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Situating Canada's Commercial Surrogacy Ban in a Transnational Context: A Postcolonial Feminist Call for Legalization and Public Funding

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Article abstract

In large part due to feminist interventions in the early 1990s about the dangers of assisted reproductive technologies (ARTs) for women, Canada banned several practices related to ARTs when it enacted the *Assisted Human Reproduction Act* (*AHRA*) in 2004. Notably, the *AHRA* prohibited commercial surrogacy. Feminists feared that a market in surrogacy would exploit and objectify marginalized Canadian women who would be pressured into renting out their wombs to bear children for privileged couples. Since the early feminist deliberations that led to the ban, surrogacy has globalized. Canadians and other citizens of the Global North routinely travel to the Global South to source gestational surrogates. In doing so, they partake in an industry that heavily depends on material disparities and discursive ideologies of gender, class, and race. Indeed, the transnational nature of surrogacy treatment substantially reshapes the earlier feminist commodification debates informing the *AHRA* that took the domestic sphere as the presumed terrain of contestation. Due to the transnational North-South nature of surrogacy, a postcolonial feminist perspective should guide feminist input on whether to allow commercial surrogacy in Canada. I argue that when this framework is applied to the issue, the resulting analysis favours legalization of commercial surrogacy in Canada as well as public funding for domestic surrogacy services and ancillary ARTs.

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SITUATING CANADA'S COMMERCIAL SURROGACY BAN IN A TRANSNATIONAL CONTEXT: A POSTCOLONIAL FEMINIST CALL FOR LEGALIZATION AND PUBLIC FUNDING

*Maneesha Deckha**

In large part due to feminist interventions in the early 1990s about the dangers of assisted reproductive technologies (ARTs) for women, Canada banned several practices related to ARTs when it enacted the *Assisted Human Reproduction Act* (*AHRA*) in 2004. Notably, the *AHRA* prohibited commercial surrogacy. Feminists feared that a market in surrogacy would exploit and objectify marginalized Canadian women who would be pressured into renting out their wombs to bear children for privileged couples. Since the early feminist deliberations that led to the ban, surrogacy has globalized. Canadians and other citizens of the Global North routinely travel to the Global South to source gestational surrogates. In doing so, they partake in an industry that heavily depends on material disparities and discursive ideologies of gender, class, and race. Indeed, the transnational nature of surrogacy treatment substantially reshapes the earlier feminist commodification debates informing the *AHRA* that took the domestic sphere as the presumed terrain of contestation. Due to the transnational North-South nature of surrogacy, a postcolonial feminist perspective should guide feminist input on whether to allow commercial surrogacy in Canada. I argue that when this framework is applied to the issue, the resulting analysis favours legalization of commercial surrogacy in Canada as well as public funding for domestic surrogacy services and ancillary ARTs.

En 2004, le Canada adoptait la *Loi sur la procréation assistée* (*LPA*), interdisant plusieurs pratiques reliées aux technologies de procréation assistée pour les femmes, et ce, en réaction aux interventions de féministes au début des années 1990 sur les risques de ces technologies. La *LPA* interdit particulièrement la maternité de substitution à visées commerciales. Certaines féministes craignaient que le marché de maternité de substitution ait pour effet d'exploiter et d'objectiver des femmes canadiennes marginalisées, qui pourraient se sentir poussées à louer leurs corps pour porter les enfants de couples privilégiés. La pratique de la maternité de substitution s'est mondialisée depuis les premières discussions féministes ayant mené à sa prohibition. Les Canadiens et d'autres citoyens de pays du Nord visitent régulièrement les pays du Sud à la recherche de mères porteuses. Ce faisant, ils participent à une industrie qui dépend fortement de disparités matérielles et d'idéologies discursives de genre, de classe et de race. En effet, la nature transnationale du traitement de la maternité de substitution reformule substantiellement les premiers débats féministes sur cette marchandisation; ces débats faisaient partie du contexte de la *LPA* et voyaient la sphère domestique comme le terrain de contestation présumé. En raison de la nature transnationale Nord-Sud de la maternité de substitution, une perspective féministe postcoloniale devrait guider l'apport féministe à la question de savoir si le Canada devrait permettre la maternité de substitution à visées commerciales. Nous argumentons que le recours à une telle perspective mène à une conclusion qui prône la légalisation de la maternité de substitution à visées commerciales au Canada ainsi que le financement public de services de maternité de substitution à visées commerciales et de technologies accessoires de procréation assistée.

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Introduction

In 2004, Canada enacted the *Assisted Human Reproduction Act*[1] eleven years after the Royal Commission on New Reproductive Technologies (RCNRT) issued its report about the ethical and legal implications of assisted reproductive technologies (ARTs) in 1993.[2] The *Act*, which started out as the ninth in a series of bills in the area, prohibits and regulates ARTs and arrangements relating to fertility treatments and other scientific research involving human embryos.[3] In large part due to feminist interventions about the dangers of ARTs for women, including the exploitation and objectification feared from markets in reproductive materials and medicine, Canada banned several practices related to ARTs.[4] Notably, payment to individuals for their gametes and commercial surrogacy were prohibited.[5] The legislation favours an altruistic surrogacy model on the grounds that commodification of pregnancy violates human dignity and poses heightened concerns for women whose bodies are heavily invested in ARTs and for children born from these technologies.[6]

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1 *Assisted Human Reproduction Act*, SC 2004, c 2 [*AHRA*].

2 See Canada, *Proceed with Care: Final Report of the Royal Commission on New Reproductive Technologies* (Ottawa: Minister of Government Services Canada, 1993) (Chair: Patricia Baird) [*RCNRT Report*].

3 See Karen Busby & Delaney Vun, "Revisiting *The Handmaid's Tale*: Feminist Theory Meets Empirical Research on Surrogate Mothers" (2010) 26:1 Can J Fam L 13 at 24; Dana Hnatiuk, "Proceeding with Insufficient Care: A Comment on the Susceptibility of the Assisted Human Reproduction Act to Challenge under Section 7 of the Charter" (2007) 65:1 UT Fac L Rev 39 at 40.

4 See Busby & Vun, *supra* note 3 at 24–26; Alana Cattapan, "Risky Business: Surrogacy, Egg Donation, and the Politics of Exploitation" (2014) 29:3 CJLS 361 at 365, 370 [Cattapan, "Risky Business"].

5 *AHRA*, *supra* note 1, ss 6–7. Although the *Act* does not prohibit women from offering to sell surrogacy services, it does prohibit payment or offer of payment to a woman to act as a surrogate, thus precluding any commercial surrogacy arrangement from arising. It is also illegal for anyone to advertise to pay a woman to be a surrogate, or to pay, offer to pay, or to advertise for an intermediary to arrange the surrogacy arrangement; an intermediary is also prohibited from accepting payment to arrange a surrogate (see *ibid*, ss 6(1)–(3)). Provinces and territories have jurisdiction for civil law and property under the Canadian federal system, but in most of them, the law does not clarify whether surrogacy arrangements will be enforced. Only Alberta and Quebec say they are unenforceable or absolutely null (see *Family Law Act*, SA 2003, c F-4.5, s 8.2(8)(a); art 541 CCQ). But this has not stopped courts from adverting to these agreements when declaring parentage and filiation (see Karen Busby, "Of Surrogate Mother Born: Parentage Determinations in Canada and Elsewhere" (2013) 25:2 CJWL 284 at 296 [Busby, "Of Surrogate Mother Born"]; Régine Tremblay, "Surrogates in Quebec: The Good, the Bad, and the Foreigner" (2015) 27:1 CJWL 94 at 103–108).

6 The purpose statements in the *AHRA* connect dignity, health, and well-being with the anti-commodification of women and children (*supra* note 1, ss 2(a)–(c), (f)). See also Busby & Vun, *supra* note 3 at 39.

Although feminist voices were instrumental in shaping the policy recommendations of the RCNRT that eventually culminated in the above-noted prohibitions, other equity-seeking groups disagreed with the dominant feminist position that ARTs or markets in reproductive materials were harmful. Of particular note, queer scholars criticized the altruistic model, fearing that without paying people for their gametes, supplies would dwindle and preclude queer couples and individuals from becoming parents.[7] More recently, some feminists have called for revisiting the *AHRA*'s core anti-commodification approach toward ARTs given changing social mores.[8]

Given very recent constitutional and political developments, however, it is unlikely that a review will materialize. Constitutionally, in the Supreme Court reference on the federal government's ability to regulate medical professionals and clinics providing fertility treatments, significant portions of the *Act* were struck down as *ultra vires* federal powers.[9] Politically, recent defunding of the already inactive regulator in this area leaves the statute without any specialized enforcer.[10] The present lack of

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7 See Angela Cameron, "Regulating the Queer Family: The *Assisted Human Reproduction Act*", Case Comment on *DWH v DJR*, (2008) 24:1 Can J Fam L 101 at 107, 116–18. For additional discussion about the *Act*'s shortcomings vis-à-vis queer communities, see the list of sources in Alana Cattapan, "Rhetoric and Reality: 'Protecting' Women in Canadian Public Policy on Assisted Human Reproduction" (2013) 25:2 CJWL 202 at 206, n 17 [Cattapan, "Rhetoric and Reality"]. Liberal feminists have also disputed the constraints placed on women's reproductive autonomy, noting the benefits that markets in certain reproductive material can bring to women (see Francesca Scala, Éric Montpetit & Isabelle Fortier, "The NAC's Organizational Practices and the Politics of Assisted Reproductive Technologies in Canada" (2005) 38:3 Can J Pol Sci 581 at 592).

8 See Kristin Lozanski, "Transnational Surrogacy: Canada's Contradictions" (2015) 124 Social Science & Medicine 383 at 388–89; Susan G Drummond & Sara R Cohen, "Eloquent (In)action: Enforcement and Prosecutorial Restraint in the Transnational Trade in Human Eggs as Deep Ambivalence about the Law" (2014) 26:2 CJWL 206 at 207.

9 *Reference Re* Assisted Human Reproduction Act, 2010 SCC 61, [2010] 3 SCR 457 [*Reference Re AHRA*]. The Attorney General of Quebec submitted that substantial portions of the *AHRA* constituted attempts to regulate the entire sector of medical research and practice related to assisted reproduction and thus were *ultra vires* the federal government. The Court held that sections 10, 11, 13, 14–18, 40(2), (3), (3.1), (4)–(5), and 44(2)–(3) were *ultra vires* the federal government, partly due to overlapping legislation. Other sections were upheld because, on the whole, while some of the *AHRA* may impinge on provincial matters neither its dominant purpose nor effect was to establish a regime that regulates or promotes the benefits of artificial reproduction.

10 See Anne Kingston, "Assisted Human Reproduction Canada: The Budget Cut Everyone Missed", *Maclean's* (2 April 2012), online: <www.macleans.ca/society/science/assisted-human-reproduction-canada-the-budget-cut-everyone-missed/>. For more on the extent to which the Assisted Human Reproduction Agency of Canada failed to enforce the *Act*, see Cattapan, "Rhetoric and Reality", *supra* note 7 at 217–19; Françoise Baylis & Jocelyn Downie, "The Tale of Assisted Human Reproduction Canada: A Tragedy in Five

political will to secure the enforcement provisions to support the *AHRA*'s prohibitions accentuates the need for critical attention to what the *AHRA* continues to ban. Indeed, given the absence of an expert regulator and the patchwork nature of the revised statute post-reference,[11] the statute and what it attempted to regulate is ripe for a regulatory overhaul.[12] The work Canadian feminists have already begun in recommending law reform in this area should continue apace.[13]

In this regard, some feminists initially opposed to commodification, but now aware of the pressure from reproductive tourism on national regulatory limits, may be ready to rethink the prohibitions in the *AHRA*. The phenomenon of Canadians travelling abroad for fertility treatment needs to be a prominent factor in these deliberations.[14] Though documentation of how many travel is scant, it is reasonable to assume that Canadians are among the global elite who now commonly travel to the Global South to actualize their desires to become parents through the reproductive materials and services that Southern women provide.[15] This phenomenon is acutely the case with gestational commercial surrogacy where scholars

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Acts" (2013) 25:2 CJWL 183 [Baylis & Downie, "The Tale"]. Indeed, only one person has ever been prosecuted under the *Act* (see Drummond & Cohen, *supra* note 8 at 208, n 6).

11 See Baylis & Downie, "The Tale", *supra* note 10 at 194–201.

12 See *ibid* at 184, 201. Also, although the 2012 amendments to the *AHRA* repealed the requirement under the old section 70 that a review be completed every three years, no such review took place between 2007 and 2012 before the amendments took effect.

13 See Rachel Epstein, "The *Assisted Human Reproduction Act* and LGBTQ Communities: A Paper Submitted by the AHRA/LGBTQ Working Group" (2008) [unpublished, archived at Shelbourne Health Centre]. I am also aware of two national feminist consultations about the statute held by the National Association of Women and the Law and the University of Manitoba Centre for Human Rights Research.

14 Scholars outside of Canada have emphasized the need for feminists to attend to the international pressures and resulting exploitative relations that restrictive domestic fertility laws can create (see Jyotsna Agnihotri Gupta, "Reproductive Biocrossings: Indian Egg Donors and Surrogates in the Globalized Fertility Market" (2012) 5:1 Intl J Feminist Approaches to Bioethics 25 at 31 [Gupta, "Reproductive Biocrossings"]; Jenni Millbank, "Rethinking 'Commercial' Surrogacy in Australia" (2015) 12:3 J Bioethical Inquiry 477 at 478 [Millbank, "Rethinking"]; Richard F Storrow, "Quests for Conception: Fertility Tourists, Globalization and Feminist Legal Theory" (2005) 57:2 Hastings LJ 295 at 295–96 [Storrow, "Quests for Conception"]). To my knowledge, only one legal feminist in Canada has called for the review of the *AHRA*'s ban on commercial surrogacy due to global considerations (see Karen Busby, "Is it Time to Legalize Commercial Surrogacy in Canada?" (3 February 2015), *Impact Ethics* (blog), online: <www.impactethics.ca/2015/02/03/is-it-time-to-legalize-commercial-surrogacy-in-canada/>).

15 See Sarah Franklin, "Not a Flat World: The Future of Cross-Border Reproductive Care" (2011) 23:7 Reproductive BioMedicine Online 814 at 815; Anindita Majumdar, "The Rhetoric of Choice: The Feminist Debates on Reproductive Choice in the Commercial Surrogacy Arrangement in Indian" (2014) 18:2 Gender, Technology & Development 275 at 280.

have remarked that it is the bodies of poor brown women that now produce babies for rich (primarily) white women and men.[16] India is a global hotspot for the practice,[17] defined as an arrangement where surrogates gestate embryos formed from the gametes of others (typically those of the commissioning parents but sometimes emanating from third party donors) and give up the baby upon birth in exchange for payment.[18]

Gestational surrogacy differs from traditional surrogacy where a surrogate also supplies the egg, and intra-uterine insemination (IUI) is used to fertilize it.[19] IUI is less invasive than in vitro fertilization (IVF), which requires the woman supplying the egg to undergo ovarian stimulation, superovulation, and egg retrieval. Gestational surrogacy relies on IVF; eggs are retrieved from the intended mother or egg donor, fertilized with the sperm of the intended father or sperm donor, and then, if an embryo or embryos result, one or more will be placed into the surrogate's uterus.[20] Gestational surrogacy is thus a pathway for single women and heterosexual or lesbian couples to produce a biologically related child when women cannot become or stay pregnant. It is also a route to such a child for single men or gay couples where traditional surrogacy is not feasible or desirable due to the absence of parentage legislation that secures the fathers' parental rights over the birth mother's. In all situations, the gestational surrogate will not have any genetic link to the child.[21]

Canadians and other citizens of the Global North travel to India to use gestational surrogates,[22] and thus partake in an industry that, as many

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16 For similar commentary in relation to the racialized black-white dynamics of affective labour in gestational surrogacy in the United States, see April L Cherry, "Nurturing in the Service of White Culture: Racial Subordination, Gestational Surrogacy, and the Ideology of Motherhood" (2001) 10:2 Tex J Women & L 83 at 117–18. For analyses of the correlation between flows of capital and racial lines for human tissue in general, see Nancy Scheper-Hughes, "The Global Traffic in Human Organs" (2000) 41:2 Current Anthropology 191 at 193.

17 See Gupta, "Reproductive Biocrossings", *supra* note 14 at 42–43.

18 See George Palattiyil et al, "Globalization and Cross-Border Reproductive Services: Ethical Implications of Surrogacy in India for Social Work" (2010) 53:5 Intl Social Work 686 at 692.

19 See Jonathan W Knoche, "Health Concerns and Ethical Considerations Regarding International Surrogacy" (2014) 126:2 Intl J Gynecology & Obstetrics 183 at 183.

20 See Lozanski, *supra* note 8 at 383; Susan Imrie & Vasanti Jadva, "The Long-Term Experiences of Surrogates: Relationships and Contact with Surrogacy Families in Genetic and Gestational Surrogacy Arrangements" (2014) 29:4 Reproductive BioMedicine Online 424 at 425.

21 See Lozanski, *supra* note 8 at 383.

22 See *ibid* at 386–87; GKD Crozier, Jennifer L Johnson & Chrisopher Hajzler, "At the Intersections of Emotional and Biological Labor: Understanding Transnational Commercial Surrogacy as Social Reproduction" (2014) 7:2 Intl J Feminist Approaches to Bioeth-

feminists have highlighted, heavily depends on material disparities and discursive ideologies of gender, class, and race.[23] My purpose here is to emphasize that the increasingly globalized nature of surrogacy treatment substantially reshapes the earlier feminist commodification debates informing the *AHRA*, which took the domestic sphere as the presumed terrain of contestation. I thus proceed from the presumption that due to the transnational North-South nature of surrogacy and Canadians' participation in it, a postcolonial feminist perspective—not earlier Westcentric feminist arguments—should guide feminist input for domestic reform in Canada.[24]

By "postcolonial feminist", I am referring to a theoretical framework that prioritizes the perspectives of women in the Global South when thinking normatively about a social problem and, in doing so, challenges Western analyses, including those authored by Western feminists, which encode colonial assumptions about the lives of non-Western women and assume certain normative framings. Postcolonial feminism seeks to resist the hegemony of Westcentric assumptions about the totalizing patriarchal nature of non-Western cultures that create reductive and monolithic representations of non-Western women as "victims" or "dupes" of their cultures.[25] To counter these discourses, postcolonial feminists seek to recu-

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ics 45 at 46; Lisa C Ikemoto, "Reproductive Tourism: Equality Concerns in the Global Market for Fertility Services" (2009) 27:2 Law & Ineq 277 at 285.

[23] The transnational focus is not meant to obscure the high internal class stratification of Indian society and the need to examine surrogates' experiences when the commissioning parents are Indian nationals—a much less studied aspect of the industry (see Holly Donahue Singh, "'The World's Back Womb?': Commercial Surrogacy and Infertility Inequalities in India" (2014) 116:4 American Anthropologist 824 at 826).

[24] As such, my argument shares a premise with other critically oriented investigations of the responsibilities of economically affluent nations in relation to globalized health and other phenomena, the conditions of which they help engender and from which they benefit (see e.g. Mira Johri et al, "Global Health and National Borders: The Ethics of Foreign Aid in a Time of Financial Crisis" (2012) 8:19 Globalization & Health 1; Natalie J Grove & Anthony B Zwi, "Our Health and Theirs: Forced Migration, Othering, and Public Health" (2006) 62:8 Social Science & Medicine 1931; Lawrence O Gostin & Robert Archer, "The Duty of States to Assist Other States in Need: Ethics, Human Rights, and International Law" (2007) 35:4 JL Med & Ethics 526). For a comprehensive analysis of the normative reasons sending states should strive to curb the deleterious effects of medical tourism on the health care access of citizens of the Global South, see I Glenn Cohen, "How to Regulate Medical Tourism (and Why it Matters for Bioethics)" (2012) 12:1 Developing World Bioethics 9 [Cohen, "Medical Tourism"]. Since Cohen's article focuses on the obligations of rich nations where the medical tourism of their citizens has a negative impact on health care access for residents of the countries they travel to—in contrast to entrenching exploitation—I do not engage in detail with his arguments here.

[25] See e.g. Ratna Kapur, "Post-Colonial Economies of Desire: Legal Representations of the Sexual Subaltern" (2001) 78:4 Denv UL Rev 855 at 866; Uma Narayan, *Dislocating Cultures: Identities, Traditions, and Third-World Feminism* (New York: Routledge,

perate and illuminate the agency and resistance of non-Western women as well as the layered logics of their choices.[26] They also aspire to elucidate how imperial relations of power interface with domestic gender relations to affect the lives of non-Western women and to excavate the knowledges that these women have about their own lives.[27]

Educing postcolonial feminism's insights about the need to attend to ongoing imperial relations of power as well as to correct the distorted view of non-Western women that Western representations generate, and applying those insights to the reform of the *AHRA*, will enable a more inclusive and just feminist response to the commercial surrogacy issue in Canada. While inquiries into how destination countries like India and international organizations should regulate the industry are certainly called for and have occurred,[28] attention to what sending countries like Canada can do within their *own* jurisdictional boundaries to respond to the inequities that sustain the practice—a much less studied phenomenon—is also required.[29] I address this central question by arguing that Canadian feminists concerned about reproductive harms advocate for: (1) the legalization of commercial surrogacy in Canada; and (2) public funding for domestic surrogacy services and the ARTs required for domestic surrogacy to be viable.

Part I explains Canada's prohibition against commercial surrogacy as well as the rise of the cross-border commercial pursuit of surrogate services. In this latter focus, Part I describes the phenomenon of the gestational surrogacy industry in India. Part II considers the main postcolonial feminist arguments for and against the industry as it currently operates

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1997). I acknowledge that the terms West, non-Western, Global North, and Global South enact their own type of essentialism, effectively glossing over the heterogeneity and fluidity of the discourses, peoples, and cultures these categories denote. Still, the terms help articulate the logics of domination that follow these geographic axes. For more on this point, see Farah Godrej, *Cosmopolitan Political Thought: Method, Practice, Discipline* (New York: Oxford University Press, 2011) at 15.

26 See Maneesha Deckha, "Pain as Culture: A Postcolonial Feminist Approach to S/M and Women's Agency" (2011) 14:2 Sexualities 129 at 132–33.

27 See Louise Racine, "The Impact of Race, Gender, and Class in Postcolonial Feminist Fieldwork: A Retrospective Critique of Methodological Dilemmas" (2011) 3:1 Aporia 15 at 17–18.

28 For details of proposals for such regulation at the domestic level in India and at the multilateral international level, see Yehezkel Margalit, "From Baby M to Baby M(anji): Regulating International Surrogacy Agreements" JL & Pol [forthcoming in 2016], online: <papers.ssrn.com/sol3/papers.cfm?abstract_id=2586651>; Centre for Social Research, *Surrogate Motherhood: Ethical or Commercial* (New Delhi: Centre for Social Research (CSR), 2012), online: <www.womenleadership.in/Csr/SurrogacyReport.pdf> at 82–83.

29 See Lozanski, *supra* note 8 at 384.

in India, explaining notable repressive and productive elements for the women paid as commercial gestational surrogates. Part III then discusses the domestic measures Canada should adopt to respond to the exploitative aspects of the industry, namely, lifting the ban and providing corollary funding for ARTs entailed by surrogacy's legalization.

Before proceeding, it is useful to consider terminology in this area. Even though many ARTs are advertised to overseas clients in medical treatment and tour packages, the common term "medical tourism"[30] risks painting those who travel as pleasure- or leisure-seekers rather than patients in need.[31] The term obscures the suffering that many of those who are keen to have a child, but cannot, experience through their inability to actualize a fundamental life interest.[32] Scholars have argued that these individuals and couples are not tourists, but rather are "in exile" from their home countries that restrict their access to treatment due to sexual orientation or marital status[33] or child welfare and anti-exploitation principles,[34] or otherwise institute unreasonable delays, costs, or other obstacles.[35] I thus use the more neutral term of "cross-border reproductive care"[36] to signal that this paper proceeds from a recognition that many in-

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30 See e.g. John Connell, *Medical Tourism* (Oxfordshire: CABI, 2010) at 1.

31 See I Glenn Cohen, "Protecting Patients with Passports: Medical Tourism and the Patient-Protective Argument" (2010) 95:5 Iowa L Rev 1467 at 1471, n 4.

32 See Storrow, "Quests for Conception", *supra* note 14 at 301–302; Hnatiuk, *supra* note 3 at 47–48.

33 See Gupta, "Reproductive Biocrossings", *supra* note 14 at 33–34; Storrow, "Quests for Conception", *supra* note 14 at 306–307, 310. Several European nations, for example, disallow singles and transgendered and gay and lesbian couples from accessing ARTs, which are otherwise covered by national health care regimes (see K Berg Brigham, B Cadier & K Chevreul, "The Diversity of Regulation and Public Financing of IVF in Europe and its Impact on Utilization" (2012) 28:3 Human Reproduction 666 at 669).

34 See Zeynep B Gürtin & Effy Vayena, "Reproductive Donation: Global Perspectives and Cultural Diversity" in Martin Richards, Guido Pennings & John B Appleby, eds, *Reproductive Donation: Practice, Policy and Bioethics* (Cambridge: Cambridge University Press, 2012) 70 at 77; John B Appleby, Sarah Jennings & Helen Statham, "Reproductive Donation and Justice for Gay and Lesbian Couples" in Richards, Pennings & Appleby, *supra* note 34, 211 at 222–24.

35 See M C Inhorn & P Patrizio, "Rethinking Reproductive 'Tourism' as Reproductive 'Exile'" (2009) 92:3 Fertility and Sterility 904 at 905; Petra De Sutter, "Considerations for Clinics and Practitioners Treating Foreign Patients with Assisted Reproductive Technology: Lessons from Experiences at Ghent University Hospital, Belgium" (2011) 23:5 Reproductive BioMedicine Online 652 at 654; Andrea Whittaker, "Cross-Border Assisted Reproduction Care in Asia: Implications for Access, Equity and Regulations" (2011) 19:37 Reproductive Health Matters 107 at 109–10.

36 Gupta, "Reproductive Biocrossings", *supra* note 14 at 28. It should be noted that cross-border reproductive care can flow both ways. Michal Nahman uses the term "reverse traffic repro-migrations" to refer to the movement not of patients, but of medical staff,

dividuals who cross borders to fulfill their dreams of a biological child suffer from intense personal anguish due to infertility, have already paid for costly yet unsuccessful ART treatment in an attempt to achieve pregnancy, and cannot secure an altruistic surrogate to try further.[37] At the same time, the deep social stratifications that animate the phenomenon compel a critical lens.

I. Canada's Ban and the Rise of Transnational Commercial Surrogacy

This Part first sets out the nature of Canada's prohibition against commercial surrogacy and the dominant feminist rationales behind it that theorized surrogacy at a domestic level. It then sketches the rise of transnational surrogacy. The discussion provides the details necessary to understand the postcolonial feminist analysis of transnational surrogacy that follows in Part II.

A. Canadian Prohibition and Feminist Influences

As an overarching principle, the *AHRA* condemns "trade in the reproductive capabilities of women and men ... for commercial ends."[38] It more specifically bans commercial surrogacy by prohibiting anyone from paying or offering to pay a woman to be a surrogate as well as prohibiting anyone from advertising to pay for surrogacy.[39] The *Act* extends these prohibitions to intermediaries as well.[40] "Surrogate" is defined as a woman who conceives through ART and intends to surrender the child to a gamete donor or other person.[41] Thus, the *AHRA* permits altruistic surrogacy with the further condition that the woman be twenty-one years or over.[42] Although

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embryologists, equipment, and gametes from where gametes are retrieved to where they are implanted ("Reverse Traffic: Intersecting Inequalities in Human Egg Donation" (2011) 23:5 Reproductive BioMedicine Online 626 at 627). Andrea Whittaker also uses the term "cross-border reproductive care" in order to avoid associating this phenomenon with touristic activities (*supra* note 35 at 108).

37 See Lozanski, *supra* note 8 at 383.

38 *AHRA*, *supra* note 1, s 2(f).

39 *Ibid*, s 6(1).

40 *Ibid*, ss 6(1)–(3).

41 The *AHRA* states that "'surrogate mother' means a female person who—with the intention of surrendering the child at birth to a donor or another person—carries an embryo or foetus that was conceived by means of an assisted reproduction procedure and derived from the genes of a donor or donors" (*ibid*, s 3). Interestingly, the definition of "assisted reproduction procedure" was repealed when the federal government revised the *Act* to align it with the Supreme Court of Canada's pronouncements in *Reference Re AHRA*, *supra* note 9.

42 *AHRA*, *supra* note 1, s 6(4).

never enacted, the *Act* permits regulations reimbursing altruistic surrogates for their expenses.[43] Anyone violating the commercial ban may be subject to a fine of up to $500,000 or incarceration for ten years.[44]

The feminist rationale for the *AHRA*'s ban on commercial surrogacy, like feminist arguments in other jurisdictions, centred on the objectification and exploitation of women[45] and, to a lesser extent, the effect on future children that would occur if women were paid to reproduce.[46] The thinking here borrows from radical feminist concerns articulated in the prostitution and pornography debates,[47] as well as socialist/materialist feminist concerns about the medicalized fragmentation of women's bodies under capitalist conditions and the resulting alienation.[48] With respect to objectification, feminists worried that payment would induce low-income women into selling their wombs, thereby demeaning their bodies.[49] Arguments prevailed that class and race stratification would also intensify as it would be disadvantaged women who would serve as surrogates and endure stigma.[50] In terms of exploitation, feminists feared that rich women

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43 *Ibid*, ss 65(1)(e)–(e.1), (z.4). See also *ibid*, s 12 (not yet in force). For a critique of the failure of the regulator to enact any regulations and bring section 12 into force, see Françoise Baylis, Jocelyn Downie & Dave Snow, "Fake It till You Make It: Policymaking and Assisted Human Reproduction in Canada" (2014) 36:6 J Obstetrics & Gynaecology Canada 510.

44 See *AHRA*, *supra* note 1, s 60(*a*). Indeed, enforcement under the *AHRA* in general has been rare (see Cattapan, "Rhetoric and Reality", *supra* note 7 at 204, 210, 217–19).

45 See Cattapan, "Risky Business", *supra* note 4 at 365–66; Naomi Pfeffer, "Eggs-ploiting Women: A Critical Feminist Analysis of the Different Principles in Transplant and Fertility Tourism" (2011) 23:5 Reproductive BioMedicine Online 634; Gupta, "Reproductive Biocrossings", *supra* note 14 at 44–47. See also Sven Bergmann, "Fertility Tourism: Circumventive Routes That Enable Access to Reproductive Technologies and Substances" (2011) 36:2 Signs 280 at 284.

46 See generally Busby & Vun, *supra* note 3. This focus on children, however, trumped concerns about risks to women's health and well-being (see Scala, Montpetit & Fortier, *supra* note 7 at 600).

47 See e.g. Jean M Sera, "Surrogacy and Prostitution: A Comparative Analysis" (1997) 5 Am UJ Gender & L 315.

48 See generally Amrita Pande, "Commercial Surrogacy in India: Manufacturing a Perfect Mother-Worker" (2010) 35:4 Signs 969 [Pande, "Commercial Surrogacy"].

49 See Cattapan, "Risky Business", *supra* note 4 at 362. Feminists express such concerns globally (see Jyotsna Agnihotri Gupta, "Towards Transnational Feminisms: Some Reflections and Concerns in Relation to the Globalization of Reproductive Technologies" (2006) 13 Eur J Women's Stud 23 at 32–33 [Gupta, "Towards Transnational Feminisms"]).

50 See Mavis Jones & Brian Salter, "Proceeding Carefully: Assisted Human Reproduction Policy in Canada" (2010) 19:4 Public Understanding Science 420 at 431, n 5; Scala, Montpetit & Fortier, *supra* note 7 at 590. Again, feminists outside of Canada have also expressed these concerns (see e.g. Amrita Pande, "Not an 'Angel', not a 'Whore': Surro-

and men would be able to take advantage of the economic vulnerability of poor women who would be willing to assume serious health risks of untested IVF and other procedures, and give up a baby for meagre remuneration.[51] With limited economic opportunities available to them, exploitation arguments contested any consent that a surrogate may give as free and valid.[52]

Both sets of arguments also intimated race-based objections.[53] Feminists argued that a surrogacy market would highlight the unpalatable race-based realities of commissioning parents' preferences—namely, the demand for white babies—leading to racialized anxiety that a gestational mother also had to be white for the baby to be considered white and the willingness of buyers to pay extra to guarantee whiteness.[54] Concerns about how transnational surrogacy continues to facilitate preferences for whiteness abound in feminist literature about this topic.[55]

With the enactment of Canada's ban against commercial surrogacy in 2004, these feminist arguments found some traction. In fact, feminists who endorsed the anti-commodification model achieved a victory with the *AHRA* even without empirical evidence to support their arguments. Alana Cattapan has interrogated the repeated legislative assertions in the multi-year lead-up to the *AHRA* that commercial surrogacy is "exploitative" and found that all such statements relied on a single study that simply assessed the demographics of commissioning parents and compared them to the surrogates without actually interviewing the surrogate women.[56]

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gates as 'Dirty' Workers in India" (2009) 16:2 Indian J Gender Stud 141 [Pande, "Not an 'Angel'"]).

51 See Cattapan, "Risky Business", *supra* note 4 at 367–68; Scala, Montpetit & Fortier, *supra* note 7 at 590; Gupta, "Reproductive Biocrossings", *supra* note 14 at 35–36.

52 See Sheela Saravanan, "An Ethnomethodological Approach to Examine Exploitation in the Context of Capacity, Trust and Experience of Commercial Surrogacy in India" (2013) 8:1 Philosophy, Ethics & Humanities in Medicine 1 at 6.

53 See generally Kalindi Vora, "Limits of 'Labor': Accounting for Affect and the Biological in Transnational Surrogacy and Service Work" (2012) 111:4 South Atlantic Q 681 [Vora, "Limits of 'Labor'"].

54 See *RCNRT Report*, vol 2, *supra* note 2 at 673–74.

55 See Vora, "Limits of 'Labor'", *supra* note 53 at 696–97; Cherry, *supra* note 16 at 117–18.

56 Cattapan, "Risky Business", *supra* note 4 at 368, 371. The study was conducted by Margrit Eichler and Phebe Poole in 1988 for the Law Reform Commission of Canada and involved analysis of thirty-two cases from an American surrogacy lawyer in which Canadians acted as either the commissioning parents or the surrogates (see *ibid* at 371, n 59, citing Margrit Eichler & Phebe Poole, *The Incidence of Preconception Contracts for the Production of Children Among Canadians: A Report Prepared for the Law Reform Commission of Canada* (Ottawa: Law Reform Commission of Canada, 1998)).

The speculative basis for legislation is not unique to Canada.[57] In addition to the speculative nature of feminist discourse on surrogacy at the time, a domestic landscape underpinned the argumentation. Feminists did not envisage the transnational contours surrogacy would soon assume. The next section explores these contours.

B. Rise of Cross-Border Reproductive Care and Transnational Surrogacy

Canada is not alone in its prohibition against commercial surrogacy. Other Western and industrialized nations have also banned surrogacy for commercial purposes or, in some cases, altogether.[58] While many American states allow commercial surrogacy, the cost for the uninsured or un-

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[57] Jenni Millbank notes how similar anti-commodification rhetoric propelled legislation against commercial surrogacy in Australia without empirical substantiation ("Rethinking", *supra* note 14). Indeed, with its objection to commercial surrogacy located in concerns about commodification, Canada's 2004 legislation joins—albeit late—the law reform measures that Millbank notes took place in Australia in the 1980s and 1990s against all forms of surrogacy and attendant practices (*ibid* at 3). Australia is also ahead in what Millbank identifies as the next stage of reforms that took place vis-à-vis surrogacy between 2004 and 2012. In this "second wave", Australian jurisdictions adopted a more permissive attitude toward IVF treatments needed for gestational surrogacy and instituted family law legislation facilitating parentage rules recognizing the commissioning parent(s) as legal parents following altruistic surrogacies. However, the prohibitions against the development of a commercial market in surrogacy remained (see Jenni Millbank, "The New Surrogacy Parentage Laws in Australia: Cautious Regulation or '25 Brick Walls'?" (2011) 35:1 Melbourne UL Rev 165 at 176–77; Anita Stuhmcke, "Looking Backwards, Looking Forwards: Judicial and Legislative Trends in the Regulation of Surrogate Motherhood in the UK and Australia" (2004) 18:1 Austl J Fam L 13).

[58] See Pande, "Commercial Surrogacy", *supra* note 48 at 972; Wannes Van Hoof & Guido Pennings, "Extraterritoriality for Cross-Border Reproductive Care: Should States Act Against Citizens Travelling Abroad for Illegal Infertility Treatment?" (2011) 23:5 Reproductive BioMedicine Online 546 at 547. For a list showcasing primarily European jurisdictions, see Susan Markens, *Surrogate Motherhood and the Politics of Reproduction* (Berkeley: University of California Press, 2007) at 24–25. For a comparative overview, see Sreeja Jaiswal, "Commercial Surrogacy in India: An Ethical Assessment of Existing Legal Scenario from the Perspective of Women's Autonomy and Reproductive Rights" (2012) 16:1 Gender, Technology & Development 1 at 4–5. Many countries, while allowing altruistic surrogacy, ban single and/or same-sex couples from availing themselves of surrogates. Several American states, for example, discriminate on this basis (see Andrea B Carroll, "Discrimination in Baby Making: The Unconstitutional Treatment of Prospective Parents Through Surrogacy" (2013) 88:4 Ind LJ 1187 at 1188; Richard F Storrow, "Rescuing Children from the Marriage Movement: The Case Against Marital Status Discrimination in Adoption and Assisted Reproduction" (2006) 39:2 UC Davis L Rev 305 at 314). Clinics in India also discriminate on this basis (see Saravanan, *supra* note 52 at 4). For the implications of this moral and political pluralism for the reproductive industry, see RF Storrow, "The Pluralism Problem in Cross-Border Reproductive Care" (2010) 25:12 Human Reproduction 2939 [Storrow, "The Pluralism Problem"].

derinsured is prohibitive. Hence, the rise of cross-border reproductive care is explained by individuals travelling for treatments they cannot access at home either due to legal restriction or due to cost, delay, privacy concerns, or a combination thereof.[59] India has emerged as a global leader in ART services as well as the overall set of cross-border medical industries.[60] The cross-border medical care industry was valued in 2012 at $2.3 billion with the most common services being "knee joint replacement, bone marrow transplant, bypass surgery, cosmetic surgery, and hip replacement."[61] The cross-border reproductive care industry grew thirty per cent in 2000 and fifteen per cent between 2005 and 2010.[62] The cross-border medical care industry in India has been forecasted as having generated "additional revenue of $1–2 billion by 2012."[63] Although the precise number of ART clinics in India is difficult to ascertain, the number has been estimated to be about 600, with clinics located in both urban and semi-rural areas.[64]

1. Growth Factors

Multiple factors have contributed to this accelerated growth. Prime among these is the comparative cost advantage and excellent standards of medical care that India offers. What is illegal or cost-prohibitive at home may be procured for much less abroad without sacrificing medical quality.[65] With respect to surrogacy, it is estimated that the cost for surrogacy in India is less than one-third to one-half of what it would be in the Unit-

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59 See Cohen, "Medical Tourism", *supra* note 24. A main reason individuals travel for reproductive care is due to the illegality of the treatment in their country of residence (see Guido Pennings & Zeynep B Gürtin, "The Legal and Ethical Regulation of Transnational Donation" in Richards, Pennings & Appleby, *supra* note 34 at 131).

60 See Amit Sengupta, "Medical Tourism: Reverse Subsidy for the Elite" (2011) 36:2 Signs 312 at 312–13.

61 Nadimpally Sarojini, Vrinda Marwah & Anjali Shenoi, "Globalisation of Birth Markets: A Case Study of Assisted Reproductive Technologies in India" (2011) 7:1 Globalization & Health 1 at 3.

62 See *ibid* at 3; Shree Mulay & Emily Gibson, "Marketing of Assisted Human Reproduction and the Indian State" (2006) 49:4 Development 84 at 85.

63 See Sarojini, Marwah & Shenoi, *supra* note 61 at 4. Others have also estimated the amount to be as high as US$2 billion (see Knoche, *supra* note 19 at 183).

64 See Centre for Social Research, *supra* note 28 at 23. Other commentators estimate the number of clinics to be as high as 3,000 (see Virginie Rozée Gomez & Sayeed Unisa, "Surrogacy from a Reproductive Rights Perspective: The Case of India" (2014) 70 Autrepart 185 at 188).

65 See Sarojini, Marwah & Shenoi, *supra* note 61 at 3. See also Amrita Banerjee, "Reorienting the Ethics of Transnational Surrogacy as a Feminist Pragmatist" (2010) 5:3 Pluralist 107 at 114 [Banerjee, "Reorienting"]; Kalindi Vora, "Indian Transnational Surrogacy and the Commodification of Vital Energy" (2009) 28:1 Subjectivity 266 at 269 [Vora, "Indian Transnational Surrogacy"].

ed States: the cost, including travel, runs between US$25,000 and US$40,000 for Americans to pursue surrogacy in India while the cost would be US$80,000 to US$100,000 to do so in the United States.[66] A *typical* cost for the overall payment to Indian clinics themselves, however, is approximately US$23,500 to US$25,000.[67] Of this amount, a surrogate may receive between US$2,000 and US$8,000 with most payments clustering in the US$3,000 to US$6,000 range.[68] The exact amount depends "on many factors, including location, education level, experience, and even the perceived beauty or other physical characteristics" of surrogates as well as the "pain, discomfort, and risk they assume."[69] When this relatively low cost is combined with high-quality clinical expertise and "the post-colonial legacies of English language usage and medical practice modeled on the British system,"[70] it is evident why India has emerged as a magnet for transnational surrogacy.

Growth of transnational surrogacy in India is also related to the national policy of promoting cross-border medical care and the rise of neoliberalism and privatization in general.[71] One feature here is the medical visas that India started to offer foreigners and their spouses in 2006; it is estimated that about one million foreigners visited India for medical reasons in 2012[72] and the growth rate for 2015 and beyond is forecasted at thirty per cent annually.[73] Also relevant are the subsidies the Indian state offers, as part of a larger neoliberal privatization project, for clinics and hospitals treating overseas patients.[74]

In addition to the economic and practical incentives offered to both prospective parents and providers that have fuelled the industry's growth, racialized ideologies about biological connections and kinship have also played a part. Most individuals and couples seeking a child through ARTs

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66 See Sayantani Dasgupta & Shamita Das Dasgupta, "Introduction" in Sayantani Dasgupta & Shamita Das Dasgupta, eds, *Globalization and Transnational Surrogacy in India: Outsourcing Life* (Lanham, Md: Lexington Books, 2014) vii at x.

67 See Crozier, Johnson & Hajzler, *supra* note 22 at 49. The authors retrieved price lists from clinics in Delhi and Mumbai that quoted these figures.

68 See *ibid* at 50–51.

69 *Ibid*.

70 Singh, *supra* note 23 at 825. See also Sarojini, Marwah & Shenoi, *supra* note 61 at 3.

71 See Charlotte Halmø Kroløkke & Saumya Pant, "'I Only Need Her Uterus': Neo-Liberal Discourses on Transnational Surrogacy" (2012) 20:4 Nordic J Feminist & Gender Research 233 at 234–37. See also Sarojini, Marwah & Shenoi, *supra* note 61 at 3.

72 See Sengupta, *supra* note 60 at 312–13.

73 See G Saravana Kumar & R Krishna Raj, "Status, Growth and Impact of Medical Tourism in India" (2015) 34:1 Intl J Pharmaceutical Sciences Rev & Research 284 at 286.

74 See *ibid* at 315.

seek a child that is phenotypically similar.[75] Even though many foreign-commissioning individuals and couples for India's surrogacy market are white,[76] India remains very popular for *gestational* surrogacy where there is perceived to be no racial genetic trace that will mark the child as non-white once born.[77] Those who require gamete donors in addition to gestational services, and can afford the higher price (than that for using donor eggs from Indian women), can purchase eggs from white egg donors in Eastern European countries to ensure the resulting whiteness of the child.[78]

Indeed, transnational surrogacy is so popular in India that the country has recently instituted visa requirements that limit foreign access to surrogacy on heteronormative and other grounds. Although India initially welcomed and attracted queer couples and single individuals as commissioning parents, now only foreigners situated in heterosexual couplings of at least two years are eligible. Additionally, they must demonstrate in their visa application, among other elements, that their home country recognizes the legality of surrogacy and that the resulting child will be allowed to enter the country upon their return home.[79] Despite the drop in surrogacy arrangements this new exclusionary position clearly entails, and that it is premature to predict the effect of the new parameters, transnational surrogacy continues to thrive in India.[80]

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75 See Bergmann, *supra* note 45 at 285; Amrita Banerjee, "Race and a Transnational Reproductive Caste System: Indian Transnational Surrogacy" (2014) 29:1 Hypatia 113 at 115–16 [Banerjee, "Reproductive Caste System"].

76 See Sayantani Dasgupta & Shamita Das Dasgupta, "Business as Usual" in Dasgupta & Dasgupta, *supra* note 66 at 195. Non-resident Indians also travel back to India for surrogates (see Banerjee, "Reproductive Caste System", *supra* note 75 at 115). Again, because of the lack of data, it is difficult to know precisely the racial makeup of Canadians travelling to India for surrogacy.

77 See Banerjee, "Reproductive Caste System", *supra* note 75 at 123–24; Gillian Hewitson, "The Commodified Womb and Neoliberal Families" (2014) 46:4 Rev Radical Political Economics 489 at 493.

78 See Sharmila Rudrappa, "Mother India: Outsourcing Labor to Indian Surrogate Mothers" in Dasgupta & Dasgupta, *supra* note 66, 125 at 134. See also Banerjee, "Reproductive Caste System", *supra* note 75 at 123.

79 See India, "Guidelines Issued by the Ministry of Home Affairs Vide Letter no. 25022/74/2011-F.1 Dated 9th July 2012 Regarding Foreign Nationals Intending to Visit India for Commissioning Surrogacy", (Delhi: MHA, 9 July 2012) (the Guidelines took full effect on November 11, 2013).

80 See Amrita Pande, "Blood, Sweat and Dummy Tummies: Kin Labour and Transnational Surrogacy in India" (2015) 57:1 Anthropologica 53 at 54 [Pande, "Dummy Tummies"].

2. Lack of Regulation and Power Disparities

There are a wide variety of professions and service providers that constitute the surrogacy industry in India. Actors include clinics and hospitals; doctors, nurses, clinical coordinators, and lab technicians; specialized travel and hotel agents; brokers for donors and surrogates; and the surrogate women whose bodies lie at the foundation of the industry.[81] Other than general laws regulating health care professionals, and the new rules cited above regarding the issuance of visas to foreigners for surrogacy, no current laws exist that directly address ART services.[82] Only guidelines exist.[83] Market forces thus shape the industry.[84]

While lax regulation for all types of cross-border medical care raises ethical issues,[85] surrogacy is especially problematic from a critical global justice perspective as it requires a woman willing to serve as a surrogate, and not just the services of a doctor willing to perform a treatment for hire. As such, the interaction is not just patient-doctor, but also involves a tertiary, and economically vulnerable, female actor.[86] Surrogates in India are almost always poor. One comprehensive survey of three prominent clinics in Gujarat distilled further socioeconomic information about women who act as surrogates. These women are (1) almost all Hindu and married with at least two children; (2) on average between twenty-six and thirty-five years old; (3) unable to read or only have a grade-school level of education; and (4) tenants on an average monthly household income of CDN$19–38 gained from being employed most commonly as domestic help, construction workers, or nurses.[87] Stark socioeconomic inequalities thus mark who is the surrogate and who is the intended recipient of the hoped-for child.[88] The lack of regulation allows these existing power dis-

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81 See Ikemoto, *supra* note 22 at 279, 281–82; Pande, "Commercial Surrogacy", *supra* note 48 at 975 (on brokers, specifically).

82 See Sengupta, *supra* note 60 at 314.

83 See Centre for Social Research, *supra* note 28 at 24 (the Indian Medical Research Council published guidelines in 2006 regarding the accreditation of clinics).

84 See Dasgupta & Dasgupta, "Introduction", *supra* note 66 at vii–xi; Pande, "Dummy Tummies", *supra* note 80 at 54. One example of the commercial imprint of the industry is the blended nature of medical services with actual tourism through medical tour packages for both ART and non-ART treatment.

85 See generally Leigh Turner, "Transnational Medical Travel: Ethical Dimensions of Global Healthcare" (2013) 22:2 Cambridge Q Healthcare Ethics 170; Cohen, "Medical Tourism", *supra* note 24.

86 See Ikemoto, *supra* note 22 at 293–94.

87 See Centre for Social Research, *supra* note 28 at 30–33, 58.

88 This class dynamic exists domestically in India as more and more economically elite Indians avail themselves of surrogacy and thus raises its own set of issues including pronounced social stigma (see Pande, "Not an 'Angel'", *supra* note 50 at 154). As my focus

parities to create unequal bargaining power in the surrogacy contract process that engenders close surveillance of and vulnerability for surrogates.

With respect to surveillance, of frequent mention in feminist scholarship on Indian surrogacy is the highly controlled nature of the life of some gestational surrogates.[89] Live-in surrogacy hostels have emerged to monitor intensely women's behaviour during their pregnancies. At some clinics, women are required to live at these hostels, apart from their families, for the length of their pregnancies under controlled eating, health care, and rest regimens.[90] As well, there can be restrictions about when the surrogates' own families can visit them and the type of physical interactions the women are allowed to have with their children when visiting.[91] Amrita Pande's influential ethnographic work studying clinic operations and surrogates' experiences details the myriad ways in which the women are instructed to develop a positive yet transient mothering relationship toward the child, which, on the one hand, means taking all precautions for a healthy pregnancy and, on the other, interpreting their role as hired uterus, their relationship as temporary, and the child as not theirs.[92] Pande argues that this paradoxical instruction and surveillance transforms surrogates into "mother-worker subjects", a construct that facilitates their easy manageability and cheap fees for the clinics and clients.[93] Despite this emphasis that they are workers, regulations or even industry standards for these surrogate hostels—where complaints about water quantity, food quality, overcrowding, sanitation, and hygiene have been conveyed to researchers[94]—are lacking.

Surrogacy arrangements outside of the hostel system do not involve such acute surveillance, but the lack of regulation leaves surrogates vulnerable on several levels. This vulnerability is perhaps most apparent when one scrutinizes the actual fertility treatments that surrogates undergo. There are no legally or contractually mandated limits on the num-

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here is on foreign access and what the obligations of sending states such as Canada are in addressing this globalized flow of reproductive desire, consumption, and bodies, I restrict my analysis to the transnational practices comprising gestational commercial surrogacy in India.

89 See Pande, "Commercial Surrogacy", *supra* note 48 at 981–85; Vora, "Limits of 'Labor'", *supra* note 53 at 686–87.

90 See Saravanan, *supra* note 52 at 8.

91 See *ibid*. See also Vora, "Indian Transnational Surrogacy", *supra* note 65 at 270.

92 Pande, "Commercial Surrogacy", *supra* note 48 at 970. Pande's research has since been published in Amrita Pande, *Wombs in Labor: Transnational Commercial Surrogacy in India* (New York: Columbia University Press, 2014).

93 Pande, "Commercial Surrogacy", *supra* note 48 at 970.

94 See Saravanan, *supra* note 52 at 5, 8–9.

ber of cycles that a surrogate can go through,[95] the number of embryos that may be inserted into her at any one transfer,[96] or the minimum time of rest between cycles.[97] There is also no guarantee that surrogates will receive any social or psychological support before, during, or after the process.[98]

Further, scholars assert that, from an informed consent perspective, the contracts are enacted in conditions that vitiate any consent the surrogate may give to her treatment protocol.[99] These conditions encompass more than the residual socioeconomic inequality between the surrogates, the doctors, and the commissioning parties. For example, although the clinics typically serve as the financial intermediary between commissioning parents and surrogate mothers, most ask women to sign forms in English (which they cannot read) before the details of payment are stipulated on the contract in writing and then do not provide copies of the contract once it is executed.[100] In addition, most surrogates are presented with and sign their contracts after the completion of the first trimester, well into the fourth month of pregnancy. It is difficult for them to back out at that time or request more favourable provisions,[101] especially since demanding more payment contradicts the selflessness and virtuousness they are supposed to adopt in their mothering role. Further, it is standard practice for women to be paid the bulk of their fee only upon a successful live birth rather than in heftier proportional installments as different stages of the pregnancy are completed.[102]

Another concern is the payment structure that exposes women—who may already be selected for their financially motivated willingness to comply and follow direction—to a heightened position of medical vulnerability even after the actual fertility treatments. One ethnographic study of a sought-after clinic in Western India noted that surrogates were all required to have Caesarean sections rather than natural births and that women were not able to refuse selective reduction (i.e., abortion) once it

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95 See Jaiswal, *supra* note 58 at 12.

96 See Saravanan, *supra* note 52 at 8.

97 See Centre for Social Research, *supra* note 28 at 44, 68.

98 See *ibid* at 9.

99 See Pande, "Commercial Surrogacy", *supra* note 48 at 976; Pande, "Not an 'Angel'", *supra* note 50 at 159; Saravanan, *supra* note 52 at 3.

100 See Centre for Social Research, *supra* note 28 at 41–42.

101 See Saravanan, *supra* note 52 at 6, 8; Whittaker, *supra* note 35 at 112; Daisy Deomampo, "Transnational Surrogacy in India: Interrogating Power and Women's Agency" (2013) 34:3 Frontiers 167 at 176; Pande, "Commercial Surrogacy", *supra* note 48 at 970, 976.

102 See Saravanan, *supra* note 52 at 10.

was discovered that multiple embryos had implanted and were developing.[103] Conversely, women who wish to avoid carrying multiple embryos also could not *refuse* multiple embryo transfer as clinics routinely treat the commissioning parent(s) as the patient(s) in procuring treatment decisions about the pregnancy.[104] Women also did not have any window of time, pursuant to the contract, to change their mind following the birth to refuse the fee and keep the baby (as is the case in Canadian jurisdictions with respect to altruistic surrogacy arrangements[105]). They were also expected, albeit compensated financially for this service, to take care of the children post-birth as per the commissioning parents' wishes regarding breastfeeding and other care while the commissioning parents waited for their parental court orders and the child's passport to be issued.[106] An overarching clinical frame for the entire process is to deter to medical authority and, where doctors do seek input in decision making, to value the commissioning parents as the decision makers instead of the surrogate, to prioritize fetal over maternal health, and to treat the surrogates as fungible.[107]

As Imrana Qadeer notes, even the proposed Bill in 2008 that would have regulated the industry did not adequately address all of these concerns.[108] The Bill would have only permitted up to three cycles per commissioning couple or individual vis-à-vis an individual woman[109] yet it would have allowed an individual surrogate to go through five complete

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[103] See *ibid* at 8. Another study of eighteen clinics in New Delhi found that eleven clinics reported that the physicians controlled the decision about the type of delivery based on what was medically indicated, that two clinics mandated Caesarean sections, and that only three clinics involved surrogates in the decision regarding selective reductions (see Malene Tanderup et al, "Reproductive Ethics in Commercial Surrogacy: Decision-Making in IVF Clinics in New Delhi, India" (2015) 12:3 J Bioethical Inquiry 491 at 497–99).

[104] See Millbank, "Rethinking", *supra* note 14 at 485; Tanderup et al, *supra* note 103 at 496.

[105] See e.g. *Family Law Act*, SBC 2011, c 25, s 29(3) [*FLA*]. For further discussion, see *infra* note 200.

[106] See Saravanan, *supra* note 52 at 9.

[107] See Busby, "Of Surrogate Mother Born", *supra* note 5 at 292; Centre for Social Research, *supra* note 28 at 77–81; Pande, "Commercial Surrogacy", *supra* note 48 at 977; Tanderup et al, *supra* note 103 at 500.

[108] Imrana Qadeer, "Benefits and Threats of International Trade in Health: A Case of Surrogacy in India" (2010) 10:3 Global Social Policy 303 at 304–305. See also India, Ministry of Health and Family Welfare, "The Assisted Reproductive Technologies (Regulation) Bill", Draft (New Delhi: MOHFW Research, 2010), online: <icmr.nic.in/guide/ART%20REGULATION%20Draft%20Bill1.pdf> [ART Bill].

[109] ART Bill, *supra* note 108, s 34(9).

surrogacies.[110] Thus, a single woman could theoretically undergo fifteen cycles of treatment in her lifetime. The Bill also did not provide protection against mandated multiple embryo transfer, abortion, or Caesarean section.[111] Further, the Bill would not have guaranteed surrogates the opportunity to change their minds and keep the child upon delivery,[112] or even to have long-term contact with their commissioning families akin to the norm of open adoption.[113] Rather, the law would have facilitated early separation in favour of the commissioning parents.[114] Concerns about the provision of health insurance for the surrogates' families, recoupment for travel, legal, and other costs, and ability to claim for damages against the medical clinic should something go wrong, were also left unaddressed.[115] The Bill also did not take up the issue of the overarching power the clinics hold in the process vis-à-vis surrogate mothers and commissioning parents.[116]

The latest attempt by the Indian government to regulate ARTs appears responsive to at least some of these concerns. The proposed Assisted Reproductive Technology (Regulation) Bill, 2014 was released for public commentary on September 30, 2015 with submissions invited until November 15, 2015.[117] The 2014 Bill would only allow a woman who is Indian, between the ages of twenty-three and thirty-five, married, has the consent of her husband, and has a child of her own who is at least three years of age to be a surrogate.[118] In contrast to the 2008 Bill, the current

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110 *Ibid*, s 34(5).

111 See Saravanan, *supra* note 52 at 8.

112 ART Bill, *supra* note 108, s 34(4).

113 See Kalindi Vora, "Potential, Risk, and Return in Transnational Indian Gestational Surrogacy" (2013) 54:S7 Current Anthropology S97 at S105 [Vora, "Potential"].

114 ART Bill, *supra* note 108, s 34.

115 See Qadeer, *supra* note 108 at 304. As Kalindi Vora observes, although the

> [d]raft ART legislation in India would grant active surrogates claim to insurance through the commissioning parents "as per the agreement and till the surrogate mother is free of all health complications arising out of surrogacy" ... [i]t is difficult to imagine that someone of the social class in which most Indian surrogates find themselves would or even could pursue commissioning parents, about whom they often have very little information, for long-term health problems attributable to surrogacy ("Potential", *supra* note 113 at S104).

116 See Saravanan, *supra* note 52 at 2, 11. Feminists roundly criticized the Bill for its failure to protect surrogates (see Majumdar, *supra* note 15 at 281).

117 See India, Ministry of Health and Family Welfare, "The Assisted Reproductive Technology (Regulation) Bill", Draft (New Delhi: MOHFW, 2014), online: <www.icmr.nic.in/dhr/ART%20Bill.pdf>.

118 *Ibid*, ss 19(a), 60(5).

proposed legislation stipulates that a woman who qualifies to be a surrogate can only do so once in her life provided the surrogacy results in a live birth (and should it not, at least two years must pass before another delivery attempt).[119] The 2014 Bill appears to retain the limit of three medication cycles per surrogacy attempt.[120] Thus, assuming a surrogate's first surrogacy attempt results in a live birth, she will only be exposed to three cycles in her lifetime. She is also limited to undergoing a maximum of three embryo transfers for one couple.[121]

With respect to a surrogate's right to choose vaginal delivery over a Caesarean section, the Bill does not contain any provision that addresses decision making about the mode of delivery, but a reading of other provisions could be reasonably harnessed to infer that a surrogate's consent is required. The umbrella provision on informed consent states that clinics cannot provide treatments or procedures "without the consent in writing of all the parties seeking assisted reproductive technology to all possible stages of such treatment or procedures."[122] It is unclear whether the provision's phrase, "parties seeking assisted reproductive technology," includes surrogates. However, a provision that follows shortly thereafter includes surrogates as one of the "parties seeking ART services"; the provision mandates that "[a]ll consent forms and agreements signed by all the parties seeking ART services including surrogacy shall be in local language also so that all the parties including surrogate mother and the gamete donor can understand the contents."[123]

Although the 2014 Bill appears responsive to the criticisms regarding the lack of surrogates' informed consent, it is not clear whether surrogates' consent is needed for selective reduction in the case of multiple pregnancies. The Bill gives the regulatory agency it establishes power to set limits on how many embryos may be transferred in a given cycle[124] yet it appears to give the power over fetal reduction in the case of a resulting multiple pregnancy to the clinics after directing them to inform the commissioning couple of a multiple pregnancy and its implications.[125] The Bill

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119 *Ibid*, s 60(5)(a).

120 *Ibid*, s 60(5)(b). The wording of this section is not clearly drafted. In saying that "a surrogate mother shall be subjected to maximum three cycles of medications while she is acting as surrogate mother" (*ibid*), does the restriction apply even where there is no successful live birth after three attempts?

121 See *ibid*, s 60(9).

122 *Ibid*, s 47(1).

123 *Ibid*, s 47(5).

124 *Ibid*, s 49(2).

125 *Ibid*, s 49(5).

does not direct that the clinic inform the surrogate.[126] With regard to the right of a surrogate to elect to keep the child once born, the 2014 Bill flatly disavows this option stating that "[a] surrogate shall relinquish all parental rights over the child or children"[127] and directing that the birth certificate list the commissioning couple as parents.[128] The Bill, however, does incorporate provisions aimed at ensuring the surrogates' postnatal care.[129]

A full assessment of the 2014 Bill is not possible here, but in view of the above points we can observe that the government has tried to address some of the specific criticisms levelled against the industry. In addition, for our purposes, it must be noted that the 2014 Bill proposes a dramatic change: to ban foreigners without established or family ties to India from engaging a surrogate. The Bill indicates that Non-resident Indians (NRIs), Persons of Indian Origin (PIOs) and Overseas Citizens of India, and foreigners married to a citizen are exempted from this ban and can qualify for surrogacy.[130] Media accounts since the Bill's release for public commentary have reported that the Ministry of Health and Family Welfare now intends to include NRIs and PIOs in the ban on the recommendation of the National Commission for Women.[131] Further, in response to public interest litigation claiming that commercial surrogacy is exploitative, the government filed an affidavit with the Supreme Court of India in late October 2015 that indicates its opposition to commercial surrogacy and even its intent to revise the draft Bill further to ban it.[132] At the time of writing, it is unclear whether the ban against most foreigners or the prohibition of commercial surrogacy altogether will materialize. It is worth noting, however, that shortly before this article went to press, the Indian Council of Medical Research issued a directive to fertility clinics instructing them "not to entertain any foreigners for availing surrogacy

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126 *Ibid*, s 49(5). The provision states that the "clinic shall inform the patient immediately of the medical pregnancy and its medical implications and may carry out foetal reduction after appropriate counselling" (*ibid*). Section 2(zg) of the Bill does not define "patient" but does define "patients" as "an infertile married couple who comes to any registered assisted reproductive technology clinic and is under treatment for infertility."

127 *Ibid*, s 60(4).

128 *Ibid*, s 60(10).

129 *Ibid*, s 60(2).

130 *Ibid*, s 60(11).

131 See Shriya Mohan, "The Surrogacy Debate: Sorry Folks, We Are Not Renting Our Wombs Anymore", *Catch News* (28 October 2015), online: <www.catchnews.com/india-news/sorry-folks-we-re-not-renting-our-wombs-anymore-1446016225.html>.

132 See Joannna Sugden, "Indian Restricts Foreigners' Access to Surrogate Mothers", *The Wall Street Journal* (29 October 2015), online: <www.wsj.com/articles/india-restricts-foreigners-access-to-surrogate-mothers-1446132042>.

services in India."[133] Media accounts indicate that the decision to bar most foreigners stems from concerns about the exploitative aspects of surrogacy when transnationally executed.[134]

With this overview of its major features, it is apparent that the commercial gestational surrogacy industry in India is amenable to a multi-pronged critique. The next section considers these industry practices through a postcolonial feminist lens to examine the exploitative elements more closely, but also to consider the benefits of the industry to surrogates.

II. Transnational Surrogacy Through a Postcolonial Feminist Lens

Given the global contours of the surrogacy industry, the domestic focus of Canadian feminist concerns underpinning the prohibition of commercial surrogacy in the *AHRA* is insufficient to address the problem of exploitation. The analytical horizon needs to broaden to include the global impacts of Canadian laws as well as those from other "sending" Northern states. Where such impacts have been adverted to, attention has coalesced on the treatment of those who seek cross-border reproductive care in destination countries.[135] It is time for ethico-legal discussions to focus instead on the impacts of the practice on surrogates in the Global South when considering how to reform domestic law and policy. Indeed, this reorientation aligns with the sensibility of evaluating ARTs based on their implications for the most disadvantaged women that drove the initial feminist anti-commodification positions, as well as more tempered feminist positions on ARTs, leading up to the *AHRA*'s enactment.[136] This Part canvasses the considerations that need to be added to the traditional feminist commodification debate in revisiting the current prohibition from the vantage point—as much as that is available to us as privileged knowledge makers interpreting the experience of the Other[137]—of economically marginalized women who opt for surrogacy work in India.

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133 *Ibid*.

134 See Mohan, *supra* note 131.

135 See Storrow, "Quests for Conception", *supra* note 14 at 325.

136 See Scala, Montpetit & Fortier, *supra* note 7 at 590, 594–95.

137 Postcolonial theory instructs us that the experience of the Other is not something those of us occupying privileged positions in Northern spaces can properly understand; the implication of power stratifications along economic, social, and discursive lines renders such experiences inaccessible beyond a certain level. In fact, the desire to "know" the Other, even for benign or emancipatory purposes, is argued to be a remnant of a colonial mindset that expects non-Western peoples and cultures to be fully available, accessible, and intelligible to Western interlocutors often as an unacknowledged pathway to

A. Postcolonial Feminist Analysis—Exploitative Elements

1. Autonomy Violations

An initial consideration that a postcolonial feminist analysis, and almost all feminist approaches, would highlight is the sacrifice of autonomy and liberty that surrogates endure if engaged in the hostel system. Pande's work on the paradoxical "mother-worker subject" model espoused in these clinics exposes their highly disciplinary nature. In her 2006 fieldwork in Anand, Gujarat—a city that is the "epicentre" for surrogacy in India[138]—she interviewed forty-two surrogates between the ages of twenty and forty-five, with education ranging from illiterate to high school. In 2007, Pande returned to Anand and interviewed twenty-three new surrogates and six surrogates from the 2006 visit.[139] Pande locates the hostel system as subscribing to a Foucauldian surveillance model that imposes autonomy-restricting working conditions on surrogates that would never be tolerated in Canada: strict diet regimens, mobility restrictions, and mandatory separation from one's own family with only limited visitation or sexual interaction with one's spouse.[140] As other ethnographic work on commercial surrogacy in India notes, apart from the lower relative cost of surrogacy in countries like India, poor countries are attractive to commissioning parents because of the lack of regulation, which enables a much higher level of control of the surrogates than would be feasible or lawful at home.[141] A related autonomy concern is the mandatory and abrupt separation of the child and mother after birth that routinely occurs.[142] In Canada, an altruistic surrogate mother has an opportunity to change her mind.[143]

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the constitution of Western subjectivity. This insight does not require abandoning postcolonial criticism of global phenomena, but instead cautions scholars to the limits of such critique in accessing the voice of the Other or her vantage point. For a classic account of this insight about colonial subjectivity and marginalized voices, see Gayatri Chakravorty Spivak, "Can the Subaltern Speak?" in Cary Nelson & Lawrence Grossberg, eds, *Marxism and the Interpretation of Culture* (London: Macmillan, 1988) 271.

138 See Sarojini, Marwah & Shenoi, *supra* note 61 at 4.

139 See Pande, "Not an 'Angel'", *supra* note 50 at 149.

140 Pande, "Commercial Surrogacy", *supra* note 48 at 970–71, 981–82.

141 See Saravanan, *supra* note 52 at 5. See also Natalie Fixmer-Oraiz, "Speaking of Solidarity: Transnational Gestational Surrogacy and the Rhetorics of Reproductive (In)Justice" (2013) 34:3 Frontiers 126 at 133; Centre for Social Research, *supra* note 28 at 81.

142 See Banerjee, "Reorienting", *supra* note 65 at 117; Pande, "Commercial Surrogacy", *supra* note 48 at 976.

143 See *FLA*, *supra* note 105, s 29(3)(b). For further discussion, see *infra* note 200.

2. Harnessing Socioeconomic Vulnerability for Reproductive and Material Ends

The surveillance model is able to operate in India due to the economic privilege and deprivation that drives the transnational market. It is the gross disparity in material conditions that generates an abundant supply of Southern surrogates for Northern parents. The industry depends on the socioeconomic vulnerability of these women whose life conditions offer no other viable opportunities for a similar level of income generation and the corresponding affluence of the Northern parents who are able and willing to pay tens of thousands of dollars because the cost is still cheaper than elsewhere.[144] At all stages of the arrangement, the imprint of this material disparity is indelible.

From the outset, most surrogates enter into the clinic system despite the severe stigma attached to surrogacy due to an internalized sense of obligation to care and provide for their families as best they can; the lure of unparalleled financial gain can generate not only external pressure from family members, but also self-pressure to be and be seen as a "good mother".[145] At the same time that their permanent motherhood status toward their own families drives their participation in a stigmatized practice, ideals of virtuous mothering that the clinics promote also undermine the surrogates' capacity to negotiate better payment. The clinics capitalize on surrogates' gendered sense of responsibility by attaching "bad mother" shame to women who would ask for a higher fee to do something, they are told, that should be undertaken with love.[146]

Once a part of the clinic system, Northern individuals and the clinics are able to harness the surrogates' socioeconomic vulnerability for their own reproductive and material goals. This ability leads to the exploitative working conditions detailed above (controlling surrogates' daily behaviour, exposing them to an unregulated number of treatments, not obtaining surrogates' consent for other medical decision making, forcing the relinquishing of the child, etc.).[147] The difficulty poor women experience in enforcing their rights in general, combined with the compromised abilities of these women to void their surrogacy arrangements once agreed upon, provide extra reassurance to both clinics and commissioning parents of

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144 See Ikemoto, *supra* note 22 at 299–300; Vora, "Potential", *supra* note 113; Singh, *supra* note 23 at 826.

145 Crozier, Johnson & Hajzler, *supra* note 22 at 51.

146 See *ibid* at 61.

147 See Pande, "Commercial Surrogacy", *supra* note 48 at 976; Pande, "Not an 'Angel'", *supra* note 50 at 159; Saravanan, *supra* note 52 at 8–9.

the viability of the arrangement despite the exploitation inherent in it.[148] From the perspective of commissioning parents who have travelled a long and expensive road trying to have a biologically related child, India's system offers peace of mind—due to these compromised rights and abilities—that any baby born via surrogate will be theirs.[149] Even after the child is delivered, the inability of surrogates to secure proper postnatal care and contingency funding for their families in the event of their disability or death from treatments directly correlates with their severe socioeconomic disadvantage.

These exploitative elements that mark every step of the process are in addition to the serious health risks the surrogates undertake,[150] most of which are not disclosed to them.[151] Indeed, the injustice of the system is intensified by the overall poor health care climate for those from marginalized socioeconomic locations in India and government policies that divert resources and talent to the private sector rather than direct them to basic public health care for these women and their own children.[152] Given that the focus in commercial surrogacy is on the desires of the commissioning parents and the health of the fetus, with little attention paid to the surrogate independent of these factors, and the surrogate entertains the risk of multiple embryo transfers and birth in a country with a high maternal mortality rate,[153] this drain in public resources from basic health care can register as insidious.[154]

3. Encoding Racialized and Colonial Sensibilities

A third and related exploitative aspect of transnational commercial surrogacy as it is practiced in India arises from the racialized and colonial narratives that imbue the process. These narratives operate in their most base and potent form in the explicit preferences expressed and accommodated—albeit at higher prices, which can be thousands of dollars more—for light-skinned surrogates despite the fact that gestational surrogates

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148 See Saravanan, *supra* note 52 at 5.

149 See Centre for Social Research, *supra* note 28 at 81.

150 See Knoche, *supra* note 19 at 184.

151 See Vora, "Potential", *supra* note 113 at S103–S104; Centre for Social Research, *supra* note 28 at 44–45, 81.

152 See Ikemoto, *supra* note 22 at 302–303; Fixmer-Oraiz, *supra* note 141 at 133; Sengupta, *supra* note 60 at 314–15, 317; Whittaker, *supra* note 35 at 110.

153 See Centre for Social Research, *supra* note 28 at 30, 36, 44.

154 See Vora, "Potential", *supra* note 113 at S104–S105. See also Crozier, Johnson & Hajzler, *supra* note 22 at 49 (pointing out that India's maternal mortality rate is 1 out of 170 births whereas Canada's is 1 out of 5,200).

have no genetic link to the child.[155] As Alison Bailey observes, "[i]t appears that the racial markers that have historically marked light-skinned women as good *mothers* and dark-skinned women bad mothers have been extended to mark 'good' and 'bad' *wombs*."[156] Less explicit, but no less troubling, are the perceptions about race that help dull the reality of the inequalities. On one level, as Kalindi Vora explains, the common use by the media of a "womb for rent" discourse to encapsulate the phenomenon of gestational surrogacy, as well as by clinics to explain it to women recruited for surrogacy, encodes a colonial logic of empty land available for appropriation. She writes: "represented in the notion of wombs for rent is a spatialization reminiscent of colonial figurations and fantasies of newly encountered land as empty and unpopulated. This figuring positions land (and resources within) as in need of organization and management to become productive, which in turn justified its seizure."[157] In this colonial frame, it is not a coincidence that the spatial-market discourse is readily applied to poor women in former colonies.

On another level, as Lisa Ikemoto has highlighted, the non-whiteness of the surrogate, coupled with her Southern location, distinguishes the surrogate racially from the commissioning individual or couple and their scope for empathy. This "racial distancing" makes the hiring, use, and separation of an economically vulnerable woman from the child she gestates and gives birth to more tolerable for some.[158] Commissioning parents also enlist the colonial idea that Southern women are more amenable to having children and performing maternal care work for others to minimize the sense of exploitation that is visited in the process and more readily conceded where the surrogates are Northern and racially marked as white.[159] Serene J. Khader also notes that cross-border reproductive care "distills the racist elements" of global fertility policies and discourse that have long sought to discourage women in the Global South from reproducing and represented them as disinterested in reproducing.[160] For Khader, transnational surrogacy's promotion of reproduction by Southern women only when the resulting babies are for affluent white women reproduces

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155 Alison Bailey notes that one clinic charged commissioning parents $5,000 more ($37,500 versus $32,500) for surrogacy with egg donation where the donor was white as opposed to Indian ("Reconceiving Surrogacy: Toward a Reproductive Justice Account of Indian Surrogacy" (2011) 26:4 Hypatia 715 at 719–20).

156 *Ibid* at 720 [emphasis in original].

157 Vora, "Potential", *supra* note 113 at S100.

158 Ikemoto, *supra* note 22 at 307–308.

159 See *ibid*; Serene J Khader, "Intersectionality and the Ethics of Transnational Commercial Surrogacy" (2013) 6:1 Intl J Feminist Approaches to Bioethics 68 at 83, 85–86.

160 Khader, *supra* note 159 at 85.

racism itself: it "strikingly recasts the problem of 'overpopulation'; it is not reproduction itself that is a problem, it is reproduction of children who are racially similar to, and will be raised by and with, women from the global South."[161] In an era of Northern countries outsourcing more and more services to India, the phenomenon of engaging a poor, formally uneducated stranger halfway across the world—in a country one has never visited and has no familiarity with—to gestate a child becomes an alarmingly normalized "reproscape" of our neocolonial, neoliberal geopolitical times.[162]

The fact that surrogates who participate in the hostel system likely receive optimal housing, health care, and nutrition during the gestation period is little solace for feminist sensibilities about such material stratification and the exploitation it enables. Indeed, some commentators classify the international surrogacy trade as human trafficking.[163] This way of characterizing what is at stake, however, does not align with the narratives of the women who pursue surrogacy work. In addition to noting the autonomy and economic stratification concerns that commercial surrogacy raises, it is equally important under a postcolonial feminist framework to consider the views of the women who work as surrogates in this field.

B. Postcolonial Feminist Analysis—Beneficial Elements

1. Economic Advancement

Ethnographic accounts reveal that women who work as commercial surrogates in India view the work as a pathway to economic advancement.[164] While many do not embrace it as an ideal way to earn income, and may even find it extremely distressing, they value the work as a way to help their families at an economic level at which they never thought

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[161] *Ibid* at 86.

[162] Singh, *supra* note 23 at 826. See also Aditya Bharadwaj, "Reproductive Viability and the State: Embryonic Stem Cell Research in India" in Carole H Browner & Carolyn F Sargent, eds, *Reproduction, Globalization, and the State: New Theoretical and Ethnographic Perspectives* (Durham, NC: Duke University Press, 2011) 113; Hewitson, *supra* note 77 at 493–94.

[163] See Knoche, *supra* note 19 at 184; Janice G Raymond, *Women as Wombs: Reproductive Technologies and the Battle over Women's Freedom* (San Francisco: Harper, 1993) at 140–44. Some feminist scholars have likened it specifically to the sex trade and organ trade (see Majumdar, *supra* note 15 at 286; Storrow, "Quests for Conception", *supra* note 14; Dasgupta & Dasgupta, "Business as Usual", *supra* note 76 at 194). Others, though not drawing this link, still stigmatize the work. As an example, Pfeffer claims that "[b]y no stretch of the imagination is selling eggs a dignified source of income" (*supra* note 45 at 640).

[164] See Saravanan, *supra* note 52 at 6; Deomampo, *supra* note 101 at 168, 184.

they could contribute.[165] On average, the fee that surrogates receive represents the equivalent of seven years of earnings.[166] In some instances, the fee is equivalent to twenty years of existing salary as domestic servants, agricultural labourers, or other similar waged work.[167] Even if a surrogate was earning the estimated average Indian per capita 2012 income of US$1,230, and only earned at the low range of the typical US$3,000–6,000 fee, the fee would still represent more than two and a half years of income from other available work. As Vora aptly remarks, these figures represent earnings "from which it is possible to imagine another future even if that future is simply coming closer to ends already mandated (dowry and wedding expenses, debt)."[168] Though not necessarily life-changing, the amount nevertheless offers most surrogates an economic elevation in income that distinguishes it from modes of trafficking related to the sex and domestic labour trades, as well as a relatively renewable use of the body that distinguishes it from the organ trade.

Women who elect to be surrogates are aware of their life circumstances and have made choices about what would be best for themselves and their families.[169] Advocating respect for surrogates' decisions to participate in commercial surrogacy is not to deny the sense of compulsion many may feel to enter the industry, but to insist that it is too reductive to dismiss these choices because they materialize amidst disadvantaged life conditions and deep structural inequality.[170] As Katy Fulfer argues, despite being cautious about the rhetoric of choice and the potential to misunderstand women's commercial gestational acts as expressions of freedom, it is still possible to recognize agency in the context of, as she prefers to call it, "contract pregnancy", that is grossly asymmetrical in terms of the power relations it organizes.[171] Specifically, Fulfer draws on Jennifer

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165 See Gupta, "Reproductive Biocrossings", *supra* note 14 at 36; Saravanan, *supra* note 52 at 6, 10.

166 See Crozier, Johnson & Hajzler, *supra* note 22 at 62.

167 See Saravanan, *supra* note 52 at 6.

168 Vora, "Potential", *supra* note 113 at S103.

169 See *ibid* at S102–S103; Majumdar, *supra* note 15 at 295. It is, of course, imperative, as Natalie Fixmer-Oraiz cautions, not to let respect for women's choices "deflect critical attention away from the material and contextual conditions of transnational commercial surrogacy" or promote "an uneasy alliance—a facile levelling of the field—between women who opt for surrogacy as a last resort for family formation and those who pursue commercial reproductive labor on the global market in the absence of more desirable forms of work or income" (*supra* note 141 at 147).

170 See Pande, "Commercial Surrogacy", *supra* note 48 at 988; Pande, "Not an 'Angel'", *supra* note 50 at 161; Deomampo, *supra* note 101 at 168.

171 Katy Fulfer, "Commercial Contract Pregnancy in India, Judgment, and Resistance to Oppression" (2015) 30:4 Hypatia 846 at 850.

Nedelsky's work on judgment and relational autonomy to "suggest that an exercise of judgment, which is a critically considered, intersubjective value claim, can be an exercise of agency and can encourage resistance to oppression, even though such situations are extremely oppressive."[172] While we may agree that surrogates' choices are deeply constrained,[173] we may hold such a view in some measure about all women and other marginalized groups given the ubiquity and daily manifestations of oppression. At some point, we need to respect the decisions of poor women instead of limiting their choices. It is not easy to ascertain when this should occur, but the views of surrogates themselves should lead such deliberations.[174]

Indeed, it would be problematic to fall into the typical cultural framing that non-Western women's choices receive under Western feminist readings—that is, one that assumes that they are pawns of a dominant culture that glorifies motherhood or traditional gender roles, or that they are always already coerced.[175] As Ratna Kapur reminds us in her work on the sexual subaltern, to assume that women in non-Western contexts who sell their bodies in some capacity must be trafficked and evacuated of agency is to fall prey to colonial understandings of the lives and choices that non-Western women can make.[176] The same caution should apply to surrogacy work, particularly given that emerging Western feminist "accounts of Indian surrogacy are prone to [a] pattern of analysis" that entrenches the reductive Western feminist representation of non-Western women "as backward, poor, illiterate, culturally oppressed, and in need of rescue."[177] Indian surrogates themselves do express positive feelings about helping others experience parenthood (as do surrogates in richer countries), but also express appreciation for the respite that surrogate hostels give them from their normal domestic responsibilities and relationships.[178] Critically, they are also very clear about their desire to access the economic windfall a successful surrogacy pregnancy brings.[179] Some surrogates go on to serve as brokers themselves or "agent-caretakers", helping to recruit more

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172 *Ibid* at 851. To support this claim, Fulfer draws on Jennifer Nedelsky, *Law's Relations* (New York: Oxford University Press, 2011).

173 For an argument that transnational surrogacy is trafficking akin to the organ trade, see Knoche, *supra* note 19 at 184–85.

174 See Pande, "Commercial Surrogacy", *supra* note 48; Bailey, *supra* note 155 at 726.

175 See generally Narayan, *supra* note 25; Chandra Mohanty, "Under Western Eyes: Feminist Scholarship and Colonial Discourses" (1988) 30 Feminist Rev 61.

176 Kapur, *supra* note 25.

177 Bailey, *supra* note 155 at 717.

178 See Saravanan, *supra* note 52 at 8.

179 See Pande, "Not an 'Angel'", *supra* note 50 at 150; Gupta, "Reproductive Biocrossings", *supra* note 14 at 35–36.

surrogates and gaining power in the process vis-à-vis other women.[180] As Daisy Deomampo summarizes in relation to her fieldwork on surrogates and agent-caretakers operating outside of the hostel system, "[w]hile the system treats surrogates as though they are no more than wombs-for-rent, their voices and hopes reveal complex histories of women and families struggling to get into a global market on the best terms they can muster."[181] We need to see these women as making decisions that they believe necessary and allow for the very real possibility that in taking up gestational work they will contest the dominant and oppressive industry and social narratives about their work and, in doing so, exercise resistance and agency.[182]

It seems necessary, given these findings, to respect women's desires to access the economic advancement that surrogacy promises and the related social or cultural capital that may flow from it. Abolition of the practice therefore presents as an extreme and paternalistic response. At the same time, respecting the economic advancement commercial surrogacy generates need not entail disavowing or minimizing the exploitative aspects of the practice and the structural inequalities of power that give rise to it.[183] Bailey attests to the value of feminist ethnographic work that contextualizes surrogates' choices, but insists that normative scrutiny of highly stratified globalized reproductive practices as a social justice matter is still needed.[184] Part of this scrutiny, in my view, involves assessing the duties of sending states whose citizens create and participate in transnational surrogacy abroad, including how such states can cultivate domestic law reform that might curtail exploitative transnational arrangements. The next Part takes up this question of law reform in the Canadian context.

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[180] See Deomampo, *supra* note 101 at 176–83. In her fieldwork, Deomampo describes the position of agent-caretakers that women can also take on, which is slightly different from that of broker insofar as agent-caretakers also take care of women throughout the pregnancy in terms of shepherding them to appointments, administering injections, and dispersing payments—services for which they receive a fee from doctors or clinics. She notes the intermediary position of class power and agency this position brings to these women. See also Saravanan, *supra* note 52 at 6.

[181] Deomampo, *supra* note 101 at 184.

[182] See Fulfer, *supra* note 171 at 857–59. For an example of surrogates challenging dominant logics about their role and value, see Pande, "Dummy Tummies", *supra* note 80 at 56–57.

[183] See Bailey, *supra* note 155 at 725.

[184] *Ibid* at 733.

III. Recommendations for Domestic Legal Reform

In light of the globalized reverberations of restrictive ART laws at home, a postcolonial framework asks Canadian feminists to advert to global, and not just domestic, considerations of justice when considering how to revise the *AHRA*. As many of the practices comprising transnational commercial surrogacy at the present time in India are exploitative, a postcolonial feminist framework thus prompts sending nations, of which Canada is one, to evaluate the impact of the *AHRA* in inducing Canadians to travel to India or elsewhere in the Global South where commercial surrogacy may develop due to conditions of poverty if Indian bans most foreign couples from hiring a surrogate or, indeed, bans commercial surrogacy altogether. Another framing of this issue is to ask: "how can we ensure that the crossing of geographic and 'biological' boundaries does not become a crossing of ethical boundaries?"[185] The remainder of this Part explores this question, offering three suggestions for law reform in Canada to encourage Canadians to remain in Canada for their fertility needs, including using a surrogate, until better regulation exists in India and elsewhere in the Global South where Canadians may travel for surrogacy. These suggestions operate from the premise that if surrogacy and surrounding fertility treatments were more accessible in Canada, Canadians would not travel abroad to India and other countries where treatments are more affordable, but occur amidst exploitative conditions. The following discussion explains the steps Canada could take to make domestic treatment and services more desirable to Canadians and demonstrates why these steps resonate with feminist concerns about minimizing women's exploitation in the regulation of surrogacy.[186]

A. Repealing Canada's Ban

The first suggestion for reform that a postcolonial feminist focus on cross-border surrogacy invites is extending the *AHRA*'s tolerance for altruistic surrogacy to include commercial surrogacy as well. It seems obvious that legalization of the commercial option is the first step to make domestic access feasible and cross-border care a less considered option.[187] Moreover, allowing Canadians to pay women for surrogacy would very likely increase the number of women willing to be surrogates in Canada and thus help alleviate the current shortage.[188] Further, the *AHRA*'s crim-

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185 Sarojini, Marwah & Shenoi, *supra* note 61 at 8.

186 See discussion in Part I.A., above.

187 See Busby, "Of Surrogate Mother Born", *supra* note 5 at 291.

188 For more on the shortage, see Denise Balkissoon, "It's Illegal to Pay a Surrogate Mother in Canada. So What Would Motivate a Woman to Do It?", *The Globe and Mail* (12 Feb-

inalization of commercial surrogacy has arguably contributed to the ongoing stigma attached to using a surrogate or to being a surrogate, thus exacerbating the social disinclination for women to act as surrogates even on an altruistic basis.[189] Lifting the commercial ban may help diminish this stigma and augment public acceptance.

1. Alignment with Feminist Concerns: A Lack of Exploitation at Home

Repealing the *AHRA*'s ban on paying a woman to be a surrogate aligns with long-standing feminist impulses in this area to prevent exploitation. Feminist scholarship has noted the value that payment for gestational services can bring to the lives of both women who provide gametes or carry an embryo to term for another woman and those who receive those services.[190] Still, the fear that third parties (brokers, clinics) or recipients (commissioning parents) will exploit surrogates remains a primary argument against commercial surrogacy (although, as Cattapan has uncovered, it was never properly substantiated and simply assumed[191]). Recent empirical work on commercial surrogates, however, has provided a counter-narrative to traditional feminist anxieties that the practice leads to the most disadvantaged women being exploited. These American studies

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ruary 2015), online: <www.theglobeandmail.com/life/parenting/an-inside-look-at-the-difficult-process-of-surrogacy/article22953150/>. Although general knowledge about economic incentives would support this conclusion, it is difficult at the moment to offer concrete evidence of this impact in Canada with respect to surrogacy as so little is known about both the number of altruistic surrogacies that take place every year and the commercial ones that may occur despite the prohibition in the *AHRA* against payment. For a discussion of how payment generally incentivizes people, see Edward P Lazear, "Performance Pay and Productivity" (2000) 90:5 Am Econ Rev 1346; Ignacio Franceschelli, Sebastian Galiani & Eduardo Gulmez, "Performance Pay and Productivity of Low- and High-Ability Workers" (2010) 17:2 Labour Econ 317.

189 See Vanessa Gruben & Angela Cameron, "Quebec's Constitutional Challenge to the Assisted Human Reproduction Act: Overlooking Women's Reproductive Autonomy?" in Stephanie Paterson, Francesca Scala & Marlene K Sokolon, eds, *Fertile Ground: Exploring Reproduction in Canada* (Montreal: McGill-Queen's University Press, 2014) 125 at 141.

190 For an in-depth ethnography on this value in surrogacy arrangements, see Elly Teman, *Birthing a Mother: The Surrogate Body and the Pregnant Self* (Berkeley: University of California Press, 2010). Scholarship has also highlighted the point that women will view their reproductive tissue in different ways and express diverse views about market alienability (see Carolyn McLeod & Françoise Baylis, "Feminists on the Inalienability of Human Embryos" (2006) 21:1 Hypatia 1 at 9–10).

191 Cattapan, "Risky Business", *supra* note 4 at 371–74. This is a fear that feminists articulate with respect to transnational reproduction in general (see Nahman, *supra* note 36 at 631). The spectre of exploitation also persuades some feminists to resist commodification of women's eggs for research purposes (see F Baylis & C McLeod, "The Stem Cell Debate Continues: The Buying and Selling of Eggs for Research" (2007) 33:12 J Medical Ethics 726 at 727, 730).

show that it is white, educated, not financially desperate, and married women with children of their own who are most often surrogates.[192] As Erin Nelson notes in discussing this empirical work, "[c]ontrary to feminist arguments made in the early days of ARTs, the women who act as surrogates are not poor, uneducated women of color who comprise some sort of reproductive 'underclass' to serve the needs of wealthy white women."[193]

Jenni Millbank's review of the social science literature on surrogates' experience in the UK reveals similar findings about the identity of surrogates and their non-exploitative experiences.[194] Millbank also discusses emergent longitudinal research assessing outcomes for children born through surrogacy that has found no reason to be particularly concerned about the welfare of surrogate-born children.[195] Finally, Karen Busby and Delaney Vun's conclusions following a review of all empirical studies of surrogate experiences published in English also confirm that surrogates do not feel exploited, and, in fact, are content with their experiences.[196] Busby has also noted the virtual absence of reported accounts—either in academic venues or even in media outlets—of Canadian surrogates' dissatisfaction with their experiences.[197]

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[192] See Busby & Vun, *supra* note 3 at 42–43, 48 (on surrogates being white and educated); Hazel Baslington, "The Social Organization of Surrogacy: Relinquishing a Baby and the Role of Payment in the Psychological Detachment Process" (2002) 7:1 J Health Psychology 57 at 62. Some studies note that surrogates have lower educational levels and socioeconomic status than the intended parents, but that they still do not feel exploited (see Olga van den Akker, "Genetic and Gestational Surrogate Mothers' Experience of Surrogacy" (2003) 21:2 J Reproductive & Infant Psychology 145 at 147).

[193] Erin Nelson, "Global Trade and Assisted Reproductive Technologies: Regulatory Challenges in International Surrogacy" 41:1 JL Med & Ethics 240 at 247.

[194] Millbank, "Rethinking", *supra* note 14 at 480–81. See also Imrie & Jadva, *supra* note 20.

[195] This research has followed children at set year intervals, most recently tracking them at the age of ten (see Millbank, "Rethinking", *supra* note 14 at 481, citing Susan Golombok et al, "Children Born Through Reproductive Donation: A Longitudinal Study of Psychological Adjustment" (2013) 54:6 J Child Psychology & Psychiatry 653 at 657–58). See also V Jadva et al, "Surrogacy Families 10 Years On: Relationship with the Surrogate, Decisions over Disclosure and Children's Understanding of their Surrogacy Origins" (2012) 27:10 Human Reproduction 3008.

[196] Busby & Vun, *supra* note 3 at 80–81. See also Busby, "Of Surrogate Mother Born", *supra* note 5 at 292, 307. Busby notes that studies published after Busby & Vun, *supra* note 3 continue to confirm the satisfaction trend, while studies emerging about Indian surrogates' experience do not (Busby, "Of Surrogate Mother Born", *supra* note 5 at 288, n 12).

[197] Busby, "Of Surrogate Mother Born", *supra* note 5 at 302–303, n 73.

Domestically, then, if we extrapolate from the American and UK contexts and factor in Busby's Canadian research, it appears that Canadian feminists' fears about exploitation are unfounded; surrogates' actual experiences in economically affluent nations have not been exploitative.[198] The speculated harm galvanizing the *AHRA* and its legislative counterparts internationally has not manifested. This reality leads to the observation that *domestic* surrogacy produces minimal, if any, exploitation even when commercialized—a statement we cannot yet make about the transnational sphere where poorer countries from the Global South are engaged. Encouraging Canadians to stay at home for surrogacy thus aligns with long-standing anti-exploitative feminist motivations in this area.

Feminists who are skeptical of the empirical findings regarding the lack of surrogate exploitation may still concede a critical difference between domestic and transnational surrogacy if they consider the respective underlying health and economic regulatory contexts in which surrogacy is practised. Specifically, parentage laws and public health care standards are in place in Canada that do not currently exist in India, which would prevent exploitative working and health conditions for Canadian women who might engage in paid surrogacy work if legalized. Regarding parentage laws, although not yet offered by all provinces and territories, regulation at the point of parentage determination can considerably enhance the power of surrogates.[199] For example, British Columbia's new family reform in this area declares the commissioning parents to be the legal parents as long as certain conditions are met.[200] Critical among these, the legislation will only recognize the commissioning parents as the

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198 As Elly Teman notes in her ethnographic account of surrogates and intended mothers in Israel, empirical work incorporating the actual experiences of surrogacy providers and recipients is sparse and most academic arguments about the practice are theoretical (*supra* note 190 at 1–3).

199 See Busby, "Of Surrogate Mother Born", *supra* note 5 at 288.

200 British Columbia's new family law legislation mandates the execution of surrogacy agreements as a precondition of parentage recognition for the intended parent(s) (see *FLA*, *supra* note 105, s 29). The *FLA* will recognize the intended parent(s) as the parent once the child is born if, *inter alia*, there is a pre-conception written agreement between the surrogate as birth mother and the intended parent(s) stipulating that: "(i) the surrogate will not be a parent of the child, (ii) the surrogate will surrender the child to the intended parent or intended parents, and (iii) the intended parent or intended parents will be the child's parent or parents" (*ibid*, s 29(2)(b)). If such an agreement is in place, the *FLA* also requires, for the intended parent to qualify as parent, that no one withdraw from the agreement before the child's birth, and that post-birth, the surrogate consent in writing to the child's surrender and the intended parent(s) receive the child into their care (*ibid*, s 29(3)). BC also inaugurated a family law system of recognizing more than two parents for a child by allowing the surrogate or egg or sperm donor that may have also been involved to parent along with the commissioning individual or couple (*ibid*, s 30).

parents if the surrogate gives her consent to the arrangement *after* the birth, a provision that scholars have noted ensures the surrogate's consent is informed and ongoing[201] and that affords the surrogate considerable power vis-à-vis the parent(s) during the entire gestational period and thereafter.[202]

Feminists assessing the prospect of exploitation from payment have also pointed to standard health care autonomy components of domestic regulatory frameworks as elements that amplify surrogates' bargaining power vis-à-vis commissioning parents. Scholars have commented that the deference to intended parental desires about prenatal testing, selective fetal reduction, and other medical decisions that may be taken in pregnancy that routinely occur in India would not transpire under medical informed consent protocols in affluent nations. Instead, the health care system would treat surrogates as patients and thus seek their informed consent.[203] This framework should allay feminist concerns that a commercial model is necessarily exploitative. Of course, regulation of Canada's fertility industry would also help ensure the absence of exploitative conditions, but general physician regulation and health care consent protocols are significant shields against the kind of exploitation that occurs in India manifesting in Canada.

2. Resolving Governmental Inconsistency

In addition to responding to traditional feminist concerns about commercial surrogacy, permitting a commercial model can also absolve Canada from its inconsistent position on the issue. Recall that payment for surrogacy is an offence punishable by up to ten years' incarceration and a $500,000 fine under the *AHRA*—quantitative amounts on both registers that are quite onerous and send a strong symbolic message that the practice deeply offends public morals. Yet, Canada will recognize those who acquire a child through a legal commercial surrogacy abroad as the legal parent of that child and permit the child to acquire Canadian citizenship (as long as at least one parent can establish a genetic link to the child).[204]

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[201] See Millbank, "Rethinking", *supra* note 14 at 488.

[202] See Busby, "Of Surrogate Mother-Born", *supra* note 5 at 297, 303–304.

[203] See *ibid* at 313; Millbank, "Rethinking", *supra* note 14 at 486.

[204] See Canada, Department of Citizenship and Immigration, "Assessing Who is a Parent for Citizenship Purposes Where Assisted Human Reproduction (AHR) and/or Surrogacy Arrangements are Involved", Operational Bulletin 381 (Ottawa: CIC, 8 March 2012), online: <www.cic.gc.ca/english/resources/manuals/bulletins/2012/ob381.asp>. A majority of the Federal Court of Appeal, despite its flagging of the potential *Charter* equality implications of government policy and legislation that uses method of conception of children as a ground to limit citizenship status, recently affirmed the federal govern-

Kristin Lozanski unpacks the hypocrisy of this position. She notes that the *AHRA* asserts that commercial surrogacy is immoral because of the exploitation of women and children it entails and therefore applies hefty repercussions on transgressors of this moral code. Yet, where this exploitation occurs abroad, Canada is unconcerned and will actually help Canadians bring home babies born from commercial surrogacy.[205] Lozanski argues that this undermines the anti-commodification and gender equality principles underlying the *AHRA*.[206] She further observes that the tacit approval it supplies through detailed instructions to Canadian commissioning parents on how to establish citizenship for their children born abroad via commercial surrogacy permits the Canadian government to sidestep controversy and ignore public ambivalence about the practice's purported immorality.[207] Lozanski points out that this transnational "safety valve"[208] that relieves the government from internal calls to relax regulation is possible because of the "bioavailability"[209] of poor women in the Global South.[210] She further reveals Canada's laws to be the most incongruous out of all other states whose internal and external approaches are not coherent.[211] Instead of advocating for an extraterritorial criminal ban, however, to achieve coherence, Lozanski calls for a genuine public conversation about whether paid surrogacy today actually yields the harms it was imagined to in 1993 at the time of the RCNRT deliberations.[212]

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ment's position in the Bulletin regarding the requirement of a genetic link (understood as supplying the gamete) in *Kandola v Canada (Citizenship and Immigration)*, 2014 FCA 85 at paras 3, 75, [2015] 1 FCR 549. The Federal Court of Appeal majority decision overturned the Federal Court trial decision *Kandola v Canada (Citizenship and Immigration)*, 2013 FC 336, [2014] 3 FCR 355, which held that pursuant to the proper statutory interpretation of section 3(1)(b) of the *Citizenship Act*, RSC 1985, c C-29, all that is required for a child to receive citizenship is for the Canadian intended parent to be recognized as the legal parent abroad where the child is born and for that parent to demonstrate an intent to act as the permanent caregiver for the child. In doing so, the Federal Court of Appeal endorsed the *jus sanguinis* position of Citizenship and Immigration Canada (see *ibid* at paras 6–14, 42–44). For a critical appraisal of the decision, see Lois Harder, "Does Sperm Have a Flag?: On Biological Relationship and National Membership" (2015) 30:1 CJLS 109 at 117–21.

205 Lozanski, *supra* note 8 at 387.

206 *Ibid* at 387–88.

207 *Ibid* at 388.

208 *Ibid*.

209 *Ibid* at 385.

210 See also Singh, *supra* note 23 at 825; Bharadwaj, *supra* note 162 at 113.

211 Lozanksi, *supra* note 8 at 386.

212 *Ibid* at 388–89.

Lozanski's call for revisiting the ban and resolving Canada's inconsistency is particularly pressing given that third parties currently profit from surrogacy in Canada in spite of the ban. Although the *AHRA* prevents third parties from accepting, and commissioning parents (or anyone else) from offering, consideration for "arranging" surrogacy, it does not prevent third parties from brokering—on a for-profit basis—altruistic surrogacy connections as long as this facilitation does not qualify as "arranging". Thus far, this term is unspecified either by statute or case law.[213] Lifting the domestic prohibition on commercial surrogacy would thus eliminate not only the inconsistency that exists within the federal government's responses to the commercial surrogacy issue in the immigration arena, but also the inconsistency that resides in the terms of the *AHRA* itself.[214]

3. Responding to Present-Day Public Preferences

A final point to note against the commercial ban is a lack of broad-based public support for it. Some Canadian feminists have recently argued that the *AHRA*'s criminal prohibitions against commodification rest on shaky morality principles that have never received widespread public approval and do not reflect current Canadian social mores.[215] Outside of Canada, though stigma persists, scholars have noted the increasing social legitimacy ascribed to surrogacy in general, including commercial surrogacy.[216] While majoritarian support for a measure should not serve as a mandatory moral compass for ethical policy and law-making,[217] discounting changes in public opinion about a social controversy can also impede a dynamic approach to the law.

4. Government-Mediated Delivery

In considering this overall argument in favour of legalizing commercial surrogacy in Canada, it is instructive to note that legalization need not entail a pure market model of delivery. Instead, the state could medi-

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[213] See Balkissoon, *supra* note 188 (discussing a business that facilitates such connections but has thus far avoided any type of prosecution under section 6 of the *AHRA*).

[214] Of course, the inconsistency can also be avoided by a Canadian criminal prohibition that had extraterritorial effect. As discussed in Part III.C., this would be a harsh and unproductive response.

[215] See Drummond & Cohen, *supra* note 8.

[216] See e.g. Jenni Millbank, "From Alice and Evelyn to Isabella: Exploring the Narratives and Norms of 'New' Surrogacy in Australia" (2012) 21:1 Griffith L Rev 101 at 106–107, 110.

[217] See Angela Campbell, "A Place for Criminal Law in the Regulation of Reproductive Technologies" (2002) 10 Health LJ 77 at 81–82.

ate the surrogacy arrangement and, ideally, fund it under Medicare.[218] Governments could develop an administrative system that connects those seeking a surrogate to women interested in the work.[219] More importantly, a set fee could be paid to all surrogates much like a set fee is paid to doctors who opt into government public health insurance schemes for a specific treatment or procedure.[220] This type of regulation could alleviate long-standing feminist concerns about a market that would place a higher premium on certain embodied traits since all surrogates would receive the same set fee. What this fee should be would need to be figured out. How it should be delivered would also need to be determined.[221] Although the model would still permit commissioning parents to express racialized and other discriminatory preferences in terms of finding a surrogate, it would eliminate higher valuation and remuneration of whiteness and the features thought to be associated with it.[222]

If the prospect of state-funded surrogacy through Medicare coverage or otherwise seems too fantastical (although it should not), the possibility of state funding for the fertility treatments necessary for gestational surrogacy is a more familiar and tested idea also worth popularizing.

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[218] At the present time, given debates about health care costs being out of control, public funding for surrogacy seems a very unlikely reality, but I flag it here to recognize that if surrogacy were a covered benefit under provincial health insurance plans, remaining in the domestic sphere to create families would be even more desirable. The argument in this section, however, does not turn on it becoming an insured service under Medicare. For an overview of the debate on the costs of health care in Canada, see William Lahey, "Medicare and the Law: Contours of an Evolving Relationship" in Jocelyn Downie, Timothy Caulfield & Colleen M Flood, eds, *Canadian Health Law and Policy*, 4th ed (Markham: LexisNexis, 2011) 1 at 5–16.

[219] See Millbank, "Rethinking", *supra* note 14 at 486 (suggesting both strengths and weaknesses of a state-mediated system in Australia).

[220] See e.g. *Medicare Protection Act*, RSBC 1996, c 286, ss 13, 14, 17–18. This fee, like all other physician fees, would necessarily vary among provinces and territories.

[221] The literature on this topic is notably sparse, but for discussion on the appropriate methods for fee delivery in a domestic context, see Kim Cotton, "Surrogacy Should Pay" (2000) 320:7239 Brit Med J 928. For a proposal in favour of imposing subsidies on sending nations like Canada to raise the fees that international surrogates in India and elsewhere get paid, see Crozier, Johnson & Hajzler, *supra* note 22 at 66–67. The scope of the present paper does not allow for a nuanced discussion of the financial considerations my proposal entails.

[222] Even if governments do not get involved in funding or facilitating surrogacy arrangements or licensing intermediaries as they do for adoption arrangements, privately arranged surrogacies could also be subject to a set fee schedule. See e.g. *Adoption Act*, RSBC 1996, c 5, ss 4–10 on licensing intermediaries for adoption arrangements.

B. Providing Publicly Insured IVF and Other ARTs

The repeal of the *AHRA*'s ban on commercial surrogacy needs to be combined with a measure that will not just decriminalize the practice, but also make it more affordable. One way to accomplish this goal, as noted above, is for governments to fund payment to surrogates. Another route worth pursuing is to mandate coverage for ART procedures under the health care plans of each province and territory.[223]

Most individuals and couples seeking to overcome infertility will unsuccessfully go through ART procedures such as IUI and IVF before seeking the services of a surrogate to carry their future child.[224] Those who engage a gestational surrogate will do so through fertility clinics where the commissioning parties must pay for ART treatments. This arrangement invariably includes IVF to retrieve the commissioning mother's eggs or procure donor eggs and fertilize them with the commissioning father or donor's sperm to create the embryo that will then be transferred to the uterus of the surrogate.[225] These costs for IVF procedures are in addition to the drug costs that commissioning parents must bear for the parties undergoing treatment. The average treatment costs per IVF cycle across Canada in 2002 averaged $7,252[226] and the cost of drugs for a woman who undergoes egg retrieval is usually between $3,000 and $5,000.[227]

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[223] For a variety of arguments in favour of the public funding of assistive reproductive technologies, see Edward G Hughes & Mita Giacomini, "Funding In Vitro Fertilization Treatment for Persistent Subfertility: The Pain and the Politics" (2001) 76:3 Fertility & Sterility 431; I Glenn Cohen & Daniel L Chen, "Trading-Off Reproductive Technology and Adoption: Does Subsidizing IVF Decrease Adoption Rates and Should It Matter?" (2010) 95:2 Minn L Rev 485 at 505–32.

[224] See e.g. Mimi Meyers et al, "An Infertility Primer for Family Therapists: I. Medical, Social, and Psychological Dimensions" (1995) 34:2 Family Process J 219 at 221.

[225] See Lozanski, *supra* note 8 at 383.

[226] See John A Collins, "An International Survey of the Health Economics of IVF and ICSI" (2002) 8:3 Human Reproduction Update 265 at 269. While the figures would be different today since this article is from 2002, it still gives a clear indication of the significant financial burden of IVF.

[227] Email from Dr. Stephen Hudson, Medical Director, Victoria Fertility Clinic (20 February, 2015). See also BabyCenter Canada, "Cost of Fertility Treatments in Canada" (January 2012), online: <www.babycenter.ca/a1028300/cost-of-fertility-treatments-in-canada#ixzz3SzrlY5uY>. The only economic relief some intended parents may receive is via an extended health care plan that covers ARTs. While all provinces and territories have gone above and beyond the requirements of Medicare—as per the *Canada Health Act* RSC 1985, c C-6 [*CHA*]—to establish drug plans to help individuals and families who pay a disproportionate amount of their income on prescription drugs, most of these discretionary provincial plans exclude the expensive injectable fertility medications often required for IUI and IVF (see e.g. Ontario, Ministry of Children and Youth Services, "Care to Proceed: Infertility and Assisted Reproduction in Ontario" (March 9, 2013),

1. Increasing Accessibility

That the commissioning parent(s) must assume the costs of these medical treatments because most public health insurance plans of provinces and territories do not cover them is a primary reason that surrogacy is expensive, despite Canada being a jurisdiction where surrogates are not permitted to receive payment. Quebec, a previous provincial leader in covering ART procedures as well as attendant medications, recently announced that it would delist these services under its provincial Medicare plan.[228] This decision is largely believed to be a cost-saving move—while the plan was in place, use of ART services increased more than anticipated.[229] Ontario, however, recently announced that it would fund one IVF cycle for eligible women that would include the costs of egg retrieval and

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online: <www.children.gov.on.ca/htdocs/English/infertility/report/caretoproceed.aspx>). Only the Quebec provincial plan includes the costs of medications for covered IVF services (see Québec, Ministère de la santé et des services sociaux, "Québec Assisted Reproduction Program" (26 August 2014), online: <www.sante.gouv.qc.ca/en/programmes-et-mesures-daide/programme-quebecois-de-procreation-assistee/remboursement-des-couts/> [Quebec Program]).

228 Quebec's plan funds the basic infertility assessment costs, egg retrieval, egg donation, preimplantation genetic diagnosis, and up to three rounds of stimulated IVF cycles, or six cycles of natural or modified IVF cycles, with the restriction that only one embryo be transferred at a time. Drug costs are reimbursed according to each individual's drug insurance plan (see Quebec Program, *supra* note 227). Quebec recently announced it would alter this generous coverage by limiting provincial funding of IVF for all but a small cohort of residents (see Geoffrey Vendeville, "Quebec Cuts Public Funding for In Vitro Fertilization", *Montreal Gazette* (28 November 2014), online: <www.montrealgazette.com/news/quebec/quebec-cuts-ivf-coverage-and-threatens-doctors-with-sanctions>). Bill 20 will introduce instead a tax credit scheme that should cost the government less. It excludes, however, women younger than eighteen and older than forty-two, those who already have a child, those who have not tried conceiving through sexual intercourse for a stipulated period of time (varying according to a woman's age), and those who are presently infertile because of a past sterilization procedure they underwent voluntarily (see Bill 20, *An Act to enact the Act to promote access to family medicine and specialized medicine services and to amend various legislative provisions relating to assisted procreation*, 1st Sess, 41st Leg, Quebec, 2014, cl 3; Katharine Browne, "Voluntary Sterilization, Personal Responsibility, and IVF Coverage" (17 March 2015), *Impact Ethics* (blog), online: <www.impactethics.ca/2015/03/17/voluntary-sterilization-personal-responsibility-and-ivf-coverage/>). For the media debate on Quebec's approach, see Vida Panitch, "Provincial Funding of IVF Should Be Restricted on the Basis of Income" (14 November 2014), *Impact Ethics* (blog), online: <www.impactethics.ca/2014/11/14/provincial-funding-of-ivf-should-be-restricted-on-the-basis-of-income/>; Neal Mahutte, "Opinion: Quebec Should Continue to Fund IVF Treatments", *Montreal Gazette* (11 December 2014), online: <www.montrealgazette.com/news/quebec/opinion-quebec-should-continue-to-fund-ivf-treatments>.

229 See Vendeville, *supra* note 228; "New Quebec Health Bill to Restrict IVF Treatments, Impose Quotas for Family Doctors", *CBC News* (28 November 2014), online: <www.cbc.ca/news/canada/montreal/new-quebec-health-bill-to-restrict-ivf-treatments-impose-quotas-for-family-doctors-1.2853715>.

single embryo transfer of all viable embryos produced, but not fertility drugs.[230] If more health insurance plans covered IUI and IVF, more women would be able to access them and perhaps prevent the need to resort to a gestational surrogate to have a biological child altogether. For those women who cannot achieve and maintain pregnancy even after multiple cycles of IUI and IVF and wish to try gestational surrogacy, publicly funded ART procedures and subsidized drug costs would make this route to family formation much more accessible in Canada. While further measures in addition to public funding are necessary to eliminate socioeconomic inequities in terms of who accesses IVF, removing financial barriers remains a central component of increasing accessibility to ART treatments.[231]

2. Responding to (Feminist) Arguments Against ART Funding

The accessibility argument in favour of funding IVF and other ART treatments loses some purchase in a climate of fiscal restraint. Some scholars have also questioned the suitability of state funding in light of other health care priorities.[232] Several feminist scholars have articulated the concern that any state funding for IVF and other fertility treatments should not exceed state support for adoption in order to ensure financial parity for different modes of family creation.[233] Other feminists worry about the pro-life message that public funding for infertility sends when the same government denies funding for abortion.[234] Finally, some femi-

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230 See Ontario, Ministry of Health and Long-Term Care, News Release, "Ontario to Expand Funding for Fertility Services" (1 October 2015), online: <news.ontario.ca/mohltc/en/2015/10/ontario-to-expand-funding-for-fertility-services.html>. Women with an infertility diagnosis as well as lesbian couples and single women are eligible up until the age of forty-three. The initiative applies to surrogates as well as intended mothers. The government has explicitly adopted this measure to recognize infertility as a serious medical condition and promote accessibility to IVF.

231 See Philipa Mladovsky & Corinna Sorenson, "Public Financing of IVF: A Review of Policy Rationales" (2010) 18:2 Health Care Analysis 113 at 121–22.

232 See *ibid* at 120.

233 See Sarah Chapple, "IVF and Adoption: Not Two Sides of the Same Coin" (3 June 2014), *Impact Ethics* (blog), online: <www.impactethics.ca/2014/06/03/ivf-and-adoption-not-two-sides-of-the-same-coin/>; Carolyn McLeod & Andrew Botterell, "Raising Expectations About IVF but Not Adoption" (6 May 2014), *Impact Ethics* (blog), online: <www.impactethics.ca/2014/05/06/raising-expectations-about-ivf-but-not-adoption>; Françoise Baylis & Jocelyn Downie, "Achieving National Altruistic Self-Sufficiency in Human Eggs for Third-Party Reproduction in Canada" (2014) 7:2 Intl J Feminist Approaches to Bioethics 164 at 178–79.

234 See Rachael Johnstone, "Privileging Infertility over Abortion in New Brunswick" (6 August 2014) *Impact Ethics* (blog), online: <www.impactethics.ca/2014/08/06/privileging-infertility-over-abortion-in-new-brunswick/>.

nists intimate that the accessibility argument is a red herring: insofar as natalist motherhood ideologies apply primarily to white, able-bodied, middle-class, and heterosexual women, non-dominant women do not experience diminished reproductive autonomy from failing to access IVF. These criticisms, while understandable, are ultimately unpersuasive as bars to public funding for IVF and other ART treatments. I address each criticism in turn.

a. Criticism 1: Other Health Care Priorities Are More Pressing

The first objection against public funding for IVF and other ARTs considers other health care priorities more pressing. This concern usually operates with an implicit assumption of which treatments are "medically necessary" and which ones are not, finding that fertility treatments, while important to the individuals who seek them out, nonetheless fall under the latter category. The delinking of medical need and infertility is contested, however, by the literature that classifies infertility as a disability.[235] Abha Khetarpal and Satendra Singh capture the core features of this argument when they write (with a focus on married couples):

> Like any other disability the couple has to adapt and integrate infertility in their sense of self thus infertility comes as a major life crisis. Medically, infertility, in most cases, is considered to be the result of a physical impairment or a genetic abnormality. Socially, couples are incapable of their reproductive or parental roles. On [a] social level, infertility in most cultures remains associated with social stigma and taboo just like the social model of disability.[236]

Khetarpal and Singh, like other scholars, argue that infertility meets the biopsychosocial model of disability that the World Health Organization has implemented that recognizes disability as both a medical and social phenomenon.[237] In addition, the authors stress the negative effects infer-

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[235] For discussion and citation of this literature, see Elizabeth A Sternke & Kathleen Abrahamson, "Perceptions of Women with Infertility on Stigma and Disability" (2015) 33:1 Sex Disability 3. See also Abha Khetarpal & Satendra Singh, "Infertility: Why Can't We Classify This Inability as Disability?" (2012) 5:6 Australasian Med J 334; Arthur L Greil, "A Secret Stigma: The Analogy Between Infertility and Chronic Illness and Disability" in Gary Albrecht & Judith Levy, eds, *Advances in Medical Sociology*, vol 2 (Greenwich, Conn: Jai Press, 1991) 17.

[236] Khetarpal & Singh, *supra* note 235 at 334.

[237] *Ibid* at 334, citing World Health Organization, "Health Topics: Disabilities", online: <www.who.int/topics/disabilities/en>. Khetarpal & Singh explain the WHO's biopsychosocial model as follows: "[The WHO] defines disabilities as 'an umbrella term, covering impairments, activity limitations, and participation restrictions. An *impairment* is a problem in body function or structure; an *activity limitation* is a difficulty encountered by an individual in executing a task or action; while a *participation restriction* is a problem experienced by an individual's involvement in life situations'" (*ibid* [emphasis in

tility can have on core relationships and the difficulty in affording treatment without private insurance coverage or government funding.[238] For all these reasons, they conclude "it becomes imperative to categorise infertility as disability."[239]

In Canadian jurisprudence, the Nova Scotia Court of Appeal accepted the disability classification and concluded that the non-funding of ARTs produces inequality in the delivery of health care.[240] This recognition enables the further argument that ART treatments that are hospital-based and physician-delivered are medically required treatments like any other that Medicare should fund as per the principle of comprehensiveness within the *Canada Health Act*[241] and section 15 of the *Charter*.[242] Thus, regardless of which health care priorities are more pressing, the non-funding of ARTs violates equality. Resource-minded courts, however, have accepted governments' desires to control health care spending despite *Charter* equality violations.[243]

As Philipa Mladovsky and Corinna Sorenson observe, however, there are serious moral shortcomings to economic justifications for de/funding IVF—by far the most prominent frame for funding that circulates in public discourse—and hence a corresponding need to entertain other policy rationales for why IVF should be funded.[244] They identify the "disability"

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original]). See also Kavita Shah & Frances Batzer, "Infertility in the Developing World: The Combined Role for Feminists and Disability Rights Proponents" (2010) 3:2 Intl J Feminist Approaches to Bioethics 109 at 118.

238 Khetarpal & Singh, *supra* note 235 at 334.

239 *Ibid*.

240 See *Cameron v Nova Scotia (AG)*, 1999 NSCA 14, 204 NSR (2d) 1 [*Cameron*].

241 *CHA*, *supra* note 227, ss 7, 9.

242 *Canadian Charter of Rights and Freedoms*, s 15, Part 1 of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11 [*Charter*].

243 See *Cameron*, *supra* note 240. The *CHA* provides that all medically necessary treatment and services provided in a clinical and hospital setting must be covered by provincial health care plans in order for provinces to receive federal funds to help pay for their health care programs (*supra* note 227, ss 2, 7, 9). ARTs would meet both criteria. It is the definition of "insured health services" in section 2 of the *Act*, and the definitions of medical services it referentially incorporates, that has heretofore provided grounds to exclude ARTs. It is on this basis that ARTs are excluded from virtually all provincial health care plans and by which the trial court in *Cameron v Nova Scotia (AG)*, 172 NSR (2d) 227, 88 ACWS (3d) 486 (SC) held that their exclusion from Nova Scotia's provincial plan did not contravene constitutional equality guarantees. On appeal, the Nova Scotia Court of Appeal held that the exclusion did violate section 15 on grounds of disability (see *Cameron*, *supra* note 240 at paras 145, 159, 208) but that this violation was justified under section 1 of the *Charter* by the government's costs rationale (see *ibid* at paras 242–45).

244 Mladovsky & Sorenson, *supra* note 231 at 114–17.

and related "medical need" justifications discussed above as important non-economic reasons.[245] The authors also highlight arguments that favour public funding for IVF on the basis that it: (1) is a human rights issue (because of the internationally recognized human right to health and to have a child);[246] (2) reduces inequality on socioeconomic grounds; and (3) increases national fertility rates.[247] The "human rights" and "inequality" justifications are egalitarian-minded and would further suggest that a position that supports public funding for IVF comports with widespread feminist principles and qualifies infertility as a pressing need.

A postcolonial feminist analysis should, ideally, be responsive to the disability, socioeconomic, and human rights frames for understanding the impact of infertility on people's lives and the cumulative argument they create that infertility is a pressing problem. For the purposes of the present analysis, it is unnecessary, however, to resolve this debate about how best to capture the harm in infertility (i.e., whether it legitimately qualifies as a disability, socioeconomic, or human rights issue). This analytical element is unnecessary because my argument emphasizes the *postcolonial* reasons for domestic funding rather than those grounded in these other frameworks.[248] Quite simply, under a postcolonial feminist lens, Canadian feminists should be persuaded to support government funding for ARTs given its potential to minimize women's vulnerability, particularly those in the Global South. By enticing Canadians to stay at home to access these services, public funding for ARTs reduces the exploitation of economically vulnerable women abroad by Canadians seeking cross-border reproductive care.[249] Whether or not other health care priorities have a greater impact on Canadians' health and thus deserve priority should be irrelevant.

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[245] *Ibid* at 117–20.

[246] *Ibid* at 120–21. This argument invokes international human rights law. See especially *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, 993 UNTS 3 art 12 (entered into force 3 January 1976) (affirming the right to health); *Universal Declaration of Human Rights*, GA Res 217A (III), UNGAOR, 3rd Sess, Supp No 13, UN Doc A/810 (1948) 71 art 16 (affirming the right to marry and form a family).

[247] Mladovsky & Sorenson, *supra* note 231 at 117–24.

[248] Of course, the concerns of feminist and disability scholars concerned about women with infertility can also readily overlap (see e.g. Shah & Batzer, *supra* note 237).

[249] See Liza Ireni-Saban, "Give Me Children or Else I Die: The Politics and Policy of Cross-Border Reproductive Care" (2013) 41:1 Politics & Policy 5 at 16 where she argues that "[i]n states with a generous and well-established social insurance provision, it might well prove possible to bolster the social insurance system and minimize the probability of seeking cross-border fertility treatment in countries with less expensive or less restrictive treatments."

b. Criticism 2: Public Funding Sends a Conservative, Pro-Life, Natalist Message

Objections that public funding for ARTs signals a pro-life position merit particular attention because it is feminists who raise them. The objections compare state support for IVF with state policies toward adoption and abortion and point to a double standard in favour of the former. Seen from this comparative angle, public funding for IVF endorses regressive, even anti-feminist, politics. Such objections are valid to the extent they emphasize that abortion and adoption services should also be supported for those who need them. But citing a double standard as a reason to oppose public funding for ARTs is misguided since marginalizing IVF and other ARTs will not necessarily generate progressive state policies toward adoption or abortion. More to the point, however, it is vital to allow that a rationale other than a conservative, pro-life position is behind public funding for IVF. Specifically, it must be recognized that reproductive autonomy is also implicated in a woman's (in)ability to conceive and gestate, and not just in a woman's decision to terminate a pregnancy. As Jody Madeira observes, most American legal scholars writing about ARTs, many of them feminist, have not made this connection. In fact, they have argued *against* recognizing women's decision making about ARTs, imagining women as desperate consumers in need of regulatory protection from themselves and from the reproductive medical and commercial establishment.[250]

Madeira contests this feminist representation of ART-seeking women and the corresponding call for stringent regulation of ARTs.[251] She documents a different double standard in need of redress: in the abortion context feminist legal scholars have vigorously emphasized women's rational decision making and the need to respect women's choices, but in the ART context they have instead maintained that women's desperation vitiates rational decision making and the ability to give informed consent to treatments.[252] Madeira argues that strong emotionally guided decision making should not undermine respect for the choices that women make—in the ART context or otherwise. She stresses that this image of women as absorbed in "emotional excess, incapacity, or irrationality" is one that feminists have rightly rejected in the abortion context and should also eschew in deliberating about ART regulation.[253] Madeira's argument forcefully

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[250] Jody Lyneé Madeira, "Woman Scorned?: Resurrecting Infertile Women's Decision-Making Autonomy" (2012) 71:2 Md L Rev 339 at 344.

[251] *Ibid* at 345.

[252] *Ibid* at 344, 346–54, 359–63.

[253] *Ibid* at 353. Canadian feminists have also noted that the psychological literature does not support a characterization of "desperation" (see Baylis & McLeod, *supra* note 191 at

conveys the autonomy interests at stake in procuring ART treatments and thus elucidates why public funding for them merits designation as a progressive, pro-choice feminist position.

But what of the concern that feminist endorsement for public funding for ARTs risks entrenching an essentialist and limiting view of women as naturally oriented toward motherhood? Would public funding not accelerate the pressure and thus entry of women into this traditional role? After all, compared to their male counterparts, pervasive natalist norms and associations of femininity with pregnancy and motherhood still centrally influence the social worth and sense of identity of women seeking to overcome infertility.[254] For many of these women, the inability to achieve pregnancy causes them "to experience a deep sense of distress and incomplete womanhood"[255] as well as the abject status of "the 'other' in societies that value children and motherhood (even if this value is not structurally supported)."[256] As Stacy Lockerbie concludes from her study of Canadian women who adopted after unsuccessful fertility treatments, "for those who struggle with infertility, becoming a mother is central to feelings about being a woman"[257]—so much so that the *adoptive* mothers she interviewed used pregnancy metaphorically to interpret their adoption experiences, translating the decidedly non-biological ties to their adopted child "as closely as possible to biological kinship."[258]

Yet, returning to Madeira's thesis, recognizing the devastation that infertility can wreak on women's lives should not engender a characterization of women as "desperate" and thus in need of regulatory protection or

729, n 35, citing A L Greil, "Infertility and Psychological Distress: A Critical Review of the Literature" (1997) 45:11 Soc Sci & Med 1679).

254 See Carolyn McLeod & Julie Ponesse, "Infertility and Moral Luck: The Politics of Women Blaming Themselves for Infertility" (2008) 1:1 Intl J Feminist Approaches to Bioethics 126 at 127 where the authors discuss the "extreme" blame that women endure for their infertility as an aspect of the suffering the condition generates. See also Stacy Lockerbie, "Infertility, Adoption and Metaphorical Pregnancies" (2014) 56:2 Anthropologica 463 at 464–65; Lauren Jade Martin, "Anticipating Infertility: Egg Freezing, Genetic Preservation, and Risk" (2010) 24:4 Gender & Society 526 at 528; Diana C Parry, "Work, Leisure, and Support Groups: An Examination of the Ways Women with Infertility Respond to Pronatalist Ideology" (2005) 53:5 Sex Roles 337 at 337; Miriam Ulrich & Ann Weatherall, "Motherhood and Infertility: Viewing Motherhood Through the Lens of Infertility" (2000) 10:3 Feminism & Psychology 323.

255 Sternke & Abrahamson, *supra* note 235 at 5.

256 Gayle Letherby, "Other than Mother and Mothers as Others: The Experience of Motherhood and Non-Motherhood in Relation to 'Infertility' and 'Involuntary Childlessness'" (1999) 22:3 Women's Studies Intl Forum 359 at 359.

257 Lockerbie, *supra* note 254 at 468.

258 *Ibid* at 469.

of submitting to false consciousness about the importance of motherhood. Rather, the extent of women's emotional and psychological investment in conceiving should lead to a recognition of how important the ability to access IVF is for many women and that, in part, the emotional distress that may be experienced is created by the regulatory and financial barriers to pursuing IVF.[259] Simply put, we need to respect the autonomy of women who use or wish to use ARTs. Respecting these choices does not always mean endorsing them or ignoring the stratified relations of power in which they are embedded. At the same time, however, public funding for ARTs should not be reduced to a conservative, anti-feminist option even though government actors may view it as a pro-life statement.

c. Criticism 3: Public Funding for ARTs is Elitist

An entrenched stereotype exists that infertility is an issue that only affects white, middle- and upper-class women.[260] Examining the causes of infertility easily topples this stereotype.[261] A more legitimate class-conscious critique, however, points out that qualitative research on IVF is heavily treatment based and thus, by extension, focused on the women affluent enough to access those clinics.[262] Even other empirical work about infertility experiences focuses on women with high socioeconomic status.[263] This narrow scope leads to a questioning of whether promoting public funding for ART treatment on the ground of promoting accessibility or otherwise truly aligns with the interests of non-dominant women, who, for a variety of structural reasons, may not experience their infertility as an impairment of their reproductive autonomy.

For example, non-dominant women may not be as concerned about biological connections or as exposed to motherhood ideologies coercing them to reproduce. Scholars have found that lesbian couples, many of whom are accustomed to queer community critiques of the limitations of biological understandings of kinship and support for families built on affect rather than blood or genetics, are more accepting of becoming parents through

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[259] See Madeira, *supra* note 250 at 353–54. Madeira's corollary goal in her article is to illuminate how legitimate decision making is often made through emotionally driven contemplation rather than in spite of it, and that this presence of emotions is to be embraced rather than mitigated.

[260] See Ann V Bell, "'It's Way Out of My League': Low-Income Women's Experiences of Medicalized Infertility" (2009) 23:5 Gender & Society 688 at 689 [Bell, "League"].

[261] See text accompanying notes 272–74.

[262] See Bell, "League", *supra* note 260 at 690.

[263] For example, it is important to recognize that in Lockerbie, *supra* note 254, the study involved heterosexual married women only.

non-biological means.[264] Located outside of heteronormative expectations, they are not subject to the dominant ideologies that heterosexual women are to achieve motherhood. To the contrary, their participation in motherhood is often the subject of homophobic skepticism and aspersion.[265] Indeed, a nuanced interrogation of motherhood ideologies leads to similar conclusions about the subdued pressures to become mothers that lower-income, Black, First Nation, and disabled women encounter due to dominant class, race, and ability ideologies about who should reproduce, the nuclear family, and nationhood.[266] Further, when we recall state policies to sterilize and otherwise limit procreation among non-dominant groups, and acknowledge current discourses questioning non-dominant women's capacity to mother, we apprehend that "childlessness may not be deviant for everyone in society."[267] From this perspective, public funding for ARTs reinforces its reputation as elitist and inegalitarian.

There are multiple arguments to counter the elitist label, however. First, despite the divergent ways that ideologies of motherhood circulate, women from all social strata experience infertility. It is reasonable to conclude that even non-dominant women can be distressed by this condition and would welcome accessing ARTs.[268] Public funding would thus benefit non-dominant groups. Critically, state funding can transform IVF and ART from a resource available to the economically privileged to one accessible across class lines. Further, if we accept that those who cannot easily afford ARTs disproportionately belong to one or more non-dominant groups, then public funding would promote reproduction by non-dominant classes—an egalitarian outcome that defies historical state eugenic policies and ongoing ideologies of motherhood that discourage reproduction by

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[264] See Abbie E Goldberg, Jordan B Downing & Hannah B Richardson, "The Transition from Infertility to Adoption: Perceptions of Lesbian and Heterosexual Couples" (2009) 26:6–7 J Social & Personal Relationships 938 at 955–56.

[265] See *ibid* at 943.

[266] Of course, once they become mothers, "intensive" mothering standards scrutinize their behaviour. For more intersectional analysis of how ideologies of motherhood apply to non-dominant women, see Marlee Kline, "Race, Racism and Feminist Legal Theory" (1989) 12 Harv Women's LJ 115 at 130–34; Dorothy E Roberts, "Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy" (1991) 104:7 Harv L Rev 1419; Bell, "League", *supra* note 260 at 690–94; Dorothy E Roberts, "Race, Gender, and Genetic Technologies: A New Reproductive Dystopia?" (2009) 34:4 Signs 783 [Roberts, "Race"]; Karen Christopher, "Extensive Mothering: Employed Mothers' Constructions of the Good Mother" (2012) 26:1 Gender & Society 73 at 76–78.

[267] Bell, "League", *supra* note 260 at 692.

[268] For an overview of the clinical research discussing the various emotions and medical conditions women can experience after an infertility diagnosis and unsuccessful treatments, see Madeira, *supra* note 250 at 369–76.

non-dominant women.[269] Public funding would also soften the disproportionate financial impact that a private model for ARTs has on single individuals and queer couples who rely more on ARTs to have biological children.[270] In short, far from reinforcing elitism, social stratification, and inegalitarian values, public funding for IVF can decrease these factors in the domestic reproductive context.

A final critique of ART funding that relates to elitism may object to its treatment orientation and the class bias it exhibits. Ann V. Bell argues that some women who do not typically see doctors, usually due to a lower socioeconomic position, do not medicalize their infertility by seeking treatment or otherwise. Instead, they may apply alternative narratives to make sense of their conditions. Yet, Bell notes, infertility scholarship is fixated on treatment because it concentrates on clinics and their elite clients.[271] Although Bell does not advance this criticism, a critic might claim that to continue to respond to infertility through treatment-based strategies rather than prevention reinforces this elite focus.

Prevention of infertility is certainly a laudable goal. Indeed, the feminist dimensions of many of infertility's causes are readily apparent. Women who are socioeconomically privileged often confront infertility due to gendered reasons for "delayed childbearing"; they focus on financial security and professional aspirations, including adjusting to the norms of male-dominated workplaces, through their twenties and thirties rather than on coupling and procreation.[272] For women from lower socioeconomic backgrounds, infertility also arises from workplace dynamics, but in their case, more commonly from exposure to workplace hazards and less recourse to health care.[273] Other women contend with social infertility due to their single status or same-sex partnership. All of these causes implicate feminist concerns about gender, race, class, and sexual orientation

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[269] See sources cited in *supra* note 266, especially Roberts, "Race", *supra* note 266 at 792, 796.

[270] See Judith F Daar, "Accessing Reproductive Technologies: Invisible Barriers, Indelible Harms" (2008) 23 Berkeley J Gender L & Just 18 at 33, 43–47. See also Ellen Waldman, "Cultural Priorities Revealed: The Development and Regulation of Assisted Reproduction in the United States and Israel" (2006) 16:1 Health Matrix 65 at 89; Gwendolyn Beetham, "Assisted Reproduction as a Queer Thing", online: (2010) 9:1&2 Scholar & Feminist Online <sfonline.barnard.edu>; Valarie Blake, "It's an ART not a Science: State-Mandated Insurance Coverage of Assisted Reproductive Technologies and Legal Implications for Gay and Unmarried Persons" (2011) 12:2 Minn JL Sci & Tech 651 at 672, 678.

[271] Ann V Bell, "Diagnostic Diversity: The Role of Social Class in Diagnostic Experiences of Infertility" (2014) 36:4 Sociology Health & Illness 516 at 519, 527 [Bell, "Diagnostic"].

[272] See Lockerbie, *supra* note 254 at 465.

[273] See Bell, "Diagnostic", *supra* note 271 at 518–19.

and clearly demarcate infertility as a subject of intersectional feminist analysis and its prevention as a pressing issue.[274]

My argument for public funding for ARTs is not meant to preclude or compromise preventive efforts, endorse a medicalized view of infertility, or dismiss alternative ways of making sense of an inability to conceive or maintain a pregnancy to term. It merely calls for making treatment available to those who want it. As even Bell notes in her analysis, the lack of access to medical care explains the absence of a treatment focus among lower-class women in the US in responding to their infertility.[275] With more options through public funding, it is reasonable to assume that at least some of these women will wish to pursue treatment. For this and other aforementioned reasons, it is unfair to characterize public funding for ARTs as elitist.

3. Are Criminal or Immigration Interventions Better?

As a final point of objection, we may query whether criminal or immigration law measures would be more productive and cost-effective deterrents than public funding. Why not simply criminalize Canadians who travel abroad for surrogacy? Canada has extraterritorial legislation in relation to practices it considers morally reprehensible (notably, having sex with children, bigamy[276], and torture[277]), so precedent exists for such a measure for surrogacy.[278] Such action, however, is harmful to the commissioning parents and the child that may be produced. In addition to dashing hopes, as Richard Storrow has argued, such laws stigmatize those who cross borders for reproductive care as morally unfit and deleterious to the national fabric.[279] Storrow also notes that restrictive laws interfere with core human interests yet commonly display an absolutism that is disproportional to the harm actually caused.[280] Criminalization also has the potential of pushing practices underground without curbing the problem.[281]

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274 See Bell, "League", *supra* note 260 at 693.

275 Bell, "Diagnostic", *supra* note 271 at 527.

276 See *Criminal Code*, RSC 1985, c C-46, s 290.

277 See *ibid*, ss 7(3.7), 269.1.

278 Several Australian states have expressed opposition to commercial surrogacy this way (see Millbank, "Rethinking", *supra* note 14 at 488).

279 Richard F Storrow, "Assisted Reproduction on Treacherous Terrain: The Legal Hazards of Cross-Border Reproductive Travel" (2011) 23:5 Reproductive Biomedicine Online 538 at 542–43 [Storrow, "Treacherous Terrain"].

280 Storrow, "The Pluralism Problem", *supra* note 58 at 2940–42.

281 See Nelson, *supra* note 193 at 248; Millbank, "Rethinking", *supra* note 14 at 488.

A less harsh response may appear to reside in immigration law where governments can refuse to issue passports, visas, or citizenship to the children conceived on their first return to their parents' home countries or refuse to recognize the parental status of commissioning parents. Various states have implemented such blockades,[282] which scholars have characterized as disproportionately harsh to both the parents and the children involved.[283] They have proposed the application of the public international law principle of comity as a better solution. Specifically, states would recognize foreign parental orders where the judgments ensure that "the transaction not have exploited conditions of poverty in the destination country and not have resulted in parentage determinations that would be anathema to the welfare of the child."[284]

But how would states successfully operationalize this standard? An understanding of "exploited conditions of poverty" that rules out all commercial surrogacy transactions in the Global South would remove a lucrative opportunity for surrogates to ameliorate their economic circumstances. The comity standard, instead, could check that judicial orders emanated from well-regulated countries. States can instruct their citizens beforehand that they will not recognize certain countries' judicial pronouncements because the surrogacy transaction will exploit conditions of poverty. This position could be but one measure flowing from a multilateral treaty in this area.[285] The question still remains, however, as to what sending states can do within their *own* jurisdictional capacities in the interim to minimize their citizens' participation in exploitative transnational surrogacy. The foregoing discussion has provided an answer for Canada.

C. Summary

There are multiple postcolonial and other egalitarian reasons Canada should allow commercial surrogacy and provinces and territories should cover the costs. Critically, the measures discussed above have the power to incentivize Canadians who otherwise would travel abroad and partici-

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[282] Busby, "Of Surrogate Mother Born", *supra* note 5 at 294–95.

[283] See Storrow, "Treacherous Terrain", *supra* note 279 at 543.

[284] *Ibid* at 544.

[285] Although there is momentum for such a regulatory instrument at the international level, a treaty does not yet exist. For more on the work of the Special Commission on the practical operation of the Hague Convention of 29 May 1993 on Protection of Children and Co-operation in Respect of Intercountry Adoption in relation to regulating transnational surrogacy, see Katarina Trimmings & Paul Beaumont, "International Surrogacy Arrangements: An Urgent Need for Legal Regulation at the International Level" (2011) 7:3 J Priv Intl L 627 at 633.

pate in an exploitative system to access the same surrogacy services at home where surrogate exploitation is far less likely to occur. Allowing a commercial domestic surrogate market and supporting it with public funds both for engaging a surrogate and pursuing the attendant ARTs also promotes reproductive autonomy for a wider range of Canadian women. It also potentially allows more women to escape the social stigma and marginalization childlessness still brings and to challenge the hegemonic scripts of undesirable fertility applied to non-dominant women. Perhaps most importantly to these women, legalization and funding would help them realize their reproductive aspirations. Concerns that infertility is not a health issue, or that public funding to circumvent it sends a conservative, anti-feminist, and pro-life message about women, or marginalizes the interests of non-dominant women, are misguided.

Democratizing surrogacy is not unassailable, however, from an egalitarian perspective. It fuels the repro-normative culture that establishes the nuclear family and parenting of biologically related children as markers of complete adulthood[286] and reduces womanhood to motherhood.[287] Troublingly for a postcolonial analysis, democratizing surrogacy in Canada permits more children to be raised in the Global North with the ecologically destructive habits that Western hyper-consumption entails.[288] Adoption, though not without its own problematic racial and class dilemmas,[289] may be a more equitable option overall.[290] Indeed, the full global justice dimensions of cross-border reproductive care are multifaceted and not easily resolved.[291]

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[286] See e.g. Usha Rengachary Smerdon, "Crossing Bodies, Crossing Borders: International Surrogacy Between the United States and India" (2008) 39:1 Cumb L Rev 15 at 28. See also Fixmer-Oraiz, *supra* note 141 at 151; Laura Mamo & Eli Alston-Stepnitz, "Queer Intimacies and Structural Inequalities: New Directions in Stratified Reproduction" (2015) 36:4 J Family Issues 519 at 533; Judith Halberstam, *In a Queer Time and Place* (New York: New York University Press, 2005) at 161.

[287] See Gupta, "Towards Transnational Feminisms", *supra* note 49 at 28.

[288] See generally Erik Assadourian, "Transforming Cultures: From Consumerism to Sustainability" (2010) 30:2 J Macromarketing 186 (outlining the unsustainable nature of current consumption patterns); Sami Timimi, "The Commercialization of Children's Mental Health in the Era of Globalization" (2009) 38:3 Intl J Mental Health 5 (comparing childhood in Western and non-Western countries).

[289] See generally Solangel Maldonado, "Discouraging Racial Preferences in Adoptions" (2006) 39:4 UC Davis L Rev 1415; Kathryn A Sweeney, "Race-Conscious Adoption Choices, Multiraciality, and Color-Blind Racial Ideology" (2013) 62:1 Family Relations 42; Lockerbie, *supra* note 254 at 468.

[290] It is not clear, however, that individuals interested in forming their families through ARTs would turn to adoption when unsuccessful. For an overview of the debate on this topic, see Cohen & Chen, *supra* note 223 at 533–73.

[291] See Mamo & Alston-Stepnitz, *supra* note 286 at 521–22, 536–37.

This analysis does not pretend to provide a panacea solution, but rather aims to be responsive to the reality that Canadians privilege biological views about family ties[292] and that many who wish to have a biological child, but cannot, will pursue that goal through ARTs.[293] Recall Lockerbie's recent study of Canadian heterosexual women who have *adopted* that demonstrates the deep-seated preference for a biological connection to one's children.[294] The discourse that even adoptive parents and the adoption industry use to articulate adoptive parental-child bonds is replete with pregnancy metaphors and other biological constructs.[295] Given this strong cultural desire for biologically related children, covering surrogacy and IVF and other ARTs under Medicare would be effective in dissuading Canadians from participating in what is currently an exploitative system abroad and instead access a non-exploitative system at home.[296] Moreover, it is important to realize, given the postcolonial feminist formation of this argument, that these recommendations for reform do not foreclose economic opportunities to Indian surrogates. The demand for surrogacy from the Indian middle-class sector will continue.[297]

Conclusion

Transnational commercial surrogacy is a growing contributor to the "globalization of motherhood"[298] that feminists have identified for some years now. The practice introduces new ethical and legal dimensions into feminist debates about the desirability and dangers of ARTs. These debates in Canada have centred on the harms to women at the domestic level and the resulting federal legislation reflects this domestic focus. As a result, the *AHRA* is ill-equipped to address the transnational nature of

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[292] See Lockerbie, *supra* note 254 at 464; Goldberg, Downing & Richardson, *supra* note 264 at 943.

[293] I recognize that queer communities are less invested in biological kinship (see Goldberg, Downing & Richardson, *supra* note 264 at 941, 953, 956).

[294] Lockerbie, *supra* note 254 at 464, 466.

[295] See *ibid* at 466–67.

[296] It is beyond the scope of this present work to specify the precise parameters of Medicare coverage for ARTs. It is worth noting, however, that most countries that publicly fund IVF incorporate exclusions relating to the number of cycles funded, the age of women who can qualify, the number of embryos that should be transferred in one cycle, etc. For such an example in the UK context, see Lucy Frith, Ann Jacoby & Mark Gabbay, "Ethical Boundary-Work in the Infertility Clinic" (2011) 33:4 Sociology Health & Illness 570 at 571.

[297] See Jaiswal, *supra* note 58 at 3.

[298] Wendy Chavkin, "The Globalization of Motherhood" in Wendy Chavkin & JaneMaree Maher, eds, *The Globalization of Motherhood: Deconstructions and Reconstructions of Biology and Care* (New York: Routledge, 2010) 3.

Canadians' pursuit of biological parenthood and the harms visited by these practices in their present-day iterations vis-à-vis Southern women who serve as their surrogates. A postcolonial feminist analysis of transnational surrogacy can help illuminate these harms as well as the benefits to women in the Global South who serve as surrogates as it is a framework that prioritizes their experiences as the most vulnerable women involved in the practices. A postcolonial feminist analysis goes beyond the domestic sphere to examine the North-South context that traditional Canadian feminist analyses of ARTs did not envision.

I have applied a postcolonial feminist framework to examine the specific case of cross-border reproductive care to access gestational commercial surrogacy in India, outlining both the exploitative and beneficial aspects of the practice for women who act as surrogates. Although the practice promotes troubling ideologies as well as exploitative material effects, it also substantially materially benefits surrogate women. A postcolonial feminist analysis would not counsel the prohibition of the practice, but rather better regulation. This, of course, must occur at the domestic level in India as well as globally in relation to economic circuits of power. But in the interim, sending countries can promote laws that try to promote more just relations between their citizens and economically vulnerable women in the Global South.

In the case of Canada's approach to surrogacy, a postcolonial feminist response to cross-border reproductive care that occurs in the midst of highly stratified social conditions should lead to a position that would support, at the very least, the lifting of the domestic ban on payment for surrogacy in Canada and the funding of ARTs through Medicare. Ideally, state-sponsored payment or at least subsidies or tax credits to pay for a surrogate would also follow. These regulatory mechanisms would create economic incentives for people to stay in Canada to achieve their biological parental aspirations, increasing the pool of domestic surrogates and making fertility treatments accessible. Greater accessibility would promote the reproductive autonomy of Canadian women as well without perpetuating exploitation. Replacing the current ban with public funding should not be read as anti-feminist, conservative, or elitist. To be sure, cross-border reproductive care is a complex phenomenon without a single simple solution. The foregoing does not pretend to resolve all ethical quandaries it poses, but articulates why Canadian feminists worried about the exploitation of women in ARTs should include women in the Global South in their calculus of exploitation and start to analyze the issues ARTs raise through a postcolonial feminist lens.