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Independent Articles

Gestational Surrogacy, the Pope, and Needs for Regulations

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Abstract

As surrogacy grows, many states and countries are enacting or considering relevant regulations, while others oppose it. Ethical, legal and policy questions arise: how to balance the rights of various kinds of parents (e.g., heterosexual and same-sex couples and single individuals) against the rights and well-being of surrogates. Concerns include risks of exploitation, autonomy, benefits of enabling prospective parents to create loving families, and mitigating possible harms through regulations. Though a few instances of abuse have been reported in developing countries, these do not appear to have occurred in developed countries, where robust regulations exist. The limited data available on surrogates in general (i.e., including traditional and non-commercial surrogacy) do not suggest exploitation or trafficking. In 2021, New York State enacted robust regulations allowing commercial surrogacy. Subsequent competing bills have sought to loosen or enhance certain restrictions. These regulations may be a model for commercial surrogacy regulations elsewhere, but certain ethical, legal and policy questions remain (e.g., where to draw the line to prevent trafficking). Additional data and exploration of these challenges are crucial

Keywords: assisted reproductive technologies; ethics; policy; surrogacy; religion

Pope Francis in January 2024 received worldwide media attention in calling for universal prohibition of surrogacy, describing the practice as "deplorable" and "inhuman," because "women, almost always poor women, are exploited." A child, he stated, may be "turned into an object of trafficking."[1] The pope's comments echoed those of Italy's extreme right-wing Prime Minister Giorgia Meloni, who criminalized use of surrogacy abroad by lesbian, gay, bisexual, transgender and queer (or questioning) (LGBTQ+) families, seen as a "crackdown" on LGBTQ+ families, "to appeal to her conservative base" opposing LGBTQ+ rights.[2] As illustrated, too, by the February 2024 Alabama Supreme Court case giving embryos personhood rights,[3] right-wing groups in many countries are restricting reproductive rights in a variety of ways that raise concerns[4] and warrant close attention and analysis. Given such shifts, advocates of reproductive rights need to be prepared to address, and respond to, such critiques.

One of the most contested aspects of reproductive care has been commercial surrogacy. In order to have a child, women who, for biological reasons, are unable to use their own uterus, along with gay couples and single-fathers-by-choice who want to have children and lack a family member or friend who can serve as a surrogate, need to arrange for a person they did not previously and personally know to serve as a gestational surrogate.

Though they could alternatively try to adopt an infant, doing so has become extremely difficult.[5] In the US, around 100,000 children are in the foster care system awaiting adoption,[6] but only about 4% of potential parents who contact the system about the possibility of adopting a child end up doing so,[7] partly due to barriers related to agencies (e.g., "red tape," staff shortages and turnover), potential families (e.g., related to background checks, and lack of interest in accepting a child with certain characteristics) and children (e.g., behavioral difficulties or special needs).[8] Children placed in, or adopted from, foster care also face increased rates of adverse childhood experiences, including exposure to violence, family mental illness, parental abuse and incarceration,[9] and often have behavioral, mental, developmental and health needs, while receiving insufficient services and resources.[10]

Three broad types of surrogacy exist. So-called traditional surrogates offer both their egg and uterus, while gestational surrogates offer only their uterus with another woman (in the case of heterosexual couples, usually the intended parent) using her own egg. Two types of gestational surrogacy exist: commercial and non-commercial. In the latter, intended parents (IPs) reimburse the surrogate only for expenses, while in the former, the IPs also provide additional payment as "profit." Such "commercial surrogacy" is now practiced in multiple countries and has been growing. In the US, California and other states have allowed commercial surrogacy, and in 2020, New York State (NYS) decided to do so as well.[11] Gestational surrogacy was a $14 billion dollar global business in 2022, with $179 billion anticipated by 2032.[12] In the US, the use of a gestational carrier among all assisted reproduction technology (ART) cycles increased from 2.2% to 5.4% of all ART cycles from 2011 to 2019,[13] in large part due to increasing numbers of gay men having children.

Recent statements by the pope and others, and several states' and countries' recent considerations of changes in regulations provide a valuable opportunity for reflection. The pope's wish to avoid exploitation due to surrogacy is important, but fuller ethical analysis, attention to past research and collection of additional data are also vital. Specifically, Francis did not consider the full range of

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ethical considerations involved (e.g., the rights of various stakeholders, and benefits, risks, and justice concerns); the data available thus far, which do not demonstrate such exploitations in jurisdictions where robust regulations exist; and the facts that different types of surrogacy exist, and that regulations can reduce the risks of such harms.

Transnational global surrogacy, in particular, has raised concerns about potential exploitation — that poorer women in the global South might be unfairly taken advantage of if they were to receive unfairly low benefits and/or face high costs and/or harms, and be unable to adequately consent due to low educational levels and relatively high monetary compensation.[14] India[15] and Nepal,[16] for instance, have in the past had large commercial surrogacy markets catering to foreigners, and subsequently enacted regulations barring non-citizens from hiring these surrogates. While a handful of anecdotal instances of abuse have been reported involving surrogacy in developing countries without regulations, such as Thailand,[17] the present manuscript focuses on US domestic surrogacy, where robust state laws have sought to reduce the likelihood of such exploitation. Commentators concerned about potential exploitation have not cited any data on its prevalence in the developing world,[18] and such instances, while possible, may currently be relatively rare and, as described below, do not appear to have occurred in developed countries where robust regulations exist.

While some prominent feminists, such as Gloria Steinem,[19] have opposed surrogacy due to fears of exploitation, other feminists and various other advocates support it with certain caveats (i.e., providing certain protections exist) since, they argue, restrictions can impede or deny women's rights to agency and autonomy if women wish to become surrogates.[20] Moreover, while concerns about possible human trafficking are important, right-wing political groups are frequently criticizing and restricting abortion, reproductive and LGBTQ+ rights to galvanize political support and using fears of trafficking to bolster these efforts.[21]

Observers have argued that in the developing world, such threats of exploitation can also be reduced in several ways — by ensuring robust informed consent and establishing standards for minimum levels of payment.[22] Commentators have described, too, how funds paid through surrogacy can, in fact, potentially improve the lives of surrogates and their families, how surrogacy can help create loving families, and how prohibition of surrogacy might simply drive the practice underground into a "black market," which can itself cause significant problems due to lack of transparency.[23] In the developing world, given concerns about potential surrogates' low levels of education, non-written information (e.g., educational videos) and robust verbal discussions can also potentially help.

While certain feminists have argued that surrogates are "selling control over their bodies," surrendering autonomy over their bodies, and relinquishing a child with whom they have a biological relationship,[24] other feminists have criticized these arguments, based, for instance, on ethnographic work in India that highlights how transnational surrogacy is also a form of labor that can be empowering, providing economic opportunity that women can choose if they wish, and that careful contracts can reduce the risks involved.[25] Smietana et al.,[26] for instance, conducted interviews in India, Russia and the US with surrogates (70 in India, 40 in Russia and 20 in California), intended parents and others, and found that surrogates viewed their work as labor, but in different ways — as involving gifts, commodities, economic self-affirmation or "a job." Women in India felt that, despite potential criticisms of exploitation, "given their meagre employment options," surrogacy gave them "greater control over their emotional, financial and sexual lives" and "allowed them to assert their moral worth".[27] Nonetheless, no representative data or large quantitative studies have been published regarding whether commercial surrogates are impoverished, feel desperate or exploited. Such data are urgently needed. Relatedly, some feminists have argued that transnational surrogacy should thus be seen not in binary ways as simply "good" vs. "bad," but rather with more nuanced perspectives.[28]

Available data: Suggestions and limitations

In the developing world, the limited data available thus far on surrogates in general (i.e., including traditional and non-commercial surrogacy), mostly from the US and the UK, do not suggest that surrogates are poor, financially desperate women or victims of trafficking.[29] Rather, the studies conducted thus far suggest that surrogates in the US tend to be White, middle class, and fully understand the risks, are pleased to receive an additional $60,000 or more for surrogacy, and do not feel exploited. Many are college graduates and/or military wives not otherwise working. [30]

Yet importantly, the available data remain limited. Studies from the US typically include less than 35 gestational surrogates each, frequently surveyed when traditional surrogacy was far more the norm. In the UK and Canada, where several surveys have been conducted, commercial gestational surrogacy is illegal.

In the US, as part of the Fertility Clinic Success Rate and Certification Act (FCSRCA) of 1992, the Centers for Disease Controls and Prevention (CDC) requests data on ART from fertility clinics.[31] The Society for Assisted Reproductive Technology (SART), affiliated with the American Society for Reproductive Medicine (ASRM), established a national voluntary reporting system and provides data to the CDC from clinics. These data are then publicly available on CDC and SART websites.[32] These data include ages of women, sources of embryos (whether they are from donors or non-donors), and numbers of in vitro fertilization (IVF) cycles, embryo transfers, and live singleton, twin or other births.[33] SART releases further data on, for instance, percent of preterm and very preterm births and outcomes from donated embryos.[34] The CDC, but not SART, audit 5%–10% of clinics to verify the information. The CDC does not currently seek data on gestational surrogates' race, ethnicity, education, socioeconomic status or perinatal health, but could potentially do so as well.[35]

Currently, reporting is voluntary and non-reporting has been rising, largely due to a small proportion of clinics.[36] Specifically, Kushnir et al. found that from 2005 to 2010, 93.5% of clinics reported data to CDC, but only 71.9% reported complete data to SART.[37] Thirteen clinics (3.8%) were responsible for 50% of excluded cycles, accounting for a mean of 37.3% of their cycles, excluding, for instance, older women, who are less likely to become pregnant. These 13 clinics were thereby able to report significantly higher pregnancy rates, and increased their share of total US cycles by 19.9%.[38] These authors recommended that cycle reporting should be prospective, and include perinatal health outcomes of the infants and mothers.[39] FCSRCA[40] could potentially be amended to make reporting of data by clinics mandatory, rather than voluntary.

Nonetheless, despite certain limitations in the current reporting system, data collected thus far reveal several areas for concern. For instance, in the US, 85% of gestational surrogacy deliveries fail to utilize single embryo transplant, and thereby pose significantly increased risks to both the surrogates and infants, with more than 30% of births being preterm.[41] Of note, sizable cross-border

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reproductive care occurs in the US: 18.3% of IPs were non-US residents, and 29.1% were from other states. In California and Connecticut, 32.8% and 35.2%, respectively, of all gestational surrogates in IVF *cycles* were for non-US residents.[42]

Söderström-Anttila et al.[43] recently published a systematic review of surrogacy in the UK, US and Canada, assessing several outcomes for surrogate mothers, children and the resulting families, and found that data were limited, but suggested that medical and psychological outcomes for children were similar to those for other births resulting from IVF, and that psychological outcomes were similar for surrogate and other mothers. Among 16 studies, none found serious psychopathology among women engaged as surrogate mothers.[44] One study, for instance, of 34 surrogate mothers, most of whom were in "traditional" arrangements, revealed that they "do not generally experience major problems in their relationship with the commissioning couple, [or] in handing over the baby." Though 11 (32%) had some brief difficulties after the handover, and one (3%) had moderate difficulty, 94% had no such difficulty one year afterwards, 100% were happy with their decision to be a surrogate, and none had doubts or difficulties at the handover or were reluctant to relinquish the child, suggesting a lack of abuse.[45] This review, however, also reported a lack of high-quality studies, stating that most "have significant methodological limitations such as small sample size, lack of controls and a low response rate."[46] These authors reported, too, that research was also lacking on children created through cross-border surrogacy or by gay fathers. These authors concluded that "the most important concerns related to surrogacy treatment is anxiety about possible harmful medical and psychological consequences for the child," and that surrogates' "primary motivation" was "altruistic."[47] Horsey et al,[48] for instance, reports on 47 surrogates, almost half of whom were a family member or friend of the IPs.

Data suggest that among children, studied up through age 10, no major psychological differences exist between those born through surrogacy vs. other types of ART or natural conception.[49]

The Söderström-Anttila et al.[50] review provides valuable data on several key issues, but does not address concerns about possible exploitation and human trafficking, and combines and does not distinguish among the different types of surrogacy (i.e., traditional, gestational, commercial, and non-commercial). While UK studies often include socioeconomics about surrogates in that country,[51] the situation there differs dramatically from that in the US, given that the UK does not permit commercial surrogacy, where exploitation would be far more likely to occur. Large amounts of money paid in commercial surrogacy can affect prospective surrogates' motives, raising questions of possible exploitation and trafficking,[52] and needs for evaluations in jurisdictions where commercial surrogacy is allowed, such as California and NYS, of the race, ethnicity, education and socioeconomic status of surrogates vs. other mothers, and of surrogates' attitudes concerning possible exploitation.

Variations in regulations

Due to ethical concerns about exploitation and relative lack of data, countries and states vary widely in specific regulations. While some countries, including France, China, Italy, Germany, Iceland, Indonesia, and Nepal prohibit all surrogacy,[53] several others have regulations, and/or are currently debating how to proceed. Israel allows gestational surrogacy, including for single and same-sex couples, and permits payment beyond expenses, but not for foreigners.

Table 1. US Surrogacy Laws by State

Types of laws	Number of states
Legally allowed	6
Allowed (since it is not explicitly allowed)	17
Permitted with restrictions	12
Allowed with unenforceable contracts	1
Supported but with no law	9
Practiced, though contracts are prohibited	5

Canada and the UK allow gestational surrogacy, including for single- and same-sex couples and foreigners, but only permits compensation for expenses, and bans commercial surrogacy.[54] Greece follows Canada and the UK, but excludes single- or same-sex parents. South Africa also follows Canada and the UK but excludes foreigners. Belarus allows payment beyond expenses but excludes same-sex couples. Benin, the Republic of Georgia, Kazakhstan, Ukraine and Russia also exclude single parents.[55] Countries' policies continue to change, with Ireland, for instance, enacting legislation regarding surrogacy for the first time in July 2024.[56]

In the US, as seen in Table 1, states differ widely in whether they permit these arrangements.[57]

These laws are also in flux. On February 1, 2024, for instance, the Virginia Legislature passed a bill that abolished a law that originally restricted individuals from participating in for-profit surrogacy.[58] In November 2023, Michigan, which has criminalized surrogacy contracts since the 1980s, considered a bill to set standards for allowing such surrogacy contracts.[59] Between 2010 and 2014, of all gestational surrogacy that occurred in the US, 29% was in California, 7.8% in Connecticut, 7.5% in Texas, 6.4% in Illinois, 4.8% in Florida, 4.5% each in NYS and New Jersey, 4.2% in Massachusetts, and the rest in other states.[60]

ASRM has issued guidelines, as a standard of care, that surrogates should have given birth beforehand to their own children, and are thus aware of what pregnancy entails.[61] IVF doctors must assess the potential surrogate's social and educational history, resources and strengths, emotional stability and absence of any financial or emotional coercion.[62] The American College of Obstetricians and Gynecologists (ACOG) recommends, in addition, that separate OB/GYNs care for the surrogate and for the IPs, to prevent possible conflicts of interest, and that potential surrogates and the IPs discuss all possible decisions that may need to be made during the pregnancy (e.g., need for COVID vaccine boosters that might become available).[63] Groups such as Surrogacy 360[64] have also laid out principles.

These variations reflect differences in how jurisdictions view and respond to underlying ethical tensions — how to balance the rights of various kinds of parents (from heterosexual couples to single and same-sex parents) against the rights and well-being of surrogates. Ethical concerns include not only risks of exploitation (which can certainly occur), but also women's autonomy to make informed decisions about their own bodies, benefits of enabling prospective parents to have a child and create a loving family when they would not otherwise be able to do so, and potential ways of mitigating possible harms through regulations.

To try to balance the potentially competing ethical considerations involved, and aid such prospective parents while avoiding

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exploitation, NYS in 2021 enacted the Child-Parent Security Act (CPSA),[65] one of the most robust sets of regulations that exists and allows commercial surrogacy. An earlier version of this law was initially approved by the NYS Senate in 2019, but rejected by the NYS Assembly. Governor Andrew Cuomo then included a version of the bill in his executive budget. In 2023, NYS Senator Liz Krueger proposed an alternative surrogacy bill, which contained more robust protections of surrogates, and elements of which the final CPSA included.[66] The final CPSA contained several novel features that other jurisdictions' earlier regulations did not, such as a Gestational Surrogates' Bill of Rights,[67] which provides rights to gestational surrogates, including IPs providing surrogates with health, disability, and life insurance; psychotherapy; independent lawyers; reimbursement for related medical costs; and rights to undergo cesarian section or to terminate the pregnancy or the contract at any time. All companies engaged in surrogacy need to be licensed by NYS. To prevent human trafficking from poorer countries, surrogates must be US citizens or permanent legal residents and NYS residents for six months.[68]

On February 27, 2023, a bill was introduced in the NYS Legislature (S5107A) and signed by Governor Hochul on December 21, 2024, loosening certain restrictions. It stipulated, for example, that the surrogates would *not* need to be a NYS resident for six months, if either intended parent was; that the name of the surrogate would not appear on the birth certificate; and that IPs can buy, instead of life insurance, a contractual liability policy or an accidental death insurance policy (which may only cover death due to illness, disease or other medical conditions caused by an accident).[69] In November 2023, Senator Krueger had introduced Bill S7749 to strengthen the CPSA by requiring that data about surrogacy be submitted, requiring that the IPs provide insurance on signing the contract (i.e., when medical interventions start), and that the surrogate be a NYS resident during the pregnancy and for one month following the birth, in case medical problems occur during these periods, and specifying what exactly the informed consent form and legal contracts should include (e.g., specific risks, and the ability for the surrogate to have the document reviewed by others).[70] Senator Kruger's bill did not pass, and she is currently revising it.

Moving forward

Given that commercial surrogacy is rapidly growing but facing opposition from the pope and others, several needs emerge for moving forward as ethically as possible. First, additional data are clearly needed to determine whether exploitation occurs. The FCSRCA and hence CDC collection of data should be changed to require that sociodemographic information about surrogacy be reported, with the FCSRCA amended to make such data reporting by clinics mandatory, not voluntary. Increasing use of electronic medical records can aid such additional data collection.[71] SART could oversee such collection and optimize compliance by continuing the current incentive of not listing non-reporters on its website, which many potential parents check to compare clinics' success rates.

Due to political and bureaucratic impediments in Washington, DC, obstacles to changing the federal law might arise, but could potentially be addressed. NYS, California and other states that now allow commercial surrogacy should, in the interim, mandate such reporting to help ensure that exploitation does not occur. Unfortunately, no states have yet done so. ASRM[38] and ACOG[72] should amend their guidelines to urge submission of such information, and also urge clinics and surrogacy companies to collect, store and report information on surrogates' sociodemographics. Questions arise as to why such data collection has not occurred. Surrogacy companies, clinicians, and advocates may not see it as in their interest to collect such information since they are profiting under the status quo, and may fear that such data might raise concerns about possible exploitation. But given potential opposition from the pope and others, reluctance is, in the long-term, short-sighted.

Though the kind of robust regulations that NYS has developed in the CPSA can also serve as an important model for commercial surrogacy regulations elsewhere, certain questions clearly remain regarding various details, such as where exactly to draw the line to ensure that trafficking and exploitation do not occur — e.g., whether to mandate collection of data to ensure that trafficking does not transpire, whether and for how long the surrogate must remain in the state after birth, when exactly disability insurance should start, given that insurance plans may have delays in the start of coverage, whether movement of potential surrogates is acceptable across not across not only national boundaries, but state lines, and what exactly the informed consent should include. Studies are and will be crucial to assess how well the CPSA works — whether, for instance, any trafficking nonetheless happens as a result, what legal or other challenges and disputes may arise and how they get addressed, and how surrogates perceive the experience.

Other states and countries that now permit commercial surrogacy or are considering doing so should adopt NYS' more robust regulations. Especially given ever-more rapid expansion of this industry, involving ever-more billions of dollars, and considerations of possible regulations by various states and countries, strong regulations and collection of data to ensure that exploitation and trafficking do not occur are essential. Abuses may still occur, as in banking, medicine, law and every other human endeavor. Yet that does not mean that commercial gestational surrogacy should be abolished. Rather, robust regulations and data collection are needed to counter recent statements by the pope and others, and to ensure that surrogacy is practiced as ethically as possible.

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References

1. See the Holy See Press Office, "Audience With the Diplomatic Corps Accredited to the Holy See for the Exchange of Greetings for the New Year," press release, January 8, 2024, https://press.vatican.va/content/salastampa/en/bollettino/pubblico/2024/01/08/240108d.html (last visited December 30, 2024).
2. E. Bubola, "Italy Criminalizes Surrogacy From Abroad, a Blow to Gay and Infertile Couples," *New York Times*, October 16, 2024, https://www.nytimes.com/2024/10/16/world/europe/italy-surrogacy-law.html (last visited January 3, 2025).
3. "Read the Alabama Supreme Court's Ruling," *New York Times*, February 21, 2024, https://www.nytimes.com/interactive/2024/02/21/us/alabama-supreme-court-embryo-ruling.html (last visited January 2, 2025).
4. See Bubola, *supra* note 2.

https://doi.org/10.1017/jme.2025.66 Published online by Cambridge University Press

5. A.D. Engler et al., "A Systematic Review of Mental Health Disorders of Children in Foster Care," *Trauma, Violence & Abuse* 23, no. 1 (2022): 255–64, doi: https://doi.org/10.1177/1524838020941197
6. Children's Bureau, *AFCARS Report #30* (US Department of Health and Human Services, 2024), https://www.acf.hhs.gov/cb/report/afcars-report-30 (last visited January 8, 2025).
7. R. Geen., K. Malm, and J. Katz, "A Study to Inform the Recruitment and Retention of General Applicant Adoptive Parents," *Adoption Quarterly* 7, no. 4 (2004): 1–28, doi: https://doi.org/10.1300/J145v07n04_01
8. A. Chanmugam et al., "Agency-Related Barriers Experienced by Families Seeking to Adopt From Foster Care," *Adoption Quarterly* 20, no. 1 (2016): 25–43, doi: https://doi.org/10.1080/10926755.2015.1121187
9. K. Turney and C. Wildeman, "Adverse Childhood Experiences Among Children Placed in and Adopted From Foster Care: Evidence From a Nationally Representative Survey," *Child Abuse & Neglect* 64 (2017): 117–29, doi: https://doi.org/10.1016/j.chiabu.2016.12.009
10. See Chanmugam, *supra* note 8; L. Gypen et al., "Outcomes of Children Who Grew up in Foster Care: Systematic-Review," *Children and Youth Services Review* 76 (2017): 74–83, doi: https://doi.org/10.1016/j.childyouth.2017.02.035
11. Legal Professional Group, "A Professional Group of the American Society for Reproductive Medicine, Surrogacy Laws by State," American Society for Reproductive Medicine, https://connect.asrm.org/lpg/resources/surrogacy-by-state?ssopc=1 (last visited December 30, 2024).
12. M.W. Roeloffs, "It's Not Just Celebrities – Commercial Surrogacy Industry Expected to Grow Tenfold by 2032," *Forbes*, July 14, 2023, https://www.forbes.com/sites/maryroeloffs/2023/07/14/its-not-just-celebritiescommercial-surrogacy-industry-expected-to-grow-tenfold-by-2032/?sh=520d01337f1e (last visited December 30, 2024).
13. "National ART Summary," Centers for Disease Control and Prevention, December 10, 2024, https://www.cdc.gov/art/php/national-summary/index.html (last visited December 30, 2024)
14. S. Wilkinson, "Exploitation in International Paid Surrogacy Arrangements," *Journal of Applied Philosophy* 33, no. 2 (2015): 125–45, doi: https://doi.org/10.1111/japp.12138
15. The Surrogacy (Regulation) Act, 2021(December 25, 2021), India, https://dhr.gov.in/document/acts-circulars/surrogacy-regulation-act-2021 (last visited January 2, 2025),
16. US Embassy Kathmandu, "Surrogacy Services are Banned in Nepal" US Embassy in Nepal, June 4, 2021, https://np.usembassy.gov/surrogacy-services-are-banned-in-nepal/ (last visited December 30, 2024).
17. A. Whittaker, M.C. Inhorn, and F. Shenfield, "Globalised Quests for Assisted Conception: Reproductive Travel for Infertility and Involuntary Childlessness," *Global Public Health* 14, no. 12 (2019): 1669–88, doi: https://doi.org/10.1080/17441692.2019.1627479
18. See Wilkinson, *supra* note 14; B. Parry and R. Ghoshal, "Regulation of Surrogacy in India: Whenceforth Now?," *BMJ Global Health* 3, no. 5 (2018): e000986, doi: https://doi.org/10.1136/bmjgh-2018-000986; J. Oksala, "Feminism against Biocapitalism: Gestational Surrogacy and the Limits of the Labor Paradigm," *Signs Journal of Women in Culture and Society* 44, no. 4 (2019): 883–904, doi: https://doi.org/10.1086/702031; K. Srivastava, "Empowerment and Subjugation: Re-Conceiving Commercial Surrogacy as Work–Labor in India," *Asian Journal of Women Studies* 27, no. 4 (2021): 575–96, doi: https://doi.org/10.1080/12259276.2021.1995153
19. V. Wang, "Surrogate Pregnancy Battle Pits Progressives Against Feminists," *New York Times*, June 19, 2019, https://www.nytimes.com/2019/06/12/nyregion/surrogate-pregnancy-law-ny.html (last visited December 30, 2024).
20. K. Busby and D. Vun, "Revisiting *The Handmaid's Tale*: Feminist Theory Meets Empirical Research on Surrogate Mothers," *Canadian Journal of Family Law* 26, no. 1 (2010): 13–93; M. Smietana, S. Rudrappa and C. Weis, "Moral Frameworks of Commercial Surrogacy Within the US, India and Russia," *Sexual and Reproductive Health Matters* 29, no. 1 (2021): 1–17, doi, https://doi.org/10.1080/26410397.2021.1878674
21. See Bubola, *supra* note 2; See *New York Times*, *supra* note 3.
22. See Wilkinson, *supra* note 14; See Oksala et al., *supra* note 18.
23. See Wilkinson, *supra* note 14; See Oksala et al., *supra* note 18.
24. See Oksala, *supra* note 18.
25. See Srivastava, *supra* note 18.
26. See Smietana, *supra* note 20.
27. See Smietana, *supra* note 20.
28. See Srivastava *supra* note 18; See Oksala, *supra* note 18.
29. V. Söderström-Anttila et al., "Surrogacy: Surrogacy: Outcomes for Surrogate Mothers, Children and the Resulting Families—A Systematic Review," *Human Reproduction Update* 22, no. 2 (2016): 260–76, doi: https://doi.org/10.1093/humupd/dmv046
30. See Smietana, *supra* note 20.
31. Fertility Clinic Success Rate and Certification Act, Pub. L. No. 102-493 (1992), https://www.congress.gov/bill/102nd-congress/house-bill/4773 (last visited January 8, 2025).
32. V. A. Kushnir et al., "The Status of Public Reporting of Clinical Outcomes in Assisted Reproductive Technology," *Fertility and Sterility* 100, no. 3 (2013): 736–41, doi: https://doi.org/10.1016/j.fertnstert.2013.05.012
33. R. Klitzman, *Designing Babies: How Technology is Changing the Ways We Create Children* (Oxford University Press, 2019).
34. Id.
35. See Centers for Disease Control and Prevention, *supra* note 13.
36. See Kushnir et al., *supra* note 32.
37. See Kushnir et al., *supra* note 32.
38. See Kushnir et al., *supra* note 32.
39. See Kushnir et al., *supra* note 32.
40. See US Congress, *supra* note 31.
41. See Whittaker et al., *supra* note 17; K. M. Perkins et al., "Differences in the Utilization of Gestational Surrogacy Between States in the U.S.," *Reproductive Biomedicine & Society Online* 5 (2017): 1–4, doi: https://doi.org/10.1016/j.rbms.2017.08.002
42. See Kushnir et al., *supra* note 32.
43. See Söderström-Anttila et al., *supra* note 29.
44. See Söderström-Anttila et al., *supra* note 29.
45. V. Jadva et al., 'Surrogacy: The Experiences of Surrogate Mothers,' *Human Reproduction* 18, no. 10 (2003): 2196–204, doi: https://doi.org/10.1093/humrep/deg397
46. See Söderström-Anttila et al., *supra* note 29.
47. See Söderström-Anttila et al., *supra* note 29.
48. K. Horsey et al., "UK Surrogates' Characteristics, Experiences, and Views on Surrogacy Law Reform," *International Journal of Law, Policy and the Family* 36, no. 1 (2022): ebac030, doi: https://doi.org/10.1093/lawfam/ebac030
49. See Söderström-Anttila et al., *supra* note 29.
50. See Söderström-Anttila et al., *supra* note 29.
51. See Horsey, *supra* note 48.
52. See Whittaker, *supra* note 17.
53. "Which Countries Allow Commercial Surrogacy?," Reuters, April 5, 2023, https://www.reuters.com/world/which-countries-allow-commercial-surrogacy-2023-04-05/ (last visited December 30, 2024).
54. UK Department of Health and Social Care, "Guidance: Having a Child Through Surrogacy," Gov.UK, last updated July 23, 2021, https://www.gov.uk/government/publications/having-a-child-through-surrogacy (last visited December 30, 2024).
55. See Reuters, *supra* note 53.
56. L. Bracken, "Prohibiting commercial surrogacy in Ireland," *International Journal of Law, Policy and the Family* 39, no.1 (2025): ebae024, doi: https://doi.org/10.1093/lawfam/ebae024.
57. "The U.S. Surrogacy Law Map™," Creative Family Connections, https://www.creativefamilyconnections.com/us-surrogacy-law-map/ (last visited December 30,2024); see Perkins et al., *supra* note 41.
58. H.B. 110, 2024 Sess. (Va, 2024), https://lis.virginia.gov/cgi-bin/legp604.exe?241+sum+HB110 (last visited December 30, 2024).
59. A.L. Nichols, "Fertility Health Care Act Decriminalizing Paid Surrogacy Passes Michigan Senate Committee," *Michigan Advance*, March 14, 2025, https://michiganadvance.com/2024/03/14/fertility-health-care-act-decriminalizing-paid-surrogacy-passes-michigan-senate-committee/ (last visited December 30, 2024).
60. See Perkins et al., *supra* note 41.
61. *Recommendations for Practices Using Gestational Carriers: A Committee Opinion* (American Society of Reproductive Medicine, 2022), https://www.asrm.org/practice-guidance/practice-committee-documents/recommendations-for-practices-using-gestational-carriers-a-committee-opinion-2022/ (last visited December 30, 2024).

https://doi.org/10.1017/jme.2025.66 Published online by Cambridge University Press

62. Id.
63. *Family Building Through Gestational Surrogacy: Number 660 (Replaces Committee Opinion No. 397*) (American College of Obstetricians and Gynecologists. February 2008, Reaffirmed 2019), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2016/03/family-building-through-gestational-surrogacy (last visited December 30, 2024).
64. https://surrogacy360.org/, Surrogacy360 (last visited December 30, 2024).
65. Department of Health. "The New York State Child-Parent Security Act: Gestational Surrogacy," New York State, revised October 2023, https://www.health.ny.gov/community/pregnancy/surrogacy/ (last visited December 30, 2024).
66. S.R. S7749, 2023–2024 Reg. Sess. (N.Y., 2023), (https://www.nysenate.gov/legislation/bills/2023/S7749 (last visited January 8, 2025).
67. S.R. S819, 2025–2026 Leg. Sess. (N.Y., 2024), https://www.nysenate.gov/legislation/bills/2023/S5107/amendment/A (last visited January 8, 2025).
68. Id.
69. Id.
70. S.R. S7749, 2023–2024 Reg. Sess. (N.Y., 2023),.
71. See Klitzman, *supra* note 33.
72. See American College of Obstetricians and Gynecologists, *supra* note 64.

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