Chapter 11

The Globalization of Assisted Reproduction

Vulnerability and Regulation

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We live in an age where dreams of reproduction can be bought and sold. Human gametes, fertility treatments of every type, and surrogates are available in the billion-dollar, unregulated global marketplace. For reproductive *consumers,* the global marketplace becomes an attractive option when restrictive regulation and policies prohibit the fulfillment of their reproduction dreams at home. For those involved in supplying the global market with eggs, sperm, and wombs to rent, ethical issues about commodification and exploitation arise, particularly when that supply originates in developing countries in the global South—increasingly the destination of choice for fertility travelers from the global North. The realities, *good-news* stories, and particularly the tragedies that globalized reproduction potentially entails are never far from media consumption. The stories of baby Manji, born in India and whose gestational and commissioning mothers relinquished any claim to her (Roy 1), and baby Gammy, who was allegedly left behind in Thailand according to newspaper reports (an account later rejected by an Australian court) when the Australian commissioning couple collected only his twin sister, are only two recent tales of surrogacy *gone wrong* (Callaghan and Newson; Photopoulos). Likewise, international media interest was sparked by the Italian case of elderly parents achieving a postmenopausal pregnancy abroad with consequent removal of the child by the Italian authorities (Margaria and Sheldon). These news stories are a preview of the vulnerabilities that can ensue, for all parties involved, from the transnational reproduction trade.

Reproduction is an area characterized by the increasing medicalization of women's bodies and state control over their decision-making. In seeking to establish control over reproductive choices, it is unsurprising that scholars and activists focused on the acquisition of bodily autonomy and formal equality. In positioning women as fully functioning liberal subjects for whom reproductive liberty has become synonymous with autonomous choice-making and freedom to contract (Fineman, "Vulnerability" 17)), law has led to some valuable gains in terms of formal equality in the way in which assisted reproductive technologies (ARTs) have been regulated by the state in many developed countries. However, what this chapter is concerned with is the extent to which "an adherence to formal equality has seemingly eclipsed our moral and political aspirations for *social justice*" (Fineman, "Equality"; my emphasis), and what aspirational social justice and well-being might look like in the context of ARTs. Fineman's concept of vulnerability is an "alternative vision for justice" based on the understanding that vulnerability is a constant, shared, and "universal, inevitable, enduring aspect of the human condition," arising from our embodiment ("Vulnerability" 20) and our differential embeddedness "in social relationships and within societal institutions" ("Equality" 613). Fineman suggests that replacing the mythical, autonomous, fully functioning liberal subject with the vulnerable subject in politico-legal discourse necessitates a mandate for a responsive state, "one with a clear duty to effectively ensure realistic equality of access and opportunity to society's resource-generating institutions for everyone" ("Equality" 613). In this essay, I position ART provision, including surrogacy, firmly within the context of vulnerability, inequality, globalization, and the discourse of social injustice and exploitation. From the stance of Fineman's vulnerability thesis, I will explore how the gains made by the liberal order's focus on formal equality and autonomy in reproductive decision-making regulation may be set against the state's

unresponsiveness to the embodied vulnerability of ART users, exposing actual inequalities and limitations on opportunity. I explore how law and policy perpetuate and facilitate globalization and continue to *other* some types of mothering. I use Fineman's vulnerability analysis to question states' accountability for their unethical domestic regulation and the consequent vulnerabilities—predominantly of women—that this facilitates and perpetuates along global geographic trajectories as a result.

The Vulnerability Thesis and Assisted Reproduction

Our need for connection and care is part of our humanity, which will include for some, but not all, a desire to reproduce, situated within particular social, cultural, and religious contexts. Such contexts may affect women more than men. It is precisely within these contexts that an inability to reproduce without assistance, whether for clinical or social reasons,[1] will be lived. It is crucial to understand that Fineman detaches vulnerability from its association with "victimhood, deprivation, dependency or pathology" ("Vulnerable Subject" 266), and therefore to be vulnerable is *not to be stigmatized.* Rather, all of us are universally vulnerable simply because we are human, simply because we are embodied. Infertility arises from our embodiment and is characterized by its very universality and ubiquity: It may genuinely affect anyone regardless of gender, sexuality, race, religion, disability, or able-bodiedness, wherever they are globally situated. While infertility is universal, it, like vulnerability itself, is "experienced uniquely" (Fineman, "Vulnerable Subject" 269) because we are differentially and uniquely embodied, and differently situated. Our vulnerability can be mitigated by our access to assets that provide us with resilience or resources to respond to vulnerability, including the state and societal institutions. For some, the lure of ARTs, including surrogacy, may represent a solution to infertility, but in turn may both exacerbate their own vulnerability and create vulnerabilities in others: ART and surrogacy users become subject to constraints imposed by law and institutions such as health care providers—which gain legitimacy and authority through the state and law—and through the medicalization of infertility, which may contribute to inequalities and disparities in treatment through social exclusion (Bell). The role of the state from a vulnerability stance must be to increase our resilience, be responsive to ART and surrogacy users' vulnerability in order not to unduly privilege some and disadvantage others, and ensure genuine equality of opportunity is realized by all.

Infertility and the (Un)responsive UK State

The Legal Regulation of ARTs

[1] Note that this is my meaning when I use the word *infertility* in the context of this chapter.

The state defines and regulates the constitution of the family. Access to ARTs is often constrained by regulation in conformity with the privileged normatively preferred family ideal, most often the sexually affiliated two-parent heterosexual patriarchal model, to the exclusion of others. The Human Fertilisation and Embryology Act 1990, as updated in 2008, regulates assisted reproduction in the UK. The UK has made significant progress in the inclusivity of diverse family forms since its initial regulation in 1990. The privileging of the heterosexual family was clear under s.13(5) HFE Act 1990, which required clinics to consider "*the need of that child for a father*" (my emphasis), and provided justification for the exclusion of single and lesbian women from infertility treatment in line with the general concern of the liberal order with the *dangerousness* of *manless* mothers apparent within much of family law (see Fineman, *Autonomy* chs. 4 and 5). This criterion was jettisoned in 2008, in recognition of both the positive findings of the literature on lesbian and solo parenting and of the unacceptable discrimination on grounds of sexual orientation (Fenton et al. 249). There has been a significant increase in the number of same-sex female couples receiving treatment in the UK in recent times (Human Fertilisation and Embryology Authority).

In addition to newfound inclusivity in terms of access, the new 2008 parentage regime brings the legal position of lesbian couples into line with that of heterosexual married and unmarried couples, although, as it is set out as a mirror image of the sexually affiliated heterosexual model, it might be thought symbolically suggestive of the notion that the alternative model is secondary or even *other* (Fenton et al. 249). More radically, however, the reform also permits a nonsexual partner to be named as the father or as the second legal parent of a child. Sexual affiliation is thus not the only determinant of family, something Fineman has argued for at least two decades (Fineman, *Neutered* and *Autonomy*). Although the new regime still maintains the normative primacy of the biogenetic two-parent model so fundamental to the liberal order, the UK approach is to be applauded for its significant and positive recognition of alternative family forms. By contrast, in the US, fertility clinics are free to refuse to treat single and lesbian women, and "studies indicate that many infertility clinics will deny access to single men, gay couples and poor couples" (Storrow, "Medical" 376–77), thus reifying heteronormative bias (Storrow, "Marital" 100).

The 2008 reform has enacted valuable and responsive gains in reproductive choice by granting access to previously excluded groups, which to a certain extent mitigates vulnerability by transitioning previously conceptualized subversive or *dangerous* mothering into the mainstream. However, a vulnerability perspective reveals that what the law actually does is permit those previously excluded to be reclassified as the liberal autonomous subject, and inclusion therefore *looks like* formal equality. Such single, male-partner-less women begin to *look like* the liberal subjects and the lesbian family begins to *look like* its heterosexual equivalent. The alternative nonsexual two-parent family takes on the *appearance* of an accepted family form (Fenton 134). But, as Fineman states, "we have merely expanded the group to whom this version of equality is to be applied" (*Autonomy* 24). The symbolic recognition of formerly excluded groups *is* important but may be deceptive: Law does not operate in a vacuum, and a vulnerability analysis, in its pursuit of social justice, requires us to explore the wider health care context and barriers to access of ARTs as a social good.

Resource Availability and Equality of Access: State Responsiveness

Law legitimates those societal institutions that distribute significant social goods and that, says Fineman, provide us with "assets" that give us "resilience" when faced with vulnerability (Fineman *Vulnerability* 22–23). In the realm of ART provision, the most important societal institutions are health care providers. The vulnerability thesis therefore suggests that the state and health care providers—as societal institutions—have a duty to be responsive and "a responsibility to structure conditions in which individuals can aspire to meaningfully realize their individual capabilities as fully as possible" ("Vulnerable Subject" 274)—in this case, parenthood.

Health inequalities exist across different socioeconomic groups, genders, and ethnicities in the UK (House of Commons Health Committee 5). Poverty and social exclusion—which may be related to sociocultural or racial groups and access to basic medical care—are determinants of women's reproductive health (Earle and Letherby 234; Cahn 35), and similar patterns of inequality are evident globally. Further, Bell argues that one of the consequences of the medicalization of infertility is the focus on the treatment of infertility as opposed to its preventable causes, which are more common among women of low socioeconomic status (635). This correlation between general health care access and fertility substantiates the argument that infertility patterns are of appropriate concern to a responsive state and indicates that reproductive health can be protected through equal health care provision provided by systems such as the National Health Service (NHS), which provides health care free of charge to all in the UK.[2] The NHS is a social asset, important in its provision of shelter and resilience against citizens' vulnerabilities, but equal *availability* of health care is not sufficient under a vulnerability analysis: It must take into account the ability of differently situated groups in society to *access* and *utilize* such health care. Genuine equality of opportunity and access, then, obviates the privilege of the least vulnerable in society. Such concerns and patterns are distinctively structural, and not merely individual—and the state is connected as the moderator of social resources in the production of the general health-provision conditions under which fertility, or infertility, is facilitated (Fenton 132).

While law may now formally include in its gaze those previously excluded on the grounds of identity, genuine equality is unlikely to result from forced conformity to the autonomous liberal subject model. Unless resources are actually available, and utilization possible, access to ARTs is merely symbolic: The questions, then, become, what does genuine equality in ART provision look like in a post-identity and post-autonomy context, and how do "asset-conferring" (Fineman, "Vulnerability" 23) societal institutions—namely, the NHS—distribute ARTs as a social good?

In the UK, some ART treatment should be theoretically available under the NHS. The National Institute for Clinical Excellence (NICE) determines the effectiveness and appropriateness of treatments for use by the NHS using best clinical and economic evidence, and the constitution of the NHS sets out the use of NICE-recommended treatment where clinically indicated as a right for patients (UK Department of Health and Social Care). NICE recommends that public health care should provide three full cycles of in vitro fertilization (IVF) for women under forty years and one full cycle for women aged

[2] The NHS provides health care free of charge in the UK based on clinical need and not ability to pay. This includes primary and secondary care, including emergency treatment. Some means-tested contributions are required, such as a small standardized prescription charge for medication irrespective of the actual cost of the medication. It is possible to purchase private health care and insurance to cover private health care.

forty to forty-two (NICE, "Fertility Problems"). Treatment for same-sex couples is included. However, research has consistently indicated that regional commissioning bodies do not provide the recommended cycles of IVF, and the trend is in a continuing decline in health care provision. By 2016, the Fertility Fairness audit had found that of the Clinical Commissioning Groups (regional commissioning bodies—CCGs), just 16 percent offered three cycles and 22 percent offered two cycles, with a majority of 60 percent offering only one cycle (Fertility Fairness). Five CCGs have now cut NHS IVF completely (2.4 percent) (Fertility Fairness), and 13 areas have cut or are consulting on reducing IVF provision since the start of 2017 (Marsh). This essentially means that access to ARTs is governed by one's geographic location—a *postcode lottery.* Access is thus fundamentally unequal and is further exacerbated by a range of arbitrary and unsubstantiated nonclinical and non-evidence-based social *deservingness* criteria by CCGs (such as excluding cases where one partner already had a child) and the imposition of age limits, many as low as thirty-five years. The *postcode lottery* is being worsened by the CCGs. In response to these cuts, NICE has issued a new quality standard calling for the end to the *postcode lottery* and emphasizing the importance of treating infertility (NICE, "NICE Calls"). Pressure has also been put on CCGs by a successful legal challenge against a CCG's refusal to fund oocyte cryopreservation as recommended by NICE for a woman undergoing chemotherapy: Here the CCG's policy was found to be unlawful, and it is possible that this decision will spark further legal challenges where the NICE guidance is not followed (*R [on the application of Elizabeth Rose] v. Thanet Clinical Commissioning Group*). While the effect of these current developments remains to be seen, in the meantime fertility treatment remains an ever-decreasing priority for commissioners, resulting in significant inequality of access to public resources distributed by a societal institution, which unjustifiably exacerbates vulnerability.

Although the regeneration of society is valuable and productive in itself, the discourses surrounding health care provision are of cost and effectiveness. Thus, this reduction in public funding of IVF by CCGs is always justified under the guise of reducing public spending. Ideologically we might question whether economic productivity arguments have any place in a vulnerability analysis, but nonetheless pragmatically we might contest them and reveal them to be illusory. Indeed, research into the fiscal implications relating to achieving ART-conceived children demonstrates an eightfold return on investment for government, and thus "appropriate funding of ART services appears to represent sound fiscal policy" (Connolly et al. 601). It is suggested that the call for a more responsive state should also involve a requirement to recognize the long-term economic advantages—particularly in the era of the increasing trend in below-replacement fertility experienced across the world—rather than entrusting the distribution of significant social goods to regional microeconomic, short-term budgeting by CCGs. Even more important should be the focus on the babies inevitably not born as a result of cuts and thus on the people who are precluded from becoming parents, and the economic context in which cuts are made. As Connolly et al. point out, "'financial access' plays a critical role in overall access to fertility treatment" (607)—not just in terms of actual cost but in affordability. In times of austerity, affordability and thus utilization declines, and of course, austerity affects different socioeconomic and cultural groups differently, with women being particularly disadvantaged (Karamessini and Rubery). The correlation between affordability and utilization is well illustrated by the US, which has one of the lowest utilization rates of developed countries and also the highest direct cost of ART treatment (by a large margin) but almost no public financing (Connolly et al. 604, 607). The lack of public funding thus creates inequality based on ability to pay, which affects different socioeconomic and cultural groups unequally. It is no surprise that financial access is used to police the norms of motherhood. Indeed, there are other structural inequalities that operate social exclusion from infertility treatment. US research demonstrates

that ART treatment is utilized more by educated, white, older women and that "racial, ethnic and educational disparities in access to fertility care are not generally reduced by state insurance mandates to cover fertility treatment" (Connolly et al. 607). Bell argues that medicine not only reinforces norms of family but also controls the application of those norms. She suggests that "not only does it do so explicitly through the private medicalized market in which only a few individuals can afford treatment, medicalization also implicitly reinforces stratified reproduction through its inherent characteristics" (634).

In addition to its nonimplementation, the NICE guideline itself raises an issue about the age limit restrictions. Although this has now been extended from thirty-nine years to forty-two years, it nonetheless limits treatment for forty to forty-two years. The law imposes no age limit, while CCGs impose their own arbitrary, often lower, age limits. The rationality of NICE's imposition of age limits has been discussed elsewhere (Fenton 136–37), but it can still be questioned whether they are at odds with social reality: There has been a consistent increase in women giving birth over the age of forty years (Office for National Statistics). The recognition of the vulnerable subject at the forefront of decision-making about the allocation of scarce resources (rationing) might suggest that older women should be prioritized, as they need treatment more than younger women. The recourse to exclusion of older mothering as a money-saving exercise, in the guise of rationing, is strongly reminiscent of the discourses that portray older mothers as subversive and morally unsuitable (Fenton et al. 246)—and perhaps bad and even dangerous. Furthermore, early motherhood is restrained by socioeconomic actualities—exacerbated in the era of austerity—that lead women to the impasse of early pregnancy and lost career positioning or potential infertility. Through this lens, the promise of ARTs in the eventuality of infertility, coupled with the subsequent exclusion from NHS treatment, simply exacerbates vulnerability. Such vulnerability is perpetuated by large businesses such as Apple and Facebook who now offer egg freezing to female employees for retention purposes (Tran). Such practices simply increase the normalization of late childbearing, lure career women into infertility with the promise of (successful) ARTs, and simultaneously entrench patriarchal norms regarding caregiving and family. NHS rules create an excluded yet privileged class of infertile women—those with the economic resilience to afford private treatment (in the UK, private clinics will treat women up until the age of around fifty years, for example). The infertile woman who is not economically self-sufficient is effectively punished for her inability to buy herself out of the state's control.

Despite the gains made by law in terms of reproductive freedom and autonomy, the centering of the vulnerable subject reveals reproductive *choice* to be, in substantive terms, illusory. The vulnerable subject is certainly not the liberal actor that the traditional identity-based formal equality analysis portrays her to be. The operation of NHS rationing reflects underlying inequality, unevenness, and discrimination in the distribution of resources that deny actual autonomy and equality. Thus, while law has certainly widened the barriers to access to ARTs, we remain bound by the familiar liberal scenario as described by Fineman: "We gain the right to be treated the same as the historic figure of our foundational myths—the white, free, propertied, educated, heterosexual (at least married), and autonomous male. We do not gain, however, the right to have some of his property and privilege redistributed so as to achieve more material and economic parity" (*Autonomy* 23). Formal autonomy, after all, is merely symbolic without actual access to treatment. Discrimination on formal identity grounds may now be unlawful, but discrimination due to geographic location is not, and thus what is missing is the recognition of our sameness, our humanness. Although currently a poor representation of

social responsibility, the NHS as an institution *could* provide assets and resilience against vulnerability in this arena. However, as Fineman suggests, institutions themselves are vulnerable; they are not "foolproof shelters," but are "potentially unstable and susceptible to challenges from both internal and external forces" ("Vulnerable Subject" 273). The NHS is vulnerable to the privilege and disadvantage created by the state and exacerbated by political choices around austerity. The responsibility of the state therefore needs to be reconceptualized to establish a more equal access to resourcing and utilization, unpolluted by privilege and inequality. We need to create a paradigm in which "the state is not a default (therefore stigmatized) port of last resort, but an active partner with the individual in realizing her or his capabilities and capacities to the fullest extent" (Fineman, *Autonomy* 271). In this context, that includes becoming a parent.

Surrogacy and the Abdication of State Responsibility

Whilst the law on ARTs may now be relevant to the twenty-first century, the same cannot be said of the law relating to surrogacy in the UK. The UK reveals itself unresponsive to surrogacy both domestically and transnationally. The UK prohibits commercial surrogacy (as do many European countries) and allows altruistic surrogacy but fails to provide a statutory regime for its regulation and for the legal enforceability of surrogacy agreements (Surrogacy Arrangements Act 1985). The law has been unable—or unwilling—to grapple with the ethics of surrogacy and therefore has chosen to simply ignore it, creating and exacerbating vulnerability in its wake and leaving the courts, who are consequently themselves rendered vulnerable, to attend to the aftermath once the child is born. The ban has meant that surrogacy arrangements not only are unenforceable but cannot be arranged professionally on a commercial basis, leaving commissioning parents without proper legal guidance and unaware of the legal complexities they are about to enter into, exacerbated by international conflict of laws.

While there is older case law on resolution of custody when the surrogacy agreement fails and the surrogate—often also the biological mother in those older cases—does not want to give up the child, the courts today have been predominantly (although not exclusively) occupied with different issues surrounding parentage transfers arising from transnational surrogacy where (intended) parentage is not necessarily contested. Where the child's living arrangements have been contested, courts must apply the welfare of the child principle, which is paramount in English law. The problem is that the parentage rules under the 2008 act simply do not consider surrogacy, and in UK law, the legal mother of the child is always the surrogate as she is the birth mother, regardless of genetics or intended parentage. Some recognition of alternative surrogacy-created families has been achieved since 2008: Parental orders, which transfer legal parenthood to the commissioning or intended parents in a surrogacy arrangement, can be issued to same-sex couples as well as heterosexual ones, provided there is a genetic tie to one of the intended parents (s.54 HFE 2008). Single people, however, remain excluded by the law. The government has announced its intention to reform the law following the 2016 decision by the High Court in the case of *Re Z* that the provision is incompatible with the European Convention on Human Rights (House of Commons). Discrimination on grounds of identity is to be remedied—here the exclusion of singles—and again in this realm of law, we see the emphasis upon formal equality. The UK finds itself in a rather curious, and arguably untenable, position in which, on the one hand, it prohibits commercial surrogacy yet, on the other, it makes some provision for the eventuality—and proven

reality—of surrogacy occurring. Awards of parental orders have doubled since 2012, and there has been considerable judicial criticism of the current legal regime, with judges being forced to manipulate orders to give effect to the welfare principle and the parentage intentions of those involved.

The law on parental orders also requires that the surrogate must not have been paid, other than reasonable expenses. However, the courts have faced a steady stream of cases in which monies that exceed reasonable expenses have been paid. Under the welfare of the child principle, the courts have sanctioned such payments so that the parental order can be made. As the judiciary has pointed out, it is practically impossible that parental orders will now be withheld (*Re L*). Despite the ban on commercial surrogacy, arrangements are in essence being sanctioned through the *back door* as they are in effect authorized by the courts and the ban is, as Jackson points out, "completely ineffective" (892). The limitations of the regulatory regime have been further exacerbated by the High Court ruling that the time limit for making applications for parental orders set down by law as within six months of birth cannot prevent the court making an order in late applications (*Re X*). The statutory regime is fundamentally flawed in its assumption that surrogacy can be regulated by after-the-fact transfers of parentage, and the law reveals itself troublingly unethical, blinkered, and unresponsive to the realities of surrogacy, which, in today's world, mostly involves cross-border arrangements. The uncertainty caused by this approach renders children, commissioning parents, and surrogates vulnerable, and courts in many countries worldwide, at all levels, including the European Court of Human Rights, are increasingly being called upon to regulate the results of cross-border surrogacy.

Cross-Border Reproduction and Cross-Border Surrogacy[3]

Neoliberal globalization situates states within a global market and their citizens as global consumers, for whom the internet provides access to a flourishing global market for clinics, gametes, embryos, and surrogates. The globalization and the commercialization of assisted reproduction and surrogacy expedites cross-border reproduction and surrogacy (CBRS), the movement of persons between jurisdictions in the quest for a child, under different conditions from those available domestically (Gürtin and Inhorn). The trajectories of CBRS are fueled by four main reasons for fertility travel: actual (non-chosen) exclusion by regulation in terms of access and treatment availability, chosen exclusion, long waiting lists, and economic costs. Different destinations become attractive to different types of fertility traveler, and as a consequence, individual state policies and regulation have repercussions beyond their domestic jurisdictional borders through juridical globalization. The universality of the vulnerability thesis requires that we consider vulnerabilities created by legislative behaviors that have global impact, in this

[3] I include cross-border surrogacy in this discussion as it mainly concerns gestational surrogacy that requires IVF treatment and is, for this discussion, another way to achieve conception and birth of a child for those unable to conceive or carry a pregnancy. While I am not suggesting that all the issues are the same or raise the same level of concern, for ease of discussion I am discussing them together under the heading of cross-border reproduction and surrogacy (CBRS).

case through CBRS. Our starting point may be to consider the construction of CBRS as a positive means of alleviating vulnerability, followed by an exploration of how CBRS may exacerbate vulnerabilities.

CBRS as an Asset

We might think that CBRS could be constructed as an asset supplying resilience in the face of vulnerability attributable to local restrictions on ARTs and surrogacy. Importantly, states themselves may purposely construct and rely upon CBRS as "a moral safety valve" (Storrow 305). Those who are excluded from local treatment by being rendered *other* (such as by sexuality) are able to purchase the means of reproduction on the international market. Likewise, those excluded because a treatment type is simply not available, such as sex selection or commercial surrogacy, can locate such treatment elsewhere. Thus, sidestepping of local regulation is an important function of CBRS and may in fact be an ally of reproductive rights. The thriving global market, under this analysis, allows access by excluded groups, facilitating alternative family forms and thus offering resilience against vulnerability. The global market facilitates access to cheaper treatment abroad—cutting economic costs and increasing the availability of reproduction for those who are privileged to have some means to purchase treatment. It makes up for shortages in local markets and allows for the purchase of autonomy by allowing choice for those who, while not actually excluded from treatment, simply disagree with the local conditions for treatment.

In its mitigation of adversity for marginalized groups, CBRS might be constructed as an important market-based asset promoting reproductive freedom, autonomy, and choice. But this market-model is flawed: It reflects a liberal construction of the parties as liberal autonomous actors, consumers, and providers operating in a context of supply and demand, able to freely contract without coercion, from a position of equality. It presumes genuine equality and opportunity of the parties involved. A vulnerability analysis mandates inquiry beyond this construction, this commodity trading, and the exploration of systematic disadvantage in access and equality, "amplified in the context of the globalised neoliberal order" (Grear 54).

CBRS as Exacerbating Vulnerability

A vulnerability analysis of CBRS must question the law's role and adequacy. First, it must examine how the law functions in acting as a market driver, a facilitator of CBRS by exclusory regulation and policy, and consequently as the creator of a dual regime in which the rich can contract out of local laws and subvert the ethical preferences of the home state, but the poor cannot. Secondly, the law's role in regulating CBRS itself both in terms of its practices and standards (such as the number of embryo transfers) and in terms of its outcomes (such as legal parentage, legal recognition, and welfare of the child) must be questioned.

The way in which CBRS operates gives rise to many potential vulnerabilities. First, the fertility tourist exits the home state in their quest for reproduction. This travel is likely to subvert home state regulation and policy and is only open to those who can pay. The tourist may find cheaper treatment abroad, but that treatment may come with welfare hazards for the traveler herself, such as the transfer

of multiple embryos. Here we witness the correlation between cheaper treatment and value for money; as Connolly et al. note: The "level of affordability is an important driver of utilization, treatment choices, embryo transfer practices and ultimately multiple birth rates" (601). The risks in terms of the lack of safety standards become clear. Multiple pregnancies resulting from treatment abroad are both high risk and high cost, which has consequences both for pregnant mother and fetuses. Second, the home state may be rendered vulnerable in that the costs will be borne by its health care system as the pregnancy proceeds. University College London Hospital, for example, has seen an increase in high-order multiple pregnancies from treatment abroad (Shenfield).

Third, gamete donation may be required to achieve pregnancy. This factor in itself may be a motivator for travel when anonymous donation is unlawful in home states and in short supply, as is the case in the UK. While UK regulation recognizes the principle of biological truth—that is, for a child to know its genetic origins—an exception is made when a citizen chooses to travel abroad for treatment. In the absence of any sanctions for using anonymous gametes abroad, the law is complicit in the privileging of the rich's ability to circumvent national rules, resulting in the vulnerability of the resulting child. Egg donors are vulnerable in terms of the health risks of donation itself and potential ovary overstimulation to maximize profit. Nahman discusses "reverse traffic repro-migration," a practice in which clinics retrieve eggs and import them to their own country to save women travel, in which she suggests "tissues/embryos/eggs and recipients are prioritized over the well-being of the oocyte seller herself," perhaps more than in other forms of CBRS (33 11). The market for egg donation can thus be criticized for turning "some women into available resources and others into consuming bodies" (Nahman 33, a differential exacerbated by inequalities between differently situated women in the global market. Whilst some trajectories for CBRS are relatively localized—such as within Europe, where there are established trajectories between similarly situated economies (Shenfield)[4]—there is a constant direction of reproductive traffic from poor to rich, from global South to global North. The intersection between developed and developing countries in the global market, and the potential exploitation of the economically vulnerable and disempowered women, raise particular concerns for a vulnerability analysis. Even a brief perusal of websites offering egg donation across the world reveals the immense price differential—of tens of thousands of dollars—for eggs between the global South and global North. The vulnerability analysis must address the invisibility of women donors and the commodification of their reproductive material both generally and particularly at the juncture of South and North, ensuring that these global donors develop visibility. These donors must be accounted for by states as part of ethical legislative behavior in their own regulation of ART.

Where pregnancy is achieved abroad, and the pregnant mother is the intended social mother, the law is relatively unproblematic in regulating the issue of birth mother parentage. It is not, however, averse to stepping in in an attempt to enforce its national moral perspectives retrospectively in relation to surrogacy outcomes.[5] For those unable to realize a pregnancy, surrogacy may be the only answer, and

[4] For example, the trajectory is from Italy to Spain for egg donation, and from France to Belgium for sperm donation (Shenfield 1366).

[5] For example, in the French cases of *Mennesson v. France* and *Labassee v. France,* France refused birth certificates to children born in the US. The European Court of Human Rights found that France had breached the children's human rights (Jackson 905; Brooks).

it is heavily restricted in many developed countries either by law or by cost. Generally, where it is permissible, such as in the US, it remains an opportunity only for the very rich, with costs estimated to be over £100,000 (Horsey). International surrogacy becomes normalized, endorsed, and perhaps even glamourized through utilization by celebrities such as Elton John, who used a surrogate in California. The attraction of developing countries such as India or the Ukraine for cheap surrogacy is therefore predictable and potentially illustrative of how "the poorest peoples and nations of the earth are forced disproportionately to bear the deepening social costs of capitalism" (Grear 9). Surrogacy arrangements are often brokered by agencies or clinics for high fees (of which the surrogate is likely to receive only a small part) and surrogacy is predominantly gestational. Because the commissioning parents are likely to be significantly more financially resilient and advantaged than the surrogate, regardless of their respective socioeconomic statuses at home, the specter of abuse and inequality of bargaining power is always looming. Much disquiet has been expressed about the exploitation of women who are structurally and socioeconomically disadvantaged in developing countries and who, for example, indicate that hunger motivates their participation in egg donation, surrogacy, and similar types of "work" (Pande 161). It is notable that as the ethical issues play out in reality, developing country surrogacy "hotspots" have begun to wind down or terminate their access to foreigners, but this simply shifts trajectories, with the same issues, as new markets open their doors (Horsey).

Can free choice ever genuinely be said to operate in such contexts? Some facts are inexorable, such as high levels of poverty and that surrogacy and egg donation in the host countries are often highly stigmatized. Ironically, part of the appeal for clients is exactly that surveillance and loss of autonomy under which poor foreign surrogates can be held during pregnancy, as demonstrated in the documentary *Google Baby* (Franz): Indian surrogates are shown living communally, lined up close to one another, provoking an image of battery baby farming, family and existing children left behind. Such surveillance is abhorrent to the basic notions of autonomy and dignity enjoyed in the developed world. Further concerns are raised about illiteracy, lack of bargaining power, and lack of (the Westernized concept of) informed consent. In the case of *AB v. CT,* for example, the legal agreement was *signed* by the surrogate's thumbprint, raising questions about whether the surrogate could ever have understood or been made to understand what was a complex contract. While on the one hand some authors document illiteracy (Pande), others report some surrogates as both literate and questioning (Deomampo); however, even literate women have no bargaining power and are fearful of jeopardizing their surrogacy contracts by asking questions of doctors and lawyers. Further, while the women are paid and this payment may allow them to purchase education or commodities otherwise out of reach, such as a home, the surrogacy market does not better the conditions of women, their reproductive heath, and their communities (Mohapatra).

In addition to the vulnerability of the bio-available women, surrogacy creates issues for the children who become entangled in its web of consequences. The situating of Indian surrogates out of sight and away from their families during their socially unacceptable and subversive othered pregnancies means that any existing children of the surrogate are likely to be deprived of mothering while their mother *mothers* for another. The law's operation can leave the children born through surrogacy vulnerable. The law may render children stateless and legally parentless because of conflict of laws, where neither of the relevant jurisdictions recognizes the commissioning couple or the surrogate as the legal parents (such as in *Re X and Y*). In one recent case, twins were unable to leave India for over a year (*Re Z* in 2015) due to immigration issues. Some states have refused to recognize surrogate-born

children: Germany, in the case of twins born to German *parents* in *Balaz v. Anand* 2009 (Crockin); and the European Court of Human Rights, to protect the Article 8 rights of surrogate born children refused citizenship by France (see European Court of Human Rights; Brooks). Children may remain uncollected with agreements unenforceable at law, as in the case of baby Gammy (mentioned at the beginning of this essay), while some children may be taken from their parents, who are retrospectively deemed unsuitable by the state (Margaria and Sheldon). Legal reforms in India have sought to ban foreign and commercial surrogacy, although the exact legal status of such reform attempts is not clear (*Indian Express,* "New Surrogacy Bill"). Such unilateral revocation of surrogacy is problematic when arrangements are already in course: For example, one British couple was told to leave their surrogate-born baby in an orphanage (Patel), and two US couples had to begin legal action to reclaim embryos stored in India (Taylor). Such responses of the host state, perhaps somewhat ironically, expose the vulnerability of the fertility tourist.

States reveal themselves unresponsive to the vulnerabilities of their own citizens and their children born through surrogacy. Western inequality in provision and the unresponsive, unethical developed nation-state, combined with corporeal vulnerability, create and perpetuate various trajectories of exploitation and commodification of all those involved in CBRS in the name of the free neoliberal global market, to the detriment of human populations predominantly in the global South.

Conclusion

The law's role in ART and surrogacy provision, as a domestic regulator, as a driver to transnational markets, and as a *fixer* of cross-border outcomes, needs careful examination. While the UK's local provision is seemingly progressive and inclusive, a focus on vulnerability's reconstruction of the politico-legal subject as vulnerable reveals the UK state is unresponsive and unethical in its approach. Genuine equality is mythical and illusory, and privilege and disadvantage abound, from which the embodied vulnerability of the global, socioeconomically disadvantaged is readily forseeable.

A more substantive vision of equality, as demanded by Fineman, can only be achieved by moving beyond autonomy—and beyond mere formal equality—to include an examination of the realities and vulnerabilities created by ART and surrogacy regulation and policy on a global scale. Vulnerability therefore requires us not only to demand the elimination of inequality, privilege, and disadvantage created by our own state's local provision, but also to call upon states to be responsive to globalized structural inequalities and to demand accountability for the vulnerabilities created externally by their own domestic legislation. Vulnerability facilitates the search for a more just and equal global social order, and while vulnerability might not give us ready solutions to the ethics of ARTs, it can be used to argue for fertility justice in the forms of global standards, ethics, and regulation in recognition of our universal embodied vulnerability.

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