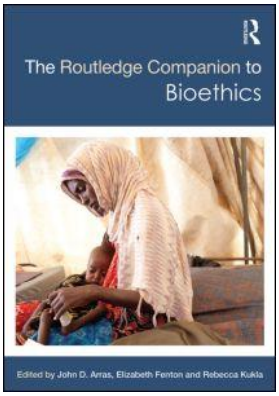

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REPRODUCTIVE TRAVEL AND TOURISM

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Technological advancements in medicine, communications, and travel have had a significant impact on how people address their medical and reproductive health needs (Reed 2008). Increasingly, patients are crossing national borders to seek reproductive goods and services, including those requiring human bodily resources such as gametes (eggs and sperm) or the services of a surrogate mother. This phenomenon—referred to here as "reproductive travel"—raises a host of ethical issues, many of which resist easy solutions. Although these ethical issues overlap considerably with those raised by surrogacy (paid and unpaid), ova harvesting, medical tourism, and other topics discussed in this volume, this essay will focus primarily on those issues that are unique to the phenomenon of reproductive travel. Specifically, I focus on tensions between reproductive autonomy of individuals and the duties of nations, the racial and gendered dimensions of reproductive travel, and the exploitation and constraints on consent of women who are paid to provide reproductive bodily resources (ova and surrogacy services, specifically).

The case of Diane Blood is widely discussed as the first high-profile contemporary case of reproductive travel. In 1995, Mrs Blood's husband died after contracting bacterial meningitis and falling into a coma. Since Mr and Mrs Blood had been trying to reproduce before he fell ill, Mrs Blood wanted to use her husband's semen to have a child with him posthumously. This was not permitted in her native United Kingdom because there was no written record of Mr Blood's consent. However, Mrs. Blood succeeded in achieving her reproductive objective by traveling to nearby Belgium, where legislation permitted the use of her deceased husband's sperm (Deech 2003). On two separate occasions, Mrs Blood was successfully impregnated using *in vitro* fertilization (IVF) and embryos created with her ova and her husband's spermatozoa, and she gave birth to two sons three years apart.

From the time of this highly publicized case, reproductive travel has become an increasingly widespread phenomenon. The accessibility of information and communication via the Internet and the ease of international travel have changed how people look for solutions to challenges they encounter in all aspects of their lives. This is no less true in the domain of reproductive medicine (Chung 2006; Korn 2012). Patients are able to locate and communicate with physicians overseas, clinics are able to advertise to foreign customers, and support groups and information forums have emerged online to connect patients with each other in order to share insights and resources regarding their experiences.

Throughout this essay, the term "reproductive travel" is used to refer to all cases where people cross national borders in order to obtain reproductive medical goods and services. This practice (or a subset of it) has variously been referred to as "reproductive tourism," "gamete travel," and "fertility tourism," among other terms. My preference for "reproductive travel" reflects the following observations: The term "tourism" potentially trivializes the activity which, for many patients, involves no recreational activities and a certain level of emotional and physical distress; the practice need not involve any medical procedures on the people who are traveling or paying for the services (for example, when prospective parents seek a surrogate mother); travel may not involve the manipulation of gametes; and fertility is not the goal in some cases of reproductive travel. Rather, the common factor here is that some kind of medical care involving reproductive health experts is required, and the activity involves the crossing of national borders by some party—whether by patients, prospective parents, gamete providers, or medical specialists.

Various practices fall under the category of reproductive travel. The attention of academia and the press has focused mainly on travel whose objective is to enhance fertility and facilitate procreation, such as travel for IVF, either with or without the gametes or surrogacy services of third parties. But it is not inconsequential that medical procedures unrelated to increasing fertility might also be involved, such as contraception, abortions, and related phenomena such as gender reassignment, female genital cutting, prostatectomies, or hysterectomies.

Motivations for Reproductive Travel

One useful way to understand the growing phenomenon of reproductive travel is to consider the various (sometimes overlapping) motivations of those who participate in it: (1) Cost, (2) limited domestic availability of goods or services, (3) avoidance of domestic legislation designed to protect the participants, and (4) avoidance of domestic legislation designed to promote social values (Crozier and Baylis 2010).

(1) One of the central motivations for reproductive travel is *cost*. Medical procedures can vary greatly in their cost among countries, and procedures relating to reproductive health are no exception. Prospective parents in wealthier countries can save thousands of dollars by obtaining medical procedures abroad, such as IVF and other medical fertility enhancing procedures, or even human gametes or surrogacy services. Countries such as Thailand and India are actively competing for a share of this lucrative market in medical travel in general, including reproductive travel. Some clinics even advertise romantic getaway packages where clients can bundle inexpensive fertility treatments with vacations in romantic locations.

(2) *Limited domestic availability* of reproductive goods and services is another factor that can drive patients abroad. Long waiting lists for gametes or IVF, for example, may be deemed unsupportable by couples for whom each additional year of waiting decreases their chances of successfully achieving a pregnancy. This category of reproductive travel also houses some of the most controversial cases—those cases motivated by domestic restrictions on payment for human reproductive resources, such as gametes or surrogacy services. Many countries limit the amount of money that can be paid to sperm and ova providers and to surrogates; frequently, payment is restricted to only what would be considered necessary to compensate the provider for time, lost wages, and expenses. This has led to shortages in human reproductive

resources in these countries (Levine 2011), and it has motivated a growing industry in reproductive travel for the purchase of gametes and paid surrogacy in countries where the regulations regarding compensation for human reproductive resources are more permissive, such as Thailand and India.

(3) In some cases, people seek to circumvent domestic regulations that are in place to *protect the health or wellbeing* of those people who would be directly involved in the procedure—prospective parents, future children, and people providing human reproductive resources. The case of Diane Blood also falls into this category, since the procedure was denied in the U.K. on the basis of consent—it is deemed in the best interests of U.K. citizens that their prior written consent must be secured if their bodily resources are to be used for posthumous reproduction.

Also falling under this category are cases of reproductive travel motivated by the desire to circumvent policies prohibiting risky procedures. For example, IVF resulting in post-menopausal pregnancy, or in higher-order multiples such as triplets or quadruplets, is unavailable in many countries because the risk to the health of the mother and offspring is deemed to be too high. By traveling abroad to countries with less restrictive policies, patients are able to obtain these procedures—sometimes resulting in high costs to their own healthcare systems at a later stage. In one recent high-profile case, a 62-year-old woman gave birth to twins after traveling to India for assisted reproductive procedures that were denied to her in Canada on account of her advanced age (Baylis and Crozier 2009).

Along similar lines, many countries do not permit gamete providers to remain anonymous on the grounds that this is contrary to the interests of the resulting offspring. For example, Denmark has become a popular destination for Europeans seeking sperm in part because, unlike some of its neighboring countries, such as Sweden, it permits providers to remain anonymous.

(4) Reproductive travel has proven to be particularly controversial in cases where legal restrictions rooted in *social or religious values* drive people abroad for goods and services related to reproductive health and fertility. Travel for contraception and abortion, although not widely discussed in the context of the reproductive travel industry, which tends to focus on people whose goal is procreation, is a perfect example of this kind of case phenomenon. Many countries reflect the social/religious values of their citizens by restricting access to contraception or abortion, either by banning it outright or by rendering it a scarce resource. One response to this is for women to travel to nearby countries with less stringent regulations. For instance, in response to the ban on abortion in Ireland, Irish women in need of abortion frequently travel to Britain for this service (Department of Health 2012; McDonald 2012). One response has been the "abortion boat" run by Women on Waves, a non-profit founded by Dutch gynecologist Rebecca Gomberts. By keeping the ship in international waters where the more permissive Dutch laws are in effect on the vessel, this group is able to offer abortion services to women who live in countries that prohibit these treatments.

(*The Week* Staff 2012)

The desire to select the sex of prospective offspring is yet another reason for reproductive travel based on social values. While the selection of certain embryos for implantation during IVF on the basis of sex is not permitted in many countries for ethical or demographic reasons, some prospective parents are willing to travel abroad for

this service. Thailand, in particular, has become a popular destination for reproductive travel in part because its clinics may offer sex selection services (Whittaker 2009).

Some countries have developed legislation regarding assisted reproduction that is grounded in a particular conception of the characteristics of an "acceptable family." For example, same-sex couples or unmarried people are not permitted access to IVF or other fertility procedures in Italy since it introduced strict regulations in 2004 limiting these procedures to heterosexual married couples. For people wishing to have "non-traditional families" in countries with strict socio-religious restrictions regarding fertility assistance, travel abroad can be a compelling alternative.

Reproductive Autonomy and the State

One focal point of discussions regarding the ethics of reproductive travel has been the tensions arising between the reproductive rights claimed by individual citizens and the objectives of the countries in which they live. Advocates of assisted reproductive technologies (ARTs) have long cited reproductive autonomy as the central benefit of these interventions. For example, although IVF is currently accepted as "normal," if not common practice, this was not always the case. In the 1970s and 1980s, critics argued that IVF was too medically risky for the "test tube babies" that would be born this way, and they also worried about the sociological ramifications of this practice for the very definition of "family"—a concept that has always been highly normatively charged. In response to these arguments, R.G. Edwards (1974) defended IVF on the basis of infertile couples' right to procreate. Similarly, advocates of reproductive travel frequently refer to the reproductive autonomy of prospective travelers as one of the strongest reasons for supporting the existence and viability of these markets.

Guido Pennings (2004) is widely cited for his arguments favoring reproductive travel as a means for balancing the reproductive autonomy of citizens with the duty of a government to adopt legislation that reflects the socio-religious views of its populace—or at least those values that are shared by the majority of the citizens of that state. National governments, Pennings argues, have a responsibility to adopt legislation that reflects the values of the majority of the people in that country, even if this means that its legislation will be inconsistent with the values of minority groups. For example, countries where predominant socio-religious mores strongly favor traditional notions of "family" will restrict access to fertility treatments—for instance, Italy's laws deny treatments to unmarried persons or same-sex couples (Boggio 2005), and Iran forbids any treatments using third-party gametes (Inhorn 2011). These laws hold despite the fact that all the countries' citizens do not universally share the values underlying them. Given the availability of reproductive travel, however, this fact need not effectively curtail the reproductive autonomy of those denied access to fertility treatments in their home countries if they can meet their needs by going abroad. Thus, Pennings favors reproductive travel as a way of ensuring the reproductive autonomy of minority groups in various nations as well as the rule of the majority.

However, reproductive tourism is unlikely to satisfactorily resolve the tension between reproductive autonomy and the rule of law. Crucially, it is not the case that anyone who wants access to these reproductive goods and services can simply travel abroad to obtain them—access to reproductive travel remains the purview of relatively wealthy and otherwise socially privileged citizens. This poses a challenge for nations with deep (constitutional or otherwise) commitments to equitable access to medical care for all

citizens (Boggio 2005), and it runs the risk of creating a class of global elites who have increased access to medical care at the expense of the poor (Martin 2009; Sengupta 2011). Additionally, the availability (even if only in principle) of reproductive travel gives the travelers' countries more leeway to pass even more restrictive laws within their borders, potentially constraining reproductive autonomy even further for citizens unable to travel abroad (Storrow 2010). Furthermore, if a country opts to push certain ART procedures abroad because they are deemed to have bad consequences, this potentially undermines the very rationale behind restricting them domestically (Storrow 2010). For these reasons, reproductive travel seems not to serve as a very effective "safety valve" (as Pennings refers to it) for easing the challenges posed by countries with diverse populations. Some authors have preferred the term "reproductive exile" to "reproductive travel" since the vast majority of these travelers would obtain treatment at home if it were possible, but instead they are forced to go abroad due to various constraints that restrict their access to key reproductive goods and services (Matorras 2005; Inhorn and Patrizio 2009).

Various measures have been suggested for minimizing reproductive travel, including punishments for physicians or clinics that inform patients about reproductive travel or facilitate this practice; suggested punishments include fines, license revocations, and even imprisonment (Heng 2006; Shanks 2010). Punishments for reproductive travelers have also been explored as a means to curtail the industry; Turkey, for example, has recently introduced legislation whereby women who go abroad for fertility treatments involving third-party gametes may be imprisoned for up to three years on their return (Shanks 2010; Van Hoof and Pennings 2011). The threat to states may be even more severe in the case of the destination countries for reproductive travelers. If competition among these countries for a share in this market becomes particularly fierce, destination countries may be tempted to enact increasingly permissive legislations regarding reproductive medical goods and services, regardless of their risks or their ethical implications. This would effectively result in what has been referred to as a "race to the bottom" (Millns 2002; Carbone and Gottheim 2006).

The health and future welfare of prospective children must also be given careful consideration in this discussion. Just as in the early debates concerning IVF, prospective parents are not the only relevant parties, even within their own families. For instance, many nations have taken measures to ensure that children born from third-party gametes have access to information about their genetic parents. By traveling abroad, parents from these countries are able to obtain anonymous gametes, with potential negative effects for the children who will be born (Blyth and Farrand 2005). There are additional risks for babies born of foreign surrogates regarding legal parenthood and citizenship, and there have been cases where commissioning parents have been unable to bring the offspring home with them (Parks 2010). Until and unless both the source and destination countries guarantee legal rights regarding parenthood and citizenship of children, offspring produced through reproductive travel are in an insecure position and the ethics of the practice will remain problematic.

Feminism, Gender, Race, and Global Justice

There are many reasons for which feminist analysis should figure prominently in bioethical investigations of reproductive travel. Questions involving sexual orientation and women's choices are among the most ethically salient features of reproductive travel,

and these are questions for which feminist scholarship has developed a specific set of conceptual tools. Feminist scholarship challenges the traditional distinction by which decisions made within the family are considered private matters, whereas decisions made outside the family are considered public, and thereby subject to evaluation in terms of equity and justice. Although reproductive travel is often the result of a deeply personal decision made by prospective parent(s) to expand their family, this intimate act has broad political implications—both within the travelers' own countries and internationally. The kinds of choices made by the people involved in the various aspects of this phenomenon—parents, ova providers and surrogates, clinicians, etc.—manifest patterns that reveal the systematic social constraints in which they find themselves. These social pressures may not be apparent to the individual people in question, but they may nevertheless be visible on analysis of groups of individuals, all of whom share particular characteristics (social status, nationality, gender, etc.) and life decisions (Young 2007; Donchin 2010).

For example, on the one hand it would ostensibly seem that the availability of reproductive travel widens the options available to women—making it possible for them to conceive without a male spouse, presenting greater opportunities for having children later in life, or when they suffer from other fertility challenges. On the other hand, in a society (as are most) where women are significantly valued for their reproductive capabilities, the increasing availability of ART in general means that women can be expected to experience greater social pressure to have children and to engage in social reproduction—for example, to have children when they might otherwise be pleased to remain childless, to engage in post-menopausal reproduction despite the costs and health risks, or to carry to term pregnancies involving multiple embryos.

Reproductive travel involving surrogacy and third-party ova requires the intimate use of another woman's body. Contrasted with sperm collection, the procedures by which ova are harvested involve multiple injections to administer hormones and a transvaginal needle to extract the ova—this is painful and invasive for the provider, and it carries medical risks such as ovarian hyper-stimulation syndrome, which can be fatal. Surrogacy itself brings obvious risks of physical discomforts and dangers, but in a transnational setting, much of the surrogacy that takes place is "gestational surrogacy" whereby surrogates carry offspring from the embryos of other women. This is preferred because it permits commissioning parents greater control over the genetic makeup of the offspring (including degree of relatedness or ethnic/physical characteristics) and also because it reduces the emotional connection a surrogate might feel towards the baby. Surrogates are encouraged to care for the developing fetus like they would their own children, but to perceive the status of the relationship they hold to that child as inferior to the bonds of genetic or contractual parenthood.

Frequently, when prospective parents are purchasing gametes to create a child, a significant consideration is the phenotypic characteristics or ethnic-cultural background of the gamete provider. For example, although Spanish legislation guarantees the anonymity of gamete providers, measures are taken to match providers and recipients across multiple phenotypic features, including coloring, height, weight, and even blood group. This serves to not only mask ART by creating the façade of a "natural" family, which renders the practice more "socially acceptable," it is also based on an outdated view of European countries as ethnically homogeneous societies (Bergmann 2011).

Within the Indian market, women who are lighter skinned or Brahmin can receive higher compensation for their ova than darker skinned women (Pande 2010). Similarly,

there is a strong market within Northern Europe for ova from women of former eastern-block countries, such as Romania, because their fair coloring is in high demand and because of the low price of their ova due to the generally low levels of prosperity common among former citizens of the USSR (Storrow 2005; Ferrari Morris 2007). Indeed, there are even clinics that import Eastern European women for their reproductive resources because the premium on their genetic predisposition for fair coloring is so high and their relative wages are so low (Sarojini et al. 2011).

Choices of prospective parents regarding where to travel and with whom to contract are frequently influenced by preferences that are rooted in global injustices. Without significant inequalities between countries and their citizens underwriting the price differential and the availability of human bodily resources (surrogacy and ova), for instance, the phenomenon of reproductive travel might not be so widespread (Ikemoto 2009).

With respect to domestic ova and surrogacy provisioning, many Organization for Economic Cooperation and Development (OECD) countries limit the compensation that can be offered to women to an amount sufficient to cover the costs involved, including time and expenses, even though restricting compensation can have a negative effect on the supply of female reproductive resources (Levine 2011; Smith 2012). There is concern in these countries that commoditization of these resources will undermine existing altruistic systems wherein these human bodily resources are perceived as gifts given freely, and altruistic gifting is preferred on the grounds that it minimizes the exploitation of those who provide these resources (Martin 2010; Crozier and Martin 2012). A central concern is that, if more money were offered than merely that which would serve as compensation for expenses incurred, people might be enticed to sell their bodily resources for profit, which would disproportionately attract providers from less privileged socio-economic groups. Arguably, a system wherein the wealthy effectively procure organs or reproductive resources from the poor in a non-reciprocal manner is exploitative of providers. The term "exploitative" typically refers to arrangements wherein one party is at a significant disadvantage relative to the other such that this results in them putting forth a disproportionately large share of the effort or other costs into an arrangement in exchange for a disproportionately small share of the benefit.

But, if a domestic market in ova or surrogacy would be exploitative, then this exploitation would likely be exacerbated when extended transnationally since the socio-economic discrepancies between commissioning parents and potential ova and surrogacy providers would tend to be increased substantially. In the reproductive travel market, women from whom these reproductive goods and services are procured are typically from countries with emerging or developing economies, and are more socio-economically vulnerable than commissioning parents. This raises concerns over coercion, exploitation, and justice—an acute concern in light of the relatively poor reproductive health care often otherwise available to women in these countries (Sengupta 2011; Jaiswal 2012). (For illuminating discussions of exploitation in the context of domestic and transnational surrogacy, see Wertheimer (1999) and Panitch (2013), respectively.)

Certainly both the commissioning parents and the surrogates gain something particularly valuable to them in the exchange—the former gain children and the latter gain money that is significant to their families. This wage is significant, and in India, for example, it is sometimes in excess of five times the average annual wage. These funds are used to eliminate debts, to start businesses, to pay for education and (sometimes life-saving) medical care for family members, and to achieve other ends that are both of huge

value to them and otherwise unobtainable (Bhatia 2012). However, the conditions under which gestational surrogates and ova providers enter into the contracts are of concern. There are documented cases wherein consent has been hampered by misleading and outright fraudulent recruitment tactics on behalf of brokers and by the providers' relatively impoverished education levels and access to information about the industry (Sarojini et al. 2011). Arguably, however, even if the conditions of the contract are completely transparent, poor women in countries with emerging and developing economies are unable to properly consent to these contracts precisely because the background conditions of their poverty provide them with no viable alternatives, and this undermines the legitimacy of their consent—they are effectively coerced into entering into a contract that they might otherwise resist (Panich 2013).

Furthermore, the working conditions of gestational surrogates working in the reproductive travel industry can be quite striking. Indian surrogates, for example, are subjected to stringent screening prior to, and monitoring throughout, the pregnancy. Often, surrogates are housed in group homes with limited contact with their own families; their diets and activities are closely controlled; and they relinquish the ability to make medical decisions related to their pregnancies, including difficult choices regarding selective termination (which is often medically recommended in the case of triplets or other higher-order multiples) (Pande 2010). Indeed, part of what makes Indian surrogacy services so attractive to many customers is that commissioning parents are able to assert a great deal of control over the conditions of the pregnancy and birth relative to what would be possible if the surrogates were hired domestically or from the U.S., for example; and the reason Indian surrogates accept these conditions is because they are unable to bargain for more favorable contracts.

What, then, can be done? The contracts can be exploitative of surrogates and ova providers, yet increasing the wages risks (it has been argued) hampered consent by increasing the coercive factor of the offer (Panitch 2013). Some advocate quashing the practice of transnational surrogacy and ova sales by criminalizing it, or by increasing the supply of domestic providers by increasing their payments (PS 2012), or by promoting national networks such that countries can be self-sufficient in their use of these female reproductive resources (Martin 2010). Others suggest that, given that this market is likely to persist, legislation introducing some minimum standards of care to ensure the informed consent and the safety of participants and resulting children is required—for example, in the form of regional trade agreements (Chung 2006; Ferrari Morris 2007) or global measures similar to the Hague Adoption Convention (Storrow 2005; Martin 2009). Beyond this, some suggest letting the free market dictate the details of contracts in order to maximize the reproductive autonomy of commissioning parents, while others suggest basic requirements for surrogacy contracts, minimizing the share taken by brokers and middle-men, measures to improve the bargaining power and benefits received by providers of surrogacy and ova (Sarojini et al. 2011; Jaiswal 2012; Panitch 2013), and strengthening the social connections between surrogates and commissioning parents (Donchin 2010; Parks 2010).

Conclusion

This essay represents a brief introduction to some of the ethical issues raised by reproductive travel. I have, as much as possible, avoided focusing too much on ethical issues that overlap considerably with other areas of bioethics—many of which are discussed elsewhere

in this book. Insofar as reproductive travel deals with the movement of patients across national borders (often from nations with more prosperous economies to nations with less prosperous ones), the chapter on Medical Tourism will be relevant to this one (see Chapter 8 in this volume). Because some reproductive travel involves payment for human reproductive resources such as gametes and surrogacy, there is much to be learned from discussions of commoditization of human biological resources, including organ sales and the sale of tissue for research purposes. Furthermore, there is overlap between this area and bioethical investigations of research conducted on test subjects in developing countries; similar to markets in reproductive travel, there are significant risks of exploiting the test subjects and their communities unless they derive sufficient benefits from the exchange—and it is no simple matter how to define "sufficient benefits." Although I have tried to minimize discussion of those issues that are likely to overlap significantly with topics in other chapters of this book, I encourage readers to investigate these issues if they wish to have a fuller appreciation of the complex ethical dimensions of reproductive travel.

Related Topics

Chapter 8, "Medical Tourism," I. Glenn Cohen
Chapter 28, "Regulating Reproduction: A Bioethical Approach," Isabel Karpin

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