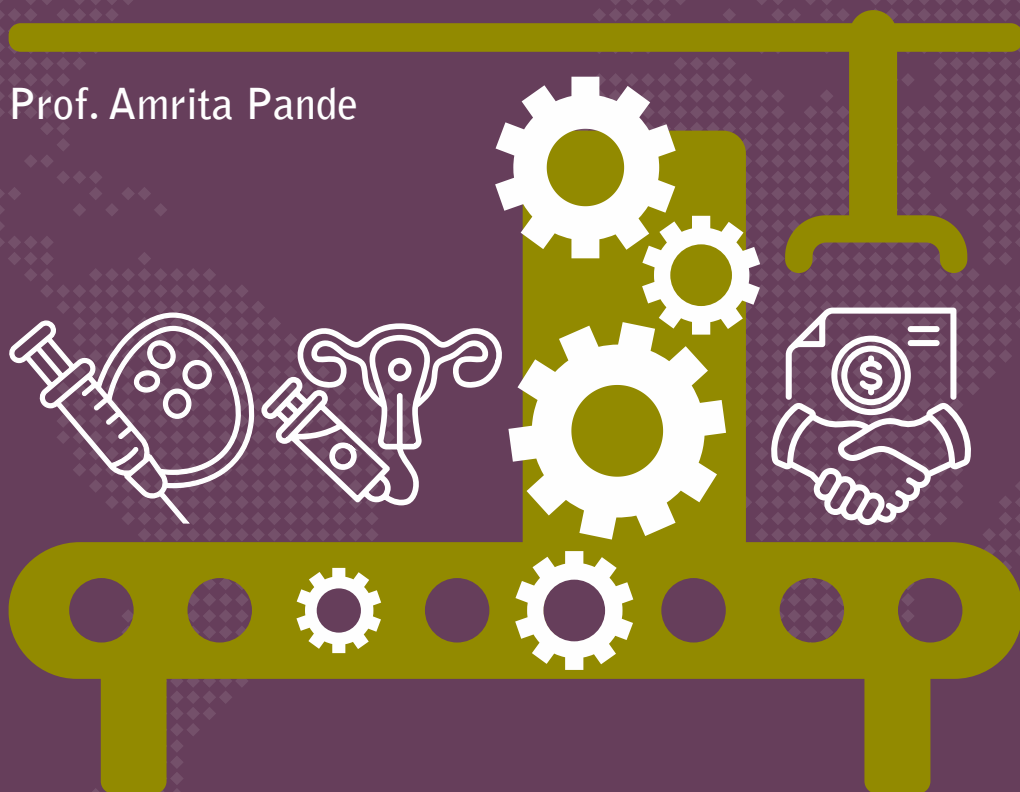


MAPPING GLOBAL SURROGACY

Care Brokers and the Politics of Supply

Prof. Amrita Pande



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Preface

A Feminist Lens on the Global Surrogacy Industry

Surrogacy is increasingly gaining attention in public and academic discourse. For many, it represents an advanced form of assisted reproduction, enabling individuals and couples – including gay couples and single parents – to build families when pregnancy is not biologically or physically possible. At the same time, it stirs up strong emotions and heated debate on the ethics, particularly around the question of exploitation. While for some surrogacy is a way to motherhood or parenthood, for others it can be (under)paid reproductive labour.

The practice of surrogacy is not new, however. For centuries, women have given birth on behalf of others out of solidarity, compassion or societal pressure. But now, technological advances such as IVF have provided a new pathway to parenthood for those that can afford it. Within our capitalist system surrogacy has thus transformed into a rapidly expanding global industry.

Recognising the complexity of this issue, the **Global Unit for Feminism and Gender Democracy** decided to address surrogacy through a different lens – by examining the logics of this industry and questioning the common narrative that either centers the needs and struggles of intended parents or those of the surrogates. It rather looks at the economic and legal structures that make this transaction possible in the first place.

Surrogacy is a matter of profound concern to feminists because it cuts across issues of gender, labour, bodily autonomy, power and social justice. From a feminist perspective, surrogacy is not just a medical or contractual arrangement, but a question of who or what really controls our reproductive capacity.

Many feminist scholars understand surrogacy as a form of reproductive labour – an extension of care work that is still undervalued. In the global surrogacy market, this labour is often outsourced to poorer women, particularly in the Global South, while the wealthier *intended* parents frequently live in the Global North. An intersectional

feminist lens shows that surrogacy is not only about gender, but also about race, class and nationality. The fertility of some women is supported and celebrated, while the bodies of others are treated as mere reproductive instruments without rights or recognition.

This comprehensive research paper, conducted, written and compiled by renowned researcher **Professor Amrita Pande**, argues that the global surrogacy industry is fundamentally shaped by the supply-side (the clinics and agencies offering assisted reproductive technologies) rather than by demand alone. This perspective allows us to deconstruct political campaigns and biased research projects that suggest that the wish for a baby is the only driving force behind this growing industry. It inspires us to look beyond this narrow scope and include the interests of other actors involved in this “reproweb”, especially those intermediaries that benefit financially.

However, this report also shows, that national laws or bans alone, cannot effectively regulate surrogacy, as they simply push the practice underground or relocate it elsewhere, thereby often worsening the situation of surrogate mothers. Pande challenges us to think in global, rather than national terms when it comes to governing this complex field of surrogacy. She also invites us, to use the vision of reproductive justice, when thinking about how to regulate reproductive markets.

Ultimately, any conversation about the future of surrogacy must move towards reproductive justice – emphasising the rights and wellbeing of those whose bodies and labour actually sustain the industry. This vision, created by Black feminists in the US in the 1990ies, adds a demand for social justice to all questions concerning the right to have or not to have children and how to raise them. As a consequence, a question must arise: Is there such thing as a right to have your own child? And if so, how does this right interplay with the right to bodily autonomy within a system shaped by capitalism and colonialism?

The answers to these question are yet to be found and we will shape the feminist debates around them in the future. With this report, we hope to inspire these debates and contribute research-based content about a topic so often pushed to the private sphere, although it concerns the very core of our societies.

While the topic of surrogacy remains deeply polarised within feminist circles, the Global Unit for Feminism and Gender Democracy aims to open an informed debate based on this important research. We invite readers to engage critically with these findings and contribute to ongoing dialogue on how, in a world shaped by capitalism and (post)colonialism, technological advancements can serve those who wish to have a baby, while also ensuring the dignity and rights of those providing this reproductive labour.

Naida Kučukalić and Derya Binışık

Global Unit for Feminism and Gender Democracy

Executive Summary

Mapping Global Surrogacy - Care Brokers and the Politics of Supply

This report offers a critical feminist and political economy analysis of the global surrogacy industry, arguing that the industry is not merely a response to rising infertility or changing family structures, but is fundamentally supply-driven – shaped by global inequalities, legal loopholes, and the strategic investments of fertility entrepreneurs, or what this report calls “care brokers”. While mainstream narratives frame surrogacy as a solution to unmet reproductive need, this report shifts the lens to the systematic management of this industry by investors and care brokers, and the systemic production of reproductive labour, revealing how certain bodies – especially those of women in the Global South – are made available for reproductive work through legal, economic and geopolitical processes.

The report traces the evolution of the global surrogacy market through three distinct phases. The first phase was dominated by “one-stop surrogacy” hubs in the Global North, particularly the United States, where surrogacy was institutionalised through state-level legal frameworks. The second phase saw the rise of Southern hubs – India, Thailand, Nepal and Ukraine – where surrogacy was offered as a low-cost, all-inclusive package. These hubs flourished in legal grey zones, often exploiting the absence of regulation and the economic vulnerability of gestational mothers. The third and current phase is marked by fragmentation and hybridity: the emergence of smaller, transient “reproductive nubs” in countries like Laos, Ghana and Colombia, where different stages of the surrogacy process – egg retrieval, embryo transfer, gestation and birth – are outsourced across borders. This report focuses on the second and third phases, with surrogacy proliferating in hubs and nubs in the Global South.

A central contribution of the report is its focus on care brokers – a category of intermediaries who manage the logistical, legal and emotional complexities of transnational

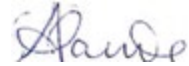
surrogacy. These actors, often former intended parents themselves, play a pivotal role in managing and sustaining the industry. They weave together what the report calls “reprowebs” – elastic, transnational networks of clinics, egg providers, gestational mothers, lawyers and logistics facilitators. Care brokers not only facilitate the process but also provide emotional reassurance to intended parents. Their work is deeply shaped by crises – wars, pandemics, legal bans – which they navigate with agility, often relocating operations overnight to more permissive jurisdictions. Care brokers play a critical role in encouraging intended parents to fulfil their wishes, normalising surrogacy and transnational surrogacy and the desire for a genetically predisposed child by presenting these processes as emotionally supported and regulated solutions. Their strategies are not mere responses to emerging crises; these crises become opportunities for them to innovate into new geographical locations, niches and add-on services.

The report draws on 17 years of ethnographic research, including interviews with gestational mothers, intended parents, fertility professionals and care brokers across Asia and Africa. It reveals how national bans on commercial surrogacy do not end the practice but displace it, creating a domino effect that pushes the industry into new, often less regulated, territories. This displacement increases the precarity of gestational mothers, who may face the threat of criminalisation or be forced to migrate or work in unsafe conditions.

The future of global surrogacy, the report argues, lies in its increasing stratification and commodification. Agencies now offer “guarantee packages”, “unlimited embryo transfers” and even “buy one, get one free” deals. Services are tailored to specific markets – gay men, single parents, HIV-positive clients – while gestational mothers remain largely invisible in the marketing narratives. The industry is expanding into new geographies, including parts of Africa and Eastern Europe, where legal frameworks are weak or absent, and where economic desperation makes surrogacy an attractive, if risky, livelihood.

The report concludes with a call for a reproductive justice framework that centres on the rights and realities of gestational mothers, rather than focusing solely on the

desires of intended parents or the rights of the child. It critiques the inadequacy of national bans and the limitations of rights-based approaches, advocating instead for global interdisciplinary dialogue and regulation that is grounded in intersectional feminist ethics. Without such a shift, the surrogacy industry will continue to thrive in the shadows – profitable, precarious and profoundly unequal.

A handwritten signature in blue ink, appearing to read "Anne".

November, 2025

Chapter 1. Introduction

The global surrogacy market, valued at over USD 4 billion in 2015, is projected to double by 2025. While most accounts attribute this growth to rising infertility and greater social acceptance of “non-traditional” families – including same-sex couples and single parents – this report shifts focus to the supply-side dynamics shaping the industry. It argues that surrogacy has always been fundamentally *supply-driven*, evolving through three phases: first, the Northern “one-stop surrogacy” hubs in the United States and parts of Europe; second, Southern hubs concentrated in Asia; and most recently, the proliferation of smaller “nubs” in Africa, Eastern Europe and South America.

This report analyses the history and geography of reproductive hubs and nodes to forecast the industry’s future. It examines the surrogacy market temporally, spatially and thematically by tracing the evolution of hubs, investment patterns and regulatory changes. At the heart of this analysis are the “care brokers” who make the industry possible. These actors – clinic managers, coordinators, agencies, recruiters and intermediaries – do far more than facilitate care; they shape the terms of access, negotiate legal and social constraints, and ultimately sustain the unequal global flows of reproductive labour and technologies. By placing care brokers at the centre of the analysis, the report foregrounds how they mediate between intended parents and gestational mothers, while simultaneously managing risk, marketing trust, and reproducing hierarchies of class, race and geography. In other words, care brokers are not neutral facilitators but key repro-entrepreneurs whose practices both enable and normalise the industry’s inequalities. Ultimately, the report offers a political-economic analysis of how these supply-side dynamics have structured the industry’s past and how they may shape its future trajectory.

The concept of “surrogacy” has long been contested (Stanworth 1987; Snowden 1994; Pande 2010; Katz Rothman 2000). While often defined as a medical treatment for infertility – where intended parents hire a gestational mother to carry and deliver a child (Brandão & Garrido

2022; HFEA 2024) – this report adopts a broader definition of intended parents that includes those experiencing “social infertility”, or the inability to conceive due to structural or relational barriers (Lo & Campo-Engelstein 2018).¹ This framing seeks to challenge stigma and highlight barriers to care beyond the purely medical.

The term “surrogate mother” is equally fraught. By implying substitution, it diminishes the role of the gestating woman, reducing her to her reproductive function. Alternatives such as “gestational carrier” or “women who give birth for pay” have been used, but this report adopts the term “gestational mother” to acknowledge gestation as a legitimate form of kin-making (Pande 2014a).

Surrogacy itself takes multiple forms. Traditional surrogacy involves both egg provision and gestation, whereas gestational surrogacy – by far the more common – involves only gestation. Models also differ by compensation: altruistic surrogacy (legal in countries like the UK, Canada and South Africa) allows only reimbursement of expenses, while commercial surrogacy (legal in Ukraine and Georgia) includes payment. The celebration of altruistic surrogacy, however, risks reinforcing stereotypes of women as naturally caring and selfless (Raymond 1990). Moreover, restrictions on either form of surrogacy rarely prevent participation; instead, they lead to outsourcing to jurisdictions with weaker or absent regulations (Pande 2016a).

Reproductive hubs are well-established centres catering to cross-border demand for ARTs, including surrogacy (Inhorn 2015). They bring together “repropreneurs” (Kroløkke & Pant 2012) or what I call “care brokers” – agencies and entrepreneurs who assemble the many elements of the baby-making process. From small-scale regional actors to multinational corporations, these brokers offer services ranging from recruitment and matching to medical coordination, travel and legal support (Pande

1 A related note about what is popularly labelled “gay surrogacy”. Conventionally, surrogacy is assumed to be a solution to the medical “problem” of physiological infertility, i.e. the inability to conceive or gestate due to medical reasons. In recent decades, however, medical professionals, social scientists and activists have advocated for a broader definition of infertility, labelled “social infertility”, such that these treatments and services are made available to anyone who is unable to conceive due to sexual orientations, life circumstances or relationship status. Such a definition of infertility is more inclusive of the LGBTIQ+ community and single people.

2020a; Whittaker et al. 2022). Initially concentrated in the United States, the “one-stop” model spread to the Global South, particularly Asia and Eastern Europe (Pande 2020a). Recently, the market has fractured into *hybrid* forms where different steps of the process – egg retrieval, IVF, pregnancy – occur in different countries. These smaller “repronubs” serve regional markets but tend to be short-lived, shaped by shifting regulations, market conditions or geopolitical disruptions (Whittaker et al. 2022).

As later chapters will show, the rise and fall of hubs and nubs is never incidental but shaped by uneven development and (post)colonial power structures that reproduce global inequalities while sustaining market profitability (Vertommen et al. 2022). While the colonial legacies underpinning these reproductive flows are well-documented (Pande 2011, 2014b, 2021a; Gondouin & Thapar-Björkert 2022; Limki 2018), this report focuses instead on mapping the supply-side logics of the industry.

Hubs and nubs together constitute the infrastructure of the global commercial surrogacy market, embedded in wider “reprowebs” (König & Jacobson 2023) – networks of individuals, technologies, skills and capital that respond flexibly to disruptions such as pandemics, war or regulatory change. Agencies and care brokers operate as the spiders of this web, weaving together its many threads and holding the system in place.

At the heart of these shifting markets and the relentless pursuit of profitability lies the question of reproductive justice. The surrogacy industry does not only redistribute reproductive capacities across borders; it also entrenches structural inequalities around whose fertility is supported, secured and guaranteed, and whose bodies are rendered disposable. The report concludes by grounding a reproductive justice lens, making visible how race, class, gender, sexuality and nationality intersect to shape access to technologies and the burdens of reproductive labour. While intended parents in resource-rich contexts are offered “guaranteed success” through packages and add-ons, the women who provide the labour often do so in precarious conditions with few protections or long-term benefits. Any serious dialogue about the future of the global surrogacy industry must therefore centre not only on regulation and market

sustainability, but on justice – ensuring that the rights, dignity and wellbeing of gestational mothers are recognised as integral, rather than peripheral, to reproductive futures.

1.1 Research Methodology, Ethics and Reflexivity

This report draws on a broader ethnographic study of global fertility clinics in Africa and Asia, and on 17 years of research across clinics and agencies in India and Cambodia, as well as two surrogacy agencies in Ghana and India. Fieldwork included semi-structured interviews with 20 medical and fertility professionals and care brokers affiliated with four global surrogacy clinics. Through agency managers and fertility professionals, I also interviewed 28 intended parents from Bangladesh, Cambodia, Canada, China, Israel and the United States. In addition, I conducted unstructured interviews with intended parents online and in person, often at hotels in India, Israel, Nepal and Cambodia. Until 2024, I collected detailed oral histories from 31 gestational mothers in Cambodia (1), Ghana (4), India (14), Nepal (6) and South Africa (6).

These ethnographic findings are complemented by desk research, including academic, policy and legal sources. The research was guided by two main aims: (1) to identify the countries central to the surrogacy industry and examine their specific contexts, and (2) to map surrogacy agencies and intermediaries, analysing their scope, services and practices. A third, overarching goal was to uncover patterns within and between these dimensions. To systematise the desk review, I developed an informal catalogue of guiding questions. For countries, I examined legal frameworks, social and cultural contexts, medical infrastructure, economic dynamics and cross-border dimensions (Appendix 2). For agencies, I focused on their role in the industry, scope (local or international), functions (intermediary only or also clinical services), origins, services offered, key personnel and distinguishing features (Appendix 3). Academic sources provided insight into legal, cultural and medical contexts, while media reports captured scandals, controversies and high-profile cases. Six

agencies – Sensible Surrogacy,² World Center of Baby,³ Tammuz Family,⁴ New Life,⁵ Gestlife⁶ and Growing Families⁷ – were studied in greater detail. Comparative tables were created to analyse countries and agencies, mapping actors, patterns and interconnections.

This report is thus grounded in deep immersion in a dynamic and fraught industry that is fundamentally structured by global inequalities of race, gender, sexuality and ability and by histories of coloniality and postcoloniality. Ethical safeguards were integral to every stage of the research. All participants – including intended parents, care brokers, gestational mothers and fertility professionals – were given clear information about the study, and informed consent was obtained verbally or in writing. Given the sensitivities of the industry, respondents were asked whether they wished to remain anonymous. In cases where care brokers gave explicit permission, their names and agency names have been included. Beyond procedural ethics, the research was guided by reflexive sensitivity to the stigma, precarity and uncertainties faced by those participating in the surrogacy industry.

2 Sensible Surrogacy, a commercial surrogacy agency, <https://www.sensible-surrogacy.com/surrogacy-in-laos/>, accessed April 2025.

3 World Center of Baby, a commercial surrogacy agency, <https://www.worldcenterofbaby.com/>, accessed April 2025.

4 Tammuz Family, a commercial surrogacy agency, <https://www.tammuz.com/>, accessed April 2025.

5 New Life, a commercial surrogacy agency, <https://www.newlifegeorgia.com/>, accessed April 2025.

6 Gestlife, a commercial surrogacy agency, <https://www.gestlifesurrogacy.com/>, accessed April 2025.

7 Growing Families, a commercial surrogacy agency, <https://www.growingfamilies.org/>, accessed April 2025.

Chapter 2. **Beginnings of the Commercial Surrogacy Market**

The period between 1990 and 2005 marks the emergence of commercialised surrogacy, which soon led to its internationalisation. Advances in assisted reproductive technologies (ARTs), especially in vitro fertilisation (IVF), coupled with the recognition of surrogacy as a lucrative business opportunity, drove this shift. Once fertility clinics, along with surrogacy and gamete (ova and sperm) agencies, entered the brokerage business, intended parents (IPs) were no longer reliant on acquaintances but could access anonymous pools of providers and gestational mothers through agencies and intermediaries (Spar 2005).

In 1980, Elizabeth Kane in the US became the first gestational mother to receive legal compensation. Yet, industry growth was initially slow, constrained by ethical uncertainty and contested legitimacy. By 1988, the US market remained small, with roughly 30 agencies making only about 100 matches annually (McEwen 1999). The true catalyst was IVF combined with gestational surrogacy, which enabled the separation of reproduction into distinct, commodifiable components. Embryos created in the lab could be transferred to gestational mothers with no genetic tie to the child. This shift dissolved the biological link between carrier and child, strengthening intended parents' claims, easing legal disputes and expanding supply chains into jurisdictions with looser regulations (McEwen 1999; Spar 2005). In short, disaggregation stabilised surrogacy both legally and commercially, creating conditions for global market growth (Markens 2012).

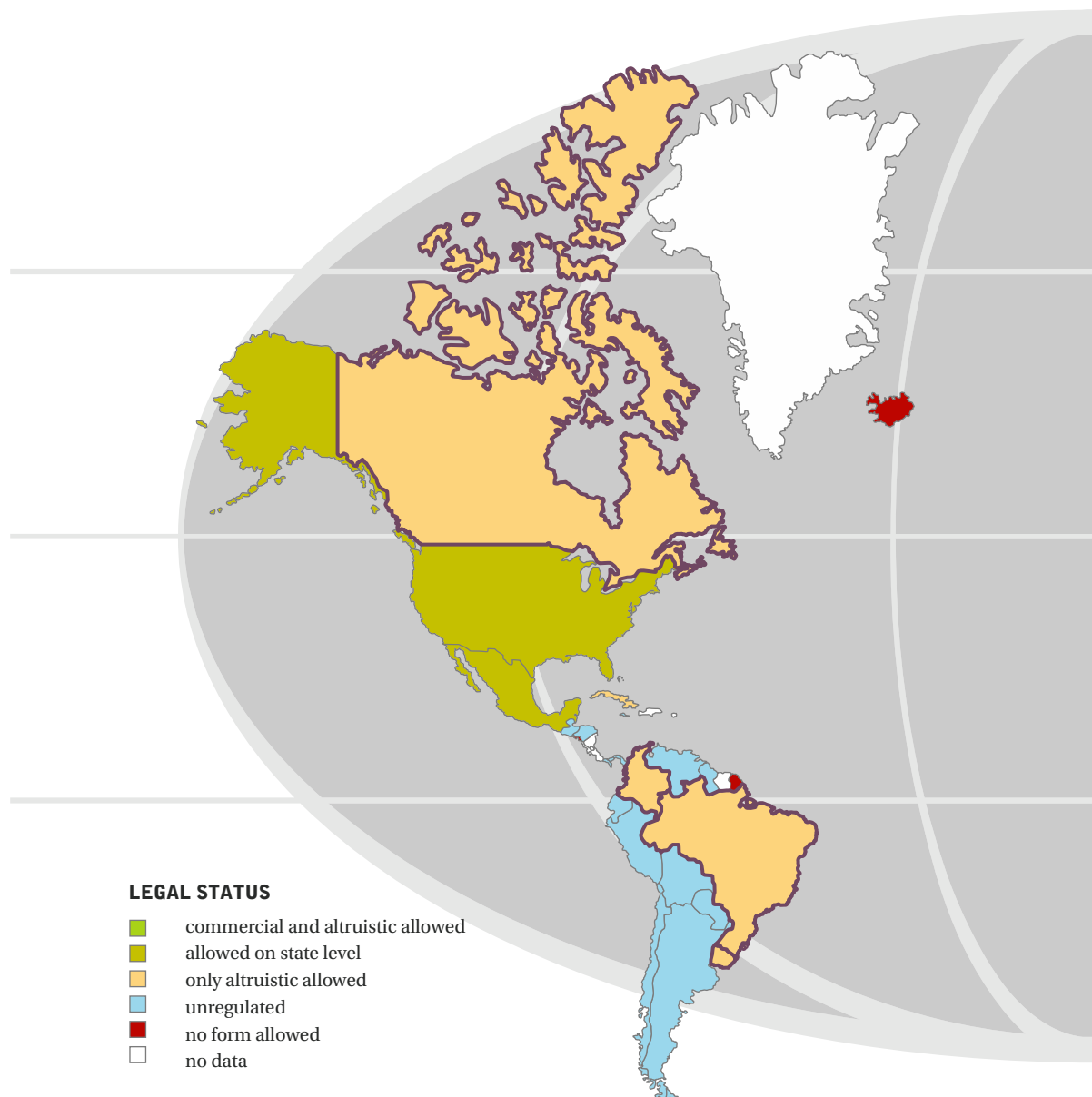
Since then, the global surrogacy industry has mirrored other transnational markets in biocapital, medical travel and global care (König & Jacobson 2023). High-tech ARTs are rarely covered by public health systems, leaving a vacuum quickly filled by private investors, agencies and care brokers. Thousands of agencies now operate worldwide, though their locations shift constantly in response to regulatory change and scandal (Boampong et al. 2023; Pande 2020c).

Jurisdictions become attractive to investors and brokers based on their regulatory environment for health, medical travel and ARTs. No international framework governs surrogacy, and national laws vary widely – and often change abruptly, sometimes in response to high-profile scandals. At present, only a handful of jurisdictions explicitly permit commercial surrogacy, including some US states, Ukraine and Georgia. Many others ban surrogacy altogether (e.g. France, Germany, Italy, Switzerland, Spain and China), while some restrict only certain aspects (e.g. Denmark, the Netherlands, Czech Republic, Brazil, Uruguay, Russia and India). A smaller set permits regulated forms of altruistic surrogacy, such as the UK, Canada, Israel, South Africa, Greece, and select US and Australian states (Horsey 2024; Surrogacy360 2023). Figure 1 (“Global Surrogacy Map”) illustrates this variation by type of regulation, including whether access is open to single or same-sex intended parents or limited to married heterosexual couples.

Yet, as the report’s timeline of repronubs shows, bans do not end commercial surrogacy. Instead, they produce shifts: when one country enacts restrictions, repreneurs and care brokers relocate to others with looser frameworks (Allen 2024; Pande 2020a). Far from eliminating the practice, prohibition fuels its transnational reconfiguration.

Apart from legalities, the economic conditions of a country and historical structural inequities shape the decisions of agencies, investors and care brokers in the surrogacy industry. The development of the global surrogacy market reflects common dynamics of the North-South divide, which are embedded in and reinforce global asymmetries and economic disparities. These disparities tend to benefit the more privileged parties, such as wealthy intended parents from the Global North and commercial surrogacy agencies, while often exploiting individuals from less privileged backgrounds, particularly gestational mothers in lower-income countries (Deomampo 2016; Pande 2010; Twine 2011). Other supply-side factors affecting the flow of investments and the movement of care brokers include the availability of medical infrastructure and technology. However, as will be explored in the discussion of Phases 2 and 3, the availability of medical infrastructure and technology shape investments in some reproductive hubs, for instance, India and Thailand, but are not always relevant for regional reproductive nubs in Africa and Southeast Asia.

Global Surrogacy Map



INTERNATIONAL / NATIONAL

- only allowed for national IPs

SINGLE AND SAME-SEX IPS

- allowed for single and same-sex IPs
- allowed for single women
- restricted to heterosexual married IPs

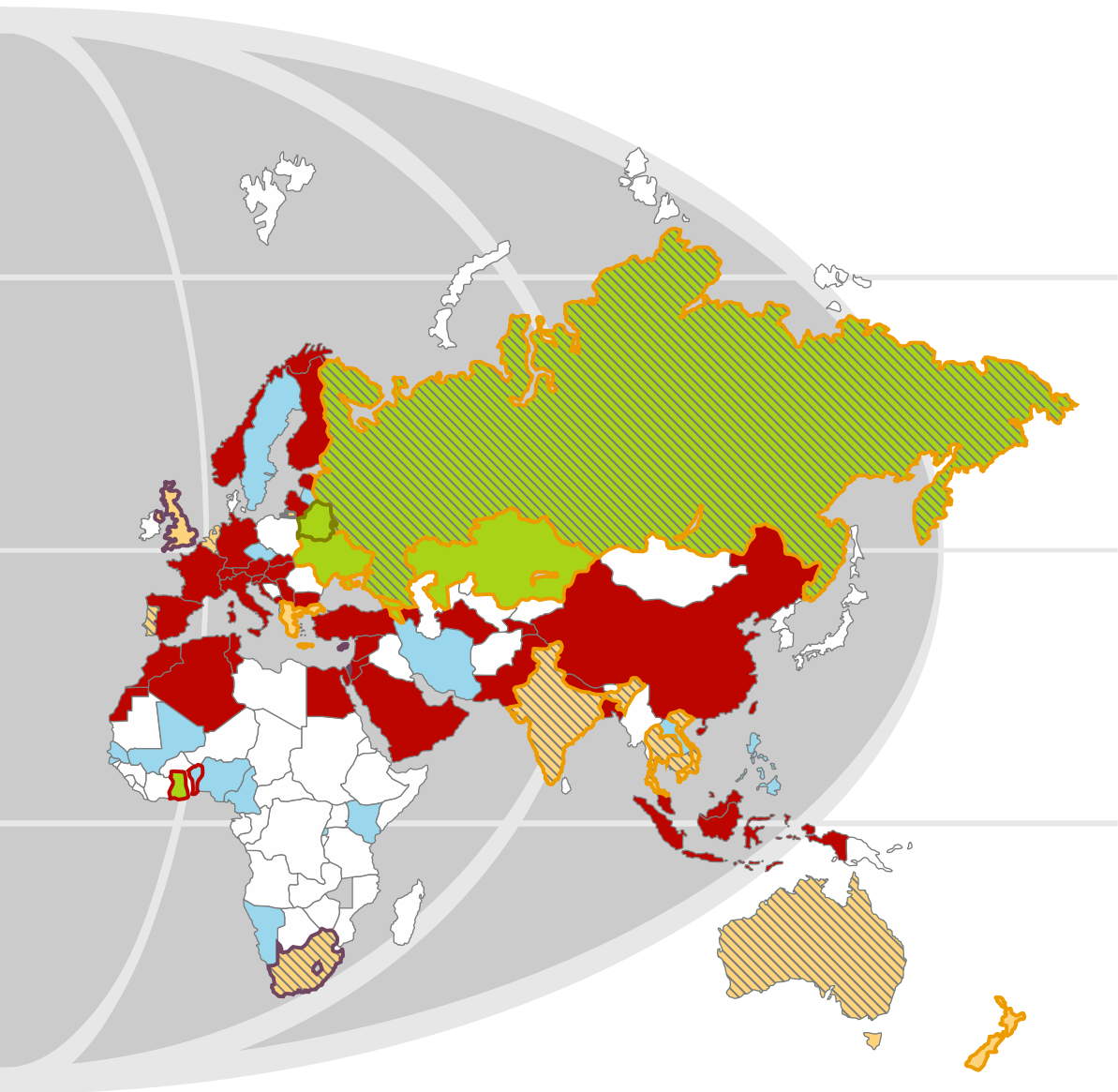


Figure 1: Global Surrogacy Map

Data source: Adapted from Surrogacy360 (2023). Map updated and converted to an equal-area projection by author to ensure accurate area representation of global surrogacy policies

2.1 Surrogacy in the Global North

As previously mentioned, many countries in the Global North have banned or heavily restricted surrogacy. However, a few specific countries – such as the US, UK and Israel – have institutionalised surrogacy and regulate it with robust legal frameworks.

United states

Although often described as a “global practice”, historically it has developed in very specific geographical hubs. The 1986 “Baby M”⁸ case in the U.S. brought surrogacy to international attention, and the country has since remained a leading reproductive hub for both domestic and international commercial surrogacy.

Between 2014 and 2020, 21,649 children were born through gestational surrogacy in the U.S., with 18.5% (in 2013) involving non-U.S. residents.

Regulation occurs at the state level (and not by federal laws): while states such as California, Florida, and Illinois have surrogacy-friendly laws, others, including Alabama, Washington, Arizona, Michigan, North Dakota, and Indiana, prohibit it (Guzman 2016). These restrictions drive intended parents to cross state lines (Guzman 2016; Spar 2005). Despite such bans, the U.S. remains the leading global reproductive hub (Perkins et al. 2016).

One of the first known cases of cross-border surrogacy occurred in 1987, when a 19-year-old Mexican woman travelled illegally to the U.S. to be impregnated with her cousin’s husband’s sperm and carry a child for her cousin (McEwen 1999). By the 1990s, cross-border surrogacy became more organised, with intended parents from the U.K., Australia, Taiwan, and Kuwait paying women in surrogacy-friendly California to bear children for them (Spar 2005).

⁸ The 1986 Baby M case in New Jersey sparked global debate on surrogacy. In this traditional surrogacy arrangement, Mary Whitehead, both gestational and genetic mother, was contracted to bear a child for William and Elizabeth Stern for \$10,000, relinquishing all parental rights. After giving birth to the baby girl (known as Baby M), she changed her mind, refused the payment, and kept the baby. In 1987, a court awarded custody to the Sterns, but in 1988 the New Jersey Supreme Court invalidated the surrogacy contract, citing the child’s best interests. Custody remained with the Sterns, while Whitehead retained visitation and parental rights.

Another notable case involved a Japanese woman whose husband's sperm was taken to the U.S. to fertilise oocytes from a Chinese-American donor, later implanted into a gestational mother - illustrating the complexity of cross-border reproductive arrangements even in the early stages of global surrogacy (McEwen 1999).

European Union

Beyond the United States, the European surrogacy market hosts several regional surrogacy hubs with diverse laws, allowing EU patients to travel freely for treatment. However, such cross-border movements by intended Parents (IPs) remain controversial, and many European countries are revising their laws to establish comprehensive domestic surrogacy regulations. These reforms aim to promote domestic arrangements and reduce the ethical and legal issues tied to transnational surrogacy, which have led to "surrogacy scandals" and even "surrogacy orphans" (Pande 2016; Parks and Murphy 2018).

United Kingdom

The United Kingdom remains an exception in Europe having regulated surrogacy since the 1980s, allowing only altruistic forms. Its current framework was shaped by the cross-border Baby Cotton case, involving a British woman, Kim Cotton, who carried a child for an infertile Swedish couple living in the U.S. under an American agency's arrangement. This case exposed the rise of a commercial, transnational surrogacy industry and triggered intense public debate.

Further scandals followed, including reports in the 1990s of a British adoption specialist planning a 'baby farm' in Hungary, where Eastern European women would be impregnated with sperm from North American men, then flown to the U.S. to give birth, with the intention of expanding to surrogacy centres in Cyprus and Russia (McEwen 1999). In response to such controversies, the British Parliament passed the Surrogacy Arrangements Act (SAA) 1985, which legalized altruistic surrogacy and permitted payment only for "reasonable expenses" (UK Government n.d.)⁹. The Act banned third parties from

⁹ Surrogacy Arrangement Acts (SAA) 1985, section 2 and section 3;
<https://www.legislation.gov.uk/ukpga/1985/49>

advertising or profiting from surrogacy, aiming to prevent commercialization while enabling the rise of non-profit intermediaries.

In 2019, the Department of Health and Social Care issued updated guidelines, and the UK became one of the first countries in Europe to regulate surrogacy and set a benchmark for countries globally to set an ethical and legal standard¹⁰ for surrogacy regulation. Its model even inspired reforms elsewhere, such as Malaysia's 2015 legislative amendment on surrogacy and egg and sperm donation (Ahmad, Lilienthal, and Hussain 2016).

Under the Human Fertilisation and Embryology (HFE) Act 2008¹¹, the woman who gives birth is recognized as the legal mother until parenthood is transferred through a "parental order." The UK's stance supports and protects surrogacy arrangements but confines them strictly to the domestic sphere (Horsey et al. 2022).

Israel

Israel has also been a pioneer in the global surrogacy landscape. It was among the first countries to legalize commercial surrogacy in 1996 under the Embryo Carrying Agreements (Agreement Approval and Status of the Newborn) Law 5756–1996¹², which permits gestational surrogacy contracts but restricts them to Israeli nationals, preventing the country from becoming an international surrogacy hub (Whittaker 2019). Initially, only married heterosexual couples were eligible, leading queer and single Israelis to seek surrogacy abroad. This demand led to commercial agencies such as Tammuz Family Israel, which facilitated arrangements in countries with more permissive regulations (Vertommen 2024).

Although Israel built a thriving domestic reproductive industry, the profitability of transnational surrogacy led its agencies to expand globally, partnering with clinics and brokers abroad. Some, like Tammuz Family in

¹⁰ Department of Health and Social Care (2025), <https://www.gov.uk/government/publications/having-a-child-through-surrogacy/the-surrogacy-pathway-surrogacy-and-the-legal-process-for-intended-parents-and-surrogates-in-england-and-wales> accessed April 2025.

¹¹ Human Fertilisation and Embryology (HFE) Act 2008, <https://www.legislation.gov.uk/ukpga/2008/22/section/33>

¹² <https://www.gov.il/en/service/embryo-carrying>

Kathmandu¹³ and Manor Surrogacy in Tbilisi and Kiev¹⁴, even opened their own fertility centres. Initially serving Israeli clients, these agencies soon attracted intended parents from Brazil, Australia, and Nordic countries.

Israel's strong pronatalist narrative is evident in its having the most fertility clinics per capita and the highest IVF usage worldwide (Vertommen 2024). However, reproduction in Israel is deeply entangled with religious, racial, and national politics. The state-promoted pronatalist agenda reinforces ethno-nationalist ideals, linking fertility and family-making to Jewish identity and state preservation (Music 2024).

Over time, Israel's reproductive sector has evolved from a domestic fertility centre into what Parry and Goshal (in Vertommen 2024, p.125) call a "reproductive empire" - a transnational network of agencies and clinics operating globally, advancing both commercial and demographic goals.

These nations were not only among the first to legalise surrogacy, setting the tone for its regulation, but also helped to significantly shape the global surrogacy landscape. It has often been the case that the restrictive laws, financial barriers and other regulatory conditions in countries of the Global North have incentivised the development of a global surrogacy industry in the Global South, shifting the supply of gestational mother services to countries with fewer legal constraints and lower costs. In this report this is labelled as the "domino effect" of restrictive laws, which shape the supply-side innovations and investments.¹⁵ The argument of the domino effect will be explored further below.

¹³ <https://www.tammuz.com/>

¹⁴ <https://manormedicalgroup.com/en/about-us-medical-tourism-in-israel/> ?

¹⁵ In this context, it is crucial to recognise that the terms "Global North" and "Global South" do not refer to geographic categories but reflect broader patterns of economic, social and political inequalities. These concepts are often used to describe disparities in wealth, development and power between regions. While the Global North is typically associated with industrialised, wealthy countries, the Global South encompasses regions with lower levels of economic development. As Sims (2024) notes, it is essential to approach this divide critically, acknowledging the ways in which colonial histories, unchallenged assumptions and entrenched power structures continue to shape global systems, including surrogacy.

2000

2010

2015

1 INDIA

2002-2012: most popular destination for international surrogacy

2012: the gay surrogacy ban shifts the focus towards Thailand and Nepal

2015: the ban on surrogacy for foreigners forces the industry to move to neighbouring countries

2 THAILAND

2010: emerges as destination for international surrogacy

2012: emerges as reprohub for gay clients after the ban in India

2014: "Baby Gammy" and "Baby Factory" scandals

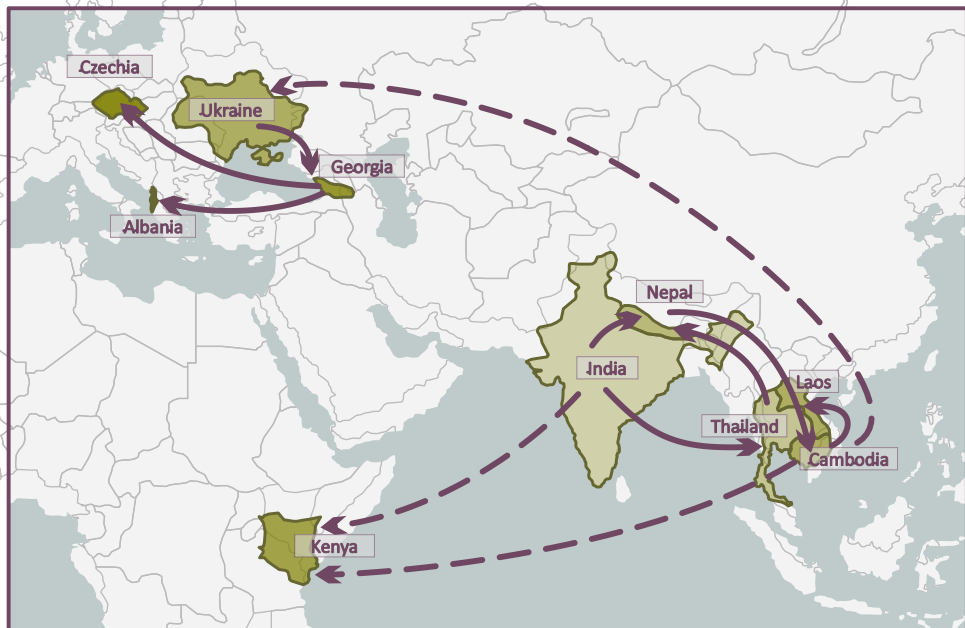
2015: cross-border surrogacy banned

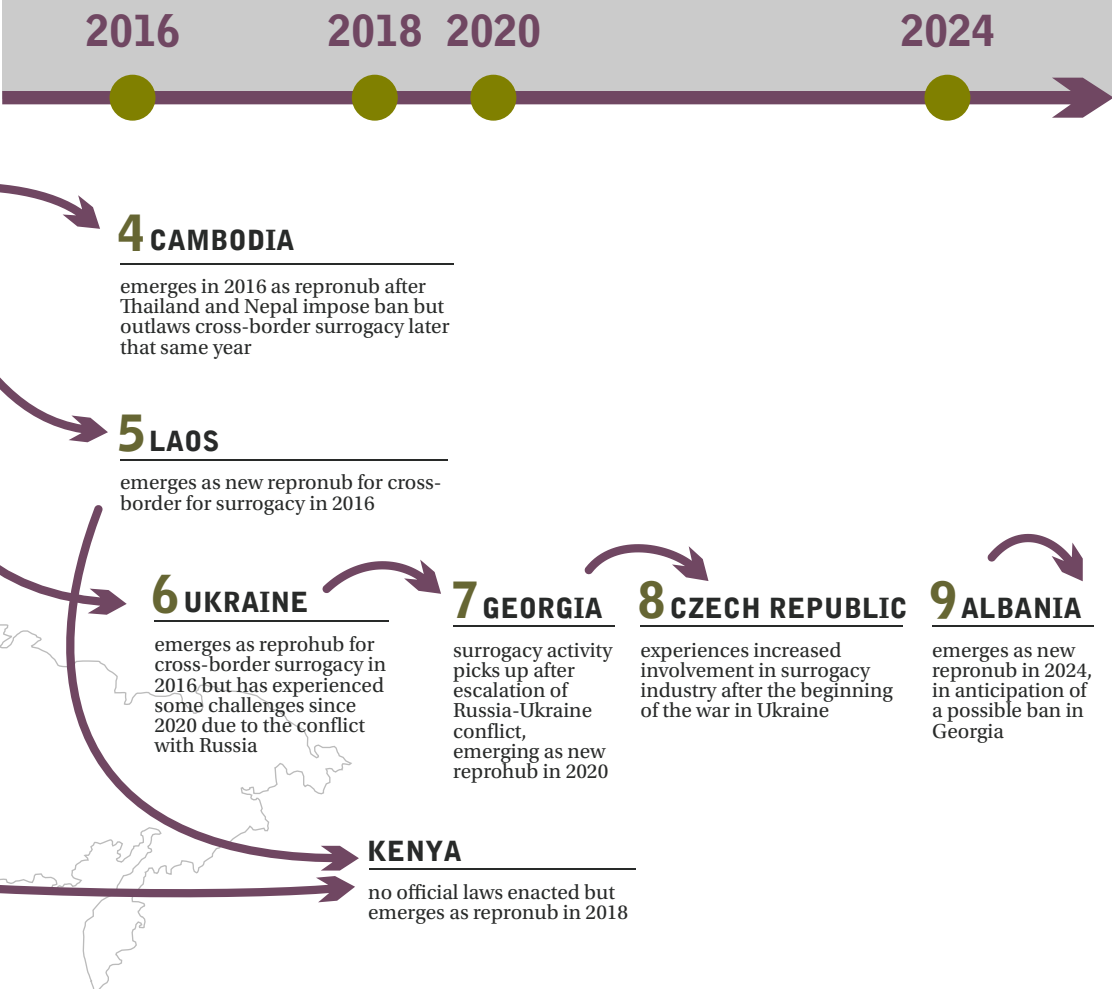
3 NEPAL

emerges as popular destination for cross-border surrogacy after India and Thailand impose ban but closes down the industry in 2015 shortly after the earthquake and ethical tensions that came with it

MEXICO

influx of international clients after bans and regulations in other countries, with surrogacy agencies becoming established in the early 2010s





INTERNATIONAL SURROGACY TIME SPAN

- India (2002-2015)
- Thailand (2010-2015)
- Nepal (2015-2015)
- Cambodia (2016-2016)
- Laos (2016-now)
- Ukraine (2016-now)
- Kenya (2018-now)
- Georgia (2020-now)
- Czechia (2022-now)
- Albania (2024-now)

Figure 2: Domino Effects of Laws
Data source: Adapted from UCT News (2019). Original map data modified and updated by author.

2.2

“One-Stop Surrogacy” and Southern Reproductive Hubs

Although the US has remained a top player in the global surrogacy market, the past decade has seen unexpected hubs for gestational commercial surrogacy emerge in Asia, Eastern Europe, and several middle- and low-income European countries. In this chapter, I broaden the notion of the “South” to include these Asian and European contexts that have become significant hubs outside Euro-America. Where do intended parents go when they cannot afford or cannot access fertility markets in their own countries, or in the Global North? This report focuses on these Southern reprohubs, which play a fundamental role in the hybrid surrogacy industry.

The industry boomed in these Southern hubs not only because it offered low-cost alternatives to the US surrogacy market, but also because of its flexibility and convenience for intended parents (Whittaker 2019). Parents could fly to a single destination and purchase “package deals”, which promised everything from the search and matching of egg providers and gestational mothers to the delivery of the child and the issuance of a birth certificate. These packages were designed to safeguard clients’ interests from the signing of a contract to the baby’s official registration. While economic disparities and ethical concerns surrounding this industry have provoked significant debate, this report argues that to understand the history and predict the future of the industry it is essential to examine more closely the strategies of those who invest in and profit from it.

As I show below, investors, agencies and care brokers take multiple forms. Once the commercial potential of these Southern hubs became evident, repreneurs quickly seized the opportunity, launching online platforms and agencies to facilitate international transactions. This transformed surrogacy into a global marketplace in which investors and brokers navigate diverse regulatory environments to deliver solutions to intended parents, even where surrogacy is formally restricted (Horsey 2024; Spar 2005). Today, repreneurs – particularly care brokers – often earn as much or more than the gestational mothers themselves (McEwen 1999). This chapter provides a snapshot of the Southern reproductive hubs that now anchor this global industry of care brokerage and inequalities.

Chapter 3. Reproductive Hubs: Country Profiles

3.1 India: The Mother Destination of Surrogacy

India, widely labelled the “mother destination” of surrogacy, was the first reproductive hub in the Global South. Its rise after 2002 was driven by intersecting structural conditions: costs less than half those in the US (Cunha 2014), a booming private health sector despite a failing public one, English-speaking doctors and an established medical tourism sector (DasGupta & Dasgupta 2014). The legalisation of commercial surrogacy in 2002, coupled with Dr Nayna Patel’s entrepreneurial turn in 2003, gave India a global reputation and institutionalised the “surrogacy hostel” model (Pande 2010).

The complete absence of regulation between 2006 and 2015 meant clinics could offer services banned elsewhere – multiple embryo transfers, bundled “package deals,” even passports for newborns. As one broker advertised: “See the Taj Mahal by the moonlight while your embryo grows in a Petri dish” (Pande 2011, 2014b).¹⁶ Structural inequality made this industry function: working-class women, surveilled and controlled throughout pregnancy, were unlikely to contest custody against wealthy clients from the US or UK. Surrogacy in India was, in effect, a “win-win” for intended parents.

By 2012, the market was worth an estimated USD 2.5 billion, with roughly 25,000 births via surrogacy annually – half for foreign clients (Narayan et al. 2023). In 2015, this system collapsed when the government banned transnational commercial surrogacy, restricting it to heterosexual, married Indian couples able to secure a relative’s altruistic labour (Najar 2015). The 2016 Surrogacy (Regulation) Bill formalised this restriction.

Agencies Involved: At its peak, India’s surrogacy sector was highly structured. Clinics like Patel’s Akanksha Hospital¹⁷ in Gujarat offered

¹⁶ The website where this advertisement was displayed is no longer accessible; the last recorded instance of its citation and viewing was in 2014 (Pande 2014).

¹⁷ Akanksha Hospital, official website, <https://akankshahospital.co.in/>, accessed April 2025.

one-stop services while working with brokers and agents who managed recruitment, housing and logistics. International agencies such as Tammuz Family, GO IVF Surrogacy¹⁸ and World Fertility Services¹⁹ were deeply embedded, until the ban forced them abroad. Some, like Tammuz, continue to invest in reproductive technologies in India – egg freezing, IVF – while relocating surrogacy programs elsewhere (Pande 2024).

Current State: India's 2016 ban did not end the surrogacy economy but restructured it. Clinics now market IVF, egg donation and embryology, producing embryos for export – a shift in the reproductive “assembly line” that mirrors India's broader economic pivot from “Made in India” to “Make in India” (Pande 2020a). Far from eliminating exploitation, the ban displaced it: driving operations underground, pushing Indian women abroad and leaving gestational mothers unprotected – as seen when Indian women contracted in Nepal were stranded during the 2015 Kathmandu earthquake (Pande 2020a).

3.2

Thailand: The “Womb of Asia”

Thailand's surrogacy boom in the early 2000s emerged from three intersecting factors: a regulatory vacuum, comparatively low costs and a long-standing reputation for medical tourism – especially gender-affirming and cosmetic surgery (Nilsson 2022; Connell 2006). These conditions made Thailand a hub for clients from countries and regions where surrogacy was banned, restricted or costly (e.g. Australia, Europe, US, China). Gay-friendly marketing further positioned it as an alternative to India once that market narrowed to heterosexual married couples (Nilsson 2022). By the early 2010s, agencies in Bangkok offered full-service packages – IVF, prenatal care, gestational mother recruitment, matching, legal and logistical support – leading to several hundred foreign births annually. The industry's scale earned Thailand the title “womb of Asia” (BBC 2015).

18 GO IVF Surrogacy, a commercial surrogacy agency that originated in India, <https://www.ivfsurrogacy.in/>, accessed April 2025.

19 World Fertility Services, a commercial surrogacy agency, <https://worldfertilityservices.com/>, accessed April 2025.

Agencies Involved: Agencies quickly capitalised. By 2013, more than 30 IVF clinics were operating, with 3,000–4,000 annual cycles (Hibino & Shimazono 2013). Alongside formal agencies like New Life (with branches in Georgia, Mexico and Nepal) and Baby 101,²⁰ “message board surrogacy” flourished – websites where women informally offered services (Hibino & Shimazono 2013). But scandals exposed deep vulnerabilities. In 2014, the “Baby Gammy” case, in which an infant with Down’s syndrome was allegedly abandoned by foreign clients, and the “Baby Factory” case, in which Japanese businessman Mitsutoki Shigeta commissioned at least 12 babies through Thai gestational mothers, made international headlines (Cornell Law School et al. 2017; Romo 2018). Clinics implicated – including New Life Thailand and All IVF²¹ – were shuttered, and frozen embryos were shipped abroad (Bowers et al. 2022).

In response, the 2015 Protection for Children Born Through Assisted Reproductive Technologies Act banned commercial surrogacy and excluded both foreigners and same-sex couples (Attawet 2021). I argue this prohibition did not end but displaced the market, driving operations underground or across borders. Surrogacy became fragmented: egg retrieval in Bangkok, embryo transfer in Laos or Cambodia, pregnancies carried in Thailand, and births arranged in China or Vietnam (Nilsson 2022).

Current State: Today, surrogacy in Thailand is limited to altruistic arrangements for infertile, heterosexual, married Thai couples. Gestational mothers must already have a child, be relatives of the intended parents and meet medical screening requirements (Attawet 2022; Hongladarom 2018). Yet policymakers now debate reopening to foreign clients under new regulations, linking this to broader shifts: legalisation of same-sex marriage and the possibility of surrogacy access for Thai same-sex couples (Bangkok Post 2025; Wong 2025).

20 Baby 101, a Taiwanese surrogacy agency based in Bangkok, no longer appears to have an active website, and further information could not be located.

21 All IVF, a surrogacy clinic, does not appear to have an active website. Information is sourced from the Bangkok Post, “Surrogacy Clinic Found to Be in Violation of Thai Law,” published February 2014.

3.3 **Nepal: Domino Hub**

The ban on surrogacy in India and Thailand triggered what I call a “domino effect”, with Nepal emerging as the next hub (Doron Mamet-Meged interviewed by Pande 2014, re-interviewed 2024). With no regulations governing the reproductive industry, Nepal quickly became a site for intended parents from countries where surrogacy was banned or unaffordable (Cornell Law School et al. 2017; Saravanan 2018), including same-sex and single parents. Reports noted a surge of Israeli gay male couples (Aviv 2015). A regulatory grey zone allowed Indian agencies to relocate to Nepal and employ Indian women as gestational mothers (Attawet 2021). Thus, the majority of many gestational mothers in Nepal were in fact Indian, continuing work after the Indian ban.

Agencies Involved: Major players included New Life (Mariam Kukunashvili), Tammuz Family (Doron Mamet-Meged), the International Fertility Centre (Rita Bakshi) and World Fertility Services (Delhi) (Lior 2016).

Current State: The Nepal surrogacy boom was short-lived, collapsing in 2015 after devastating earthquakes left gestational mothers, parents and newborns stranded. Media outrage over babies being evacuated while gestational mothers were left behind sharpened public scrutiny (Cornell Law School 2017; Saravanan 2017; Pande 2020). Soon after, Nepal banned all surrogacy. Fertility centres like the IFC, however, continue to provide IVF and related reproductive services.

3.4 **Ukraine: Low-Cost Global East Hub**

Ukraine legalised commercial surrogacy in 2002 for heterosexual married couples, with intended parents recognised immediately on birth certificates (Family Code Art. 123, amended 2006). By 2022, Ukraine was the world’s second-largest surrogacy market, filling the low-cost gap left by India (Inhorn 2015; König 2023). Single parents and LGBTIQ+ individuals remain excluded, and most clients are foreign nationals (Siegl 2023).

Agencies Involved: BioTexCom serves clients across Europe, the US, Australia, and Nordic countries, with 99% foreign clients (Lamberton 2020). WCOB expanded to Colombia, Mexico, Cyprus and Georgia, offering IVF, embryo transfer and cross-border services (Bunetskiy 2019).

Current State: The 2022 war forced gestational mother relocation to safer countries, like Cyprus, while agencies continued operations (Huet & Davlashyan 2022; Tondo & Mahulin 2023). Despite conflict, Ukraine's permissive legal framework, affordability and strong medical infrastructure maintain demand. Annual foreign revenue is estimated at USD 1.5 billion (Lamberton 2020). Gestational mothers often navigate war zones, air raid shelters and evacuation logistics, highlighting their precarious position and the market's resilience.

3.5 Georgia: The Rising Hub

Georgia legalised commercial surrogacy in 1997 for married couples and single parents, with intended parents recognised on the birth certificate. India's and Thailand's 2015 bans drove growth and consolidation of Georgia as a reproductive hub, especially in Tbilisi (Guichard 2024).

Agencies Involved: Key agencies include New Life, Tammuz Family, WCOB, World Fertility Services, Gestlife, Nordic Surrogacy, GO IVF Surrogacy and Surrogacy by Pons²² (Finance Uncovered, Allen 2024; Surrogacy by Pons 2025). New Life, founded by Mariam Kukunashvili, operates globally with branches in Ukraine, Kenya, Mexico, Poland and South Africa, serving over 70 countries (Bowers 2023b). Clinics recruit gestational mothers from Central Asia and neighbouring countries to meet high demand (Guichard 2024; Allen 2024).

Current State: Commercial surrogacy is legal for domestic and international heterosexual married couples. Only 5% of clients are Georgian nationals (Allen 2024). Shortages have led agencies to expand to Albania and Armenia. The Georgian Orthodox Church advocates restricting international clients, but financial incentives maintain government support (Guichard 2024). Georgia exemplifies the "domino effect", absorbing demand displaced from other restrictive markets (Pande 2020a).

Until 2015, intended parents had several "Southern hubs" as reliable options for cross-border surrogacy. Since then, however, the industry has been scuttling across the globe, pushed from one country to another by the domino effects

22 Surrogacy by Pons, a commercial surrogacy agency, <https://surrogacybypons.com/>, accessed April 2025.

of restrictive national bans (Pande 2020a). Each ban does not end the practice but rather displaces it, pushing it into new geographies where women's reproductive labour is more precarious and even less protected. This makes visible the structural inequities at the heart of the market: it is always the most vulnerable women – migrants, rural poor, women with limited economic choices – whose bodies are made available, while intended parents retain mobility, choice and legal recognition.

This movement is not just a story of demand but of supply and brokerage. Care brokers and investors have become experts at navigating and exploiting the gaps created by uneven regulation, constantly rebranding “new” hubs in ways that conceal the risks and uncertainties. In this sense, the so-called “crisis” of regulation has become the very engine of the industry, producing fresh opportunities for profit while reproducing old hierarchies of race, class and geography.

The next chapter traces these trajectories to show how the domino effect has shaped the evolution of the global surrogacy market since 2015. By following the shifting geographies of investment, the entrepreneurial logics of care brokers, and the political economies of states that either invite or expel the industry, I argue that the market not only survives regulatory disruption but actively thrives on it. In doing so, it further entrenches global reproductive inequalities.

Chapter 4. **Hybrid Surrogacy and Southern Reproductive Nubs**

Surrogacy scandals, especially cross-border ones, starkly shape laws and are especially important to highlight for the nubs outlined below as they often dictate the difference between a transient nub and one that may evolve into a hub. This report highlights some over the others based on findings around investors and care brokers, especially given the presence of some key international brokers. Other factors that shape the nature of nubs is the scope of surrogacy – whether they allow for international IPs to seek commercial surrogacy or restrict it to nationals.

Table 1: Overview of Southern Reproductive Hubs and Nubs

Surrogacy's Legal and Market Status	Country
Transitory reproductive nubs	Cambodia Laos Malaysia (not prohibited for non-Muslims, prohibited for Muslims) Nepal
Hubs and nubs that allow international commercial surrogacy	Armenia Belarus (only heterosexual married couples & single women) Georgia (only heterosexual married couples) Kazakhstan (only heterosexual married couples) Ukraine (only heterosexual married couples)
Nubs in legal grey zones	Albania Colombia Cyprus Czech Republic Ghana Greece (only heterosexual couples and single women) Kenya Mexico (state regulations) Nigeria Uganda
Hubs and nubs that allow for national IPs to seek commercial surrogacy	Mexico (state regulations) Russia ²³ (only heterosexual couples and single women)
Hubs and nubs that allow for national IPs to seek altruistic surrogacy	India (only heterosexual married couples) Thailand (only heterosexual married couples)

Source: Author's own work.²⁴

23 While Russia and Czech Republic are not low- or middle-income countries, their emergence and growth trajectory within surrogacy resonates with other Southern hubs described below.

24 This list includes selected countries that are relevant to the scope of this report. It is not an exhaustive list.

Please note that in some countries the legal situation does not necessarily say anything about surrogacy practices. Some countries with permissive frameworks view surrogacy as culturally unacceptable, while other countries with restrictive frameworks develop an underground market (interview with Sam Everingham, Growing Families 2025).

TRANSITORY REPRODUCTIVE HUBS

4.1 Cambodia: The Brief Boom

Following restrictive surrogacy bans in India, Nepal and Thailand around 2016, Cambodia briefly became a hub for international surrogacy, with no clear legal guidelines to regulate the industry. However, the Cambodian Health Ministry imposed a snap ban on commercial surrogacy in 2016, with an amnesty deadline of 8 January 2018, allowing gestational mothers to transfer children to intended parents without prosecution (Handley 2018). Gestational mothers delivering after this date faced potential legal consequences. Fieldwork in Phnom Penh revealed that anyone associated with surrogacy risked prosecution.

Current State: The ban drastically reduced opportunities for foreign intended parents. Couples must now undergo DNA verification and court approval to take children home, with delays often caused by embassy inaction (Channyda & Meta 2018; Handley 2018; Meta 2018). Underground surrogacy persists but carries high legal risk, with high-profile arrests and convictions for human trafficking (Attawet 2021; Loftus 2024). Some former providers sought relocation to Malaysia, while IVF and gamete import/export continue, sustaining cross-border hybrid cycles (Kohlbacher 2016; Sensible Surrogacy n.d.).

Agencies Involved: Prior to the ban, prominent agencies included New Life, World Fertility Services and GO IVF Surrogacy.

4.2 Laos: Hybrid Surrogacy Hub

Laos has emerged as a regional hub for hybridised surrogacy following bans in Thailand and Cambodia in 2016. Its regulatory ambiguity makes it attractive to gay couples and Chinese intended parents, though limited healthcare infrastructure poses challenges (Whittaker et al. 2022). Surrogacy in Laos often functions as a cross-border process: embryo transfers occur in Laos, pregnancies are monitored elsewhere, and births may happen in countries with better medical infrastructure, such as Thailand, Singapore or China.

Current State: Loopholes allowing both Thai and international gestational mothers to engage in commercial surrogacy without

violating Thai law sustain a hybrid regional market (Attawet 2021; Whittaker et al. 2022). Gestational mothers migrate along familiar economic pathways, replicating rural-urban and cross-border labour patterns (Weis 2017).

Agencies Involved: Four agencies and two IVF clinics operate, primarily serving foreign clients. Cross-border programs are run by New Life Asia,²⁵ GO IVF Surrogacy, Talent IVF Asia, IVF Bangkok, Sensible Surrogacy, Laos Fertility,²⁶ Gay Surrogacy²⁷ and World Fertility Services (Whittaker et al. 2022). Thai gestational mothers may travel to Laos for embryo transfer, return to Thailand for pregnancy care, and relocate to Singapore for delivery.

4.3 Malaysia: Legal Grey Zone

Malaysia's dual legal system complicates surrogacy. Civil law for non-Muslims remains largely unregulated, while Shari'ah law prohibits Muslims from participating (Ahmad et al. 2016). Following Cambodia's ban in 2016, some providers considered relocating to Malaysia due to its regulatory ambiguity (Kohlbacher 2016). Legislative reform modelled on the UK's 1961 Artificial Reproduction and Tissue Act was proposed in 2016 but never enacted.

Current State: Surrogacy is generally limited to heterosexual married couples under Malaysian Medical Council guidelines (MMC 003/2006). The lack of comprehensive legislation leaves legal rights and protections for gestational mothers and intended parents uncertain, and social stigma limits official reporting (Siu Lin 2016).

Agencies Involved: The industry is small and underdeveloped. Active providers include GO IVF Surrogacy and the Perfect Fertility Center²⁸ in Kuala Lumpur, offering IVF, artificial insemination, intracytoplasmic sperm injection and other reproductive technologies (Siu Lin 2016).

25 New Life Asia, a branch of the commercial surrogacy agency New Life, <https://www.surrogacyasia.com/>, accessed April 2025.

26 Laos Fertility, a commercial surrogacy agency, <https://www.laosfertility.com/>, accessed April 2025.

27 Gay Surrogacy, a commercial surrogacy agency, <https://www.surrogacyforgay.com/surrogacy-in-laos/>, accessed April 2025.

28 Perfect Fertility Center, a commercial surrogacy agency, <https://global-pfc.com/treatments-and-services/gestational-carrier-surrogate/>, accessed April 2025.

REPRODUCTIVE NUBS IN GREY ZONES

This spatial analysis concludes with countries highlighted by agencies and care brokers as of interest but with complicated or murky legal frameworks for global commercial surrogacy. These “grey zones” emerge due to unclear laws, inconsistent enforcement, or loopholes that allow surrogacy to continue despite legal ambiguity. The countries discussed here – Colombia, Cyprus, Greece, Kenya, Mexico, Nigeria and Uganda – are not exhaustive but are strategically significant. As noted above, laws shape the industry but do not determine it: surrogacy flourishes despite, or because of, regulatory ambiguity.

4.4

Mexico: The Northern Alternative

Surrogacy laws in Mexico vary by state, with some allowing commercial arrangements and others prohibiting them (Finkelstein et al. 2016).²⁹ Its proximity to the US and low costs have made Mexico attractive to international clients, especially after bans in India, Thailand and Nepal. The state of Tabasco, legalising commercial surrogacy in 1997, became a major hub by 2010. However, scandals in the early 2010s involving financial exploitation, stolen eggs and inadequate care exposed ethical and legal ambiguities (The Guardian 2014).

Current State: In 2021, the Supreme Court allowed both altruistic and commercial surrogacy, including for same-sex couples, while leaving detailed regulation to individual states (Brandão & Garrido 2022; Hovav 2019). Regulatory fragmentation persists: availability varies by state, and foreign gestational mothers are generally prohibited. The US Embassy warns intended parents about the inconsistent legal framework and risks involved (US Embassy 2021). Mexico is particularly popular among gay couples and single parents.

Agencies Involved: International agencies previously operating in India and Thailand have moved to Mexico. Key players include Miracle Surrogacy,³⁰ founded by a gay couple who

29 See Surrogacy360 for an overview of state regulations in Mexico, <https://surrogacy360.org/considering-surrogacy/current-law/>, accessed January 2025.

30 Miracle Surrogacy, a commercial surrogacy agency, <https://miraclesurrogacy.com/>, accessed April 2025.

experienced surrogacy themselves; Surrogacy Mexico;³¹ Sensible Surrogacy; WCOB; New Life Mexico;³² and Tammuz Family's Repro Vida Clinic³³ (Miracle Surrogacy 2025; Surrogacy México 2025; Sensible Surrogacy 2025; WCOB 2025).

4.5 Greece: Altruistic Legal Precision

Greece established a fully regulated altruistic gestational surrogacy framework in 2002 under Law 3089/2002, initially for citizens, later extending to foreign intended parents (Zervogianni 2019).

Current State: As of 2024, surrogacy is limited to gestational arrangements for heterosexual couples and single women, requiring residency and court approval for legal parentage (Hance & Becheikh, 2016). Altruistic surrogacy is permitted with compensation for expenses and lost wages, but commercial arrangements may occur underground.

Agencies Involved: Despite legal restrictions, a few international agencies operate in the country. These include Gestlife (Athens, Thessaloniki), Growing Families and Fertility World. Global Surrogacy suspended its Greek program after a child trafficking incident involving a local clinic (Global Surrogacy 2024).

4.6 Cyprus: Sunny Grey Zone

Since 2015, Cyprus allows altruistic gestational surrogacy with compensation for pregnancy-related expenses, creating a blurred line between altruistic and commercial practice (Zervogianni 2019). Dual authorisation procedures add bureaucratic complexity.

Current State: Commercial surrogacy is officially banned; altruistic arrangements require both mother and gestational mother to be residents. Agencies have exploited loopholes, e.g. relocating Ukrainian gestational mothers to the island nation after the Ukraine war began and classifying

31 Surrogacy Mexico, a commercial surrogacy agency, <https://surrogacymexico.mx/>, accessed April 2025.

32 New Life Mexico, a branch of the commercial surrogacy agency New Life, <https://www.newlifemexico.net/>, accessed April 2025.

33 Repro Vida Clinic, a branch of the commercial surrogacy agency Tammuz Family, <https://www.tammuz.com/surrogacy-in-mexico-2/>, accessed April 2025.

payments as reimbursements (Surrogacy360 2024; WCOB 2024). Factors such as climate and lifestyle are cited as attractive for intended parents. Limitations include language barriers, short-term visas and partial residency, often requiring births to occur elsewhere.

Agencies Involved: International agencies include WCOB, Miracle Baby Surrogacy³⁴ and Dunya IVF Clinic³⁵ (WCOB 2024).

4.7 **Albania: Emerging Affordable Hub**

Albania has no explicit surrogacy legislation but became significant after the Ukraine war disrupted agencies' activities. Rising local ART infrastructure and competitive pricing have attracted agencies like Gestlife and WCOB. Albania hosts clinics offering high-quality care, including for HIV-positive intended parents, signalling a growing but nascent hub (Gestlife/WCOB interviews, March 2025).

Agencies Involved: Gestlife, WCOB and a few other emerging clinics provide services in Albania, leveraging flexible laws and competitive operational costs.

4.8 **Colombia: Latin America's Legal Free Zone**

Colombia has no formal regulations governing surrogacy. Attempts to create a legal framework in 2009 and again in 2016, which would have banned commercial surrogacy while permitting altruistic surrogacy, failed to enter into force. Despite this, Colombia has risen in popularity as a destination for international surrogacy, especially among single parents and gay male couples. This popularity is supported by the country's generally progressive stance on LGBTIQ+ rights and the absence of legal obstacles for intended parents seeking reproductive services.

Agencies Involved: International surrogacy agencies operating in Colombia include Tammuz Family, Growing Families, Sensible Surrogacy and Nordic Surrogacy. These agencies have leveraged Colombia's legal flexibility and inclusive stance toward LGBTIQ+ and single intended parents to attract a diverse clientele.

34 Miracle Baby Surrogacy, <https://www.miraclebabysurrogacy.com/surrogacy-in-cyprus/>, accessed April 2025.

35 Dunya IVF Clinic, <https://www.dunyaivf.com/en/surrogacy/>, accessed April 2025.

4.9 **Ghana: West Africa's Emerging Frontier**

Although the first IVF baby in Ghana was born in 1995, surrogacy has only recently begun to expand. Fertility agencies appear to consider Ghana a potentially lucrative market, even though the country does not provide a fully enabling environment for the industry. Ghana faces several structural challenges, including its relative distance from major international transportation routes and a shortage of local experts with high-level embryological knowledge. Consequently, fertility clinics in Ghana often rely on foreign medical specialists to provide surrogacy services.

Current State: Ghana currently has no or limited regulations governing surrogacy. This regulatory vacuum leaves the market largely to self-regulation and market forces. Commercial surrogacy is available to both national and foreign intended parents, and Ghana is increasingly attracting international clients alongside members of the diaspora. Under Section 22 of Ghana's Registration of Births and Deaths Act 2020, intended parents may apply for pre-birth parental orders, which formalises parentage before birth.

Agencies Involved: Several agencies operate in Ghana, including World Fertility Services, Growing Families, Afrigha Surrogacy³⁶ and Surrogacy 4 All.³⁷ Fertility clinics recruit women, often single and from economically disadvantaged regions, to serve as gestational mothers. These women typically reside in shared apartments during their pregnancies, reflecting the labour-intensive and collective nature of the surrogacy arrangements.

4.10 **Kenya: Nairobi's Legal Loophole**

Kenya does not have formal regulations regarding surrogacy, which has made it an attractive destination for international commercial surrogacy. The absence of a regulatory framework became particularly appealing not only after countries such as India, Nepal and Thailand put restrictions on surrogacy, but also after the disruptions caused by the Ukraine war. Fertility clinics and agencies in Kenya have capitalised on this legal ambiguity to recruit both domestic and international intended parents.

36 Afrigha Surrogacy, a commercial surrogacy agency, <https://afrigha-surrogacy.com/>, accessed April 2025.

37 Surrogacy 4 All, a commercial surrogacy agency, <https://www.surrogacy4all.com>, accessed April 2025.

- Current State:** Although the commercial surrogacy market in Kenya is relatively new, it is currently experiencing rapid growth. The 2016 Assisted Reproductive Technology Bill requires that gestational mothers be at least 25 years old and grants the biological mother and father initial parental rights over the newborn. These rights are transferred contractually to the intended parents after birth. Agencies actively promote surrogacy services to single parents and same-sex couples, despite the fact that homosexuality is illegal in Kenya. Kenya's ART industry maintains strong interconnections with Indian fertility networks, including cross-border reproductive travel and collaborations between clinics.
- Agencies Involved:** Several international agencies promote Kenya as a surrogacy destination, including Go IVF Surrogacy, International Fertility Centre (IFC) and African Fertility Agency Limited, a branch of the international Become Parents network. Some agencies, such as Sensible Surrogacy, issue warnings to intended parents about Kenya due to regulatory uncertainties, illustrating the fragile and shifting nature of the surrogacy market in the country.

4.11

Nigeria: Local Roots, Global Gaps

In Nigeria, surrogacy is neither explicitly prohibited nor formally permitted. This regulatory void creates legal uncertainty regarding contracts, parental rights and the protection of gestational mothers, but it does not prevent the practice from taking place. Cross-border surrogacy occurs occasionally, though it remains relatively uncommon. Fertility clinics in major cities such as Lagos and Abuja primarily serve local clients and the Nigerian diaspora.

- Agencies Involved:** There are no widely recognised international surrogacy agencies operating in Nigeria. Local operators include Nigeria Surrogacy Agency and Fertility Hub Nigeria,³⁸ as well as clinics such as Care Women's Clinic, DIFF Hospital, FertiGold Fertility Clinic and Lily Hospitals. These local agencies often rely on direct marketing and personal networks rather than formal international promotion.

38 Fertility Hub Nigeria, <https://fertilityhubnigeria.com/surrogacy-clinics-nigeria/>, accessed April 2025.

4.12

Uganda: East Africa's Quiet Contender

Surrogacy in Uganda remains unregulated, which has allowed the practice to grow despite the absence of formal legal protections. Legislative efforts are underway to introduce a regulatory framework that would formalise compensated and altruistic surrogacy and limit its use to individuals facing significant infertility or health challenges. Uganda's first fertility clinic opened in 2004, with support from medical experts from the UK and Belgium. The staff includes international nurses and embryologists, and patients come not only from Uganda but also from neighbouring countries such as Rwanda, Congo, Tanzania and Sudan. The Ministry of Health is actively exploring ways to develop a legal framework that accommodates both national and international intended parents.

Agencies Involved: The surrogacy market in Uganda is still emerging and primarily operates through informal networks and word-of-mouth referrals. However, new data from the International Surrogacy Forum in Cape Town indicate that a growing number of repreneurs from Kampala are actively involved in shaping the market and contributing to legislative discussions, particularly regarding the 2023 Human Assisted Reproductive Technology Bill. These efforts illustrate the dynamic and strategic role of local actors in fostering a nascent surrogacy industry.

The global surrogacy industry is dynamic and complex, shaped by a multitude of factors across legal, social and economic landscapes. As the country profiles above illustrate, a network of "hubs" and "nubs" has emerged across the Global South, each with its own regulatory ambiguities, market opportunities and reproductive infrastructures. From Albania's nascent but technologically advanced clinics to Colombia's legal flexibility, Ghana's emerging infrastructure and Kenya's regulatory loopholes, these destinations reveal how surrogacy operates not merely in response to patient demand but as a strategically constructed industry.

What these profiles collectively demonstrate is that the growth and mobility of surrogacy markets are actively driven by fertility entrepreneurs – clinicians, investors and care brokers – rather than by intended parents' demand alone. These actors anticipate shifts in legal frameworks, relocate services across borders, and create demand by

designing services and narratives that appeal to specific client populations, including single parents and LGBTIQ+ couples. In this way, the industry functions as a proactive, globally interconnected ecosystem, rather than a passive response to reproductive needs.

In the next chapter, attention turns to one of the key facilitators of this evolution – what I call “care brokers.” Care brokers operate at the intersection of clinical expertise, legal navigation and intimate relational work, connecting intended parents to gestational mothers, clinics and services across borders. By examining their strategies, networks and decision-making processes, we can better understand how the global surrogacy market is actively shaped and expanded – and how the lived experiences of both intended parents and gestational mothers are mediated through these actors.

Chapter 5. **Care Brokers and the Global Surrogacy Web**

The surrogacy industry relies on two distinct groups of entrepreneurs. The first group consists of fertility professionals – doctors, clinics, fertility lawyers and medical staff – who provide the technical and medical expertise needed to facilitate surrogacy. The second group consists of multiple layers of intermediaries. Among these, this report focuses on a specific type of intermediary the author calls “care brokers”. Care brokers mediate the movement of actors involved in surrogacy and manage crises that arise from the legal, ethical and emotional ambiguities of the industry. They draw on specialised expertise in law, networking or logistics to navigate the complex spaces inhabited by intended parents (Whittaker & König 2025).

While other scholars have examined the role of the state in shaping the global surrogacy market (Vertommen et al. 2022) or explored the demand side of the industry (Gilchrist 2023; The Economist 2023; Horsey 2024), the analysis in this report is centred on care brokers. By highlighting their diverse roles, the analysis shows how the “baby-making” industry uniquely intertwines legalities, financial strategies, ethics and emotions. A systematic look at care-broker strategies exposes the industry’s dynamism and resilience and provides insight into emerging trends.

Role of Care Brokers

Whittaker and König (2025) describe reproductive brokers as navigating cyclical crises, such as infertility, and episodic crises, such as legal changes or war, devising solutions to keep surrogacy moving. Expanding on this, this report shows that care brokers operate both within and outside moments of crisis. Their importance stems from two key characteristics of the surrogacy market: its fragmentation due to restrictive national laws and the fundamentally emotional nature of the process.

First, market fragmentation has made surrogacy services less centralised and more distributed across countries and continents. As care broker Sam Everingham of Growing

Families explains, “Surrogacy in India may have worked like an unethical factory, but with its one-stop shop, the risks were known. Now with so many countries involved, even the risks are uncertain.” The once relatively straightforward “one-stop” surrogacy process has become increasingly complex, with different services outsourced across borders. The “domino effect” where bans or legal restrictions in one country create opportunities in another has further intensified this fragmentation, requiring care brokers to coordinate international linkages and ensure smooth journeys for IPs.

Second, fragmentation increases vulnerability for both intended parents and gestational mothers. IPs often must move gametes, embryos, treatments and even gestational mothers rapidly across countries, navigating multiple legal jurisdictions and contractual loopholes. This creates more points of uncertainty, higher costs and increased precarity. National restrictions similarly displace gestational mothers. Historical examples include women from India travelling to Nepal after gay surrogacy was banned in India in 2013, or women from Thailand, Laos, Vietnam and the Philippines travelling to Georgia and Cambodia for surrogacy work. Many faced legal uncertainty and criminalisation. For instance, in December 2024, thirteen Filipino women were convicted of human trafficking in Cambodia for acting as gestational mothers in a scheme that allegedly sold babies to foreigners (Cheang 2024). Yet, during my fieldwork, I observed many women from the US and Europe travelling internationally for embryo transfers, later returning home to give birth. While media accounts often label cross-border surrogacy as “trafficking”, these movements frequently represent economic strategies and the pursuit of opportunity.

The first such movement the author observed was in Kathmandu when gay surrogacy was displaced from India in 2013. Media attention after the earthquake focused on Israeli clients allegedly abandoning Indian gestational mothers, but less discussed was the vulnerability imposed by India’s legal ban. In Skype interviews, eight Indian women pregnant as gestational mothers in Nepal reported feeling abandoned, not by intended parents, but by their own government. Their legal status was uncertain, travel was costly, and contractual obligations and payments remained precarious (Pande 2020a). Despite these

vulnerabilities, very few care brokers encountered worked consistently with gestational mothers, reflecting the uneven profitability of different forms of care work.

Ultimately, the emotional and moral dimensions of surrogacy – alongside legal and financial complexities – create the space for care brokers. Unlike other globalised medical industries, the ultimate “product” here in the surrogacy industry is a baby. IPs seek not only technical expertise but also moral reassurance, emotional support and legitimacy. Many care brokers leverage their own surrogacy experiences, offering autobiographical narratives, shared struggles and personal guidance to build trust. Most care brokers profiled in this report have a direct personal connection to the industry, often as former intended parents themselves.

Care-Broker Profiles

In the following section, six key care-broker agencies identified during field research are introduced. Selection was based on global visibility and direct engagement rather than systematic sampling.

Even a brief glance at Table 2 highlights the diversity of these agencies. Some, such as New Life, are multinational conglomerates with a global footprint and have been the focus of multiple journalistic and research reports (Bangkok Post 2014; Bowers 2023a, 2023b).³⁹ New Life is often described as the world’s leading low-cost surrogacy agency. Other agencies, such as Growing Families and Sensible Surrogacy, operate under the public radar, partly due to the fear of scandal. They tend to offer consultation-based services, connecting IPs to clinics and other service providers. These agencies are usually family-owned with minimal board oversight and limited financial investment in the surrogacy industry (Personal communication 2024, 2025).

Despite differences in scale, these care brokers share one

³⁹ Allegations of ethical breaches and questionable corporate strategies at the New Life agency prompted a team of international journalists from four continents to conduct a major joint investigation entitled “The Baby Broker Project”, coordinated by Finance Uncovered. The investigations have revealed troubling findings, such as the lack of contracts and legal protection for the gestational mothers as well as shadowy ownership structures of the company (Bowers et al. 2022).

critical characteristic: the ability to navigate and resolve tensions within a rapidly evolving legal landscape while balancing the moral and emotional complexities inherent to surrogacy (Whittaker & König 2025). Each of these agencies strategically leverages the uncertainties of the global surrogacy market, sustaining their businesses and shaping the industry.

Table 2: Agencies' Profiles

Sensible Surrogacy ⁴⁰	
Head-quarters	Spain
Founded / Founder	2012 / Bill Houghton (personal connection with surrogacy)
Main Markets	Operates primarily in Colombia, other key locations include Ukraine, the US, Mexico and Argentina. Consultation worldwide, connections to fertility professionals in various locations ranging from Greece to Kenya
Approach	Markets itself as an independent advisory service, emphasising the “hand-holding” aspect of the process. Describes itself as “boutique agency focused on personal attention and unique solutions” (Sensible website, accessed 12 Feb. 2025)
Key Services	Consultation before and during the surrogacy process, cost guidance, legal guidance, emotional support, referrals to “the best clinics worldwide, and a network of first-class professionals” (Sensible website, accessed 12 Feb. 2025)
Online Presence	Modest online presence (1K IG, 1.5K FB) Mixed reviews (3.5/5 on Trustpilot) 21.5K website visits/month Main audience: US, Canada, UK
World Center of Baby (WCOB) ⁴¹	
Head-quarters	Ukraine
Founded / Founder	2018 / Vladyslav Natochii (personal connection with surrogacy)
Main Markets	Main market is Ukraine (even after the war). Further key locations include Albania, Colombia, Mexico, Czech Republic, Georgia and Cyprus Runs its own fertility clinic in Kiev, Ukraine
Approach	Surrogacy coordination, incl. legal and medical guidance
Key Services	Education, consultation, logistical support, emotional services for IPs Surrogacy programs (shipped embryos, own eggs, egg donation, unlimited, unlimited double, extra care), IVF, egg donation, PGD and

⁴⁰ Sensible Surrogacy, <https://www.sensible-surrogacy.com/>, accessed April 2025.

⁴¹ World Center of Baby, <https://www.worldcenterofbaby.com/>, accessed April 2025.

	PGS For heterosexual (married or single), LGBTIQ+, HIV, cancer survivors
Online Presence	Solid online presence (2.6K FB, 4.5K IG) Mixed reviews (3.7/5 on Trustpilot, 18 reviews) 17.3K website visits/month Main audience: US, UK, Canada
Tammuz Family ⁴²	
Head-quarters	Israel
Founded / Founder	2008 / Doron Mamet- Meged (personal connection with surrogacy)
Main Markets	Originally established to serve Israeli IPs, the agency has now grown into a global surrogacy provider with programs in the US, Mexico, Colombia, Argentina and Armenia. It also has offices in many other countries, incl. Sweden, Denmark, Norway, Iceland, Finland, Brazil, Portugal, China, India, South Africa, Japan and Australia Runs its own fertility clinics in Nepal, Mexico, Colombia and Argentina
Approach	Describes itself as an “international surrogacy fertility and egg donation company” with a “one-stop shop” approach for surrogacy, providing all services under one umbrella (Tammuz website, accessed Feb 17 2025) In addition to offering medical fertility procedures, Tammuz Family positions itself as an advocate for surrogacy rights. It claims on its website to be “at the forefront of the legal battle to make surrogacy available to everyone without discrimination” (Tammuz website, accessed 17 Feb. 2025)
Key Services	Surrogacy programs (basic, guarantee, double guarantee, two parallel journeys, guarantee plans with egg donations). For heterosexual (married or single), gay, HIV
Online Presence	Active online presence (1.5K IG, 3.6K, FB) No Trustpilot profile; mixed reviews on Global Fertility Network 10.5K website visits/month Main audience: Brazil, US, Taiwan, Switzerland, Israel
New Life ⁴³	
Head-quarters	Georgia
Founded / Founder	2008 / Mariam Kukunashvili (personal connection with surrogacy)
Main Markets	Has grown into a global network of offices, offering programs in Georgia, Ukraine, Mexico, India, Colombia and other Latin American and Asian countries Egg donation centres in Poland and South Africa Consultation offices in many other countries
Approach	-
Key Services	Surrogacy programs incl. matching, medical and psychological screenings, legal and financial services, gestational mother selection and care, as well as gender selection in certain countries

⁴² Tammuz Family, <https://www.tammuz.com/>, accessed April 2025.

⁴³ New Life, <https://www.newlifegeorgia.com>, accessed April 2025

	For heterosexual (married or single), gay, HIV
Online Presence	Large online presence (37.5K FB, 4.3K IG) No Trustpilot profile; 4.7/5 rating on QanoMed (89 reviews, authenticity questioned) Website visits per month vary by country (1-5K per site/month) Main audience also varies by country, for New Life Georgia: Georgia, US, Germany
Gestlife ⁴⁴	
Head-quarters	Spain, US
Founded / Founder	2010 / No information available; belongs to US-based group Invest Medical LLC
Main Markets	Gestlife has offices in 10 countries, with over 190 employees worldwide. It offers surrogacy programs in the US, Ukraine, Georgia, Albania, Greece, Kazakhstan, Armenia, Colombia and Mexico Runs its own fertility clinic in Ukraine ⁴⁵
Approach	Provides legal and medical support for IPs
Key Services	Legal aid and guarantee surrogacy packages Interestingly, Gestlife highlights a variety of add-ons in the surrogacy process that some other agencies offer as well but not to the same extent. For instance, it advertises providing IPs with baby strollers, a local phone, and a nanny for children. It also offers a “restart guarantee” in case of an infant’s death For heterosexual (married or single), queer, HIV, hepatitis
Online Presence	Low online presence: (139 FB, 4K IG) No major review presence 6.3K website visits/month Main audience: Spain, France, Italy
Growing Families ⁴⁶	
Head-quarters	Australia
Founded / Founder	2011 / Sam Everingham (personal connection with surrogacy)
Main Markets	While being based in Australia, Growing Families operates globally, maintaining connections with fertility professionals in 40 countries. It currently claims to offer surrogacy services in the US, Canada, Georgia, Colombia, Mexico and Ghana, depending on marital status and sexuality. In addition, it offers country-specific surrogacy programs that are restricted to national residents, e.g. in South Africa, Australia, the Netherlands, New Zealand, Israel and the UK
Approach	Describes itself as an educational and support network, which operates to provide a smooth and informed process for everyone involved in the surrogacy process
Key Services	Education, networking Connects IPs with a network of fertility professionals, gestational

44 Gestlife, <https://www.gestlifesurrogacy.com/en/>, accessed April 2025.

45 Intereco Clinic, <https://www.intereco-clinic.com>, accessed April 2025

46 Growing Families, <https://www.growingfamilies.org/about/>, accessed April 2025.

	mothers, clinics, lawyers, egg banks and counsellors The agency also partners with leading academics to inform policy and best practices and to keep up with the latest reliable information available
Online Presence	Large online presence (2K IG, 4.4K FB) Sam Everingham featured in media & books 6.2K website visits/month Main audience: US, Australia, Canada, Czech Republic

Source: Author’s own work. Data collected through agencies’ websites and interviews with individuals affiliated with the agencies

Table 3: Mapping Care-Broker Services

COUNTRY	Sensible Surrogacy	WCOB	Tammuz Family	New Life	Gestlife	Growing Families
United States	OP	OP	OP	NA	OP	OP
Canada	OP	OP	NA	NA	OP	OP
Mexico	OP	OP	OP	OP	OC	OP
Colombia	OP	OP	OP	NA	OP	OP
Argentina	OP	NA	OP	NA	AA	AA
Ukraine	OP	OP	OP	OP	OP	AA
Georgia	OP	OP	OP	OP	OP	OP
Armenia	NA	NA	OP	OP	OP	NA
Albania	NA	NA	NA	NA	OP	NA
Poland	NA	NA	NA	ED	AA	NA
Czech Republic	NA	NA	NA	NA	AA	AA
United Kingdom	OC	OP	NA	OC	OCN	OPN
Netherlands	OC	NA	NA	NA	AA	OPN
Greece	OC	NA	NA	NA	OP	AA
Cyprus	NA	OP	NA	ED	AA	OC*
Russia	OC*	NA	NA	NA	OCN	AA
Kazakhstan	NA	NA	NA	OP	OP	NA
Kyrgyzstan	NA	NA	NA	OP	OP	NA
India	FP	OP	OC	OPN	OCN	AA
Nepal	OC*	NA	FP	OCN	OCN	AA
Thailand	FP	NA	FP	FP	OCN	AA
Cambodia	OC*	NA	NA	FP	OCN	AA
Laos	OC*	NA	NA	FP	OCN	AA
Vietnam	NA	NA	NA	NA	OCN	NA
South Africa	NA	NA	NA	ED	OCN	OPN
Kenya	OC*	NA	NA	OP	NA	AA
Ghana	NA	NA	NA	NA	NA	OP
Australia	NA	OP	NA	NA	NA	OPN
Abbreviation	Phrase					
OP	Offers programs					
OPN	Offers programs for national citizens					
OC	Offers consultation					
OCN	Offers consultation for national citizens					
OC*	Offers consultation with caution					
ED	Offers egg donation programs					
FP	Former program					
AA	Advises against it					
NA	No information					

Source: Author's own work. Data collected through agencies' websites and interviews with individuals affiliated with the agencies.

Care Brokers in the Reproweb

The early global surrogacy industry was concentrated in a few “one-stop” reproductive hubs, such as the US and India, where the entire process – from fertilisation to pregnancy – was completed in a single location. However, both the research done for this report and other scholarly studies indicate that one-stop hubs are now the exception. They have been replaced by a highly fragmented, multi-step supply chain (Whittaker 2018:176). Scholars describe this shift as global fertility chains (Vertommen et al. 2022), reproflows (Inhorn 2015) or global fertility flows (Pande cited in Nicolson 2019). The term “flows” captures the fluid, unpredictable nature of the connections the author witnessed in the industry.

To further illustrate the role of care brokers, this report uses the concept of a “reproweb” (König & Jacobson 2023). This imagery reflects the multiplicity of borders and the complex connections created by the global fertility industry. The global surrogacy network functions like a spider’s web, spun, woven and maintained by care brokers.

Care brokers, much like spiders, play a central role in connecting the various nodes and hubs of the agile global surrogacy network. Just as a spider weaves its web with precision and care, the care broker arranges the various stages of the surrogacy process, managing everything from legal requirements to medical procedures and logistical arrangements to emotional support. They act as a nexus for all socio-technical actors, including fertility clinics and hospitals, pharmaceutical and biotechnological companies, gestational mothers, egg providers, ARTs, medicines, embryos, sperm and egg cells, medical staff, law firms, shipping companies, scientists, national ministries of health and foreign affairs, national embassies, social media groups, nannies, drivers, translators and intended parents. In case of legal or other crises, they even become emergency rescue workers. By holding together these multiple layers, care brokers serve not only as actors within the web, but as the vital force that sustains the reproweb and ensures the resilience and adaptability in the fragmented and ever-changing surrogacy landscape.

With fragmentation of the industry and the outsourcing of different processes to different reprohubs and nubs, the role of care brokers has become even more foundational. The process requires a reproweb of medical, legal, logistical and economic actors with hubs and nubs carving different niches and package models.

For instance, the fragmentation and webbing process could require IPs to travel to a clinic in New Delhi to be matched with an egg provider from Ukraine, South Africa or Georgia. At the clinic the sperm of the intended father may be used to fertilise this egg. The resulting embryo may be exported to a country with surrogacy-friendly laws, such as Thailand, Ghana, Kenya or Uganda, to be gestated

by a paid gestational mother. The gestational mother may not necessarily be from the country where the paid surrogacy is taking place, as many gestational mothers travel from other countries for the process. The woman may live in a dormitory next to the fertility clinic, or her own house, for the duration of the pregnancy. When she gives birth, the IPs take the child to their home country in yet another part of the world.

This multi-border process and the dynamic and, even elusive, nature of surrogacy hubs and nubs, along with the rapid changes in laws and regulations, create a space for care brokers. As the founder of one of the surrogacy agencies explains, *“The parents pay me ... essentially to accompany them through the program and to get the benefit of my experience in terms of helping them choose a clinic and choose a program.”* Another founder describes himself as an “educator, harmoniser” and, with the recent criminalisation of many surrogacy-related activities, a “rescue worker”. These narratives reveal the multiple responsibility of care brokers as active managers of the surrogacy process. Their role involves the curation and coordination of various steps in the fragmented, cross-border reproductive industry. Another care broker mentions having “partners around the world” and leveraging “good relationships” with them, including offering “special pricing”, further underscoring the care brokers’ strategic networking and web-like influence.

Care brokers connect IPs with various service providers across different countries. Depending on the level of “hand-holding” required (and paid for), their responsibility can range from facilitating group educational events for IPs to more personalised counselling and concierge services.

For instance, Growing Families, a care brokerage, based in Australia, but catering to IPs from across Euro-America and Australia, advertises its “strong support network to guide you through every step of your journey” and its ability to “provide all the information about surrogacy and egg/sperm provider in a single, comprehensive resource”. According to their website, they also guide clients to the “most reputable agencies” and offer referrals to professionals, from lawyers and migration agents to doctors and cryoshippers as well as governments.⁷⁴ In an interview, the founder, Sam Everingham describes the chronology of care. They start by providing an initial list of service providers. Then depending on the age of the IP, their placement in the fertility journey (whether they are married, heterosexual, with or without embryos, etc.) and their budget, they devise a plan and timeline.

The interview with WCOB and Growing Families suggests that the range of services provided by care brokers are not always planned. With war, pandemic and geopolitical uncertainties, they play an increasingly critical and,

sometimes, risky role, as “rescue workers” in times of legal and other crises. In times of crises, their role shifts from educators and counsellors to rescuing and even exporting embryos, egg providers, gestational mothers, or even IPs and newborn babies, from crisis-ridden countries.

For the expected coordination, and unexpected rescue work, care brokers rely on trustworthy relationships with a whole range of other professionals and brokers – for instance, embryo couriers who transport cryopreserved embryos across borders and brokers to facilitate the relocation of gestational mothers when necessary, such as moving Ukrainian gestational mothers to Cyprus in response to the ongoing war. Matthew from Gestlife recounts that at the beginning of the Russian invasion of Ukraine, they received many requests from IPs who had independent contracts with local clinics in Ukraine, which suddenly closed and disappeared, without the baby and with the money. He therefore emphasises the advantages of having an agency with a large infrastructure and ability to redirect processes in unexpected situations. When needed, care brokers even facilitate lawyers for babies or IPs stuck in countries that criminalise surrogacy overnight, for instance, in Cambodia. These strategic adaptations and navigations demonstrate the critical role played by care brokers as hand-holders for IPs and coordinators of global fertility flows.

Care Brokers’ Strategies of Investment

As the conditions surrounding the reproductive industry shift, care brokers must continuously reassess their networks and make strategic decisions about where and how to facilitate services. Within this, two distinct (but sometimes overlapping) strategies emerge for care brokers to adapt to the changing landscapes. Some opt to move down the ladder, shifting operations to countries and jurisdictions with fewer legal restrictions and lower costs, seeking convenience and legal vacuums. Others choose to work up the ladder, prioritising locations with stronger legal protections and established regulatory frameworks, focusing on stability and legal certainty.

Moving Down the Ladder

Care brokers interviewed discussed their strategies for sustaining their brokerage work in face of various levels of crises. While many care brokers just disappear permanently or temporarily during crisis (such as the ban or criminalisation of surrogacy in Cambodia and Nepal), the care brokers in this report managed to sustain their activities. Some decided to move to neighbouring countries with a legal vacuum so as to continue, at least temporarily, and continue unnoticed, while others chose safer and more stable avenues.

As Bill from Sensible Surrogacy explains, after the surrogacy ban in India, he initially opted for the path of least resistance, choosing to move his operations to Thailand, a country with no regulations in the surrogacy industry at that time. However, the scandals that followed, along with the subsequent legal restrictions on surrogacy in Thailand, served as a hard lesson for Bill. Without a legal framework for surrogacy in the country, the local authorities were able to suddenly and unexpectedly reframe surrogacy as human trafficking, which led to the mass raiding of surrogacy clinics and the threat of arresting gestational mothers. He continues, “Thailand was a very friendly destination and there were a lot of agencies there. And when the prohibitions came, the agencies who wanted to stay had two choices, right? They could either pick up their business and move to the next easiest spot, or you could pick up and go to the next secure spot.” Bill goes on to recount, “I spent the better part of the year shutting my business down where we did nothing but try to get our couples and our clients home with their babies, right? Making sure the gestational mothers were well taken care of, that the babies were born and ... under cover of darkness move these children out of the countries.” This experience led him to recognise the importance to operate only in places with supportive legal frameworks and explicitly defined roles and rights.

Bill’s experience mirrors that of agencies such as Tammuz Family’s and New Life’s response to shifting regulations. After the ban on surrogacy in India in 2014, Tammuz and New Life intuitively chose to expand operations into neighbouring and unregulated Nepal.

After the ban on surrogacy in India in 2014, Tammuz Family and New Life” intuitively chose to expand operations into neighbouring and unregulated Nepal. Tammuz, for instance, flew gestational mothers from India and Thailand to Kathmandu, where they opened their own fertility clinic (Pande 2020a; Vertommen et al. 2022). However, the massive earthquakes in Nepal in 2015 and the lack of a legal framework, left gestational mothers, IPs and newborn babies in a dramatic state of uncertainty and mistreatment. This, combined with a scandal involving an Israeli gay couple and a genetically unconnected baby, forced Tammuz to reassess its position. While Tammuz initially took advantage of the less-regulated environment, the legal and ethical risks they faced in Nepal led them to reorient their strategy towards destinations with stronger legal protections, which Bill refers to as “working up the ladder”. On the other hand, New Life chose to further expand to Cambodia following the bans in Nepal. Shortly after, they experienced yet another legal snap ban forcing them to move again, this time to Laos. New Life is clear about their bold strategy of moving

to markets and countries such as Kenya, where “the local law neither prohibits nor promotes surrogacy and egg donation”.

Moving Up the Ladder

Growing Families discloses a deliberate decision to always move up the ladder and caution IPs against taking “naive and desperate decisions”. Sam, the CEO of Growing Families, hosts an international advisory board to share knowledge of “on-the-ground” risks of pursuing surrogacy in different parts of the world, with the goal being “harm minimisation while advocating for minimum standards in surrogacy practices”.

After Sam and his team helped rescue embryos from countries such as Greece, they have decided to minimise risks and focus on countries with transparent legal frameworks, such as Georgia, Mexico and Colombia.

Market development and saturation in specific countries play an additional role in expansion decisions for agencies. A respondent from WCOB shared that their agency withdrew from Georgia due to an oversaturated market, a shortage of gestational mothers, and rising prices. In contrast, Matthew from Gestlife explained that Albania, despite having had a suitable legal framework for surrogacy for a long time, only became attractive when multiple agencies began to enter the market and drove the prices down through competition.

These choices show how care brokers must be resourceful and adaptable in responding to the shifting global surrogacy industry. As König and Jacobson (2023) note, the reproductive web is under constant strain from regulatory shifts, external disruptions and new ARTs. This unpredictable environment threatens the survival of care brokers and surrogacy agencies, but it is also central to their profitability. To endure, they continually build networks and partnerships, drawing on relationships to attract clients. In doing so, they serve a dual role: sustaining their own operations while also enabling the growth and resilience of the wider industry – much like a spider’s web that supports both the spider’s survival and the interconnected ecosystem around it.

Emotional Services

The surrogacy industry is characterised not only by cross-border fragmentation and the complexity of different regulatory frameworks, but also by the **emotional weight** connected to the process. The emotional and psychological impact resting on everyone involved goes beyond the

medical, technical and logistical challenges, making emotional support an invaluable service.

As Matthew from Gestlife poignantly points out, “It’s not like buying a car ... we don’t sell phones, no, no, no, we sell dreams.” He further goes on to explain that many clients “have gone through hell”, are “emotionally destroyed” and have “no more hope” before approaching the surrogacy agency.

There is rich, interdisciplinary literature on the emotional and psychological effects of the infertility journey on intended parents (especially intended mothers) (Cousineau and Domar 2007; Hasanpoor et al. 2014). In recent decades some literature has focused on gestational mothers (Jadva et al. 2015; Lamba et al. 2018) – including the exploration of feelings of attachment, fear of medical interventions, anxiety about relinquishing the child, and postpartum emotions (Canadian Fertility Consulting 2023).

In this section the analytical focus is shifted to the ways in which the emotional weight of this process creates opportunities for care brokers to provide, and capitalise on, emotional support. Many who step into this role have been through the surrogacy process themselves, having conceived children through a gestational mother. Their personal journey allegedly equips them to provide guidance, reassurance and comfort to IPs, supporting them to navigate not only medical and logistical complexities but also the emotional rollercoaster of the process. As Bill from Sensible Surrogacy elaborates, his role is not to support the clinics, but to support the parents: “I hold their hand until they’re home.” This metaphor of “holding their hand” underscores the crucial emotional role care brokers play, acting as a guide in the often complex, emotional and sometimes overwhelming experience.

The scientific literature repeatedly highlights the heavy emotional burden of (both social and medical) infertility, showing that the unfulfilled desire to have a child is strongly associated with anxiety and feelings of insecurity and depression (Bolvin & Lancaster 2010; Deka & Sarma 2010). This literature indicates that heterosexual intended parents grapple with feelings of guilt and shame, often combined with a sense of failure to live up to the expectations of other family members or society, all of which significantly impact their quality of life. The emotional burden can be further

intensified by repeated fertility treatment failures, adding to their distress (Shi et al. 2024). For same-sex parents, infertility presents different emotional challenges but remains significant. Same-sex IPs often face added layers of logistical and legal constraints as well as discrimination in navigating access to reproductive technologies, especially surrogacy services.

Although married heterosexual couples comprise a vast majority of users of ARTs within national fertility markets, same-sex IPs – mostly same-sex men, popularly labelled “gay IPs” – are conspicuous at the global level as they are more likely to be barred from accessing third-party reproductive services at home. They are also more likely to be implicated in the ethical and justice scandals around the industry, hence their disproportionate visibility and, sometimes, significant emotional burden in accessing these services (Mamo & Alston-Stepnitz 2015).

For all IPs the surrogacy process brings relief and gratitude, but also uncertainties and worries. IPs may worry about the wellbeing of the gestational mother, potential difficulties in bonding with the child after birth, fear of failure, and the broader social, ethical and moral aspects of surrogacy. While on the one hand, the care brokers hold together the fragmented market and the many different actors and stages of the surrogacy process, they also play their own essential role in managing the relations and emotions involved in this industry of baby-making.

Care brokers are particularly well-positioned to support IPs, especially when they have lived through similar experiences themselves. Most founders have conceived children through surrogacy; the websites of other agencies often indicate that their founders or CEOs have experienced infertility, either medically or socially, or have themselves had children through surrogacy services (see Table 2: Agencies’ Profiles). Their first-hand experience allows them to connect with IPs on a personal level of mutual understanding, recognising the fears, anxieties and glimmers of hope that IPs go through. It is this shared experience that puts them in a unique and invaluable position.

Agency websites often feature sentences emphasising that the agency’s founders or team members have been through similar situations and want to offer their full support: “As most of the Tammuz team has been on the surrogacy journey, we know the emotional rollercoaster and challenges you might be facing along the way. We will guide you through every step of the way – until birth!” (Tammuz Family n.d.).

A recurring element on the websites of the agencies is a personal letter from the founder or CEO to the intended parents. These letters are often written in a detailed and emotive manner, sharing the personal experience.

For example, one letter reads: “Doron’s Letter: A number of years ago, my partner and I were in a position similar to yours. We longed for a child. We desperately longed for a child. And like you, we were unable to create a child the conventional way.” (Tammuz Family n.d.).

These letters appear to attempt to establish a connection with IPs through expressions of shared experience and shared pain, as seen in statements of New Life’s founder Mariam Kukunshavili: “The pain I’m sure you can understand and feel in your heart right now at this very moment” (Kukunashvili n.d.) and “we understand your pain, your struggles, and your unending desire to have a baby and family of your own” (ibid.).

Alongside the emotional pleas, the letters often contain the promise “to be a trusted guide every step of the way” (Growing Families n.d.) or “will be with you every step of the way” (Global Surrogacy n.d.). They further emphasise their aspiration “to create a better path for others” (Growing Families n.d.). In our interview, Bill, the founder of Sensible Surrogacy, also shares his experience of uncertainty and lack of knowledge when he began the process of using a gestational mother to conceive a child, which reinforced his desire to make it easier for IPs today. Both Sam, the founder of Growing Families, and Doron, from Tammuz, have similar stories and advertising strategies. Both founders had their own children via gestational mothers in India and the US, and the challenges their own journey presented inspired them to start their agencies.

While much of the public discourse and existing literature on the surrogacy industry focuses on the demand side, often attributing the growth of the industry to the increasing demand from medically and socially infertile couples, this report highlights the crucial role of key actors on the supply side who significantly influence and shape the industry. In particular, this report argues that “care brokers” play a critical role in encouraging intended parents to fulfil their wishes, normalising surrogacy and transnational surrogacy and the desire for a genetically predisposed child by presenting these processes as emotionally supported and regulated solutions. Conversations with agency founders confirm that emotional support is no longer seen as an “add-on”, but as an indispensable part of the whole process. But as the work of facilitating networking, trust-building and relational services shifts from being a

specialised service provided by a few global brokerage services to a mandatory service provided by all, fertility professionals, care brokers and agencies carve out new niches through “add-on” services.

In the last chapter of the report expands on the notion of add-on and guarantee services to make predictions about the future of the surrogacy market, based on the temporal, geographical and strategic investment patterns outlined above.

Chapter 6. The Future of the Baby Making Industry

Analysing Care-Broker Services Through Word Clouds

To understand how agencies and care brokers promote their surrogacy services, a word cloud was created based on data from the websites of 15 internationally operating agencies, including the six agencies followed closely in this research. Selection was based on visibility and subjective relevance throughout the study.⁴⁷

A preliminary analysis revealed frequently occurring keywords, particularly around packages and guarantee programs. These keywords were then used to examine the services advertised by agencies and care brokers, and to speculate on potential industry trends. The word cloud uses colour coding to highlight broad thematic groupings: red marks core services such as surrogacy, egg provision, and services for heterosexual, queer, single, married and unmarried intended parents; yellow shows package options, often presented as all-inclusive, complete or fixed-price plans; green indicates guarantees and assurances; blue represents emotional support, such as stress reduction and understanding; and orange signals specialised services, including gender selection or surrogacy for HIV-positive clients.

⁴⁷ For this purpose, data was taken from the websites of 15 agencies, all of which operate internationally. These agencies include, but were not restricted to, the six agencies that were followed more closely. The selection of agencies for this purpose is based on their appearance and subjective relevance that emerged throughout the research. Copy and paste from all agency websites was used to create a document that was then scanned through a word list generator. This word list was manually cleaned and structured to ensure clarity and relevance. Multi-word phrases were also included to preserve contextual meaning. Similar terms and phrases such as "guaranteed program," "guaranteed success" and "full guarantee" were grouped into categories to reflect broader themes throughout the data set. The categories, such as general guarantees, service-specific packages and risk protection, are reflected in different colours in the word cloud. While term frequency was obviously a leading factor in determining a term's prominence, insight from the broader research was used to aggregate the frequencies of similar terms to ensure their representation and key message. In the word cloud above, term frequency was a leading factor in determining a term's prominence and relative font size. A rudimentary analysis of services offered revealed some frequently occurring keywords, particularly around packages and guarantee programs.

Although the words in red may seem obvious, they underscore the diversity of clients served and the breadth of services offered. Agencies routinely promote third-party reproductive services, egg freezing and surrogacy for LGBTIQ+ individuals, single men, single women and unmarried couples. Interviews with care brokers confirmed these trends. Sam from Growing Families, for example, reported that half of his clientele were “gay surrogacy” clients, while new destinations such as Colombia and Kenya primarily cater to gay and single men. Bill from Sensible Surrogacy and Matthew from Gestlife reported that 70–75 percent of their clients were gay men, reflecting both client demographics and the care brokers’ own autobiographical connections to the industry.

Similar terms, such as “guaranteed program”, “guaranteed success” and “full guarantee”, were grouped into broader categories – general guarantees, service-specific packages and risk protection – and represented by different colours in the word cloud. While term frequency shaped the prominence of words, qualitative insight ensured that key themes were accurately captured.

Affordable packages have historically defined the global fertility industry, particularly as it expanded into the Global South. However, with increasing fragmentation and restrictive laws, affordability alone no longer defines agency niches. Agencies now routinely offer “guarantee packages” and symbolically unlimited services, such as “unlimited surrogate matchings until a live birth”, “unlimited embryo transfers” or even “buy one, get one free” deals. These guarantees, linked to the emotional hand-holding of intended parents, are central to sustaining the industry.

The yellow and green terms reveal the financial and risk management aspects of these packages, while “luxury guarantees” extend assurances beyond standard agreements, including reimbursement for unexpected complications and additional emotional support. Blue terms reflect this emotional support, with promises such as “peace of mind”, “no unpleasant surprises” and “stress-free solutions”. These programs provide intended parents with a sense of predictability despite the inherent uncertainties of surrogacy.

Care brokers and their networks remain foundational to the industry, particularly as crises create both challenges and opportunities. While some brokers disappear during crises, those interviewed in this research leverage such moments to innovate, expand into new regions and introduce specialised services.

As the global surrogacy market continues to shift, legal landscapes remain pivotal. Recent reports indicate that countries in Asia, including Thailand, are reopening to international surrogacy (Bangkok Post 2025), while several sending countries are revising their laws to manage cross-border surrogacy. Reforms are underway in the UK (Callus 2023), Ireland and New Zealand (Tanderup et al. 2023), while commissions in Denmark and Germany have been tasked with exploring gestational surrogacy (Tanderup et al. 2023; Dauke & Gesley 2024).

As this report reaches its conclusion, significant developments in the United States highlight the shifting political terrain in which assisted reproduction is situated. The newly elected President, Donald Trump, publicly styled himself as “the father of IVF” and “the fertilisation president” (Sherman 2025), before signing an executive order aimed at expanding access to IVF treatments. Shortly thereafter, however, he dismissed all infertility researchers at the Centers for Disease Control and Prevention (Robinson 2025), raising concerns about the politicisation of reproductive science. In an even more consequential move, the Trump administration has proposed a reinterpretation of the Fourteenth Amendment to restrict birthright citizenship. An accompanying executive order seeks to deny US citizenship to children born in the country to parents who are neither citizens nor lawful permanent residents. Such a measure carries profound implications for international intended parents engaging in surrogacy in the United States, as their children would no longer be automatically granted citizenship (Vaughn 2025).

Amid these uncertainties, intended parents, brokers and professionals are actively seeking alternatives to US surrogacy in particular, and surrogacy in the Global North in general. Countries previously considered “nubs”, such as Kenya, Nigeria and Uganda, may evolve into new international hubs, creating opportunities for agencies and care brokers to shape future markets.

Conclusion: Global Dialogue and Reproductive Justice

As emphasised in this report, a global phenomenon like surrogacy cannot be effectively regulated through nationally restrictive laws. In the absence of international regulation, restrictive laws primarily push the surrogacy industry elsewhere, as illustrated by the “domino effect”. In some countries, such laws drive the industry underground, as seen in Cambodia, Greece, India and Thailand, effectively absolving governments of responsibility. Another consequence of restrictive laws is the increasing vulnerability of gestational mothers, who have always been the weakest link in the global fertility industry. Within the hybrid surrogacy model, their precarity has intensified, and few global care brokers choose to work intensively with them.

A further consequence is the emergence of countries with no national clinic registries or regulations as new hubs and hubs. These countries offer services not available elsewhere, such as sex selection through preimplantation genetic testing (PGT). My survey of global surrogacy agency websites found that clinics in Albania, Thailand, Mexico, Northern Cyprus, Ukraine and the US routinely offer sex selection for non-medical purposes. In response, countries with strong son preference and associated risks of female mortality, feticide, infanticide and skewed sex ratios have imposed bans on some of these techniques. For context, several countries – including China, India, South Africa, Turkey, Australia, Canada and most of Europe – restrict sex selection, and the European Convention on Human Rights and Biomedicine (Oviedo Convention, 1997) permits it only to prevent serious hereditary sex-linked disease. Some countries, such as Austria and Switzerland, prohibit sex selection entirely (de Wert & Dondorp 2010).

How does one govern this booming unregulated industry of making babies? If restrictive national bans on global surrogacy are not the solution, what is the way forward? Over the past decade, there have been intercountry dialogues and efforts to create international guidelines, such as the Verona Principles for protecting the rights of children born through surrogacy, drafted by the International Social Service (ISS) and supported by the UN Special Rapporteur on the Sale and Sexual Exploitation of Children (International Social Service 2021). However,

these initiatives focus primarily on the rights of the child and pay little attention to the pragmatics of the global surrogacy industry, including the complex web of actors and competing rights. Protecting the rights of one party cannot come at the expense of another. In my prior work, I have argued that a purely rights-based approach is inadequate where trade-offs are unavoidable (Pande 2022). A more promising approach is to foreground reproductive justice, which situates reproductive rights within broader intersectional realities of race, gender, sexuality and class (Ross 2017; Chiweshe et al. 2017). This framework is essential for grounding debates on global surrogacy, particularly given the industry's predicted expansion into the Global South.

The global surrogacy industry operates as a highly dynamic transnational network, driven not only by intended parents' desires but by the strategies of fertility entrepreneurs and care brokers. While care brokers are often lauded for their organisational skills and ability to navigate complex legal, logistical and emotional landscapes, their centrality also sustains systemic inequities. By orchestrating the movement of gestational mothers, embryos and information across borders, care brokers enable the expansion of surrogacy markets while the burdens and risks disproportionately fall on the most vulnerable: women from economically marginalised communities who serve as gestational mothers. These women face precarity, legal ambiguity and often exploitative conditions, while intended parents and agencies benefit from relative security, financial leverage and emotional support.

Focusing on hubs and nubs in the Global South – rather than conventional Northern or Western destinations – reveals dimensions of the industry that remain hidden in dominant discourses. It exposes how surrogacy intersects with histories of postcolonial inequality, global mobility, and neoliberal investment in reproductive labour. These hubs often emerge in contexts with limited regulation, weak legal protection and constrained economic opportunities, highlighting the stark imbalances of power and the ways global capital exploits structural vulnerabilities. Examining these contexts reveals the contingency, fluidity and precarity underlying the global surrogacy industry – dynamics often masked by the perception of surrogacy as a stable, regulated market in the Global North.

Focusing on the Global South also underscores how reproductive labour is globalised: the desires of wealthy, often Northern, intended parents are fulfilled through the labour of women in countries with fewer safeguards, reinforcing existing patterns of global inequality. A reproductive justice lens makes these inequities explicit. Unlike narrow rights-based frameworks that prioritise the legal status of the child or the contractual protections of intended parents, reproductive justice situates reproductive autonomy within broader social, economic, geographic and racial inequities. It emphasises that access to reproductive technologies is deeply stratified: some actors enjoy choice and protection, while others bear risk and precarity. True ethical governance of surrogacy requires recognising and centring the needs, rights and dignity of those most exploited in the system – gestational mothers and egg providers – rather than merely facilitating the desires of intended parents or the profit motives of agencies.

Finally, sustainable and just regulation of global surrogacy cannot rely solely on national law or market-driven mechanisms. It requires a coordinated, international approach grounded in reproductive justice, which protects the most vulnerable, enforces ethical standards, and ensures equitable participation across all actors in the reproductive chain. Without such a framework, the industry will continue to reproduce global inequalities, expanding its reach while concentrating risk and precarity on those least able to defend themselves.

Appendix 1: Key Concepts

Surrogacy

Surrogacy^{48 49} is an arrangement where intended parents (IP) - such as clinically infertile couples (heterosexual), same-sex couples, single people, or LGBTQI+ individuals (categorized as “socially infertile”) - hire a surrogate or gestational mother to carry a pregnancy and give birth to a child on their behalf.

The expanded definition (beyond “medical treatment of infertility”) challenges stigma and reflects the evolving nature of the surrogacy industry beyond just medical treatment.

Intended Parents

Intended Parents (IP) are assumed infertility patients, but broadening the definition IPs encompass all clients looking for/wanting surrogacy, due to medical infertility, social, relational, or structural factors, and it includes heterosexual couples (in a marriage or civil union who have a history of medical infertility), single individuals, same-sex couples or LGBTQI+ individuals.

Intended parents, also called commissioning parents, are those who arrange surrogacy procedures with a gestational mother to have a child when they are unable or unwilling to carry it themselves.

Surrogate or Surrogate mother or Gestational mother

Surrogate, “surrogate mother” or “gestational mother” is defined as a substitute or a replacement, implying that the woman giving birth is (somehow) less than a mother, objectifying and reducing her to her reproductive capabilities.

The phrases “women who give birth for pay” or “gestational carrier” are also used by scholars, as an alternative, while, this report uses the phrase “gestational mother” to recognize the kin contributions made by these women, and it as a legitimate tie of mothering

48 Brandão and Garrido 2022; Human Fertilization & Embryology Authority 2024

49 Many of the existing scholars define surrogacy as a medical treatment for infertility

**Traditional
Surrogacy
(processed
based)**

Traditional surrogacy, involves the gestational mother's egg being artificially inseminated with the intended father's sperm. In this form, the gestational mother and the child are genetically related.

**Gestational
Surrogacy
(process based)**

Gestational surrogacy is done through in-vitro fertilisation (IVF), a technique of assisted reproduction technologies (ART) - in which the egg of the intended mother or an anonymous donor is fertilised in a petri dish, with the sperm of the intended father or of a donor and the embryo is transferred to the gestational mother's uterus.

This is the most frequent form in the global surrogacy industry, wherein the gestational mother has no genetic connection with the baby and is believed to be unlikely to build strong connections with the baby. and, allegedly, is believed

**Altruistic
Surrogacy**

(nature of compensation based, even though drawing a strict binary between commercial and altruistic surrogacy is problematic)
Pande 2016; Pande 2020

Based on the nature of compensation, altruistic surrogacy refers to an arrangement in which the gestational mother, often a relative or a friend, carries the pregnancy and does not receive any monetary compensation, except for pregnancy related expenses. This surrogacy is permitted and practiced in many countries (UK, Canada, South Africa).

**Commercial
Surrogacy or
Compensated
surrogacy**

In contrast to altruistic surrogacy, commercial surrogacy, involves financial compensation for surrogate services (Guzman 2016). Commercial surrogacy is restricted in the majority of countries, although there are a few countries that allow for it or have no regulations at place. In a handful of these countries, commercial gestational surrogacy is permitted for foreign intended parents.

**Artificial
Reproduction
Technologies
(ART)**

Assisted Reproductive Technology (ART) is a set of medical procedures that are primarily used to treat infertility.

**In-Vitro
Fertilisation
(IVF)**

A technique of artificial reproduction technologies (ART) in which the egg of the intended mother or an anonymous donor is fertilised in a petri dish with the sperm of the intended father or of a donor and the embryo is transferred to the gestational mother's uterus.

**One-Stop-
Surrogacy**

The entire process from fertilisation of gametes (a reproductive cell - an egg from a female or sperm from a male - that carries genetic material) to gestation (carrying a pregnancy, from conception to birth) is conducted in one clinic or hub.

**Reproductive
Hub or
Reprohub**

Reproductive hubs or reprohubs (Inhorn 2015) are well known and well established centres serving cross-border and international demand for various reproductive trades, including surrogacy. The hubs are the meeting points for various

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