

University of Minnesota Law School Scholarship Repository

Minnesota Journal of International Law

2016

Setting Norms: Protections for Surrogates in International Commercial Surrogacy

Xinran “Cara” Tang

Follow this and additional works at: <https://scholarship.law.umn.edu/mjil>

 Part of the [Law Commons](#)

Recommended Citation

Tang, Xinran “Cara”, "Setting Norms: Protections for Surrogates in International Commercial Surrogacy" (2016). *Minnesota Journal of International Law*. 305.

<https://scholarship.law.umn.edu/mjil/305>

This Article is brought to you for free and open access by the University of Minnesota Law School. It has been accepted for inclusion in Minnesota Journal of International Law collection by an authorized administrator of the Scholarship Repository. For more information, please contact lenzx009@umn.edu.

Note

Setting Norms: Protections for Surrogates in International Commercial Surrogacy

Xinran “Cara” Tang*

I. INTRODUCTION

Surrogacy is the “process of carrying and delivering a child for another person.”¹ The first baby born through in-vitro fertilization (IVF) occurred in England in the mid-1970s, and shortly thereafter, surrogacy began in the United States.² Three decades later, this form of reproduction has become a popular solution for infertile couples or individuals,³ and has grown into a thriving global industry.⁴

In the international surrogacy market, infertile parents from the United States, Canada, Australia, and other countries choose to obtain surrogacy abroad, motivated either by substantially lower expenses, or by favorable, pro-parent regulations in these countries.⁵ Surrogates in these countries

* Juris Doctor Student, 2016, University of Minnesota Law School; LL.B., Renmin University of China.

1. *Surrogacy*, BLACK’S LAW DICTIONARY (9th ed. 2009).

2. Tamar Lewin, *Coming to U.S. for Baby, and Womb to Carry It: Foreign Couples Heading to America for Surrogate Pregnancies*, N.Y. TIMES (July 5, 2014), http://www.nytimes.com/2014/07/06/us/foreign-couples-heading-to-america-for-surrogate-pregnancies.html?_r=0.

3. See Mark Hansen, *As Surrogacy Becomes More Popular, Legal Problems Proliferate*, A.B.A. J. (Mar. 1, 2011), http://www.abajournal.com/magazine/article/as_surrogacy_becomes_more_popular_legal_problems_prolife_rate.

4. Usha Rengachary Smerdon, *Crossing Bodies, Crossing Borders: International Surrogacy Between the United States and India*, 39 CUMB. L. REV. 15, 15 (2008).

5. Hague Conf. on Private International Law *Study of Legal Parentage and the Issues Arising from International Surrogacy Arrangements*, ¶ 130, Prel. Doc. No. 3C (Mar. 2014) [hereinafter *The Study*].

generally come from low-income families and face risks of exploitation, physical and physiological harm, and loss of autonomy.⁶ However, in the case of destination countries, little international regulation or domestic legislation exists to address these concerns.⁷

Part II of this Note summarizes potential harms in the international surrogacy market and offers suggestions for improving the human rights standing of surrogates. Part III provides an overview of the international surrogacy landscape and reasons for its growing popularity. Part IV discusses potential risks for surrogates in international commercial surrogacy arrangements, based on their limited protection in the current legal system. Finally, Part V examines possible legal protections for surrogates' basic rights, finding that international conventions and domestic legislation is desirable. Understanding the time-consuming process of forming a new international convention, this Note suggests that international legal actors must set up a non-governmental organization that can establish legal surrogacy norms and enforce these standards by certifying clinics.

II. BACKGROUND

A. THE LANDSCAPE OF INTERNATIONAL COMMERCIAL SURROGACY MARKET

Surrogacy is the process of carrying a child to term for another person.⁸ While more common in the last few decades, this practice is not as recent as modern reproductive technologies, and dates back to Biblical times.⁹ Generally, there are two types of surrogacy: traditional, where the surrogate's egg is fertilized with the intended father's sperm, so the mother is genetically related to the child; and gestational, where an embryo is created through IVF and implanted in the surrogate's

6. *E.g.*, Smerdon, *supra* note 4, at 44–57; Seema Mohapatra, *Stateless Babies & Adoption Scams: A Bioethical Analysis of International Commercial Surrogacy*, 30 BERKELEY J. INT'L L. 412, 441–43, 445–46 (2012).

7. The Study, *supra* note 5, ¶¶ 109–114, 193 (discussing general human rights conventions that do not apply to international surrogacy).

8. JUDITH DAAR, REPRODUCTIVE TECHNOLOGIES AND THE LAW 404 (2d ed. 2013).

9. *See id.* at 408 (referring to a Biblical story in which a childless Sarah offers her handmaid, Hagar, to Abraham hoping that “I may obtain children by her”).

womb.¹⁰ In gestational surrogacy, the embryo is created from the gametes of the intended parents or those of donors.¹¹ Intended parents may prefer gestational surrogacy instead of the traditional method due to the lack of genetic ties between the child and the surrogate—regardless of increased expenses—and thereby reducing the likelihood of the surrogate changing her mind and exercising custodial claims over the child.¹²

Surrogacy can also be characterized as altruistic or profit-based depending on the surrogate's compensation.¹³ For altruistic surrogacy, the intended parents tend to seek help from their friends, relatives, or volunteers via the internet to serve as surrogates, and cover only expenses related to surrogacy.¹⁴ Conversely, in for-profit surrogacy, the surrogate mother profits from the arrangement.¹⁵ In an international context, for-profit and gestational surrogacy are by far the most common arrangement¹⁶ and will be the focus of this Note.

This market has expanded tremendously during the last twenty years. In the United States, there are approximately two hundred IVF clinics, which generally serve affluent couples from Europe, Asia, and Australia.¹⁷ These couples may choose surrogates in India, Thailand, Ukraine, Mexico, and other countries.¹⁸ Particularly in India, no definite numbers exist, but the Indian Council of Medical Research, estimates “about 200 clinics in 2002,” and “today have identified over 1100 IVF clinics from public sources . . . This number is increasing every day.”¹⁹

10. Tina Lin, *Born Lost: Stateless Children in International Surrogacy Arrangements*, 21 *CARDOZO J. INT'L & COMP. L.* 545, 550 (2013).

11. *Id.*

12. Radhika Rao, *Hierarchies of Discrimination in Baby Making*, 88 *IND. L.J.* 1217, 1221 (2013).

13. DAAR, *supra* note 8, at 408.

14. *Id.*

15. *Fact Sheet: International Surrogacy Arrangements*, AUSTL. DEP'T OF IMMIGR. & BORDER PROTECTION, <http://www.border.gov.au/about/corporate/information/fact-sheets/36a-surrogacy> (last visited Jan. 3, 2016). However, the line between altruism and profit is not always clear. Some states, such as New York, do not recognize commercial surrogacy. In these cases, parents hire directly a surrogate over the internet and pay fees, some of which are characterized as reimbursement for expenses, discomfort, inconvenience, etc. *Id.*

16. The Study, *supra* note 5, ¶ 135.

17. Lewin, *supra* note 2.

18. *Id.*

19. See Alope Tikku, *ICMR Has Not Delayed Surrogacy Law: RS Sharma*, *HINDUSTAN TIMES* (Mar. 25, 2013), <http://www.hindustantimes.com/india/icmr-has-not-delayed-surrogacy-law-rs-sharma/story->

In fact, the surrogacy industry in India was reported to be worth more than \$400 million in 2008.²⁰ A whole range of professionals—infertility specialists, psychologists, lawyers, middlemen—has developed, all of whom profit greatly from this business.²¹

B. A BLOOMING INDUSTRY

The journey of seeking surrogacy may be motivated by one of two reasons. For infertile couples or individuals and gay partners,²² surrogacy may be the only way for them to procreate a genetically related child. A second reason is the complexity or inaccessibility of adoption.²³

To understand the foundations of the international surrogacy market, the different regulations that exist in each country should be considered. States generally fall into four categories: (1) countries that prohibit surrogacy arrangements; (2) states that surrogacy is largely unregulated; (3) states that expressly permit and regulate surrogacy; and (4) states that have a permissive approach to surrogacy, including commercialism.²⁴

According to the Preliminary Report on the Issues Arising from International Surrogacy Arrangements (Hague Report),

ym0EnOfXu8qJk15tsBzPbN.html.

20. Smerdon, *supra* note 4, at 24. The exact number varies among different sources.

21. *E.g.*, Nilanjana S. Roy, *Protecting the Rights of Surrogate Mothers in India*, N.Y. TIMES (Oct. 4, 2011), http://www.nytimes.com/2011/10/05/world/asia/05iht-letter05.html?_r=1&.

22. Jim Hill, *Gay Couples Use Surrogates to Help Grow Families*, CNN NEWS, Aug. 2, 1998, <http://www.cnn.com/US/9808/02/gay.surrogacy/>.

23. *See* Jo Daugherty Bailey, *Expectations of the Consequences of New International Adoption Policy in the U.S.*, 36 J. SOC. & SOC. WELFARE 169, 172 (2009) (stating “primary providers must carry \$1 million per aggregate of liability insurance”); Bruce Hale, *Regulation of International Surrogacy Arrangements: Do We Regulate the Market, or Fix the Real Problems?* 36 SUFFOLK TRANSNAT'L L. REV. 501, 505 (2013) (explaining that it normally takes two to three years to complete a process of international adoption, and in certain situations, the process may last for eight years); John Tobin & Ruth McNair, *Public International Law and the Regulation of Private Spaces: Does the Convention on the Rights of the Child Impose an Obligation on States to Allow Gay and Lesbian Couples to Adopt?* 23 INT'L J.L., POL'Y & FAMILY 110, 110 (2009).

24. Hague Conf. on Private International Law: *A Preliminary Report on the Issues Arising from International Surrogacy Arrangements*, Prel. Doc. No. 10, at 9–17, (Mar. 2012) [hereinafter *The Report*].

the first approach is based on a policy perspective that the agreement is a violation of human dignity, where a whole person is reduced to stable and disposable parts in the “supermarket of reproductive alternatives.”²⁵

The nations in the second group do not have express prohibitions in law concerning surrogacy arrangements in general, but such contracts are usually void and unenforceable, e.g., the obligation of the surrogate to surrender the children to the intending parents following the birth.²⁶ Moreover, commercial surrogacy may be prohibited while altruistic arrangements are usually left to standards set by individual clinics.²⁷

States in the third group expressly permit certain forms of surrogacy arrangements for eligible persons and make specific provisions for the legal parentage of a child born as a result of an agreement, while denying the access to surrogacy for ineligible groups.²⁸ For example, under the Israeli Embryo Carrying Agreement Act, surrogacy is available only to couples composed of a man and a woman and the sperm must be from the intended father.²⁹

States in the fourth category normally allow commercial surrogacy following a surrogacy contract, provide procedures that enable legal parentage to be granted to one or both of the intended parent(s), and set no domicile or habitual residence requirement for the intended parents.³⁰ The diverging legal regulations listed *supra* partly explain one reason for the blooming international surrogacy market. Intended parents from a country prohibiting surrogacy or strictly regulating it may participate in forum shopping and select countries with few

25. *See id.* at 9. *See also id.* at 9 n.40 (observing that nations which appear to be in this category include: France, Germany, Italy, Mexico, Sweden, Switzerland, the United States (e.g., Arizona and D.C.), and China).

26. *Id.* at 10.

27. *See id.* at 10–11. *See also id.* at 10 n.51 (including Argentina, Australia, Belgium, Canada, Japan, Ireland, Netherlands, and the United States of America (e.g., New York, Michigan)).

28. *See id.* at 12. *See also id.* at 12 n.59 (placing Australia, Canada, Hong Kong, Greece, Israel, South Africa, United Kingdom, and New Zealand in the third category).

29. Sharon Shakargy, *Israel*, in INTERNATIONAL SURROGACY ARRANGEMENTS: LEGAL REGULATION AT THE INTERNATIONAL LEVEL 231, 235 (Katarina Trimmings & Paul Beaumont eds., 2013).

30. *See* The Report, *supra* note 24, at 16. *See also id.* at 16 n.98 (Georgia, India, Thailand, Uganda, Ukraine, and the United States (e.g., California, Maryland, and Massachusetts)).

regulations or jurisdictions more friendly to intended parents.

However, the reasons that countries such as India, Thailand, and Ukraine serve as hubs for international surrogacy are deeper than merely being hospitable to intended parents. If legal complexity was the only concern, citizens of the United States could seek surrogacy in friendly states like California instead of traveling thousands of miles to India. Notably, the living and medical cost in these countries is considerably lower than developed countries.³¹ For example, surrogacy in the United States will generally cost over \$100,000.³² Couples can expect to pay surrogates \$20,000 to 30,000, egg donors \$5,000 to 10,000, fertility clinics \$30,000, while the surrogacy agency can be paid as much as \$20,000 and lawyers \$10,000.³³ In contrast, having a child through a surrogate in Ukraine costs between \$30,000 and \$45,000 for foreign parents, with \$10,000 to \$15,000 going to the surrogate.³⁴ This monetary difference provides a large incentive for infertile parents to search for surrogacy abroad.

It is also worth mentioning that India's marketing of medical tourism contributed to the flourishing of the country's surrogacy market as well.³⁵ India's effort to promote medical tourism took off in late 2002 when the Confederation of Indian Industry produced a study showing that the country's medical sector had immense potential.³⁶ The following year, India's finance minister called for the country to become a "global health destination."³⁷ After years of effort to improve infrastructure and a concerted focus to issue more medical visas, India remains a very attractive destination for many parents due to the existence of surrogacy clinics with skilled infertility practitioners and advanced infrastructure.³⁸

In addition, the large population base, limited employment opportunities for poor women, and huge financial incentives

31. Mohapatra, *supra* note 6, at 438.

32. Lewin, *supra* note 2.

33. *Id.*

34. Seema Mohapatra, *Achieving Reproductive Justice in the International Surrogacy Market*, 21 ANNALS OF HEALTH L. 191, 195 (2012).

35. Rupa Chinai & Rahul Goswami, *Medical Visas Mark Growth of Indian Medical Tourism*, 85 BULL. WORLD HEALTH ORG. 164, 164 (2007), <http://www.who.int/bulletin/volumes/85/3/07-010307/en/>.

36. *Id.*

37. *Id.*

38. See Jeffrey Kirby, *Transnational Gestational Surrogacy: Does It Have to Be Exploitative?*, 14 AM. J. BIOETHICS 24, 24 (2014).

naturally creates a large pool of women willing to be surrogates.³⁹ India's population is over 1.2 billion people, with seventy percent living on less than two dollars per day,⁴⁰ and a significant infant mortality rate due to limited prenatal care.⁴¹ Moreover, Indian women usually do not use drugs or alcohol, which contributes to their popularity in the international market as well.⁴² A large pool of qualified candidates also helps to save time in matching commissioning parents with a viable surrogate.⁴³ Finally, wide access to the Internet has facilitated many aspects of surrogacy and contributed immensely to the trade's proliferation.⁴⁴

39. See Kristine Schanbacher, *India's Gestational Surrogacy Market: An Exploitation of Poor, Uneducated Women*, 25 HASTINGS WOMEN'S L.J. 201, 211 (2014) ("[F]or some Indian women from the lower socio-economic levels, \$6,000 is equivalent to 15 years of wages [M]ost women who become surrogates have no other meaningful employment opportunities where they can earn a comparable wage."); Holly Williams, *Are Indian Surrogacy Programs Exploiting Impoverished Women?*, CBS NEWS (Apr. 11, 2013), <http://www.cbsnews.com/news/are-indian-surrogacy-programs-exploiting-impoverished-women> (stating "[t]here are so many women who don't want to see their own child dying out of . . . bad health, or not getting educated, not getting two meals a day. So that's why so many women are available"). *E.g.*, MADE IN INDIA (Chicken and Egg Pictures 2011).

40. Zeba Siddiqui, *Exclusive—India Likely to Extend Price Caps to More Drugs: Sources*, FISCAL TIMES (June 23, 2014), <http://www.thefiscaltimes.com/latestnews/2014/06/24/exclusive-india-likely-to-extend-price-caps-to-more-drugs-sources>.

41. See Jayashree Nandi, *More Indian Newborns Die on the First Day Than in Any Other Country*, TIMES INDIA (May 7, 2013), <http://timesofindia.indiatimes.com/india/More-Indian-newborns-die-on-the-first-day-than-in-any-other-country/articleshow/19924488.cms>.

42. See Durgesh Nandan Jha, *IVF Brings Two-Fold Joy to Spanish Businessman*, TIMES INDIA (Jan. 4, 2012), <http://timesofindia.indiatimes.com/city/delhi/IVF-brings-two-fold-joy-to-Spanish-businessman/articleshow/11357280.cms> ("There is a huge demand . . . because . . . Indian women are not usually into drugs and alcohol.").

43. *Compare Surrogate Motherhood—Ethical or Commercial*, CTR. FOR SOC. RES. 54, <http://www.womenleadership.in/Csr/SurrogacyReport.pdf> (last visited Oct. 14, 2015) (stating that commissioning parents were typically paired with a surrogate in one to three weeks in India), *with Working with a Surrogate*, FAMILIES THROUGH SURROGACY, <http://famielsthrusurrogacy.com/working-with-a-surrogate> (last visited Oct. 17, 2015) (noting that typical match time between commissioning parents and surrogates in the United States is between one to eight months).

44. See J. Brad Reich & Dawn Swink, *Outsourcing Human Reproduction: Embryos & Surrogacy Services in the Cyberprocreation Era*, 14 J. HEALTH CARE & POL'Y 241, 241 (2011) (explaining that the Internet provides many more possibilities for conception than traditional male-female intercourse).

III. RISKS FOR SURROGATES IN INTERNATIONAL COMMERCIAL SURROGACY MARKET: AN INDIAN CASE STUDY

This section discusses the risk for surrogates in the international surrogacy market, with particular focus on India as a case study. Existing literature has examined the risk or harm for international commercial surrogates from feminist,⁴⁵ bioethics,⁴⁶ and race and inequality perspectives.⁴⁷

A. THREAT OF EXPLOITATION

Some scholars deem international commercial surrogacy to be a “form of slavery or prostitution in which the surrogate is exploited through the enticements of money, the social expectation of self-sacrifice, or both”⁴⁸—though the understanding of exploitation may differ from person to person.⁴⁹

It is common for surrogates to be women from low-income groups with limited education and resources.⁵⁰ Scholars share concern that the choice of being a surrogate for these women is not freely made but stems from some sort of socially and economically constructed oppression.⁵¹ Surrogates may be coerced by poverty or by their husband’s control over their bodies. The husband’s control, particularly over a woman’s reproductive capacities, may dictate her choice, and from the feminist perspective, these are some of the main factors in the domination and oppression of women.⁵² The societal value of female child-bearing may be another source of oppression.⁵³ Girls in India are socialized to be obedient, self-sacrificing, show

45. See, e.g., Mohapatra, *supra* note 34, at 197–98.

46. See, e.g., Darryl Macer, Editorial, *Ethical Conditions for Transnational Gestational Surrogacy in Asia*, 14 AM J. BIOETHICS 1, 2 (2014).

47. See, e.g., FRANCE WINDDANCE TWINE, *OUTSOURCING THE WOMB: RACE, CLASS AND GESTATIONAL SURROGACY IN A GLOBAL MARKET* 32–36 (2011) (finding that “skin color . . . is a form of symbolic capital that has exchange value”) (alteration in original).

48. Katherine B. Lieber, *Selling the Womb: Can the Feminist Critique of Surrogacy Be Answered?*, 68 IND. L.J. 205, 211 (1992).

49. See Kirby, *supra* note 38, at 25–26.

50. See *Surrogate Motherhood*, *supra* note 43, at 38, 78.

51. See Lieber, *supra* note 48, at 205–06.

52. *Id.* at 211.

53. See *id.* at 215.

self-restraint, and to contribute to family harmony.⁵⁴ In this way, surrogates from countries with limited economic mobility and significant disparities between rich and poor, like India, may actually have no choice at all.⁵⁵

Commissioning parties are typically from developed or rich countries, are educated and fully employed.⁵⁶ Affluent women do not usually act as surrogates in any country.⁵⁷ This drastic contrast raises concerns that surrogacy will occur for the benefit of the rich at the expense of poorer women. Also, just as medical tourism raises concerns for enlarged disparities between urban and rural areas,⁵⁸ reproductive tourism also raises concerns that “Western dominated institutions champion market supremacy and privatized national economies, diminishing access to social benefits for women, children, and other disadvantaged groups.”⁵⁹

Many feminists also fear that surrogates will be turned into a class of breeders and that a “reproductive brothel” will emerge.⁶⁰ Surrogates face the danger of being degraded as commodities at the lower end of the profit chain.⁶¹ “Surrogacy estranges surrogate women from their embodied reproductive selves and alienates them from the ‘live products’ of their reproductive labor.”⁶² Further, “[A] person’s wholeness [is] reduced to saleable and disposable bits and pieces.”⁶³ As a result of the above-mentioned circumstances, surrogates may face

54. See SUSAN C. SEYMOUR, *WOMEN, FAMILY, AND CHILD CARE IN INDIA: A WORLD IN TRANSITION* 55 (1999).

55. See Pamela Laufer-Ukeles, *Mothering for Money: Regulating Commercial Intimacy*, 88 IND. L.J. 1223, 1271–72 (2013).

56. See *Surrogate Motherhood*, *supra* note 43, at 73; Kirby, *supra* note 38, at 24.

57. See Lewin, *supra* note 2.

58. Sunta Reddy & Imrana Qadeer, *Medical Tourism in India: Progress or Predicament?*, 45 ECON. & POL. WKLY. 69, 69 (2010).

59. Anne Donchin, *Reproductive Tourism and the Quest for Global Gender Justice*, 24 BIOETHICS 323, 325 (2010).

60. Lieber, *supra* note 48, at 213 (quoting Gena Corea, *The Reproductive Brothel*, in *MAN-MADE WOMEN: HOW NEW REPRODUCTIVE TECHNOLOGIES AFFECT WOMEN* 38, 39 (Gena Corea et al. eds., 1987)).

61. See *Surrogate Motherhood*, *supra* note 43, at 75–76 (mentioning that clinics often retain a big share of the money paid by commissioning parents, while only one percent is given to the surrogate).

62. Kirby, *supra* note 38, at 25.

63. Maria Mies, *From the Individual to the Dividual: In the Supermarket of “Reproductive Alternatives”*, 1 REPRODUCTIVE & GENETIC ENGINEERING: J. INT’L FEMINIST ANALYSIS 1, 1 (1988).

considerable risk of exploitation.⁶⁴

B. LACK OF CONSENT

Unlike surrogates in the United States, child-bearers in developing countries may experience a lack of informed consent. As mentioned *supra*, surrogates in India often have limited education and some are illiterate.⁶⁵ Without assistance from legal or medical professionals, surrogates often do not know what they are signing.⁶⁶ They are often given no explanation before they sign a contract, and receive no copy of the contract to bring home.⁶⁷ Many surrogates even thought that it would be necessary to sleep with another man in order to conceive, evidencing general ignorance about what the procedure entails.⁶⁸

Surrogates are likely attracted to the extremely high compensation compared to normal employment, which may constitute a form of economic compulsion.⁶⁹ When a woman's need for money is so acute, and when so many people compete to be surrogates,⁷⁰ their bargaining power is reduced. Moreover, agencies who arrange the surrogacy and provide the contract are sometimes vague about the specific terms, and consequently,

64. See, e.g., Schanbacher, *supra* note 39, at 204–20. See also Elizabeth S. Scott, *Surrogacy and the Politics of Commodification*, 72 L. & CONTEMP. PROBS. 109, 137–44 (2009).

65. See Amrita Pande, “At Least I Am Not Sleeping with Anyone”: Resisting the Stigma of Commercial Surrogacy in India, 36 FEMINIST STUD. 292, 297 (2010); *Surrogate Motherhood*, *supra* note 43, at 43; Laufer-Ukeles, *supra* note 55, at 1272.

66. See Amana Fontanella-Khan, *India, the Rent-a-Womb Capital of the World: The Country's Booming Market for Surrogacy*, SLATE (Aug. 23, 2010, 7:03 AM), http://www.slate.com/articles/double_x/doublex/2010/08/india_the_rentawomb_capital_of_the_world.html. See also *Surrogate Motherhood*, *supra* note 43, at 43.

67. See *Surrogate Motherhood*, *supra* note 43, at 43; Malene Tanderup et al., *Informed Consent in Medical Decision-Making in Commercial Gestational Surrogacy: A Mixed Methods Study in New Delhi, India*, 94 ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA 465, 468 (2015) (reporting that in this study, “none of the S[urrogate] M[other]s was able to explain how many embryos had been transferred, or the possible complications”) (alteration in original).

68. Fontanella-Khan, *supra* note 66.

69. See Schanbacher, *supra* note 39, at 213–14. See also Kirby, *supra* note 38, at 29 (explaining that “escalated financial inducement” may be a coercive factor in Indian surrogacy arrangements).

70. See Williams, *supra* note 39 (“[T]here is a long line of women who want to be surrogates. They are put through medical tests and many are turned away.”).

surrogates are often not paid the full amount promised.⁷¹ Surrogates may not also know or understand how much they will be paid if a pregnancy is terminated due to health concerns or if the surrogate gives birth to twins or triplets.⁷²

There are also arguments that women cannot give informed consent until they have the experience of giving birth. Because of the hormonal changes that occur during pregnancy, not experiencing such changes could interfere with proper decision-making.⁷³ However, surrogates who have had at least one successful delivery would not be able to use this argument. Further, this argument might not be compatible with principles in other legal areas.⁷⁴

C. POTENTIAL PHYSICAL AND MENTAL HARMS

The surrogacy process involves heavy medical intervention, weeks of preparation, and nine months of pregnancy.⁷⁵ Prenatal medical complications may harm surrogates.⁷⁶ Furthermore, some of the more severe physical harms associated with surrogacy-related medical procedures may not have been detected yet. The stigma of being a surrogate and separation from families and children may also cause distress⁷⁷—one of the unique circumstances in international surrogacy.⁷⁸

As mentioned *supra*, surrogacy is accompanied by exposure

71. See *Surrogate Motherhood*, *supra* note 43, at 70, 76. See also The Study, *supra* note 5, ¶ 138.

72. See *Surrogate Motherhood*, *supra* note 43, at 46–47, 60.

73. See Lieber, *supra* note 48, at 216.

74. *Id.* at 219.

75. See James M. Golfarb, *Gestational Carrier: Medical Aspects*, in *THIRD-PARTY REPRODUCTION: A COMPREHENSIVE GUIDE* 61, 63–65 (James M. Golfarb ed., 2014). See also Jonathan W. Knoche, *Health Concerns and Ethical Considerations Regarding International Surrogacy*, 126 *INT'L J. GYNECOLOGY & OBSTETRICS* 183, 184 (2014).

76. See Celia Burrell & Leroy C. Edozien, *Surrogacy in Modern Obstetric Practice*, 19 *SEMINARS IN FETAL & NEONATAL MED.* 272, 276 (2014).

77. See Amrita Pande, *Not an 'Angel,' Not a 'Whore': Surrogates as 'Dirty' Workers in India*, 16 *INDIAN J. GENDER STUD.* 141, 154 (2009).

78. See Susan Imrie & Vasanti Jadva, *The Long-Term Experiences of Surrogates: Relationships and Contact with Surrogacy Families in Genetic and Gestational Surrogacy Arrangements*, 29 *REPRODUCTIVE BIOMEDICINE ONLINE* 424, 425, 428 (2014) (reporting that surrogates in the United Kingdom do not experience psychological health problems as a result of the surrogacy arrangement in the short and long term, and that surrogates in United States have lower levels of anxiety and higher resilience to stress compared with a normative female sample).

to long-acting hormonal adjustment. The surrogate's own ovulatory cycle has to be suppressed, which is done by taking birth-control pills and hormone shots.⁷⁹ Estrogen shots are then given to build the surrogate's uterine lining.⁸⁰ Once the surrogate is impregnated, she must take daily injections of progesterone until her body realizes it is pregnant so it can sustain the pregnancy on its own.⁸¹ It has been reported that "significant side effects" including mood swings, headaches, hormonal imbalances, and drowsiness occur in addition to normal pregnancy-related side effects.⁸²

Physical health concerns extend beyond hormonal intervention. If more than one embryo is implanted, there is an increased possibility of multiple gestation, which increases the risk of miscarriage, preterm births, and cerebral palsy in the infants.⁸³ Moreover, intentionally selective abortion may take place. The commissioning parents may ask that the fetus be aborted because of birth defects or a certain sex.⁸⁴ Significant concerns arise regarding the extent to which commissioning parents can ask for an abortion, at which stage of the pregnancy is an abortion request allowed, and how these issues may alter the compensation for surrogates.⁸⁵ When the time comes to give birth, international surrogacy has a very high use of Cesarean section (C-sections) compared to domestic surrogacy.⁸⁶ C-sections may be risky for surrogates, which is exemplified by incidents such as the one in which several Indian women had babies delivered by C-section but experienced lingering pain that kept them from resuming other work they had done prior, such as housekeeping.⁸⁷

The qualification requirements for surrogacy are weakened in the international market. For example, important medical standards such as age, overall health, previous pregnancies, and past surrogacy do not adequately reflect the viability of any

79. See *Surrogate Motherhood*, *supra* note 43, at 14.

80. *Id.*

81. *Id.*

82. *Id.*

83. Kirby, *supra* note 38, at 28.

84. See *Surrogate Motherhood*, *supra* note 43, at 5.

85. See *id.* at 46–47.

86. See Laufer-Ukeles, *supra* note 55, at 1268.

87. Stephanie M. Lee, *Outsourcing a Life*, SAN FRANCISCO CHRONICLE (2014), <http://www.sfchronicle.com/local/bayarea/item/India-surrogacy-23858.php>.

particular individual.⁸⁸ One commissioning parent reportedly said she was paired with a woman who was only eighteen, had a nine-month-old child of her own, and had uterine cysts removed the day before the embryo transfer.⁸⁹

Despite these issues, Indian surrogates reported that relinquishing the baby and living in secrecy are the two worst parts of being a surrogate.⁹⁰ The psychological risks women face and the potential for regret about relinquishing a child are extremely high.⁹¹ In India, few families support a woman's choice to be a surrogate, so women lie to their relatives or friends.⁹² Husbands may also treat surrogacy as an encroachment on their rights, and even if they consented to surrogacy, they may change their minds later⁹³—encouraging secrecy in order to earn money.⁹⁴

In India, a lack of follow-up treatment is another problem.⁹⁵ Right after a preterm birth or delivery of the baby to the commissioning parents, a surrogate is left on her own and the clinic does not take any responsibility if her family and village do not accept her back. Surrogates may also lose the state medical care they were previously entitled to as a result of the surrogacy.⁹⁶

D. LOSS OF AUTONOMY

Stories abound that Indian surrogates often live in group homes during their pregnancy.⁹⁷ Their daily activities, living schedule, food intake, and prenatal medical treatment are all

88. See Usha Rengachary Smerdon, *India*, in INTERNATIONAL SURROGACY ARRANGEMENTS: LEGAL REGULATION AT THE INTERNATIONAL LEVEL 187, 187 (Katarina Trimmings & Paul Beaumont eds., 2013).

89. Tamar Lewin, *A Surrogacy Agency That Delivered Heartache*, N.Y. TIMES (July 27, 2014), <http://www.nytimes.com/2014/07/28/us/surrogacy-agency-planet-hospital-delivered-heartache.html>.

90. See *Surrogate Motherhood*, *supra* note 43, at 57.

91. See, e.g., Lieber, *supra* note 48, at 215.

92. *Surrogate Motherhood*, *supra* note 43, at 39–40.

93. *Id.* at 5.

94. *Id.* at 29.

95. See *id.* at 76.

96. See Lee, *supra* note 87.

97. See Rina Chandran, *Poverty Makes Surrogates of Indian Women in Gujarat*, REUTERS (Apr. 8, 2009), <http://www.reuters.com/article/2009/04/08/us-india-surrogate-idUSBOM1574520090408>.

closely monitored.⁹⁸ Their contact with their families may be limited, if not cut off.⁹⁹ Some clinics allow children to live with surrogates whereas some permit visits with children and prohibit sexual intercourse with spouses.¹⁰⁰ On one hand, these restrictions are touted as ensuring the health of the fetus, but they also allow the clinics to make sure that surrogates are complying with their contracts. On the other hand, domestic surrogacy in developed countries rarely interferes with surrogates' lives to such an extent.¹⁰¹

Loss of autonomy can even occur after pregnancy. After nine months of disconnection from society, surrogates may face social stigma. Before pregnancy, many surrogates had little education, low to no income, and were not competitive in the employment market. After surrogacy, they likely become even less competitive. Thus, surrogates may develop dependency on making money in this way.

Surrogates also lose the right to claim parentage—often the key issue of the legitimacy of surrogacy. In India, surrogates' legal right to the fetus or child and emotional connection is purposely severed at the beginning, when they are repeatedly told that the child is not theirs. This is a common practice under the Guidelines for Accreditation, Supervision & Regulation of Assisted Reproductive Technology (ART) clinics in India.¹⁰² This certainly is one of the reasons why India has become so attractive for commissioning parents from other countries.

III. POSSIBLE REMEDIES

A. WHY NOT PROHIBIT INTERNATIONAL SURROGACY ENTIRELY?

After reviewing potential harms, the question remains whether to allow an international commercial surrogacy market to exist. An answer in the negative stems from three reasons.

98. See Amrita Pande, *Commercial Surrogacy in India: Manufacturing a Perfect Mother-Worker*, 35 SIGNS: J. WOMEN IN CULTURE & SOC. 969, 981–985 (2010).

99. *Id.*

100. See Alison Bailey, *Reconceiving Surrogacy: Toward a Reproductive Justice, Account of Indian Surrogacy*, 26 HYPATIA 715, 721 (2011).

101. See Laufer-Ukeles, *supra* note 55, at 1267.

102. See INDIAN COUNCIL MED. RES., GUIDELINES FOR ACCREDITATION, SUPERVISION & REGULATION OF ART CLINICS IN INDIA 68 (2005), http://icmr.nic.in/art/Chapter_3.pdf.

First, from a feminist perspective, women should have the right of self-determination as independent economic beings and be allowed to decide whether or not they wish to become surrogates.¹⁰³ Surrogacy may not necessarily be more dangerous than natural biological pregnancies. Surrogate mothers can seek care from clinics, while poor women who are not surrogates may not even have access to prenatal care.¹⁰⁴ Individuals also do other risky things such as fire-fighting based on informed consent.¹⁰⁵ If we treat surrogacy differently and dismiss informed consent, it may reinforce a stereotype that women cannot decide for themselves. Moreover, some scholars also argue that selling labor as a surrogate may not be meaningfully different from other forms of labor.¹⁰⁶

Secondly, there are well-founded fears that an absolute ban on international surrogacy will be unenforceable and create a black market where surrogates would face an even more substantial risk of exploitation.¹⁰⁷ Commissioning parents who yearn to have their genetically-related child can circumvent any *de jure* ban and search for willing surrogates through the Internet. While international regulations may have a beneficial effect on agencies, clinics, or other institutions, they cannot effectively touch the black market, where there is no recourse for the parties involved.

Finally, international surrogacy may provide a mutually beneficial solution for both parties involved, satisfying both the demand of infertile women and the financial need of others—thus creating a relationship of mutual dependency. A traditional Western framework therefore may not always be appropriate in this setting.¹⁰⁸ In some developing countries, compensation for surrogacy may be life-changing. Rather than prey on desperate

103. See Lieber, *supra* note 48, at 225.

104. See Jason Gale & Ketaki Gokhale, *Mother's Death Shows Bribes Buy India Worst G-20 Maternal Care*, BLOOMBERG BUS. (Dec. 21, 2014), <http://www.bloomberg.com/news/articles/2014-12-21/mother-s-death-shows-bribes-buy-india-worst-g-20-maternal-care>.

105. Mies, *supra* note 63, at 5.

106. *Id.* at 7.

107. See Richard A. Posner, *The Ethics and Economics of Enforcing Contracts of Surrogate Motherhood*, in APPLICATION OF FEMINIST LEGAL THEORY TO WOMEN'S LIVES: SEX, VIOLENT, WORK AND REPRODUCTION 1105, 1111 (D. Kelly Weisberg ed., 2009).

108. Some writers criticize the attempted application of Western moral frameworks and the privileging of choice and opportunity in low income surrogacy settings. See, e.g., Kirby, *supra* note 38, at 25.

women,¹⁰⁹ commissioning parties may help surrogates with their “transformation.”¹¹⁰ Surrogates may use compensation earned through surrogacy to pay off debts, buy a house, fund higher education for their children, save their children’s lives by paying for surgery, or develop a family business.¹¹¹ For surrogates, the hope that their children or husband will use the money to build a brighter future may be the driving force that propels them to surrogacy.

However, validity of the transformation argument is debatable. The degree that surrogacy compensation affects or changes a surrogate’s way of living is doubtful, since the money is not enough to build a new house in India or to pay for all college expenses.¹¹² Surrogacy compensation has been used for questionable purposes,¹¹³ but nevertheless, there is no evidence in the available literature to suggest that surrogacy fees are typically used to preferentially benefit the male members of surrogate families.¹¹⁴ Consequently, any international ban of surrogacy is undesirable.

B. DOMESTIC LEGISLATION

As discussed in Part II *supra*, countries generally fall into one of four regulatory approaches regarding surrogacy. The international market in this area places significant challenges on national regulations that forbid or limit surrogacy.¹¹⁵ Regardless of the fact that surrogacy diverges from the essence of their national philosophy,¹¹⁶ parents from Germany, Italy, and France find ways to pursue surrogacy in other nations.¹¹⁷ These countries used to deny citizenship to babies born from

109. *India’s Multimillion-Dollar Surrogacy Industry*, CBS NEWS (Apr. 10, 2013, at 2:20 min.), <http://www.cbsnews.com/videos/indias-multimillion-dollar-surrogacy-industry>.

110. Michele Goodwin, *Reproducing Hierarchy in Commercial Intimacy*, 88 IND. L.J. 1281, 1296 (2013).

111. *Surrogate Motherhood*, *supra* note 43, at 4.

112. India’s college costs vary dramatically. See INT’L COMPARATIVE HIGHER EDUCATION & FINANCE PROJECT, HIGHER EDUCATION FINANCE AND COST-SHARING IN INDIA 4 (2009), http://gse.buffalo.edu/org/IntHigherEdFinance/files/Country_Profiles/Asia/India.pdf.

113. *Surrogate Motherhood*, *supra* note 43, at 48.

114. Kirby, *supra* note 38, at 28.

115. See The Report, *supra* note 24, at 9.

116. See *id.*

117. See Ruby L. Lee, *New Trends in Global Outsourcing of Commercial Surrogacy: A Call for Regulation*, 20 HASTINGS WOMEN’S L.J. 275, 276 (2009).

foreign surrogates.¹¹⁸ This approach has been challenged on human rights grounds, however, since it is a common view that no child should be stateless upon birth.¹¹⁹

In the summer of 2010, eight European countries issued letters demanding that IVF clinics not initiate surrogacy procedures for citizens of those countries until their respective consulate was consulted for permission.¹²⁰ Since surrogacy is a profit-driven industry, these letters provided loopholes that allowed couples to bypass this requirement.¹²¹ In addition, based on the understanding that sovereignty is a community's monopoly on the legitimate use of force,¹²² one country cannot dictate the actions of citizens of another country, further undercutting their effectiveness.

Conversely, countries with welcoming approaches to surrogacy, e.g., India, Ukraine, and Mexico, generally lack surrogacy welfare regulations.¹²³ The United States may be an exception. Some states have established rules, and clinics have more experience dealing with surrogacy-related issues.¹²⁴ The

118. See The Report, *supra* note 24, at 11.

119. See G.A. Res. 44/25, Convention on the Rights of the Child, ¶ 3 (Nov. 20, 1989); Hague Conf. on Private International Law, *The Parentage/Surrogacy Project: An Updating Note*, Prel. Doc. No. 3A, ¶ 5 (Feb. 2015) [hereinafter The Note] (noting *Mennesson v. France* and *Labassess v. France*, in which the European Court of Human Rights held that France's refusal to recognize, or permit the establishment of the legal relationship between children born in the USA violated the European Convention on Human Rights concerning the children's right to respect with regard to their private life).

120. Sumitra Deb Roy, *Bar Our Nationals, European Countries Tell Surrogacy Clinics*, TIMES INDIA (July 14, 2010), <http://timesofindia.indiatimes.com/india/Bar-our-nationals-European-countries-tell-surrogacy-clinics/articleshow/6164949.cms>. The letter, signed by the Consuls General of Belgium, France, Germany, Italy, the Netherlands, Poland, Spain, and the Czech Republic, and sent to the clinics, stressed the importance of directing nationals from their countries to their respective consulates before initiating the surrogacy process. *Id.*

121. *Id.* ("Unfortunately, there are plenty of loopholes that allow clinics, as well nationals, to bypass the law and illegally offer or seek surrogacy. Shah explains: 'If a couple lives in India for two years and gets a child delivered through surrogacy, a DNA test will prove paternity.'")

122. NEWTON KENNETH & JAN W. VAN DETH, FOUNDATIONS OF COMPARATIVE POLITICS: DEMOCRACIES OF THE MODERN WORLD 22 (2d ed. 2005).

123. See generally Helier Cheung, *Surrogate Babies: Where Can You Have Them, and Is It Legal?*, BBC NEWS (Aug. 6, 2014), <http://www.bbc.com/news/world-28679020> (explaining the consequences of having no internationally recognized surrogacy standards).

124. See *Surrogacy in the US*, FAMILIES THROUGH SURROGACY, <http://familiesthrusurrogacy.com/surrogacy-by-country/surrogacy-in-the-us> (last

Indian government has recently attempted to fill this gap through the introduction of the Assisted Reproductive Technology (Regulation) Bill, which has not yet passed.¹²⁵ If the legislation is passed, it will require the husband's consent and reduce the front-loaded payment of most of the surrogacy fees.¹²⁶ Additionally, Thailand has stated that it will enact stricter rules regarding surrogacy after many disturbing scandals.¹²⁷ Vietnam has followed Thailand's lead by passing a bill that allows surrogacy for humanitarian reasons.¹²⁸ However, this legislation largely does not regulate surrogacy agencies, which play a dominant role in recruiting potential child-bearers. The lack of regulations in this area may be caused by the large profits generated by the industry.¹²⁹ Accordingly, domestic legislation from commissioning countries will not greatly alter the lives of surrogates abroad because of human rights restrictions and sovereignty issues, while regulation in countries where children are born has not provided much protection to surrogates either.

C. INTERNATIONAL CONVENTIONS

As discussed *supra*, legislation created by a single country or a few countries may be inadequate to effectively protect the rights of surrogates. Therefore, an international framework may be needed. Since 2010, the Hague Conference on Private International Law has addressed some of the issues surrounding cross-border surrogacy arrangements.¹³⁰ Three reports were submitted by this body in 2011, 2012, and 2014.¹³¹ Among these studies, it is widely held that the cross-border surrogacy situation is comparable to the state of international adoption law in the early 1990s, where concerted action was ultimately taken

visited Sept. 30, 2015).

125. Smerdon, *supra* note 88, at 187.

126. See Kirby, *supra* note 38, at 30.

127. Mengyang Liu, *Grey Area Between the Law and Emotion: International Surrogacy Industry*, CHINA DAILY (Aug. 29, 2014), http://world.chinadaily.com.cn/2014-08/29/content_18513624.htm.

128. *Id.*

129. Pikee Saxena, Archana Mishra & Sonia Malik, *Surrogacy: Ethical and Legal Issues*, 37 INDIAN J. COMMUNITY MED. 211, 212 (2012).

130. See *What is the Permanent Bureau of the Hague Conference?*, HAGUE CONF. ON PRIVATE INT'L L., http://www.hcch.net/index_en.php?act=faq.details&fid=30 (last visited Jan. 3, 2016).

131. HAGUE CONF. ON PRIVATE INT'L L., A PRELIMINARY REPORT ON THE ISSUES ARISING FROM INTERNATIONAL SURROGACY ARRANGEMENTS 1, 3 (2012).

in an attempt to tackle problems caused by inconsistent practices.¹³² The Hague Adoption Convention proved to be a workable model for solving issues concerning international adoption, but debate exists whether international surrogacy should follow that model.¹³³

While an international convention is desirable, it may not sufficiently solve the problem of surrogates' rights. First, there is much more to be done before the convention becomes a reality. It may take years of drafting, ratification, and adoption to implement. For example, the Hague Adoption Convention took over five years to be drafted.¹³⁴ Based on nationality and cultural differences in this area, the drafting of a surrogacy convention could take even longer.¹³⁵ Even signatory countries may not follow all of the provisions.¹³⁶ Furthermore, the United Nations does not always have the ability to enforce every provision.¹³⁷ As a result, non-signatory countries have the potential of becoming new surrogacy hubs.¹³⁸ Finally, the 2014 Hague Study emphasized that legal parentage and the nationality of the child, rather than the rights of surrogates, are the paramount concerns.¹³⁹

132. Erica Davis, *The Rise of Gestational Surrogacy and the Pressing Need for International Regulation*, 21 MINN. J. INT'L L. 120, 129 (2012). See generally Katarina Trimmings & Paul Beaumont, *International Surrogacy Arrangements: An Urgent Need for Legal Regulation at the International Level*, 7 J. PRIVATE INT'L L. 627 (2011) (explaining the issues of cross-border surrogacy, as well as potential frameworks to regulate surrogacy arrangements); Lin, *supra* note 10, at 556 (noting the issues related to nationality with respect to surrogacy).

133. Hale, *supra* note 23, at 501; Hannah Baker, *A Possible Future Instrument on International Surrogacy Arrangements: Are There "Lessons" to be Learnt from the 1993 Hague Intercountry Adoption Convention?*, in INTERNATIONAL SURROGACY ARRANGEMENTS: LEGAL REGULATION AT THE INTERNATIONAL LEVEL 411, 426 (Katarina Trimmings & Paul Beaumont eds., 2013).

134. See Gonzalo Parro-Arranguren, *History, Philosophy and General Structure of the Hague Adoption Convention*, in CHILDREN ON THE MOVE: HOW TO IMPLEMENT THEIR RIGHT TO FAMILY LIFE 63–64 (Jaap Doek, Hans van Loon & Paul Vlaardingerbroek eds., 1996).

135. Casey Humbryd, *Fair Trade International Surrogacy*, 9 DEVELOPING WORLD BIOETHICS 111, 116–18 (2009).

136. See The Study, *supra* note 5, ¶ 59.

137. Davis, *supra* note 132, at 143.

138. Hale, *supra* note 23, at 509.

139. See The Study, *supra* note 5, ¶ 122.

D. REGULATING THE MARKET

It is undeniable that surrogacy represents an economic market.¹⁴⁰ It is also undeniable that non-governmental institutions form part of the infrastructure that currently attempts to regulate surrogacy arrangements.¹⁴¹ These institutions are in the proper position to conduct the experiment of regulating this market, and their role must be increased accordingly. As it has done for thirty years,¹⁴² surrogacy may continue to provoke controversy, and as a result, policymaking by state powers may not be appropriate in such an atmosphere.¹⁴³

Any potential framework of standards could follow that of the Non-GMO Project,¹⁴⁴ where a third-party organization was set up to provide certain labeling for non-GMO food and products that met its standards.¹⁴⁵ The international surrogacy market could also benefit from creating such an organization. A NGO might set standards for surrogacy agencies concerning the treatment of surrogates and classify those clinics that meet the organization's requirements. Parentage issues cannot be addressed in this labeling system—just as the Non-GMO Project does not address whether or not GMO food is allowed in different countries—since these issues are more appropriately dealt with in the legal arena.

A classification approach could provide verified choices to commissioning parents, and promote industry protections for surrogate women. By eliminating some concerns about exploitation, this system could make an agency more appealing to certain customers. Thus, clinics would be encouraged to meet the organization's standards to obtain a favorable rating, which is less time-consuming and more flexible than drafting and enforcing an international convention. The idea of comparing surrogates to Non-GMO products may be disturbing to some. The proposal is not to say that human beings are products, but it is merely a suggestion to use a similar scheme to rate surrogacy agencies in order to provide better protection.

140. See Hale, *supra* note 23, at 502.

141. *Id.* at 517–18.

142. See The Study, *supra* note 5, at 31 n.291.

143. See *id.* ¶ 53.

144. GMO stands for genetically-modified organism.

145. *E.g., About: Everyone Deserves an Informed Choice*, NON-GMO PROJECT <http://www.nongmoproject.org/about> (last visited Dec. 30, 2015).

Hospital-rating systems are a perfect analogy.

The next question concerns which kinds of regulations or standards are appropriate. First, the standard should be appealing to all parties, such as commissioning parents, surrogates, clinics, and the public in general, so that they take them into consideration. It cannot be overly stern or lenient. The standard could be set according to different phases during the surrogacy agreement.

Before signing a surrogacy contract, a screening process for surrogates and commissioning parents should exist. For surrogates, a minimum nationality requirement should exist in order to avoid human trafficking. Mental and medical screening may also be necessary with respect to age, physical and mental health, and the number of healthy pregnancies. Commissioning parents should also be infertile or subject to unreasonable risks from a pregnancy, and surrogacy should be their only option to have a genetically-related child. At least one parent should also be genetically related to the child.¹⁴⁶ To make the best effort to allow the surrogate to make an informed decision, she should be provided with an interpreter other than the doctor, or a social worker to guide her through the process. The husband's consent should not be required.¹⁴⁷

Payment is another important issue. There should be an up-front payment for the surrogate, instead of executing the contract and arranging payments after two months of surrogacy.¹⁴⁸ Some scholars call the "mandated fee structure unrealistic," noting that "details of financial accountability of accredited bodies should be left to domestic regulation."¹⁴⁹ Nevertheless, third-party organizations should arrange a more fixed compensation arrangement to specify the compensation surrogates may receive in case of multiple deliveries or an abortion.

During the pregnancy, a minimum medical treatment standard should be established. Hormone treatments should be

146. Sara L. Ainsworth, *Bearing Children, Bearing Risks: Feminist Leadership for Progressive Regulation of Compensated Surrogacy in the United States*, 89 WASH. L.R. 1077, 1094 (2014) (surrogacy laws in many states of the United States, place a strong emphasis on genetic ties).

147. However, husband's consent should be required if the statute of the governing jurisdiction assumes the surrogate and her husband to be the lawful parents of a child born if the surrogacy contract becomes void, e.g., N.D. CENT. CODE § 14-18-05 (2013).

148. See *Surrogate Motherhood*, *supra* note 43, at 40–42.

149. Trimmings & Beaumont, *supra* note 132, at 644.

administered by registered medical practitioners and applied using the safest and least intrusive pre-pregnancy and early-pregnancy protocols. The number of IVF cycles one woman may undergo as a surrogate should also be limited. Abortion conditions should be mandated, including whether to prohibit fetal reduction and sex-selective abortion. Undue coercion to terminate a pregnancy and harsh penalties for breach of a surrogacy agreement should be prohibited. Clinics should not economically coerce surrogates to continue with an arrangement when she no longer wishes to do so. As for surrogates' mental health issues, clinics should provide 'progressive' surrogacy hostels. Surrogacy agencies could provide courses in English, financial management, and computers to surrogates, making the "transformation" and the pregnancy easier.

After the child is born or the pregnancy is terminated, medical and psychological counseling should continue under specified circumstances. Mandated insurance should last for a certain time from the beginning of the process through a period after birth. Running a clinic requires a certain workforce; therefore, the clinic may hire a percentage of its former surrogates as nurses or brokers.¹⁵⁰ The idea behind this is that the clinic is in the best position, and is highly responsible to provide assistance to the surrogate in her recovery to normal life.¹⁵¹

IV. CONCLUSION

This Note has summarized the potential harms to the surrogates in the international surrogacy market, and advocates important reforms for the protection of surrogates' human rights. First, this work demonstrated that surrogates are vulnerable and lack protection through effective international or domestic legal frameworks. Next, this Note explained that although international agreements and domestic legislation are desirable, these approaches are far from satisfactory. The process of drafting an international convention is time-

150. See Lee, *supra* note 87 (mentioning that some Indian clinics employ former surrogates as short-term nannies and their husbands as security guards).

151. See *Surrogate Motherhood*, *supra* note 43, at 62, 72 (stating that Indian clinics charge an exorbitant amount for the complete package, including fertilization, matching, fee arrangement, delivery of the baby at a hospital, medical procedures, and hotels).

consuming, while domestic regulations face hardship from their inadequate reach and have little, if any effect on surrogates' conditions. Finally, this Note advocates that international organs establish a non-governmental organization that can establish standards for treating surrogates worldwide and enforce the standards by labeling surrogacy clinics that comply with its rules.