate agencies. The agencies that were examined were the Center for Surrogate Parenting (CSP) [Retrieved from], Circle Surrogacy [Retrieved from], Growing Generations [Retrieved from], Conceive Abilities [Retrieved from], and Surrogate [Retrieved from].

These five organizations specified several traits they wanted in potential surrogate mothers:

1. Age 21-42.
2. Body mass index (BMI) between 18-34 or 18-31.
3. Not take aid from any of the following government programs: public housing, cash assistance, welfare, or Section 8.
4. Must live in a surrogacy-friendly state.
5. In a financially stable situation.
6. Must have given birth to and be raising at least one child.
7. No use of drugs or tobacco.
8. Willing to submit to psychological testing and physical examination.
9. No history of mental or severe medical illness.
10. Must provide OB/GYN records and a clearance letter.
11. Must provide driver's license, or other identification, and evidence of health insurance.

These organizations have strict criteria for surrogates to ensure compatibility between the intended parents and surrogates. They reject women who are below the poverty line because the women might not have medical insurance and can be at a greater risk for health concerns and coercion. They also reject women who do not have children of their own, since having children proves that the surrogate can carry a baby and know what the process is like. Indeed, the CSP receives about 400 applications a month of women wanting to be surrogates. They only select about 20

of them because most candidates either live in states not friendly to surrogacy or because psychological screening reveals what CSP considers to be an undesirable focus on the potential compensation.

However, it is not only the surrogate mothers who come under scrutiny. Most agencies grant surrogates the right to screen out intended parents for any reason, such as age, religion and plans for childcare. There are very few rejections due to the initial screening accurately finding compatible surrogate mothers and intended parents.

Surrogate mothers, egg donors, and intended parents are typically quite different in every aspect. Surrogate mothers' ages cluster around 28, and they have their own children. Most egg donors are middle or upper-middle class, and are college students (Bindel, 2017). Melissa Brisman, CEO of Reproductive Possibilities, noted that around 20 percent of surrogate babies born in the United States are carried by military wives simply because of economic possibilities since most military couples move around a lot and salaries are not high for soldiers. In the United States, surrogate mothers' average household income was less than \$60,000 in 2015, according to the CSP (Steiner, 2016). There is no updated statistic on surrogate household income published by the CSP.

Medically, infertility is defined by the lack of the ability to get pregnant despite frequent, unprotected sexual intercourse. According to Mayo Clinic, approximately 10 to 15 percent of couples in the United States are infertile. The intended parents are usually richer and better educated than their surrogate mother. On its website, the CSP stated that most of its clients came from large urban cities like New York, Paris, Tokyo, or Beijing. Most intended parents are heterosexual couples who are either infertile by birth or face difficulties conceiving due to medical issues such as hormone deficiencies. A recent trend has been the increase in the use of gestational surrogates by male homosexual couples and single parents (both female and male). Melissa Brisman, a New Jersey attorney who specializes in surrogacy and is prominent in the field, notes that 70 percent of her company's clientele is from abroad, which is also a recent pattern. The reasons are the harsher judicial treatment of commercial surrogacy in countries such as Japan, Australia and China, and the fact of certain states in the United States (California and Oregon) having well-known surrogacy organizations.

### 6. Surrogacy statistics

It is a Herculean challenge to find accurate statistics for the number of surrogate births in the United States. An issue complicating the effort to accurately determine the number of births is traditional surrogacy: surrogacy organizations mostly release the number of gestational surrogate births. The number for traditional surrogate births or altruistic surrogacy births is unknown.

According to Fertility SOURCE Companies, over 1,400 babies are born a year through gestational surrogacy. Since the firm only operate in the United States, it is reasonable to assume that this number refers to gestational surrogate births in America; however, there is no indication on the firm's website where the information is from.

In 2011 the Society for Assisted Reproductive Technology (SART) reported 1,593 babies born in the United States to gestational surrogates, as tracked by its member clinics. This figure is up from 1,353 in 2009, and 738 in 2004 (Jackson, 2017). These numbers are likely much higher since many surrogate births go unreported. Kristine Schanbacher, an attorney at the large international law firm Dentons, notes that in 2014, the cost of a gestational surrogacy pregnancy was between \$59,000 to \$80,000 (Schanbacher, 2014). Currently, surrogacy can fetch a price of over \$150,000. The average cost of gestational surrogacy is \$100,000; it starts around \$80,000 and can go up to \$200,000 depending on individual circumstances.

Assume a cost of \$100,000 for a gestational surrogacy. Of that \$100,000, the surrogate mother will take home around \$30,000 to \$35,000, and even more if she

delivers more than one child. Experienced surrogates can command higher fees—in the range of \$40,000 to \$50,000. Surrogate mothers also get paid more if they work with international intended parents due to the language barrier and inability to keep in contact with the delivered child (Yan, 2015). The remainder of the money goes to the intermediaries: surrogacy agencies, attorney fees, counseling services and health insurance. Interestingly, the per hour pay for surrogate mothers comes to around \$5 per hour for the entire nine months. The surrogate mother receives her money in stipends. The schedule is determined by the surrogate agency and the intended parents. For example, Devon Cravener, a surrogate mother, received her first installment upon confirmation of a fetal heartbeat (Howard, 2015).

Dr. John Zhang is CEO of New Hope Fertility Center in Manhattan, one of the busiest fertility centers in the United States. Ever since its establishment in 2004, the five doctors Zhang employs have performed more than 4,000 cycles of IVF per year and coordinate an exponentially growing number of surrogate pregnancies. Zhang notes that births through surrogacy have more than doubled since 2004 (Weigel, 2017).

Teo Martinez, CEO of Growing Generations, a surrogacy clinic in Los Angeles, has stated that over 17 years, his clinic was responsible for more than 1,000 babies. He mentioned that surrogacy in the U.S. is increasing every year, and his client list is becoming mainly composed of foreign couples (Pardes, 2016).

### 7. A case study of commercial surrogacy in Maryland

We choose to examine the surrogacy practices in the state of Maryland since the institution that this paper is being published under is based in that state.

To fully understand the decision made by Maryland's Court of Appeals in the case *In Re: Roberto D.B.* it is important to examine the history of surrogacy law in Maryland. After the Baby M case was resolved in 1988, Maryland's legislature attempted to pass several bills to regulate surrogacy. In 1988, the first Senate proposal, Bill 795, called for a complete ban on commercial surrogacy. The bill passed in the Senate but was defeated in the House of Delegates. House Bill 649 proposed establishing minimum protections for parties involved in surrogacy agreements. It was also defeated in the House (Bashur, 2008). In 1992, the legislature, through Bill 251, passed a complete ban on surrogacy contracts, but then-Governor William Schaefer vetoed the bill, citing public opinion being divided on this issue as well as his own personal view that the creation of family is a personal decision that should be left to the parties involved (Brandel, 1995). In 1993, a bill similar to Bill 251 was introduced in the Senate and passed there; however, it was rejected by the House. It is important to note that this bill was the final attempt prior to the 2000s to pass legislation on surrogacy.

Maryland's judicial system addressed the topic of surrogacy twice, both times in circuit courts. In *Ex Parte Petition for the Adoption of a Minor Child*, Howard County Master Bernard Raum ruled that a surrogacy contract, if it provides compensation to the surrogate mother, was unenforceable since it violated the baby-selling statute<sup>1</sup> (section 3-603 of the Maryland criminal code). Interestingly, the court noted that, "the public policy on the general subject of the surrogacy contracts was in a 'state of turmoil,' and was best left to the Legislature." In the 1993 case *Ex Parte M.S.M and G.M. for Adoption of an Infant Minor*, Judge Peter J. Messitte for the Circuit Court of Montgomery County ruled that surrogacy contracts do not violate the baby-selling statute since it would be near impossible to prove that the parties involved in a surrogacy contract had the required *mens rea* (intention to commit a crime). Contrary to Master Bernard Raum's decision, Judge Messitte expressed doubt that, "a court in an adoption proceeding could fairly conclude that surrogacy parenting contracts otherwise violate Maryland's public policy" (Bashur, 2008).

<sup>1</sup>Section 3-603 of the Maryland Criminal Law Code

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*In Re: Roberto D.B.* was the case that officially determined Maryland's stance on gestational surrogacy. The appellant, Roberto D.B. (Roberto), artificially inseminated two eggs from an egg donor, and he made a contract with a woman, the appellee, that she be a gestational surrogate and allow these two fertilized eggs to be implanted within her. The eggs were implanted into the surrogate on December 21, 2000, and she delivered twins on August 23, 2001. Before issuing the birth certificate, the Maryland Health Code requires the birth records to be submitted from the hospital to the Maryland Division of Vital Records (MDVR). When the MDVR receives the records, it issues a birth certificate. The hospital reported the surrogate as the "mother" to the MDVR. However, Roberto and the surrogate did not want the surrogate's name to appear on the birth certificate (Sills, 2016). As such, the surrogate joined the petition in which Roberto requested that the surrogate's name be removed from both birth certificates and that Roberto be declared the father. The Circuit Court for Montgomery rejected Roberto's petition for the two following reasons:

- i. "No Maryland case law exists that would give a trial court the power to remove the mother's name from a birth certificate.
- ii. "Removing the name of the surrogate from the birth certificate is inconsistent with the 'best interests of the child' [due to health reasons]" (Roberto, 923).

Roberto appealed this decision. The Court of Appeals of Maryland did not find the reasoning from the Circuit Court for Montgomery to be persuasive, and accepted the appeal. The Court of Appeals reversed the decision by the circuit court under three premises:

- i. Maryland's parentage statutes allow men to deny paternity, but do not allow women to deny maternity, which violated the Equal Rights Amendment to the Maryland constitution. The court reasoned that since the statute used the word "parentage," it was neutral and did not preclude the courts from issuing an order authorizing a birth certificate that did not list the mother's name. The court rejected the reasoning that putting the surrogate's name on the birth certificates was in the best interest of the twins, stating that this analysis can only be used if there is a disagreement between one or two parents and a third party fighting over custody of the child. Since the surrogate had no desire to assert her parental rights, the court found this path of thought to be no applicable and inappropriate.
- ii. The court noted that since the MDVR stated no objection to removing the name of the surrogate from the birth certificates if a court order was given, a circuit court had the authority to approve and order this action (Bashur, 2008).

This ruling held that birth certificates should be issued without naming the gestational surrogate if the child in question is carried to the term using a surrogate. However, the court did note the following: "This opinion does not attempt to predict the future of reproductive technologies, it does not attempt to write policy on the topic of surrogacy, and it does not define what a 'mother' is" (Sills, 2016).

Through this ruling, gestational surrogacy was implicitly approved through case law, but the court explicitly stated that the final decision regarding surrogacy would be determined by the legislature. Legislation passed since 2007 became increasingly surrogate-friendly, yet all attempts to regulate gestational surrogacy have failed. According to Senator Delores G. Kelley, Maryland lacks "standards as to what the courts should find enforceable [regarding gestational surrogacy]." Indeed, in 2013 Senator Kelley attempted to pass the Maryland Collaborative Reproduction Act, which would have required gestational surrogates to have a minimum age of 21 and to have already given birth to at least one live child. Surrogates would also be required to undergo a physical examination by an obstetrician or gynecologist and a mental health evaluation by a clinical psychologist. The surrogate would agree to surrender custody of the child upon birth. The intended parents would agree to cover all expenses appropriate for the gestational surrogate such as child care, lost wages, maternity clothing, postpartum recovery and attorney fees. These requirements, according to Senator Kelley, were

to ensure that a potential surrogacy knows what to expect and to ensure the quality of the surrogate, so the child can be carried safely (Lash, 2015). Although the Maryland Collaborative Reproduction Act was approved by the state Senate, it was killed by the House of Delegates. Despite the lack of legislation, surrogacy agencies, doctors, psychologists, intended parents and surrogates have developed a system of best practices that protect the interests of the child.

However, traditional surrogacy has a far different story than the rulings for gestational surrogacy. Precedent in Maryland suggests that traditional surrogacy violates Maryland's anti-baby selling statute, which states that a birth mother cannot receive any compensation with respect to an adoption besides medical or legal expenses. Additionally, in 2000, the Attorney General for Maryland issued an opinion concluding that traditional surrogacy is in violation of the baby-selling statute since a traditional surrogate is essentially a "birth mother" and as such, is giving up parental rights to her own child, which is not allowed by the statute. Also, the traditional surrogate has to be treated like a "birth mother" in regard to payment. The Attorney General also differentiated gestational surrogacy as not needing to satisfy the criteria imposed by the anti-baby selling statute since the gestational surrogate has no biological relation to the child. As a result, most attorneys will not take on traditional surrogacy cases, and most of the surrogacy cases in Maryland deal with gestational surrogacy. As a side note, Maryland courts do not discriminate between heterosexual, same-sex, unmarried couples, single parents or couples using donors in regards to cases concerning gestational surrogacy. Ultimately, Maryland surrogacy law will be an interesting arena to watch since the state is so heavily involved in the artificial reproductive technology business, and legislation is introduced and killed each year (Hinson, & ReVeal, 2017).

Maryland is home to several surrogacy agencies, such as Creative Family Connections, The Surrogacy Group, Golden Surrogacy, Conceive Abilities, ART parenting, and the Johns Hopkins Gestational Carrier Surrogacy Program. All have similar requirements for prospective surrogate mothers, such as being between the ages of 20 and 44, having a normal body mass index (BMI), being in a stable financial situation, and other conditions that were discussed earlier. Though it is difficult to find how many babies are born each year through gestational surrogacy in Maryland, in 2013, Dr. Gilbert Mottla, a physician who works for the Shady Grove Fertility Service in Annapolis, estimated that the number was about 200.

### 8. Ethical issues

Commercial surrogacy has been criticized from a variety of perspectives. Primarily, the arguments concern potential *harm* to the surrogates or the children of surrogates, where harm can be physical or mental *commodification* of surrogates; and the *exploitation* of surrogates. Religious arguments can also be made to either support or ban commercial surrogacy. We will present the arguments of anti-surrogacy activists and then present counterclaims on why we think such a line of thought has some deficiencies. Note that all arguments apply only to surrogacy cases in the United States.

As discussed previously, the United States does not regulate surrogacy on the federal level, and the rising use of gestational surrogates without any minimum national regulation may pose some challenges. The exploitation argument argues that surrogates suffer since their bodies are allegedly controlled by others—the intended parents, agents, or doctors. They also suffer psychologically by having their babies removed. Proponents of this line of thought assert that surrogacy is of the last resort for financially desperate woman, and they are exploited upon this vulnerability. Another popular argument, the harm argument, claims that surrogacy is immoral because it causes harm or endangers the welfare of the children it produces. They claim that psychological harm will be inflicted upon the child due to the nature of surrogacy arrangements; specifically, the child is harmed when it is separated from its gestational carrier in emotional ways due to the child's

confusion of identity and the possibility the child feels as if he or she was abandoned by the “real mother” (Sills, 2016). A second version of the harm argument, proposed by the Swedish philosopher Marcus Agnafors, claims that surrogacy “involves great incentives to keep the gestational mother’s level of maternal-fetal attachment low, which tends to increase the risk of harm to the child” (Agnafors, 2014). Another extension of the harm argument focuses on potential bodily consequences for the surrogate. Gestational surrogates who utilize IVF often have more than one egg implanted into their uterus, which often results in multiple births and increases the risks for the surrogate mother. Also, the possibility of a Cesarean section increases with a multiple gestation pregnancy, and this surgery is complex and poses a plethora of risks to the surrogate mother—in some adverse cases, a hysterectomy may be performed, which removes the surrogate mother’s source of livelihood. Thus, gestational surrogacy has some very undesirable costs (Deonandan, *et al.*, 2012).

The commodification argument contends that women are reduced to their reproductive capacity, with a dollar value placed on their services. Surrogacy agencies use recruiters, advertise their services and make large profits off the commercialization of pregnancy. Pregnancy is simply degraded down to a service and a baby becomes a product. The exploitation argument notes that maternal surrogacy exploits financially vulnerable women (Havins, & Dalessio, 2017).

There also exist feminist critiques of maternal surrogacy. For many feminists, surrogacy represents an avenue where women are primarily valued for their fertility rather than their skills. Second, feminists claim that the women’s reproductive right is infringed upon when the surrogate gives the baby away, “a decision that powerful men...were seeking to override.” Feminists find it alarming that the bond that develops between a baby and the mother is severed due to a contract. Feminists allege that these contracts “prostitute” women in exchange for money, since surrogates supposedly become surrogates due to financial necessity. Continuing that line of thought leads to the conclusion that since prostitution is immoral and illegal, gestational surrogacy should also be (Lieber, 1992). Last, feminists claim that surrogacy contracts are ineffective due to insufficient knowledge of the substantial risks that the surrogate faces later in the pregnancy, such as the difficulty of relinquishing a child to the intended parents.

Proponents of gestational surrogacy have counterarguments to these criticisms. The harm argument claims that surrogacy is wrong because it could result in psychological harm of the child, but it must be shown that there exists sufficient evidence to sustain this claim. A recent meta-analysis concluded to the contrary that “Most surrogacy arrangements are successfully implemented, and most surrogate mothers are well-motivated and have little difficulty separating from the children born as a result of the arrangement...There is no evidence of harm to the children born as a result of surrogacy” (Söderström-Anttila *et al.*, 2015). The harm argument also claims that children of surrogate mothers face psychological issues. However, Vasanti Jadva of the University of Cambridge demonstrated in a study that relationships between the surrogate’s own family remain stable, and there is no indication of the children experiencing any negative feelings towards their mother’s decision to become a surrogate (Jadvaand & Imrie, 2013). Jadva conducted another study where she examined the psychological well-being of the surrogate after 10 years. Contrary to the notion that surrogates may experience psychological discomfort due to giving up the baby, her findings showed that the surrogate mothers showed no signs of depression and scored within normal ranges for self-esteem. None expressed regrets about their decision to become involved in surrogacy, though it is acknowledged the sample size was small (20 surrogates), so it is unknown to what extent these findings can be generalized (Jadvaand, Imrie, & Golombok, 2014).

Furthermore, in the case of *Johnson v. Calvert*, the court stated that “gestational surrogacy contracts do not exploit women of lower economic status any more than any other poorly paying and undesirable employment. Therefore, gestational

surrogacy contracts are not unconscionable or coercive as a matter of law” (Havins, & Dalessio, 2017). The exploitation argument is also undermined by the fact there is little evidence to show that surrogate arrangements, in the United States at least, are exploitative. Many surrogate mothers have altruistic intentions, and nearly all surrogacy agencies require maternal surrogates to be of stable financial condition, which reduces the possibility that the surrogate mother agrees to the contract out of fiscal necessity. Even if commercial surrogacy can be exploitative, the exploitation argument seems weak. Let us posit that commercial surrogacy is exploitative, and as a result, it is banned. However, this ban can lead potential surrogates to engage in more harmful and exploitative activities, such as sex work.<sup>2</sup> Ergo, such a ban reneges on its initial premise, that is, protecting women from being “exploited” as commercial surrogates. The exploitation argument proclaims that the transfer of money from the intended parents to the surrogate constitutes the exploitation. However, this argument is flawed as it is the belief that exploitation can be claimed when there is a *failure* to provide adequate compensation for such a service (Sifris, 2015). Consider fertility clinics that charge tens of thousands of dollars to provide artificial insemination or in-vitro fertilization services. To prevent individual women from choosing to provide their gestational abilities as a service when established reproductive organizations such as fertility clinics can charge large fees for their services seems inconsistent. If women have the right to work, it can be interpreted as including a right to provide their gestational capabilities in exchange for compensation, and compensation is justifiable since pregnancy and childbirth imposes risks on the pregnant woman’s health.

The commodification argument was also examined by Professor Richard Epstein of New York University, one of the most prominent legal scholars in America. He rejected the argument under the basis that the U.S. Supreme Court in *Casey v. Planned Parenthood* ruled that moral reasoning is insufficient to be the basis for a law. The implication is that surrogacy contracts cannot be blocked because opponents disapprove of the actions surrogates take and opponents cannot impose their own definition of the proper thing to do with sperm, ova and the female ability of gestation. For a contract to be exploitative requires it to take advantage of a vulnerability that prevents the victim from making a rational decision. Commercial surrogacy contracts issued by major surrogacy agencies often require extensive legal assistance for the clients and the surrogate mother, which reduces the chances of exploitation. Indeed, as discussed above, the client pays the attorney’s fees, so receiving subpar legal counsel is not an issue (Epstein, 1995). Furthermore, while most American surrogates are not as affluent as the intended parents, most are by no means poor. Surrogates have indicated that they do desire to enhance their family welfare, and surrogacy allows them to do so while staying at home and taking care of their biological children. Contrary to the feminist claim that surrogacy degrades motherhood to a mechanized process, surrogates view themselves in a positive light, performing services of great benefit to others (Scott, 2009). Kim Cotton, the United Kingdom’s first surrogate mother, makes that argument. In an op-ed in the *British Medical Journal*, she strongly contends that “surrogate mothers should be fully recompensed for their incredible sacrifice,” noting that the experience of pregnancy (often multiple pregnancies) imposes significant personal risk. Furthermore, she states that in her experience as a surrogate, traditional surrogacy poses more problems than commercial surrogacy due to the lack of an explicit compensation agreement. She states that the “[surrogate mother] comes away feeling used instead of fulfilled” (Cotton, 2000). Sensational cases such as that of Baby M are the exception, and even in that

<sup>2</sup>Arguably, sex work such as prostitution can be viewed as more exploitative than commercial surrogacy because while prostitution is only legal in Nevada, commercial surrogacy is allowed in several states. As a result, sex markets in states other than Nevada have no protections or regulations for prostitutes unlike commercial surrogacy, where states or surrogacy agencies impose guidelines.

incident, if there were clearly defined contract terms, such a case would not result. Deciding on whether maternal surrogacy commodifies women is not of a simple question; there are multiple angles that must be considered.

Under Act 17 of the United Nation's International Covenant on Civil and Political Rights, women have the right to autonomy, which encapsulates their right to do as they choose with their lives and bodies (United Nations, 1966). The concept of autonomy includes two prerequisites: authenticity and competency. Authenticity requires that the decision be made voluntarily, free of any coercion. Competency requires the decision-maker to understand the possible consequences of his or her decision. Thus, she may make a free and fully informed decision to become a surrogate, and to prevent her is infringing upon her right to autonomy.

*Religious attitudes* towards gestational surrogacy (GS) have not changed much since the birth of the first surrogate baby 30 years ago. The three major monotheistic religions—Christianity, Islam, and Judaism—hold three widely different views, and this work does not seek to provide a comprehensive overview of these differences and attitudes. Judaism places a duty on Jewish couples to have children, which can be interpreted either as favoring or opposing surrogacy. However, the Israeli government has legalized gestational surrogacy through the “Embryo Carrying Agreements Law,” which made Israel the first country in the world to legalize commercial surrogacy on a national scale (Golinkin, 2017).

The Bible does not exclusively prohibit surrogacy, but it raises questions about the morality of using a surrogate. It also maintains that children are a gift from God. Specifically, it is impossible to evaluate the appropriateness of surrogacy without also judging the ethics of the procedures needed for commercial surrogacy such as IVF. The Catholic Church forbids all forms of these procedures, from ovum or sperm donation to IVF (Sills, 2016). Additionally, the “one flesh” principle that binds husband and wife is breached if a surrogate is used. In 1987, the Congregation for the Doctrine of the Faith issued the “Instruction on Respect for Human Life in Its Origin and on the Dignity of Procreation,” which tackled biomedical issues from a Catholic perspective and declared surrogacy to be immoral. Many Protestant denominations are more liberal on the issue and allow for surrogacy, but they note the possibility of psychological problems for the conceived child and questions dealing with whom the child belongs to (Fleischmann, 2018).

Islam, like Christianity, has no explicit scriptural prohibition of maternal surrogacy. The two major sects of Islam are Sunni and Shia; they hold differing views on the issue. Shiite Muslims do not prohibit surrogate motherhood and religious leaders have issued fatwas (decrees) that allow gestational surrogacy as a treatment for infertility in married heterosexual couples. Hence, Iran, where the Shia sect dominates, allows for gestational surrogacy (Aramesh, 2009). Sunni Muslims, however, do not allow for the use of gestational surrogacy. They reason that surrogate motherhood is similar to adultery (*zina*) since the surrogate carries fertilized ovum of someone who is not the surrogate's husband. Additionally, a fundamental belief of Muslims is *aquidah* (everything that happens is due to Allah<sup>3</sup>), so those that are infertile or cannot carry a child to term were made that way. Additionally, Sunni Islamic scholars have decreed that it is forbidden (*haram*) to introduce sperm of any man other than her husband into a woman, and embryos that were developed in a haram manner cannot be implanted (Kholwadia, 2010). Though there is no explicit ban on gestational surrogacy, the process itself cannot occur since the first key step, the implantation of a fertilized ovum in the surrogate, is banned under the fatwa.

<sup>3</sup>Allah is the Arabic name for God.

## 9. Conclusion

Policies that limit the supply of commercial surrogates impose consequences on parties seeking a child through this method, mainly that they will be unable to have children. Regulations limiting supply will only create costs for two mutually consenting parties and externalities for others. When there is demand, supply usually is provided. Consider for instance the market for illicit substances. When the Colombian government cracked down on the cartels in Medellin and Cali, they simply shifted operations to Mexico, where they grew even greater in power. Commercial surrogacy is a need for infertile couples who have tried all other assisted reproductive technologies but failed, and when there is a need, there exists a market. Lawmakers can either establish a proper regulatory framework for this market, or parties will turn to the black market to satisfy their needs, which can impose undesirable externalities as well as transaction costs to the parties involved. Indeed, when China banned commercial surrogacy, a robust black market grew. Wang Bin, a professor at Nankai University, observed that “China’s underground market shows that there is a need for surrogacy in society.”

Consider also India, where great controversy exists regarding maternal surrogacy. In 2012, India banned commercial surrogacy for gay couples and then passed legislation in March 2017 that completely banned commercial surrogacy and only allowed for altruistic surrogacy. Critics of surrogacy were pleased by this development, claiming that poor women had been coerced and that intended parents had yielded more power than the surrogate. However, fertility expert Dr. Archana Bajaj stated that “an outright ban isn’t logical.” Surrogacy agencies will find legal loopholes that may produce even more risks for would-be surrogate mothers. When India banned commercial surrogacy for gay couples, various surrogacy agencies continued to sign gay clients and had them ship their frozen sperm to the agency. The sperm was then implanted into the Indian surrogate mothers, and before delivery, the mothers were moved to Nepal to give birth (Rudrappa, 2017). Surrogate mothers in these circumstances face far more vulnerabilities because they are unfamiliar with the language and culture of the countries where they give birth. Furthermore, these surrogacy agencies control their housing, money and food, which results in a lopsided power balance. The surrogate women have neither the power to terminate their contracts or go home nor do they have any legal possibilities to address potential breaches of contract or medical malpractice. Last, unregulated surrogate markets have no quality control in medical treatment. A surrogacy clinic has the incentive to utilize quality medical care to ensure the pregnancy is carried to term successfully. By moving the surrogate mother to a foreign country for birth to evade restrictions at home, though, it may sacrifice quality of medical care, which imposes risk to the surrogate mother as well as to the baby. Similar situations can be seen in black markets where surrogates receive medical care from any provider willing to engage in such illegal activity. While in regulated markets, women can sue the agencies if the contract is broken, in a shadow economy, the government will punish them for entering the contract, which can allow surrogacy agencies to neglect their surrogates.

Besides creating black markets, banning commercial surrogacy results in loss of potential tax revenues and other economic benefits. While opponents of surrogacy decry the paltry payments surrogates receive, it is important to remember the buying power of the U.S. dollar in other countries. As an example, Cambodian women receive around \$14,000 for nine months of surrogacy. While that seems meager, the average annual salary of a Cambodian woman working in garment factories (the highest-paying option) is \$1,000 in dangerous conditions. A payment of \$14,000 is small by U.S. standards, but it offers Cambodian women the possibility to avoid such dangerous conditions where hundreds die in factory fires and thousands sustain permanent injuries, and this is the best alternative for many. Otherwise, these women may turn to prostitution, which has significantly higher risks than surrogacy (Glaser, 2016). Beyond the notion of allowing maternal

surrogacy to serve as a better field of work, such comparatively large payments can help women make beneficial long-term economic choices. A study done by Professor Johannes Haushofer of MIT's Abdul Latif Jameel Poverty Action Lab and Dr. Jeremy Shapiro, cofounder of Give Directly, concluded that cash transfers are an effective method of improving quality of life and breaking out of poverty traps (Haushofer and Shapiro, 2013). A proper regulatory framework would seek to maximize the benefit for both parties while prioritizing the safety of the surrogate. Some suggestions would include implementation of a price floor in the gestational surrogate market to prevent economic exploitation. Government also has a revenue incentive to set baseline standards for surrogacy agencies since they can levy fines on those firms who do not meet the minimum prerequisites. Legalized price floors would also allow surrogate mothers to sue firms or intended parents if there is any attempt to breach the compensation clause of a surrogacy contract. Though price floors and regulations may create additional costs, they should be a minimal issue for firms participating in the surrogacy market since it has high profit margins. Furthermore, it can be assumed that demand is moderately price-inelastic for such services, so firms can pass extra costs onto consumers. Another strong suggestion would be minimum medical standards to ensure a safer surrogacy for the parties involved. Such implementation will not be an easy task, but it is extremely worthwhile to carry such policies to term.

To control the surrogacy market, there are four choices. First, leave it to the invisible hand of supply, demand and self-interest to determine the market. However, there may be significant negative externalities, such as the exploitation of surrogate mothers and donors. Second, ban surrogacy outright, which would create shadow markets, and drive up prices, so only the affluent could afford such services. Third, establish a system similar to that for organ transplants. However, that seems undesirable because the organ market in the United States and most other countries is extremely inefficient in supplying organs, which leads to hundreds of preventable deaths due to a self-instilled shortage. Removing high-tech reproduction from the market in a similar way to organs were removed from markets in the 1980s<sup>4</sup> would create a shortage and result in intended parents going to black market clinics, where the safety of the pre-embryo and the surrogate mother could be at risk. The most viable alternative therefore appears to be an open, but regulated, market where there are defined property rights.

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<sup>4</sup>In the United States the relevant legislation was the National Organ Transplant Act of 1984.

## Appendix

### A Proposed Gestational Surrogacy Act

A model legislative act for regulating commercial surrogacy contracts would have the following parts: a clear definition of gestational surrogacy, a set of minimum requirements for potential surrogate mothers, a compensation clause, and a guarantee of enforcement of the contract. The contract could be drawn up by the intended parents and the surrogate and then taken to court for approval. See below for a sample gestational surrogacy legislative piece inspired by an act proposed by Weldon E. Havins, M.D.

**Section I:** Herein, gestational surrogacy is defined as the act of implanting an embryo that is non-genetically related to the woman who will carry the embryo (the surrogate) till birth of a live baby either naturally or through medical intervention such as caesarean section.

**Section II:** A surrogate contract will be negotiated between counsel for the intended parents (the parents hiring the services of the surrogate mother) and the surrogate mother.

**Section III:** At minimum, the surrogate contract will ensure that the following conditions are met:

- a) The surrogate is at minimum of age 18 and must not be menopausal.
- b) The surrogate must not have pre-existing health conditions that may threaten the chances of a successful pregnancy such as preeclampsia.
- c) The surrogate must be pre-screened by a mental health professional and a physician to determine if she is of sound mind and body.
- d) The surrogate must have at least one successful pregnancy and currently be raising a biological child in her residence.
- e) The surrogate must not be receiving financial assistance from the government.
- f) Prior to negotiation of a contract, the surrogacy agency will ensure that the surrogate has access to legal representation.
- g) The surrogate mother will be compensated reasonably for her services, and such compensation must be negotiated and agreed upon prior to submitting the contract to a court of law.
- h) The surrogate may not be coerced, manipulated, exploited or put under duress to fulfill the requests of the intended parents.
- i) The surrogate mother has the right to terminate the pregnancy as provided by law, such as when the life of the surrogate is threatened by the pregnancy.

**Section IV:** Upon mutual satisfaction of the terms of the contract by both the intended parents and the surrogate, the contract will be taken to a court of a law where the court will conduct a hearing for the two parties and ensure the contract was not signed under duress, coercion or any such vulnerability.

**Section V:** The court has the right to demand medical examinations, psychiatric evaluations and examine the finances of both parties if the court deems it relevant to determine the validity of a surrogate contract.

**Section VI:** If the court is satisfied by the terms of the surrogacy contract and is satisfied the contract is in the best interests of the parties, it will declare it valid and enforceable. Henceforth, the surrogate contract between the two parties may not be amended without written consent given by all parties concerned in the contract (Havins & Dalessio, 2017).

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