

## DIALOGUE: Proposed changes to the Human Assisted Reproductive Technology Act (2004)

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### Introductory remarks

DIANNE YATES, FORMER LABOUR MP

In Marge Piercy's novel *Women on the edge of time*, she portrays a world where each child has five parents. The reason for this is that she regards child rearing as such a complex and demanding role that it needs to be shared by a group with multiple talents and skills. Piercy was concerned about the physical, intellectual and emotional development of a child. Some time ago, when I was employed by the Centre for Continuing Education at the University of Waikato, I attended a public lecture by Dr Fisher of Fertility Associates. In this lecture, he described how a child could have five physical and legal parents: An egg donor, a sperm donor, a gestational mother, and social or contracting mothers and fathers. At that time there was considerable discussion about the Baby M case in the United States (where a contracting gestational mother did not wish to hand over the child to contracting parents after the birth) and Geoffrey Palmer (now Sir) introduced a bill into Parliament to ensure, as a result of this case, that the gestational or birth mother of a child born in New Zealand was the legal mother. One of the outcomes of the Fisher lecture was that I saw the need for further legislation in New Zealand to protect the rights of all parties involved in new and emerging 'birth technologies' – to try to get the best possible outcomes for all parties, particularly the child, who is unable to speak for him or herself.

The United Nations Declaration of Human Rights states that one has the right to found a family. For those readers of a philosophical bent, you will note that it doesn't define a right, or a family. Also, it does not say if an individual, or couple, or unit/group can demand of the system that it provide them with a family – assuming we mean children. It can be argued, however, that birth technologies are just a form of medical treatment curing infertility rather than creating families, but there are differences and new life is created. In the case of body part transplants, most times, the donor is dead (not necessarily with kidney transplants) and the donated body part is sustaining the life of an existing human. There are, however, issues over body transplants; also, as we have been made aware, of a black market in some countries, illegal operations, and prisoners used as donors, etc. There have been cases where sperm is taken from a dead man and there are ethical issues around this too. Did the donor give consent before death (as with body parts)? There are also legal issues connected with this. Would the child of a dead sperm donor inherit the donor's estate? Could this be a motive? We would like to assume that a woman may wish to have a child by her deceased spouse and preserve his genes and memories, but there could be other motives.

In 1994 I introduced my Human Assisted Reproductive Technology Bill into Parliament. This bill was very much a cut and paste version of the United Kingdom Act, although I was influenced by a Canadian Royal Commission on the topic. The bill was very much changed through the select committee stage and greater emphasis and power was given to ethics

committees and the discretion of the Minister of Health. As a Member of Parliament I learnt to be somewhat wary of a couple of issues around legislation. Firstly, there is the Act of Parliament which sets out the basic tenet of the law. Secondly, Acts often contain the words ‘by Order in Council’, which means that an issue within the law is left up to the Minister and Cabinet to sort out – sometimes through an appointed agency. Thirdly, there are regulations which state how the law is to be implemented. These regulations are checked by a select committee that tests if they are consistent with the intention of the Act. This process is usually monitored by organisations concerned with implementing a law, but does not receive as much publicity or scrutiny as the original Act. The devil may be in the detail in some cases.

Laws have different intents – some laws are enabling, others are about prevention and protection. My main intention in this bill was to ensure the protection of the rights of the parties involved in reproductive technologies – particularly the child, the donors, and the birth mother. I was very much concerned that babies should not become marketable commodities and that women should not be regarded as ‘rent-a-womb’ or womb slaves, as in Margaret Atwood’s dystopian novel *The handmaid’s tale*. As mentioned above, to what extent can those who are infertile or who wish to utilise birth technologies be able to demand of the system that it provides them with babies or components thereof? Are donated embryos similar to donated kidneys?

Since the time of Sarah and Abraham, and maybe earlier, there have been surrogate mothers. In the royal hierarchies of Europe there have been many ‘bastard’ children who were unable to inherit and many a story and Shakespearean play to illustrate how badly they were treated. Even in fairy tales stepmothers always seem to be ‘wicked’! The problem that I saw with the new technologies was the exchange of funds, expenses, compensation and the added medical and legal risks when payment is involved. I anticipated dangers around the payment of donors – that young women university students could be exploited or given limited information about the medical dangers involved in donating ova. With increased payment, women students may be enticed into becoming donors in order to pay off student loans, without considering medical and other complications. The recent ACART document does not mention this as a problem but concentrates on compensating donors for medical costs, time lost from regular employment, and other costs. The movie *Saigon baby* is a classic example, however, of how a couple unwittingly exploited a mother in the Third World in order to adopt a baby and avoid the hassles and rules in their home country. It also shows how difficult it is to ensure that rules in one country are adhered to in another, despite reassurances.

Some of the reasoning behind recent proposals to change the New Zealand HART Act around the issue of importing and exporting gametes and embryos is to assist those couples who wish to access fertility services, but find there are not enough or appropriate donors in New Zealand. It may be that people who immigrate to New Zealand have conceived through birth technology and have embryos stored overseas – and wish to grow their family using those embryos. There is also the possibility that potential parents in other countries might prefer embryos and gametes from New Zealand donors.

The proposal from January 2014 suggests that checks would be made in the countries from which importing is proposed, to ensure that donors were not exploited in those countries. This is where I have difficulties. There have been reports of scams and exploitation around adoption, with poor Third World women and girls being exploited, despite facilitating lawyers in those countries making large profits. There have also been pictures of the smiling faces of women in the United Kingdom and India on our television screens, who are happy to be ‘career’ gestation mothers, and who consider the money earned as a legitimate way of earning a living. These are the success stories. We do not hear of the problems – what insurance is

taken out if the mother becomes ill, what if the child is deficient or deformed – who is literally left ‘carrying the baby’? What if the young egg donor has complications as a result of ova stimulation, or becomes infertile? These ‘what ifs?’ were intended to be covered by the New Zealand legislation and the bans it contains.

During the ten years my HART bill was in ‘gestation’ in the New Zealand Parliament, I attended a number of conferences and meetings around the issues that it highlighted. The issue of payment and exploitation at some conferences, I observed, divided attendees into roughly two camps. There was what appeared to be an Anglo-American attitude: ‘If I can afford treatment and technologies then it is my right to have them’, and governments should not interfere. On the other hand there was what I termed a more European attitude, which was influenced, it appeared to me, by two strands of thought. The first was by modern German (and perhaps Jewish) presenters who were wary of any reversion to Hitler-type experimentation on women (eugenics), and the second by a Roman Catholic concern not just for the mother but for the wider social implications. I have already mentioned the difficulty of defining ‘rights’ in this regard in terms of the United Nations declaration.

The current ACART proposals seem to me to emphasise the benefit of the changes proposed in their January paper, but are weak on the problems, difficulties and possible exploitation. They are also weak in explaining how the proposals and checks and balances would be employed and enforced. Given that we do need checks and balances to prevent exploitation, I think it is important that any changes are surrounded with strong rules embedded in the ACT (not Order in Council or ethics committees). We also need to consider, as our laws should, just how many people in New Zealand the law will apply to, and which people. I do not think we should make a law just for those who are better able to afford treatments, and we should consider laws that prevent exploitation. Paying donors will not necessarily prevent exploitation, but may increase it. We should also ensure that there is adequate protection with education, counselling, health and insurance around voluntary donors.

Before any major changes are made to the HART Act there needs to be due consideration made of some of the questions raised above. There also needs to be a review and audit of:

- The effectiveness of reproductive technologies – the numbers of pregnancies and live births
- The health outcomes of children born as a result of the technologies and their development
- The number of premature babies and any health problems they incur
- The present costs incurred
- And perhaps a review of infertility problems in general and related causal factors such as age, general health, obesity, etc.

There also needs to be a review of the decisions made by ethics committees and their reasoning, and whether they have been consistent with the principles of the Act outlined above.

Given that laws should probably deliver the greatest outcome to the greatest number, would our attention and the health dollar be better spent on caring for the children already born and ensuring better and healthier environments and health education for young families?

## **Rights, relationality, and reproductive tourism**

**RHONDA SHAW, VICTORIA UNIVERSITY OF WELLINGTON**

First, thanks are due to the WSJ editorial team and Dianne Yates for putting the proposed HART Act amendments on the agenda for discussion. I have organised my response to Dianne’s introductory comments under three broad headings: reproductive rights; questions

about relationality; and reproductive tourism. The aim of my contribution is to provide the reader with a way of thinking sociologically about some of the issues raised by the proposed amendments, and to present a number of different perspectives, drawn from empirical research, which relate to these debates.

A major focus of second wave feminist scholarship has been the demand for the right to control human reproduction. This demand not only entails freedom from reproduction, but also the right to reproduce and parent one's offspring. With the introduction of a range of new reproductive technologies in the 1980s, feminist scholars began to ask whether people had a basic right to have a child, given the emotional and psychological suffering that may be experienced from not being able to have children. They also questioned whether conceptive technologies such as in vitro fertilisation (IVF) and ovarian egg donation, for example, reinforced conventional ideologies of family life. Rather than relaxing norms around family formation, feminist scholars voiced concerns that these new technologies would end up sanctioning pronatalism and the cultural expectation that all women should mother, rather than enhancing and extending reproductive possibilities. By the mid to late 1990s, a new wave of writing began to emerge around the movement of the biological materials involved in assisted reproduction, and what this meant for various parties participating in these strategies. This literature was not only concerned to address the perspectives of the women and men receiving fertility treatment, but the views of donors, and donor-conceived persons. In short, questions began to be asked about the capacity of assisted reproductive technologies (ART) to mimic normative conceptions of kinship as based in biology and deny the relatedness between the parties involved. Accordingly, questions were raised about the sharing of information relating to genetic origins.

Many countries, such as Austria, New Zealand, Norway, Sweden, and the United Kingdom, now support policies relating to the openness of information regarding donor-conception. Although this is a positive initiative, the practice of openness is complicated by the globalisation of commercial transactions. This is not only the case in respect of international surrogacy arrangements, but also with respect to the import and export of donor gametes and embryos in and out of national states.<sup>1</sup> Before considering this issue further, it is important to briefly review the rationale for policy and legislation around the requirement for information sharing and the shift away from donor anonymity and secrecy in assisted conception.

It was not long ago that physicians and fertility clinics encouraged prospective parents receiving fertility treatment not to tell offspring how they were conceived, and, in many cases, this information was kept a secret. Secrecy around donor insemination was often seen as protecting the father from the shame and stigma associated with male infertility, and the perceived failure of masculinity. Non-disclosure of information was regarded as important to protect the child's psychosocial wellbeing, and the child's family from interference from the donor. Secrecy also ensured the donor was not responsible in any way for offspring resulting from the donative act, although this was often protected in law.

Approaches to the disclosure of information around the donation of reproductive tissue are practised differently around the globe. Since the late 1980s and early 1990s in New Zealand, fertility clinics have operated with a policy of openness and identifiability regarding donor information for children conceived with the aid of donor-assisted technologies. A key influence for this openness in New Zealand policy stems from the move toward open adoption, which recognises the interests of the child and their right to kinship knowledge. In New Zealand, this coincided with the Adult Information Act 1985, and the importance placed on the ability of children to access their genetic heritage, ensuring a sense of identity and psychosocial wellbeing.

In 2004, this policy of openness was made law by the HART Act, and was subsequently followed by the introduction of a legal register for records of gamete donations resulting in birth after 20 August 2005 (embryo donors are also required to register their identities, after embryo donation was allowed by ACART in 2005). Prior to 2005, no official records were kept for sperm donors in New Zealand, and their identities could be anonymous. As well as acknowledging the psychological and emotional wellbeing of openness for donor offspring, the rationale for change in policy and law also recognised the importance of tracing genealogy, and the exchange of information about genetic origins. This is deemed to be of special significance to Māori, as the transfer of biological materials between known and unknown donors and recipients has implications for Māori in terms of social identity, in ways that may not be as important for non-Māori.

From this perspective, not knowing the origin and genetic legacy of donative material is problematic. These cultural values have recently coincided with broader social trends in the media and popular culture, emphasising the place of genetic information as a key determinant of identity formation. Such trends highlight the importance of being able to trace one's identity as a donor-conceived person. Aside from practicalities such as obtaining medical and family history information about donors, donor-conceived people typically want to be able to place their donor into their existing life story. Donor-conceived people may be curious about the kinds of traits and characteristics they share with the donor, what the donor looks like, the kind of person he or she is, and why they decided to donate. Sharing information about the donor is thus seen as an important step in ensuring psychosocial wellbeing for donor-conceived persons. This perspective, however, is often juxtaposed with the views of parents who do not want to disclose information about the genetic origins of their offspring. Parents who elect non-disclosure about assisted conception to their offspring state a preference to keep third party donation private; often because they seek to duplicate the conventional, normative nuclear family.

In her introductory remarks, Dianne makes a comparison between different tissue exchange practices. I have likewise suggested that useful analogies can be drawn between donating human gametes, organs, blood, and breast milk (see Shaw, 2008, 2012). We do need to be mindful, however, of pushing analogies between different kinds of biological materials and tissues too far. For instance, because reproductive tissues such as sperm, eggs, and embryos have the potential to create new individuals, rather than saving or improving the quality of another person's life as is the case with organ donation, some people may regard the differences as more salient than the similarities. Alternatively, for members of some cultural groups, the transfer of donated tissue such as solid organs may in fact be perceived as contributing to the production of new identities, symbolising kinship connections through the meanings people give to biological elements of relatedness.

Certainly embryo donation has the potential to generate these kinds of dilemmas, which may be magnified in light of the proposed HART changes. Embryo donation occurs in situations where couples are required to make a decision about the fate of frozen IVF embryos that have been stored for future treatment, but are no longer needed (usually because a couple has completed their family) and must be disposed of within a specific time period. Depending on local policy and legislature, embryos can be thawed and discarded, donated to an anonymous or known couple, or donated to research. Decision-making regarding these options typically rests on people's interpretation of the moral and ontological status of the embryo.

In their ethnographic research of the California-based 'Christian Snowflakes' embryo adoption programme, Collard and Kashmeri (2011) distinguish several understandings of embryo donation. Participants that they observed in this programme viewed their embryos as 'preborn children', whereas the accepted legal terminology used to refer to embryos is

‘property’, and the language reproductive clinics tend to use is ‘human reproductive tissue’. For Collard and Kashmeri’s participants, who held pro-life views, embryos were ‘adopted’, not anonymously donated. The same tension between embryo donation as adoption, on the one hand, and medical tissue donation on the other, is present here in New Zealand (see Goedeke and Payne, 2009), and in South Australia (de Lacey, 2007). Research findings from these local studies confirm that some people envisage embryo donation as congruent with the idea of pre-birth adoption.

De Lacey’s (2007) study found that participants who framed the embryo as a potential rather than actual child were more likely to see embryo donation as akin to organ donation. They discussed the importance of not ‘wasting’ their embryos, which they saw as precious biological material ‘in short supply’, and thus sought to donate them. In this case, the embryo was construed as a scarce resource. These participants referred to the family resulting from assisted reproduction as a social and relational unit, rather than an organic entity based on genetic makeup and gestational experience.

The existence of these diverse views suggests that the status of an embryo is a potentially contentious issue for more people than is the ontological significance of a solid organ. Decisions about what to do with excess embryos are also shaped by legislative differences between various jurisdictions. In some countries, embryos that are deemed surplus to reproductive needs must be disposed of, and cannot be donated for therapeutic or research purposes. In New Zealand, embryo donation for reproductive purposes was permitted in 2005. Prior to that time, New Zealand couples could either store frozen embryos for up to 10 years, or discard them. Given differing perspectives about the embryo as either a collection of cells or a potential child, the decisions people make about whether to discard or donate embryos, either for reproductive or research purposes, are not at all clear-cut. The fact that the embryo is likely to be composed of the full genetic material of a couple, while gametes comprise half that genetic make-up, is a key factor in people’s decision-making about embryo donation. If embryo donation is constructed along similar lines to open adoption, as it is practised in New Zealand, then it is unlikely to be construed as a resource or a bodily ‘gift’ over which donors altruistically relinquish all connection or control.

The extent to which information sharing is possible in a globalised world is increasingly shaped by the phenomenon of reproductive tourism. In the ACART (2013) consultation document relating to the proposed amendments to the HART Act, reproductive tourism is euphemistically referred to in the language of ‘transborder reproduction’ or ‘cross border reproductive care’. Reproductive tourism occurs where people seek fertility treatment in another country because of a lower price, a shortage of donated gametes, embryos or reproductive services in the home country, or due to restrictive legislative regimes prohibiting particular services in their own jurisdiction. For example, because some countries (e.g., Italy) do not permit third party donation of gametes, people travel elsewhere. Other jurisdictions do not set a maximum age for in vitro fertilisation (IVF) treatment (e.g., United Kingdom); some do not allow more than two embryos to be implanted in a woman’s uterus at once, or only allow implantation of three embryos if a woman is older than 39 (e.g., United Kingdom); some require prospective parents using IVF (e.g., Italy) or surrogate pregnancy services (e.g., India, Israel) to be in a heterosexual relationship; some do not require identifying information about donors to be kept on a register (e.g., Spain); some countries do not allow embryos to be frozen (e.g., Italy) or do not permit PGD for sex selection purposes; and some countries do not allow commercially sourced gametes and embryos to be imported (the situation in New Zealand at the time of writing).

The recent rise in fertility tourism has led to much discussion around the ethics of allowing prospective parents to bypass fertility laws and accepted practices of their own country in order to build a much wanted family. For instance, the HART Act (s.13) prohibits commercial ovarian egg donation and surrogate pregnancy arrangements, but New Zealanders can travel elsewhere to purchase donor eggs or the services of a surrogate mother. A key issue is whether individual nation states have a responsibility to provide fertility treatment for their own citizens, as well as protecting citizens elsewhere from exploitation. Advocates of transborder reproduction argue that travelling overseas to seek fertility treatment is a matter of individual choice. For critics, however, it is choice for wealthy people only, and, like the matter of illegal organ sales, countries offering treatment invariably provide little in the way of health care services, follow up care and safety for their donors.

There are, therefore, multiple ethical issues to consider relating to reproductive tourism. In New Zealand, the length of time and effort it takes for people to access publicly funded fertility services (approximately an 18 month wait) or to gain application approval from ECART, and the availability of so few women offering their services as altruistic surrogates, has prompted increasing numbers of couples to travel to countries such as India, the United States, and Thailand, where commercial surrogacy is legal, to pursue such arrangements. However, unless the requisite legal paperwork is in order to enter the country, bringing new born offspring produced as a result of international assisted reproduction into New Zealand is unlawful, and may border on human trafficking. All offspring born of a surrogate mother must be adopted under the Adoption Act 1955, by the intended parents, even those children born in New Zealand to surrogate mothers.

A second issue facing New Zealanders seeking fertility treatment is the shortage of anonymous egg donors, a problem not encountered in the United States, where gamete donation is commercialised. Media reports indicate that New Zealand couples are increasingly travelling to countries such as the United States, Spain and Argentina to buy donor eggs. Critics note that this practice could have further implications for such couples if they want to import commercially sourced cryopreserved eggs, sperm, or embryos, into the country, as New Zealand prohibits the commercialisation of all tissue exchange including reproductive material.

A further question raised by reproductive tourism is how to balance the rights of donors, donor-conceived people and embryos with the interests of prospective parents. For instance, do the rights of donor-conceived persons or IVF babies, gestated by a surrogate mother in one country, outweigh the right of parents who reside elsewhere to decide whether or not to tell their children that they are donor-conceived as a result of procreative tourism? What if a donor's biological material ends up in an entirely different country from the origin of donation due to transborder reproduction, and is used for purposes that the donor did not initially consent to? Is it possible to take the reproductive 'gift' back? If so, is a conditional gift still a donation?

At the beginning of Dianne's paper, she made reference to the debates about rights to reproductive freedom. Although claims around reproductive rights are contested by feminist scholars from different schools of thought, most would agree that people have both a legal and moral right to non-interference in the case of procreation, reproduction, and family building. Health care systems may even assist people in realising their aims to have children by providing publicly funded fertility treatments.

This is important in social contexts where large emphasis is placed on the value of family and where pro-natalist discourses reinforce ideas that women's identity rests on their reproductive capacity and ability. I empathise with people who want to have children and are unable to for whatever reason. Having said that, I do not believe that legislative processes are responsible

for the right to obtain a child at any cost, any more than moral arguments securing the rights of parents should outweigh the rights of donors of reproductive materials and donor-conceived persons.

## **Making sense of ART through the lens of reproductive justice**

**GEORGE PARKER, Strategic Advisor, WOMEN'S HEALTH ACTION TRUST**

Despite more than two decades of grappling with the implications of the burgeoning field of assisted reproductive technologies (ART), feminist positions on these technologies remain as complex and contested as the technologies themselves. On one hand, some feminist responses have framed such technologies as inherently repressive, representing patriarchal and medical control of women's bodies, and as threatening a descent into a dystopian future whereby women will be reduced to being womb servants for society, famously fictionalised in Margaret Atwood's *The handmaid's tale* (Corea, 1985; Raymond, 1993). Indeed, such a possibility is not confined to the realm of science fiction with the rise of fetal personhood and protectionism in Western societies corresponding with increased surveillance and control of the pregnant body, resulting in the prosecution and imprisonment of women for fetal abuse in some cases (Parker, 2014). However, other feminist positions on ART have emphasised the emancipatory potential of such technologies to provide a means for overcoming infertility or for those who wish to form families outside of heterosexual nuclear families, including single women, and queer and gender diverse people. Feminist scholars influenced by poststructuralist perspectives point to the diverse and located meanings of assisted reproductive technologies (Balsamo, 1996; Franklin, 1995). From these perspectives, such meanings are mediated across axes of difference amongst women and through the matrix of language/power/representation whereby our sense-making of assisted reproductive technologies is understood as socially constructed, highly inflected by social and cultural understandings about women's roles, the products of conception, and what it means to form families. Further complicating the formation of feminist positions on Assisted Reproductive Technologies is the growth of so called 'reproductive tourism'. This is the movement of patients from predominantly wealthy nations to often poorer countries with more permissive regulatory regimes, or no regulation at all, to undertake reproductive treatments and surgeries. 'Reproductive tourism' adds questions of global justice and decolonisation to feminist positions on ART highlighting 'the commodification of the body and stratification of reproduction across class, wealth, race and nation as subaltern bodies across the globe service wealthy first world patients' (Whittaker, 2010, p. 404).

Women's Health Action is a not-for-profit organisation born out of the feminist women's health and patient rights movements and is perhaps most well-known for instigating the Cartwright Inquiry (1987-1988), a watershed moment in patient's rights, not only in New Zealand, but also globally. For three decades Women's Health Action has worked to improve the health and wellbeing of women, their whanau and communities by promoting understanding of the social determinants of health including but not exclusive to gender; identifying and challenging the gendered power dynamics and discrepancies in the delivery of medical care and health services; and analysing, educating, and advocating for social justice in women's health. We are a dynamic organisation in that we seek to be engaged with, and informed by, developments in critical feminist theoretical perspectives and research, translating these into informed and responsive women's health policies, services and programmes. The starting place for our position on ARTs is the recognition of female infertility as an important and growing women's health issue and the important role ARTs play in the treatment of infertility (Allot et al., 2013). We also recognise that motivation to use ARTs extends beyond the treatment of



infertility, offering procreative potential to queer and gender diverse people; single women; women undergoing chemotherapy; women who want to delay childbearing; and for those couples who want to use pre-implantation genetic diagnosis to screen against disability (Allot et al., 2013). Acknowledging that an estimated 1-4% of all conceptions are due to ARTs we have come to hold a pragmatic acceptance that ARTs are now an integral part of the women's health landscape (Allot et al., 2013).

However, we believe that the debate about ARTs has for too long been focused on questions of morality, the personhood of embryos, and commerce rather than concern for women's health – both those women undergoing IVF and the women whose reproductive material and embodied labour are used in ART procedures (Bercovici, 2008). We believe it is essential that women are able to make fully informed choices, including understanding the medical risks involved, when they engage with ARTs either as donor or recipient, but recognise that 'choices' can be constrained through (for example) desperation to have a baby, familial or friendship bonds, and providers' conflicts of interest. It is also clear that access to these technologies – both publicly funded and private – is currently strongly delineated by socio-economic status, ethnicity and along other axes of difference amongst New Zealand women privileging heterosexual, partnered, Pākehā women with higher incomes. For example, eligibility for publicly funded fertility treatment in New Zealand is determined by CPAC (Clinical Priority Assessment Criteria) which includes as a mandatory requirement that a woman's BMI be less than 32 (Gillett, Putt & Farquhar, 2006). The links between high BMI and deprivation, and the variation in average BMI between different ethnic groups and different age groups of women, have been well established (Ministry of Health, 2006; University of Otago and Ministry of Health, 2011). Indeed, as Gillett, Putt and Farquhar (2006, p. 1221) note, 'The BMI level of 32 kg/m<sup>2</sup> for a 30-year-old European woman is at about the 90th percentile compared with 70th percentile for Maori and Pacific Island women. Despite this, the same CPAC model and the BMI threshold are used for all ethnic groups.' Thus, while ARTs have created new hopeful possibilities for reproduction, they also require that we pay attention to issues of health, ethics, law and policy, including: health equity in access to services, the potential health and psychological effects on women and children, the potential for the devaluation of the lives of people with disabilities, the potential for exploitation in commercialised reproduction, and discrimination against LGBTQI individuals and couples (Galpern, 2007).

In pursuit of a framework for making sense of the complexities of ARTs, and in order to develop a position that progresses social and gender justice, we have turned to the intersectional feminist lens of reproductive justice (Price, 2010; Ross, 2006). Reproductive justice was first articulated by women of colour and indigenous women in the United States, out of frustration that the prevailing (white) feminist paradigm of reproductive autonomy, choice and rights failed to take account of the full spectrum of factors impacting women's lives and thus their ability to control their reproductive destiny. Reproductive justice offers a model for understanding reproduction that emphasises the structural inequalities that affect women's reproductive health and their ability to control their reproductive lives, which are 'linked directly to the conditions in her community – and these conditions are not just a matter of individual choice and access' (Ross, 2006, p.14). A reproductive justice model offers a way to address the complex issues posed by ART, in which individual autonomy and collective good do not need to be in conflict with each other (Galpern, 2007). The goals of a reproductive justice model of ARTs as described by The Gender, Justice, and Human Genetics Program (Galpern, 2007) are to: decriminalise the reproductive decisions of women; prevent eugenic outcomes for society and policies that devalue the lives of people with disabilities; insist on high industry standards for health and safety of ART and access to the information necessary to make truly informed choices; affirm

family formation and support equal access to ART, particularly for people with disabilities, women of colour, LGBTQI individuals and couples, and low-income women; direct resources toward environmental causes of infertility and address the disproportionate rate of infertility among women of colour; integrate an intersectional analysis and a human rights framework into work on ART issues; and conduct advocacy in partnerships and coalitions with those who use and are affected by ART.

So how does a reproductive justice lens inform our position on the current proposed changes to New Zealand's regulatory framework for ARTs? The current proposed changes were informed by two public consultations by the Advisory Committee on Assisted Reproductive Technology (ACART) in 2013, and again in 2014. These consultations asked how New Zealand should manage the import and export of gametes (eggs and sperm) and embryos, practices about which the Human Assisted Reproductive Technology (HART) Act is largely silent. Of particular interest for us was the question of whether New Zealand, in order to address gamete shortages, should allow the import of gametes and embryos sourced in circumstances that do not comply with the principles and requirements for the treatment of local gametes and embryos as specified in the HART Act. New Zealand's regulatory framework for ART is relatively conservative by global standards. The law requires altruistic donation of, rather than commercial payment for, gametes and surrogacy and the ability of donor offspring to be aware of their genetic origins, thus disallowing anonymous donation. The HART Act also bans the use of Preimplantation Genetic Diagnosis (PGD) for sex selection. While there are strong ethical justifications for these requirements, they are argued to contribute to the shortage of gametes (in particular eggs) as well as willing surrogates in New Zealand and thus the appeal to those seeking fertility treatment, and fertility service providers, of importing gametes sourced from countries with more permissive (or no such) regulations. Alternatively, ACART asked whether New Zealand should increase the levels of donor expenses available (current payments are minimal) to increase the supply of locally sourced gametes, raising the bigger question of whether the reliance of New Zealand fertility services on altruistic donation of gametes rather than commercial incentives will be able to be sustained given the current and future demand for fertility services.

WHA submitted on both consultations. Applying a reproductive justice lens, we asked whether allowing the import of gametes and embryos from countries with little or no regulation surrounding ARTs could increase exploitation of women – particularly young women, economically vulnerable women, and women of colour. We also asked whether a more liberalised approach to the import and export of gametes and embryos would be likely to contribute to the commodification of women's reproductive capacity and reproductive tissue. And would regulations on the import and export of gametes and embryos significantly decrease women's reproductive choices and individual control over decision-making and perpetuate unequal access to ARTs in New Zealand? Weighing the answers to these questions, we returned to our long held position that gametes, whether sourced locally or imported, should, at least for now, be from non-commercial sources only on the basis that the risks of exploitation in the commercial 'egg trade' as it currently operates internationally are too high, and there may be other ways to address the shortage of gametes in New Zealand. As Bercovici (2008, p. 193) argues, 'the "egg trade" takes place in a culture of inequality, raising valid concerns relating to the commodification and exploitation of reproductive materials within a context where women are subject to pervasive and persistent discrimination'. Indeed, as Bercovici goes on to observe, notably missing from the debates about the trade in eggs are discussions over the harvesting and procurement of eggs, including 'questions of donors' health and safety, disparities in payment for egg donation, and whether a woman is able to make a truly informed and non-

coerced choice to donate her eggs'. In other words, as it stands, like Dianne Yates concludes in her commentary, we are unsatisfied that a more liberalised approach to the movement of reproductive materials across borders will promote reproductive justice at this time, and are cautious of a discourse that tends towards highlighting the benefits of liberalisation while downplaying the risks and costs.

In regards to the question of increased expenses payable to donors, we agree that this holds the potential to increase the appeal of gamete donation in New Zealand but recommend that remuneration of donor expenses is actually consistent with expenses incurred by donors to ensure that it doesn't end up operating as a proxy for commercial payment. We also suggested that there may be other ways to increase the supply of locally sourced gametes, through for example, education and social marketing about egg donation. However, while we continue to advocate for altruistic gamete and embryo donation, and surrogacy, in New Zealand as a way to address the exploitative potential of commercialisation, we do acknowledge its limitations. These include the gendered connotations of privileging 'altruism' which assumes that the immense caring and bodily labour, and health risks, involved in egg donation and surrogacy can be unpaid because it is 'women's work' (Persad, 2012). There is also an inherent inequality in the 'gift relationship' in altruistic donation where the giving can never really be mutual (Van Zyl & Walker, 2012). We anticipate, and support, further examination of the issue of paying New Zealand egg donors and surrogates in the future.

Finally, a guiding principle of our submissions was that allowing a different set of standards and rules to apply to the import and export of gametes and embryos than those that govern the use of gametes and embryos sourced in New Zealand risks undermining New Zealand's governance of ARTs through the HART Act. We believe that any significant changes to New Zealand's regulatory framework for assisted reproductive technologies must be done via amendments to the HART Act rather than circumventing it, and must be informed by a national conversation to ensure New Zealand's regulation of assisted reproductive technologies is consistent with the different ethical, spiritual, and cultural perspectives held within the New Zealand population, including specifically the needs, values, and beliefs of Māori (HART Act, 2004). Indeed, research on 'public' perceptions of the practice of gamete (egg and sperm) donation suggests that the value of 'public' opinion has been underestimated (Hudson et al., 2008). Yet, despite regular consultations on the manner with which infertility treatments should be regulated, consultation processes tend to be dominated by a small number of interested parties rather than accessing wider public perspectives. We agree with Hudson et al. (2008, p. 2) that such consultations need to be 'opened up' to include a range of views, including those of disabled, minority ethnic, and diverse religious groups, supported by social scientific research to attempt to capture the perceptions of a wider range of people, especially those groups rarely included in formal public consultations. This will help ensure that the future, whatever it holds, belongs with the people.

## **Response to George Parker**

**LIEZL VAN ZYL and RUTH WALKER, UNIVERSITY OF WAIKATO**

George Parker quite rightly claims that the focus of the debate about ARTs needs to be on women's health, rather than on abstract philosophical questions regarding for instance the personhood of embryos, as this is a central moral concern that is not always taken as seriously as it should be when it comes to surrogate motherhood and egg donation. We also think reproductive justice is a helpful framework for evaluating current practices in these matters. In particular, we share Parker's concerns about the import of gametes from less regulated

jurisdictions. The risk that the gametes have been gained in coercive or exploitative situations is a real one. The right of any child born of donated gametes to know his or her genetic origins also precludes sourcing anonymous gametes. Willing, registered donors are required regardless of whether gametes are imported or donated locally. It may be possible to extend the range of potential donors beyond New Zealand borders if a similarly regulated system was willing to export gametes.

However, on the matter of payment and exploitation we differ from Parker with respect to both gametes and surrogacy. We have argued elsewhere that altruistic surrogacy is also exploitative and risks commodification of the woman and the baby (Van Zyl & Walker, 2013). Whether or not surrogacy amounts to commodification of babies depends on what is being donated or given: the baby or the committed service of the woman who carries it. If the baby is the gift, then commodification occurs whether she is paid or not. If it is her time and service that she is giving, then commodification is avoided whether she is paid or not. Similarly, in egg donation the worry is that if she is paid it will be for the eggs. However, in each case the women involved undergo significantly risky and unpleasant procedures over an extended period of time. If we paid them for time and service then we would avoid commodification. There are good reasons for thinking that the women should be paid.

A surrogate mother gives a large amount of time to the project, and egg donation also requires more than popping into the clinic to have the eggs harvested. In altruistic surrogacy and donation these women receive no compensation for the risks they run or the time they spend. Taking Stephen Wilkinson's (2003) view of exploitation – the unjust distribution of harms and benefits without valid consent – we argue that altruistic surrogacy and egg donation are exploitative. It is often argued that women do give consent to be donors or surrogates and so are not being exploited. However, we argue that it is questionable whether this consent is valid. If these women strongly desire to help people whose infertility prevents them forming a family they have to consent to an altruistic arrangement or not donate at all. It may be a technically valid consent in that they understand the risks and are fully informed, but it is not an entirely free consent given the conditions of participation. The unjust distribution is very clear: all the harms accrue to the donor and all the benefits to the recipient. The only way to redress the balance is to compensate the donors.

It is important to understand that compensation for surrogates and egg donors does not equate to a market in wombs and eggs as so many commentators fear. A robust regulatory framework would control the fees and the way the services are delivered in order to protect women's rights and health.

## **The future of surrogacy in New Zealand – Beyond the adoption model**

LIEZL VAN ZYL and RUTH WALKER, UNIVERSITY OF WAIKATO

Surrogacy in New Zealand is treated as a form of adoption. ACART (2014) proposes that the Health Minister consider compensating women who act as surrogate mothers. We think this is a step in the right direction, but until the adoption model is abandoned surrogacy will not be a safe practice for New Zealanders. ACART's consultation document does not address the issue of legal parenthood, but it is one that is intimately linked to the issue of compensation to surrogates because the Adoption Act (Section 25) prohibits payments in consideration of adoption. If, as we will argue below, surrogates deserve to be compensated for their labour, it is imperative that we acknowledge that the adoption framework is inappropriate in surrogacy.

The HART Act (Section 14.1) states that '[a] surrogacy arrangement is not itself illegal, but is not enforceable by or against any person'. Although people are free to enter surrogacy arrangements, any previous agreement regarding legal parenthood will not be enforced. Instead, legal parenthood is determined in accordance with the Status of Children Act 1969 (as amended in 1987 and 2004). Section 17 states that if a woman conceives with donor gametes, she is for all purposes the mother of the child, and Section 18 states that if a woman's partner consents to the ART procedure, he will be the parent of the resultant child. The implication for surrogacy arrangements is that the surrogate and her partner will be the legal parents at birth. She can then decide whether to give the child up for adoption by the intended parents. Effectively, surrogacy in New Zealand operates as a form of adoption, despite the fact that it has two rather distinct features: the surrogate becomes pregnant with the intention of relinquishing the child; and one or both of the adoptive parents is also the biological parent of the child. According to the Adoption Act 1955 the birth mother is not legally able to give consent until at least 10 days after the birth of the child (Section 7). Like any other person who wishes to adopt a child, the intended parents will have to be vetted by Child, Youth and Family (CYF), and an adoption order will only be approved if the court is satisfied that the adoptive parents are fit and proper persons to raise the child (Section 11).

Prior to the 1987 Amendment parenthood in New Zealand was grounded in genetic connection. In law, a gamete donor was a legal parent, despite the fact that he or she did not want the rights, duties and liabilities of parenthood. The 1987 Amendment was motivated by the belief that parentage 'should be decided on a social rather than a biological basis' (Henaghan & Atkin, 2013, p. 270). The Amendment achieved the desired result for couples who use donor gametes to overcome infertility, but in our view it achieved the opposite in the case of surrogacy, where the surrogate and her partner are recognised as the legal parents, while the intended parents, who are also the genetic parents, are treated as gamete donors. That appears to have been the intended result. The 1987 Amendment was promoted, at least in part, to prevent a Baby M case in New Zealand.<sup>2</sup> Opponents of surrogacy used this case to support their view that a woman cannot possibly decide ahead of time whether she would be capable of relinquishing her baby at birth. The introduction of the 1987 Amendment was aimed at protecting women by recognising the birth mother as the legal mother, regardless of whether she entered a surrogacy arrangement, and regardless of whether the child was genetically related to her.

The old adage 'hard cases make bad law' applies to surrogacy legislation both here and abroad. There is now sufficient evidence that the vast majority of surrogacy arrangements run smoothly. Women who become surrogates do decide in advance to give the baby to the intended parents and do relinquish the baby. That is the only reason they became pregnant. We believe that the law should change, and that intended parents should be recognised as the legal parents at birth. This would serve the interests of all parties to the agreement.

The HART Act aims to protect surrogates but actually makes them vulnerable, because the intended parents can also change their minds about adopting the child, or the Family Court may not grant an adoption order in their favour. Indeed, ACART (2013, p. 2) accepts this as a major risk factor for the surrogate. We believe it is an unacceptable risk to bear. In particular, if the child is born with an abnormality the surrogate may find herself responsible for a child that she cannot raise without significant hardship to herself and her family. Putting that child up for adoption by strangers is her only other option.

The intended parents are especially vulnerable given that ACART requires that at least one of them is the genetic parent of the intended baby. This genetic status is never again formally acknowledged. Should the surrogate change her mind about relinquishing the child or the

Family Court not grant an adoption order in their favour they face the loss of their genetic child. We do not want to suggest that the child is their property because it is their biological issue, but wish to highlight the horror for them of having a child to whom they are closely related raised by non-relatives who may not even maintain contact. New Zealand makes strenuous efforts to find family members to foster children who are taken from their biological parents, but in surrogacy this principle seems to have no force.

Even where the adoption process ends up running smoothly, the knowledge that either party can change their mind introduces a huge amount of fear and uncertainty into the relationship. Much of the uncertainty, as well as the fear and mistrust this can engender, will be eliminated by making surrogacy agreements legally binding. In addition to the benefits that certainty about legal parenthood would have for both the intended parents and the surrogate, it also serves the interests of the resulting child, for it will eliminate the risk that the child will 'become the subject of a dispute if the relationship between the surrogate and the intending parent(s) breaks down' (ACART, 2013, p. 2). The interests of the child are not being taken seriously in a system that maintains the fiction that the birth mother is the mother and the intended parents merely another couple applying for adoption under the 1955 Adoption Act. Adoption is a service that aims to find permanent legal parents for a child whose parents, family or whanau are unable to care for the child. As noted by Henderson (2013, p. 43), this does not encompass the motivations behind surrogacy arrangements.

A further undesirable consequence of retaining the adoption framework for surrogacy is a lack of procreative privacy for the intended parents. They are forced into the most public way of becoming parents: permitted by the state to adopt a child following suitability tests that assume the child is not theirs. They must participate in the fiction that the baby is not their child, even if they are its genetic parents, unless the state says it is. The state can only grant them parental status if the surrogate relinquishes a baby that is not hers. We do not object to suitability tests in themselves and support some screening of intended parents as well as surrogates, but it should be done before any surrogacy arrangement is validated. Once the agreement is confirmed the state should not play a role in the fate of the child. The intended parents should be the legal parents from birth and the surrogate should not be able to renege on the agreement at that point.

Section 14(3) of the HART Act prohibits commercial surrogacy, holding that it will be an offence to give or receive valuable consideration in exchange for participation in a surrogacy arrangement. Commercial surrogacy is widely condemned on the grounds that payment commodifies babies and exploits women. However, we argue that what makes commercial surrogacy morally wrong (when it is wrong) are practices such as:

- A failure to obtain free and informed consent before entering the arrangement;
- Restriction of the surrogate's freedom during pregnancy;
- Violation or restriction of her right to make decisions that may affect her health, including whether to terminate the pregnancy, have selective termination or even have a natural or caesarean delivery;
- Providing inadequate health care, which can lead to high rates of late miscarriage or perinatal death and premature birth;
- Transferring more than two embryos, which results in a high incidence of multiple pregnancies.<sup>3</sup>

New Zealanders should be strongly discouraged from seeking out commercial surrogacy services overseas, but this should be accompanied by an attempt to make domestic surrogacy more attractive to both infertile couples and potential surrogates. The prohibition of commercial

surrogacy is based on the mistaken assumption that payment of surrogates amounts to embracing a crude business or contractual model, which typically has the following features:

- The aim is to make a profit, and both parties are motivated by self-interest;
- A competitive market is encouraged: providers compete with each other to offer clients the most attractive deal;
- It is based on the principle 'Let the buyer beware';
- Clients 'get what they pay for'.

The contractual model inevitably leads to the unsafe practices listed above. Fortunately it is not the only model for paid surrogacy. We argue that not paying surrogates is unfair and a form of exploitation in itself. Instead, we have developed a professional model in which surrogates are motivated by a desire to do something worthwhile but are nevertheless compensated for their labour (see Van Zyl & Walker, 2013; Walker & Van Zyl, 2015). It is widely accepted that the work done by members of other caring professions – such as taking care of the sick and vulnerable – is in some sense priceless, but people still expect to be compensated for their labour. To guard against exploitation of surrogates and other harmful and unethical practices we favour the creation of a professional body, which will have the task of screening and registering surrogates, regulating fees, and licensing and monitoring clinics that offer surrogacy services. Licensed clinics will be required to use registered surrogates and provide all support services that the parties may need at any time during the arrangement (including post-natally).

Commercial surrogacy is often opposed on the grounds that the child is treated as a commodity: the surrogate is paid to hand over her child to the commissioning parents. What is less often noticed is that altruistic or unpaid surrogacy also commodifies the child – this time as a gift.

Instead of viewing surrogacy as a form of adoption, we favour viewing it as a way of overcoming infertility: the surrogate makes it possible for an infertile couple to have their own child. The intended parents are not buying a child, nor are they receiving it as a gift. Instead, a woman who is able to is providing the gestation of their own child. This requires a fundamental shift in the legal approach to surrogacy in New Zealand, but would align regulation more closely with the way in which participants usually view it. It is quite common for a surrogate not to think of the developing foetus as her own. Intended parents, in turn, rightfully think of the baby as theirs from the outset, which makes it particularly reprehensible that the surrogate has the freedom to change her mind. The intended mother is in the same position as the genetic father in more traditional arrangements: someone else is pregnant with, and gives birth to, her child.

## Response to Liezl van Zyl and Ruth Walker

GEORGE PARKER, *Strategic Advisor, WOMEN'S HEALTH ACTION*

The 2013 documentary *After Tiller*<sup>4</sup> follows the only four remaining doctors in the United States who openly perform late-term (third trimester) abortions following the murder of their colleague Dr George Tiller by an anti-abortion activist in 2009. The film follows the doctors' daily lives and work as they negotiate the complex ethical issues presented by third trimester abortion, whether for fetal abnormality or for any other reason leading to the pregnancy no longer being a tenable option for the woman concerned. They do this in the midst of hostile oppositional forces including threats to their safety, and social, structural and legislative barriers that would see them prevented from providing care to women who present to their services as a last resort, and often in desperate circumstances. In the course of the film, the

doctors grapple with their power to decide, on behalf of a woman, if her circumstances warrant the procedure she is seeking. The doctors emphasise that women themselves are best placed to make correct ethical decisions concerning their own lives and that the furore surrounding abortion could be transformed if they were trusted to do so. As Dr Robinson of Albuquerque's Southwestern Women's Options explains, 'what I believe is that women are able to struggle with complex ethical issues and arrive at the right decision for themselves and their families; they are the world's experts on their own lives.'

The importance of trusting women to navigate moral and ethical dilemmas and make their own health care and reproductive decisions has become a catchcry for pro-choice advocates in recent years. This is particularly the case in the United States, where a constant stream of proposed legislative amendments seek to move decision-making power about abortion away from women and into the hands of politicians and doctors. While the United States may be the front line in the struggle over women's right (and ability) to make their own reproductive decisions, the legislation governing abortion in New Zealand also represents a fundamental mistrust of women. New Zealand legislation retains abortion in the Crimes Act, requiring that women seeking abortion obtain approval from two 'certifying consultants' who agree that a woman meets one of the limited grounds for abortion, all with the constant oversight of the Abortion Supervisory Committee. It is widely agreed by those working in abortion care, and by women's health advocates, that legislative change is very long overdue.

As I read Van Zyl and Walker's analysis of surrogacy in New Zealand I was struck by the parallels between abortion legislation and that which regulates surrogacy as a form of adoption. Both pieces of legislation represent a fundamental mistrust of women to make the right reproductive decisions for themselves and their families, and the empowerment of lawmakers and doctors to do so on their behalf. In the case of surrogacy, the law is designed to protect the woman entering into a surrogacy arrangement from herself, and assumes, as Van Zyl and Walker note, 'that a woman cannot possibly decide ahead of time whether she would be capable of relinquishing her baby at birth'. Yet, as Van Zyl and Walker observe, there is now sufficient evidence that women who enter surrogacy arrangements do decide in advance to give the baby to the intended parents and do relinquish the baby. In the case of abortion legislation, the law is designed to protect society from women's potentially poor navigation of the moral terrain of abortion. The great irony of these protectionist pieces of legislation that govern women's reproductive bodies, as Van Zyl and Walker observe, is that they actually make women more vulnerable. In the case of surrogacy, women are made more vulnerable because they cannot enter surrogacy arrangements with the confidence that the law supports the intentions and agreements of both the surrogate and intended parents. In the case of abortion, because the law creates barriers that affect the accessibility and timeliness of abortion, abortions are performed later with a greater risk of harmful outcomes.

In summary, we agree with Van Zyl and Walker that law change is required in order to recognise the unique circumstances of a surrogacy arrangement and the intended parents as the legal parents at birth. We believe that it is enhanced access to support services for surrogates and intended parents, rather than laws, that will provide the greatest protection for both parties and for the resulting child, particularly when issues arise, such as the identification of a fetal abnormality. As I have noted in my contribution to this dialogue, we continue to hold significant reservations about the commercialisation of surrogacy; however, we anticipate and support further examination of the issue of payments to surrogates in the future. We are interested in learning more about the professional model developed by Van Zyl and Walker and look forward to new ways of conceptualising surrogacy arrangements that recognise and value the caring labour involved.



## Response to Liezl van Zyl and Ruth Walker

RHONDA SHAW, VICTORIA UNIVERSITY OF WELLINGTON

In her commentary, George Parker asserts ‘that the debate about ARTs has for too long focused on questions of morality, the personhood of embryos, and commerce rather than concern for women’s health.’ I agree with Parker’s sentiment, but take the view that we cannot disentangle (bio)ethical issues from sociological matters about human wellbeing and the social good (Shaw, 2015). For this reason, I will direct my response to Liezl van Zyl and Ruth Walker’s paper. Although legislation around assisted human reproduction in New Zealand is piecemeal and arguably needs to be revisited, I question some of the claims Van Zyl and Walker make in their commentary. As a sociologist with a longstanding interest in altruism and morality, my sympathies are with the rights and welfare of persons who donate biological materials and reproductive services.

Van Zyl and Walker comment that it often goes unnoticed by analysts debating surrogate motherhood that ‘altruistic or unpaid surrogacy commodifies the child – this time as a gift’. Certainly, in the bioethical literature the concept of altruism has been largely taken to mean ‘non-commercial’. This narrow understanding applies both to the case of reproductive body material and services as well as organ transplantation. However, unlike bioethicists, social scientists regard gift-giving, untainted by commodity exchange, as an illusion and increasingly argue that the gift-commodity distinction oversimplifies the interpenetration of gift and market economies. For social scientists, the dividing line between the world of donated bodily gifts such as human blood, hip bones, oocytes, and foetal tissue and the commodification of those gifts is invariably blurred. Biological material not only moves between institutions and across geographical locations, it is often transformed into derivatives during the course of travel. Additionally, in jurisdictions where the commercialisation of the fertility industry is lawful, ovarian egg donation and surrogate pregnancy is framed as an affective, altruistic act and an invitation to exercise reproductive mobility.

In their paper, Van Zyl and Walker advocate discouraging overseas surrogate pregnancy services, but seek to ‘make more attractive domestic surrogacy to both infertile couples and potential surrogates’. Their suggestion rests on the idea that surrogate mothers would benefit from the opportunity to sell reproductive services, and that a regulatory professional body providing legal advice and ongoing healthcare for donors would leave them well-off in the long term. I question why we would want to offer women the opportunity to temporarily outsource their bodies to strangers in this way. Unless a prospective surrogate mother seeks to assist a family member or relative, or acts voluntarily out of genuine altruism (the existence of which has long been disputed in medicine and psychology), it is difficult to see the benefits of surrogate motherhood, aside from remuneration. Would women seek to become surrogate mothers if other options were available through which to secure income or engage in altruistic activity? For instance, there is limited evidence to suggest that women do this because they enjoy being pregnant or giving birth. While improved self-esteem may be a consequence of surrogate pregnancy, it is not a primary motivator. More commonly, the decision to act is based on the desire to help a relative or alleviate their suffering. For unrelated surrogate mothers, the desire to do a good deed is sometimes linked to the idea of a body project (Shaw, 2008). This is not only conceptualised as an existential act; where assisted reproduction is commercialised, it is also entrepreneurial.

Van Zyl and Walker state that ‘it is widely accepted that the work done by members of other caring professions – such as taking care of the sick and vulnerable – is in some sense priceless’. Yet, non-professional care work is notoriously undervalued. I would agree that failure to

acknowledge the labour involved in gestating a pregnancy (like that involved in donating an organ) naturalises ideologies of caring undertaken in the informal sector (and outside the market economy), and that such work, which has historically been associated with women, hides a significant subsidy to the fertility industry. It also capitalises on women's altruism – a point noted in the final pages of Parker's commentary.

Van Zyl and Walker conclude that 'not paying surrogates is unfair'. At the beginning of their paper, they state that ACART proposes compensating women who act as surrogate mothers. Compensation is not the same as payment. However, in their paper Van Zyl and Walker advocate paying surrogate mothers for their services. The bioethical literature around this issue distinguishes between financial incentives for donation, designed to reward donors, and the removal of disincentives to donate, such as recompense. Recompense includes compensation for non-financial losses such as inconvenience, discomfort and time, and reimbursement of direct financial expenses such as taxi and train fares, medical expenses, childcare costs, and lost earnings. I have argued for the removal of financial barriers to living related and unrelated kidney donation, on the basis that donation is too expensive for some (particularly lower income) groups to consider as an option (Shaw, 2014). Consequently, the donative act of living kidney donation to a family member, which is publicly lauded as a moral ideal, ends up financially burdening individual families who pay for costs that could otherwise be met by a more robust healthcare system. The matter of payment is a critical issue and we need to be precise about whether we are advocating for reward, commercialisation, or recompense.

Van Zyl and Walker want to unyoke surrogate pregnancy and the issue of legal parenthood in New Zealand from the adoption model, but I do not think they are concerned enough with the lived experience of the surrogate mother. They assert that the intended parents of a surrogate pregnancy 'rightfully think of the baby as theirs from the outset, which makes it particularly reprehensible that the surrogate has the freedom to change her mind'. Is reneging on a promise always wrong? If we take a phenomenological approach to the donation of bodily material and argue that all human subjects are in a never-ending process of becoming, then changes to one's physical body such as pregnancy (or organ donation and transplantation) invariably spell change to the self. The project to which a surrogate mother consents to engage, and the attendant changes she experiences along the way, may result in shifts to her sense of identity. In the event of such changes, forcing a surrogate mother to relinquish the child she gives birth to is not only an annulment of her experience, it reduces her body to a thing, violates her right to full consent, and thereby restricts her freedom. Surrogate pregnancy should not be about outsourcing baby-making. Despite the wishes of stakeholders who seek to reproduce conventional atomic families, the technologies that enable these arrangements come with new kinds of relationships and a responsibility to think differently about how we do family in the twenty-first century.

When feminist scholars began debating surrogate pregnancy arrangements and oocyte donation in the early 1980s, there was a tendency to censure donors as cultural dopes conforming to social norms of feminine self-sacrifice. Fortunately, feminist commentary has transcended such condescension. Nevertheless, neoliberal arguments about agency and choice (e.g., I have the right to sell my eggs to a medical centre in Barbados, enjoy an exotic travel experience and go shopping) have limitations in the context of globalisation and reproductive tourism. The freedom to move and be global is a privilege; one not accorded to women who donate eggs or act as surrogate mothers in clinics in India, for example.

A further problem with Van Zyl and Walker's account is the claim that 'it is quite common for a surrogate not to think of the developing foetus as her own'. It is unclear whether the authors include both traditional and gestational surrogate pregnancy in their account. Either

way, they paint an incomplete picture of how the fertility industry works, especially how it frames altruism and how it organises the production of opportunities to donate. Up-to-date sociological studies show that in commercial contexts such as India, for example, surrogate mothers receive instruction to cultivate emotional detachment from the intended parents and to think of their wombs as containers or 'vessels'. For many of these women, this is a difficult thing to do. Contrariwise, in the USA, egg donors calculatngly construct their donor profile narrative so as to appear altruistic and thus desirable to prospective couples seeking donor oocytes. That is to say, women may espouse altruistic values as a condition of institutional rhetoric and as a means to a non-moral end.

My initial commentary included thoughts about genetic relatedness and its significance – or not – for the psychosocial wellbeing of participants in assisted reproduction. While there is a growing body of research that indicates that the absence of genetic relatedness does not negatively impact children's well-being in donor-conceived families, we still need to fully consider the impact of importing and exporting human gametes and embryos on a global scale. Van Zyl and Walker seem to be proposing to pave a way for commercial surrogate pregnancy in New Zealand. This is a messy and complex topic, and one that should be debated, but it is largely outside the scope of the proposed amendments to the HART Act.

## Concluding comments

DIANNE YATES

The making of children is not quite the same as someone saying 'if I give you the wool, will you make me a sweater?'. The making of a sweater takes a degree of physical effort or work. It takes time. It involves previously acquired skill. It may involve adhering to a pattern and it may require some artistic flare. It does not usually involve blood, sweat, and tears – the sharing of bodily fluids, food, and the physical and emotional processes gestation in the womb have for both baby and mother. In handing over the sweater some loss may be experienced but there is usually no health cost. The paper by Liezl van Zyl and Ruth Walker in favouring, in my opinion, the contracting parent(s) in surrogacy does seem to regard the process as 'renting a womb' – a rather antiseptic process similar to knitting a sweater or baking a cake. I assume that Van Zyl and Walker, in prioritising the rights of owners of the genetic material over the right of the gestational mother, would have ruled differently in the Baby M case. While the Adoption Model is not perfect – even for children already born – it does give greater rights, more time and choices to the gestational mother. Van Zyl and Walker do tend to dismiss the emotional involvement of the gestational mother. They indicate that giving the gestational mother rights after pregnancy and a chance to change her mind indicates a weakness on the part of that mother. They give priority to the elements of a legal contract over the lived experience of the woman involved. I think we have to remember that the law is a human construct and that it must serve reality, rather than human experience being forced to comply with a judicial framework.

It was brave of the producers of the long running popular television soap opera, *Coronation Street*, to recently tackle the moral, ethical, emotional, societal and financial questions of surrogacy through the interplay of its characters. They avoided discussion of the law and the legal framework in the United Kingdom, but did illustrate the moral issues regarding payment and the rights and wishes of the adoptive/donor parents and the birth mother. The questions were not presented as one off or black and white decisions, but were played out over a number of episodes and the characters changed their opinions in the light of the different life circumstances that faced them. The birth mother experienced a discomforting degree of

oppressive control by the contracting parents. She came to have doubts about the contracting parents' ability to parent well and lost her trust in their ability to care for the child adequately. She became involved and protective of the baby. Her motives – to earn money, as well as help her friends become parents – were in conflict when the care of the child was problematic and in question. While the decision-making of the genetic and birth parents were discussed, the rights of the child were a secondary matter for the contracting parents for a time. Fortunately the child was healthy and 'normal', but, in the case in point, if the child had manifest imperfections I am sure there would have been even more issues to be resolved.

The issue of changes to the HART Act are largely about compensation to the gestational mother. Having worked through in Select Committee some of the regulatory frameworks that would need to be put around this, it is a difficult task and hard to enforce. Is the mother to be compensated for loss of income from her regular employment, for the inconvenience and discomfort of pregnancy (if having difficulties or medical interventions), for travel, for medical expenses (would there be a limit)? What if the child is rejected by the contracting parents as not up to specification – does the mother get maintenance payments, or does the child become a ward of the state? If a gestational mother makes a career of being a gestational mother do other laws of employment, contract, self employment, ACC, tax, and so on, apply? They may do, but will be quite complex to adjust to the situation, and would they also apply to career organ donation (although the number of organs one can donate is limited usually to a one off from a living donor!). I would be reluctant to move fully into the application of the law of contract in surrogacy matters, given that even altruism is surrounded with difficulties and moral issues.

When science makes interventions such as modern genetic surrogacy possible we are faced with questions about these. Science on the one hand, while revelatory, should not dictate our morals and ethics. Our morals and ethics, on the other hand, should not be so rigid as to not recognise new technologies and new ways of defining rights and principles to encompass these. New ways of becoming surrogate parents through new and improved birth technologies create new possibilities and choices for those previously infertile or incapable, but also bring about new possibilities for exploitation – especially by those with funds to do so. The rights of individuals also need constant rebalancing within the wider context of societal and community rights. Doubt is also hard to measure, but where there is doubt it is best to tread carefully and slowly.

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## Notes

<sup>1</sup> Events, such as those documented in the media around 'baby Gammy' from Thailand in 2014, highlight these complications. See <http://www.stuff.co.nz/world/asia/10353731/Thai-surrogacy-agency-investigated-over-Gammy>

<sup>2</sup> Mary Beth Whitehead was paid to act as a traditional surrogate for William and Elizabeth Stern, but upon birth refused to hand over the child to the intending parents. The New Jersey court ruled that the agreement was invalid and recognised Whitehead as the legal mother, given that she was both the birth mother and the genetic mother. Using the 'best interests of the child' approach, the Family Court subsequently awarded legal custody to William Stern, while Whitehead was given visitation rights.

<sup>3</sup> For example, the incidence of multiple birth in commercial surrogacy arrangements in India and Thailand is over 60 percent, compared to 6.9 percent in Australia and New Zealand. See Stafford-Bell et al., 2014.

<sup>4</sup> <http://aftertillermovie.com/>

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