

# **CALL FOR AN INTERNATIONAL DECLARATION ON ABUSES OF WOMEN'S HUMAN RIGHTS IN THIRD PARTY REPRODUCTION**

## **I. The Problem**

The worldwide use of reproductive technologies has grown exponentially in recent years. While these developments have brought benefits to many by successfully treating some types of infertility, deep regulatory divides have fueled a growing international market in which relatively privileged individuals and third party intermediaries, who benefit financially from the commodification of reproduction, exploit vulnerable, uninformed, low income and poor women for their reproductive capacities. Surrogacy and the trade in human eggs in particular have become pervasive international phenomena in which women's poverty and subordinate status throughout the world increase their exposure to gender-based exploitation and physical harms.<sup>i</sup>

## **II. What is the Harm?**

Unequal relationships between the buyers (intended parents) and the women who sell their eggs or rent their uterus, favor the needs and desires of the buyers. These unequal transactions, in the absence of regulation of the fertility-industrial complex, result in inadequate "informed" consent, low payments, coercion, poor health care, and severe risks to their short and long-term health. In addition, both the children conceived through commercial transactions and the intended parents may suffer as a direct result of these arrangements. While the full magnitude of the harms resulting from reproductive exploitation is unknown due to lack of regulation and oversight in many of the most significant jurisdictions, reports of egregious harms continue to mount.

### **A. Trafficking/Trade in Human Eggs**

Egg providers are subjected to a lengthy and intrusive medical process lasting up to six weeks, during which time they are injected with synthetic hormones to shut down the natural ovulation cycle. They are then required to self-inject additional powerful hormones to produce many times the normal number of eggs per cycle in both ovaries simultaneously. This places them at risk for a common short-term side effect known as Ovarian Hyperstimulation Syndrome (OHS) that includes discomfort, bloating, cramps, nausea and headaches. More serious short-term side effects may also result, such as ovarian torsion, blood clots, kidney disease, and in some cases even death. These risks are in addition to potential damage caused by anesthesia and surgical removal of eggs.<sup>ii</sup> Longer-term side effects may include chronic pelvic pain, ovarian cysts, severe mood swings, impaired fertility, and premature menopause.<sup>iii</sup> Of particular concern to women's health advocates, given the disastrous history of overzealous use of synthetic hormones (diethylstilbesterol<sup>iv</sup> and hormone replacement therapy for the treatment of menopause symptoms<sup>v</sup>)<sup>vi</sup> are the under-studied long-term risks of reproductive (uterine, breast, endometrial, cervical) and other cancers. While some of these side-effects are well documented, others (particularly the long-term cancer and infertility risks) have not been adequately studied to make consent truly informed. Nevertheless, evidence is climbing of significant long-term increases in cancer risk.<sup>vii</sup> Deceptive advertising intensifies the problems of providing informed consent.<sup>viii</sup>

## **B. Trafficking/Exploitation in Surrogacy**

Unless her own eggs are used with intrauterine insemination, women recruited to serve as surrogates are subjected to the same risks of synthetic hormonal stimulation outlined above when drugs are administered to synchronize their menstrual cycles with those of the egg provider. In addition, surrogates are often separated from spouses and their own children for the duration of the pregnancy; this is a common practice at clinics in India. While the surrogate is undergoing pregnancy and childbirth for someone else while separated from her family, her own children often develop psychological problems from separation and trauma. High rates of multiple births and infection resulting from IVF (Invitro Fertilization) place both surrogates and babies at high risk for complications. When problems arise during the pregnancy, the wellbeing of the fetus tends to be given precedence over the health of the woman serving as a surrogate since the intended parents are paying large sums of money for the baby being produced. Care of the surrogate ends with the birth of the baby even when the woman who bears the child suffers lasting effects.

If the intended parents' circumstances change during the pregnancy, or if the child is born with health problems or disabilities, the infants may be left to the surrogate, abandoned or placed in an orphanage in the country of their birth. Intended parents may find that they face unplanned financial costs and inadequate legal protections, including difficulty establishing citizenship for the child in their home country.

## **III. What Do We Want?**

An international declaration under the auspices of the United Nations (UN) concerning reproductive trafficking and exploitation is urgently needed. The practices of reproductive organ, tissue and cell commerce, particularly ova sale and surrogacy, infringe upon several basic human rights under international law, and are violations of international agreements on health and medical standards. The international community must recognize trafficking/trade in reproductive organs, tissues and cells as a unique kind of human exploitation.

Elements to be included in an international agreement and in national legislation on reproductive justice are as follows:

1. The *commercial* use of women's reproductive capabilities both within and across national borders should be prohibited. The act of egg provision or surrogacy must not be a commercial transaction.<sup>ix</sup>
2. States should take strong measures to prevent black market trade of ova and surrogacy arrangements.
3. Surrogates and ova providers should be perceived as human participants in a complex birth-giving process, rather than as biological commodities. Consequently, practices that bar human contact between surrogates, egg providers, and the child/children born in the process should be strictly prohibited. Surrogacy and egg provision should be permitted

only under circumstances allowing for the viable possibility of a prolonged relationship between and/or among surrogate, gamete donor, child, and developing family.

4. The health of the woman providing the eggs or serving as a surrogate must be the *primary* concern in any ova provision or surrogacy arrangement. Her basic right to health must be protected by comprehensive medical screening prior to the procedure, in which her health risks will be assessed and fully explained to her in a language and method such that she can understand her individual health risks and potential consequences fully.<sup>x</sup> “Donors” and surrogates should receive adequate medical supervision during and following egg retrieval, pregnancy and childbirth.
5. Insurance should cover all health risks associated with these procedures, including their short and long-term sequelae.
6. Recipients of ova and intended parents who contract with surrogates must have a *medical basis of need for the service*.<sup>xi</sup>
7. Advertising ova donation or trade and surrogacy, whether for compensation or voluntary, must be strictly prohibited.<sup>xii</sup>
8. All medical procedures must be conducted within the country of origin of the intended parents by legally authorized fertility experts in licensed hospitals and/or clinics.
9. Recipients of fertility treatment hormones of any kind must be informed that past uses of synthetic hormones have led to significant increases in cancer rates among women to whom they were prescribed, and that the long-term medical risks of hormones currently used in fertility treatment (often unapproved for this purpose) are unknown due to a dearth of long-term studies of the effects of these drugs on recipients.
10. Ova providers and surrogates must provide their *voluntary and informed consent* after having legally testified that all of the known medical, psychological and legal risks and ramifications of the procedure have been disclosed; the nature, duration and purpose of the procedures; and their rights in the short and long-term have been explained in a language and manner they understand.
11. Those involved must have the *legal capacity to give consent*, and it must be given without the involvement of any element of coercion, fraud, deceit, duress, constraint or other form of manipulation.<sup>xiii</sup>
12. Each party to the contract must be treated by different medical professionals in order to prevent a conflict of interest in determining the eligibility of each party to provide or receive. Likewise, each party must have *separate legal representation* in order to avoid a conflict of interest.

13. All jurisdictions permitting egg provision and surrogacy must establish registries to collect short and long-term health information on participants and keep medical records to be made available to any offspring of such arrangements at or before the age of 18.
14. All countries must redouble their efforts to achieve Goal 5 of the UN's Millennium Development Goals of improving maternal and child health, with emphasis on preventing the annual 500,000 deaths related to pregnancy and childbirth. This can be achieved with low cost, low tech, targeted interventions, policies and services that have been widely known for decades.<sup>xiv</sup>
15. All countries must develop policies to prevent infertility. These include expanding child care availability for working women and career advancement opportunities so that they do not have to postpone childbearing past optimal fertility age; reducing untreated sexually transmitted diseases that impair fertility by improving access to adequate medical care; and reducing toxins in the environment, food and cosmetics, all of which contribute to infertility.

These elements provide a framework for the creation of an international treaty on reproductive exploitation and trafficking that protects the human rights and health of women and the children to whom they give birth.

#### **IV. How Can These Goals Be Achieved?**

The international community must recognize human rights abuses in trafficking in reproductive organs, tissues and cells as a unique kind of human exploitation. The responsiveness of the international community to issues of trafficking in women and girls as sex slaves and to organ transplant "tourism" through international treaties has provided mechanisms to address these problems. Specific international principles have been established in the Declaration of Istanbul on Organ Trafficking and Transplant Tourism.<sup>xv</sup> These ethical and legal standards should be expanded to apply to reproductive organs, tissue and cells.

The practices of reproductive organ, tissue and cell trafficking, particularly ova sale and surrogacy, infringe upon several basic human rights under international law, and are violations of international agreements on health and medical standards. Beyond the basic right of every individual to human dignity, enshrined in the major international<sup>xvi</sup> and regional<sup>xvii</sup> human rights law instruments, the trafficking in ova and surrogacy have implications for *women's rights*,<sup>xviii</sup> *the right to an adequate standard of health*,<sup>xix</sup> *the right to be free from discrimination*,<sup>xx</sup> *the right to a family*,<sup>xxi</sup> and *the rights of the child*.<sup>xxii</sup>

Universal legal agreements on the trafficking of ova and surrogacy should protect the basic rights and interests of women listed above, which form part of the set of legally binding obligations on countries that have agreed to be bound by these treaties, and can be said to be of international consensus.<sup>xxiii</sup> Specifically, these agreements must take into consideration the special vulnerability of women around the world and particularly in Least Developed Countries; it must protect the rights of women to be free from discrimination, to have access to adequate medical care and an adequate standard of health, and to choose the number and spacing of their children;

it must pay special attention to the international standards regarding voluntary and informed consent; and it must protect adolescent girls as a particularly vulnerable sub-group of females.

Additional documents that should inform a universal declaration on ova trafficking and surrogacy include the Nuremberg Code (1947)<sup>xxiv</sup> on human experimentation; the World Health Organization's Draft Guiding Principles on Human Organ Transplantation (1991) and its Commentaries;<sup>xxv</sup> the European Convention on Human Rights and Biomedicine (1997)<sup>xxvi</sup> and its Additional Protocol on Transplantation of Organs and Tissues of Human Origin (2002);<sup>xxvii</sup> the Helsinki Declaration (Sixth Revision 2008) on Human Experimentation.<sup>xxviii</sup> While these documents more specifically pertain to human experimentation and organ transplantation (and in some cases even deliberately exclude reproductive tissues including ova), they *can* be applied to reproductive organs and tissues; a case in point is the Draft Guiding Principles on Human Organ Transplantation of 1991.<sup>xxix</sup> Application of these principles is particularly critical in the context of women's reproductive rights and family rights, e.g., the rights to bear children, to choose their number and spacing, and to an adequate standard of medical care.

In 2005, following exposure of ova trafficking in Romania, the European Parliament issued an official Resolution on the Trade in Human Egg Cells and affirmed an absolute opposition to payment for ova, classifying such payments as organ trafficking.<sup>xxx</sup> A specific resolution on the situation was issued the same year, the Resolution on the Planned Trading of Human Egg Cells by Great Britain and Romania, which barred the granting of high fees for ova donation, stating that such high fees constitute the prohibited trade of human parts and *should be regarded as an extreme form of exploitation of women.*<sup>xxxi</sup>

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<sup>i</sup> ICMART. 2009 International Committee for Monitoring Assisted Reproductive Technology World Collaborative Report on Assisted Reproductive Technology, 2002. *Human Reproduction*. Vol. 24, No. 9 pp. 2310-2320.

<sup>ii</sup> Spar, D.L. 2006. *The Baby Business: How Money, Science, and Politics Drive the Commerce of Conception*. Boston: Harvard Business School Press (p.214-217).

<sup>iii</sup> DeSutter, P., Gerris, J., and Dhont, M. 2008. "Assisted Reproductive Technologies: how to minimize the risks and complications in developing countries." *Human Reproduction*.

<sup>iv</sup> Guidice, L. et al., 2007. *Assessing the Medical Risks of Human Oocyte donation for Stem Cell Research: Workshop Report*. Institute of Medicine and National Research Council. Published by The National Academies Press, Washington, D.C.

<sup>v</sup> Dutton, D.B. 1988. "DES and the elusive goal of drug safety." In *Worse than the Disease: Pitfalls of medical progress*. New York: Cambridge University Press. Pp. 31-90, and Cody, P. 2008. *DES Voices: From Anger to Action*. Columbus, OH: DES Action.

<sup>vi</sup> Uroz, V and Guerra L. 2009. "Donation of Eggs in Assisted Reproduction and Informed Consent." *Medicine and Law*. 28: 565-575.

<sup>vii</sup> For a brief historical overview of the unintended side-effects of the overzealous prescribing of synthetic hormones see Diane Beeson & Abby Lippman, 2006. "Egg Harvesting for Stem Cell Research: Medical Risks and Ethical Problems", 13 *Reproductive Biomedicine Online* 573, 575, p. 427.

<sup>viii</sup> Whittemore, AS, et al. "Characteristics relating to ovarian cancer risk: collaborative analysis of 12 US case control studies. II. Invasive epithelial ovarian cancers in white women. Collaborative Ovarian Cancer Group. *American Journal of Epidemiology* 1992; 136:1184-203; Rossing, MA, et al. "Ovarian tumors in a cohort of infertile women. *New England Journal of Medicine*. 1994; 331:771-6. Brinton, L. "Long-term effects of ovulation-stimulating drugs on cancer risk." *Reproductive BioMedicine Online*:www.rbmonline.com/Article/2808 on web 16 May2007. Jensen, et al. 2009 "Use of fertility drugs and risk of ovarian cancer: Danish population based cohort study." *British Medical Journal* 338;b249. Lerner-Geva, et al. 2006. "Infertility, Ovulation Induction Treatments and the Incidence of Breast Cancer—a Historical Prospective Cohort of Israeli Women." *Breast Cancer Research and Treatment* 100, 201-212. Venn A, et al., 1999. "Risk of cancer after use of fertility drugs with in-vitro fertilization. *Lancet* 346. 995-1000. Modan, et al. 1998. "Cancer incidence in a cohort of infertile women. *American Journal of Epidemiology* 147. 1038-1042. Althuis, M.D., et al. 2005 "Uterine cancer after use of clomiphene citrate to induce ovulation." *American Journal of Epidemiology* 161, 607-615; Hannibal, C.G., et al. 2008. "Risk of thyroid cancer after exposure to fertility drugs: results from a large Danish cohort study," *Human Reproduction*, Volume 23, No. 2, pp. 451-456; Althuis, M.D. et al., "Uterine Cancer after Us of Clomiphene Citrate to Induce Ovulation." *American Journal of Epidemiology*, pp. 607-615; Calderon-Margalit, R. et al. 2008. "Cancer Risk After Exposure to Treatments for Ovulation Induction." *American Journal of Epidemiology*, (Advance Access published November 26, 2008.

<sup>ix</sup> Compensation for organ donation is strictly prohibited by the European Additional Protocol to the Convention on Human Rights and Biomedicine, on Transplantation of Organs and Tissues of Human Origin of 2002 (hereafter "Additional Protocol on Transplantation"), Art. 22; Guiding Principle 5 of the WHO Draft Guiding Principles on Human Organ Transplantation of 1991 (hereafter "Guiding Principles"); the European Parliament Resolution on the Trade in Human Egg Cells; as well as in United States federal legislation under the National Organ Transplant Act of 1984.

<sup>x</sup> See overview of women's human, health and reproductive rights and requirement of informed consent, below.

<sup>xi</sup> A similar provision may be found in Guiding Principle 9.

<sup>xii</sup> A similar provision may be found in the Additional Protocol on Transplantation, Article 21(2) and in the WHO Guiding Principle 6. Note that in the Commentary on Guiding Principle 6 a distinction is made between "promotion and encouragement of altruistic donation" and "advertisements that have a commercial (profit-making) purpose."

<sup>xiii</sup> Informed consent is a basic notion in most countries' national legislation and in the few international documents that have been drafted on the subject, particularly surrounding human experimentation but not limited to that context. Informed consent in this context is paramount, given the medical, psychological, social and legal ramifications of the procedures, as well as the tendency of poor and otherwise vulnerable women to serve as donors and surrogates. Basic international health rights also suggest that no one should be subject to any medical procedure whose consequences and risks are not known to her. Informed and voluntary consent are particularly questionable

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when the donor or surrogate is mentally disabled, an adolescent, or otherwise legally incapable of giving consent. *See, e.g.*, the ICCPR, Art. 7; the European Convention on Human Rights and Biomedicine, Arts. 5 and 6, especially, as well as 7, 8 and 9; the Additional Protocol on Transplantation Arts. 12, 13, and 14; the Helsinki Declaration (Sixth Revision 2008) Arts. 24 and 25; the Nuremberg Code Art. 1.

<sup>xiv</sup> Pillay, Navanethem. "Address at International Roundtable on Maternal Mortality, Human Rights & Accountability." Thursday, 2<sup>nd</sup> September. Geneva Business Center.

<http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=1030/&LangID=e>

<sup>xv</sup> The Declaration of Istanbul on Organ Trafficking and Transplant Tourism. *Clinical Journal of the American Society of Nephrology*, August 13, 2008 Online; September 2008 in Print. (pp.1227-1231).

<http://www.ncbi.nlm.nih.gov/pubmed/18810784>.

<sup>xvi</sup> *See, e.g.*, the Universal Declaration of Human Rights (UDHR, 1948); the International Covenant on Civil and Political Rights (ICCPR, 1966); the International Covenant on Economic, Social and Cultural Rights (ICESCR, 1966).

<sup>xvii</sup> *See, e.g.*, the Inter-American Convention on Human Rights (1969); the African (Banjul) Charter on Human and Peoples' Rights (1981). Regional agreements are only binding on those states within the region that have elected to become states' parties to the instrument; however, the repetition of certain rights from region to region (such as human dignity, women's rights, health rights, anti-discrimination rights, etc.) demonstrates an international consensus on these basic rights and the obligations of states.

<sup>xviii</sup> The Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) of 1979 serves as a "bill of rights" for women and has 186 states parties. It was adopted with the express intention to elevate the status of women of the world and to protect them from gender-based discrimination, including in the area of reproductive rights. The preamble, for instance, states that "the role of women in procreation should not be a basis for discrimination." Article 6 calls on states to "suppress all forms of traffic in women;" Article 11 protects women's rights in employment, particularly in 11(f) "The right to protection of health and safety in working conditions, including the safeguarding of the function of reproduction; Article 12 calls on states "to eliminate discrimination against women in the field of health care; and Article 16(e) ensures the equal right of women "to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights." Additionally, the ICCPR and ICESCR (*see supra note 1*) stipulate that all rights under the convention be guaranteed equally to men and women. Article 7(a)(i) of the ICESCR guarantees a fair and equal wage for men and women for comparable work. *See also* the United Nations International Conference on Population and Development (ICPD), 1994, Cairo, Egypt, and the conferences that followed every five years in Beijing and New York, which dealt with women's reproductive rights and created the term "reproductive justice," emphasizing the particular vulnerability of women of color to "reproductive oppression."

<sup>xix</sup> *See* Article 25(1) of the UDHR (*supra note 1*); Article 12(1) of the ICESCR (*supra note 1*); Article 5(e)(iv) of the International Convention on the Elimination of all forms of Racial Discrimination (CERD, 1965); Articles 11.1(f) and 12 of CEDAW (*supra note 3*); and Article 24 of the Convention on the Rights of the Child (CRC, 1989). *See especially* UN Committee on Economic, Social and Cultural Rights, General Comment 14. Several regional human rights instruments also recognize the right to health, such as the European Social Charter of 1961 as revised (Article 11), the African Charter on Human and Peoples' Rights of 1981 (Art. 16) and Additional Protocol to the American Convention on Human Rights in the area of Economic, Social and Cultural Rights of 1988 (Art. 10). The right to health has been reaffirmed by the Commission on Human Rights, the Vienna Declaration and Programme of Action of 1993 and other international instruments.

<sup>xx</sup> *See* CEDAW (*supra note 3*); CERD (*supra note 4*); ICCPR Arts. 4(1), 26; ICESCR Art. 2(2). Regional instruments also prohibit discrimination based on sex and race, among other traits, such as the European Convention on Human Rights of 1950 (Art. 14); the African Charter on Human and Peoples' Rights (Art. 18(3)); and the Inter-American Convention on Human Rights (Arts. 1, 17, 24, 27).

<sup>xxi</sup> *See* UDHR Art. 16; ICESCR Art. 10; ICCPR Art. 23; CEDAW (Arts. 9, 16); and CRC (Arts. 9, 10, 20, 21, 22). The African Charter, Art. 18 also contains a right to respect for the family unit.

<sup>xxii</sup> The Convention on the Rights of the Child (1989) protects children, including in the area of health, and is relevant to the extent that the ova of girls under 18 are trafficked, or that they serve as surrogates.

<sup>xxiii</sup> For instance, over 150 states are parties to the ICESCR and the ICCPR, suggesting consensus among an overwhelming majority of the world's nations.

<sup>xxiv</sup> The Nuremberg Code (1947) In: Mitscherlich A, Mielke F. *Doctors of Infamy: the Story of the Nazi Medical Crimes*. New York: Schuman, 1949: xxiii-xxv. <http://www.cirp.org/library/ethics/nuremberg>

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<sup>xxv</sup> The World Health Organization (WHO) is an organ of the United Nations and is the leading authority on health within the United Nations system.

<sup>xxvi</sup> <http://www.conventions.coe.int/Treaty/Commun/QueVoulezVous.asp?NT=164&CL=ENG>

<sup>xxvii</sup> <http://www.conventions.coe.int/Treaty/Commun/QueVoulezVous.asp?NT=186&CL=ENG>

<sup>xxviii</sup> The Helsinki Declaration was developed by the World Medical Association. It is not a binding legal instrument, but its principles were drawn from worldwide regional and national legislation.

<sup>xxix</sup> Such is the case in the Draft Guiding Principles on Human Organ Transplantation of 1991.

<sup>xxx</sup> Clearly the vast majority of ova donation and surrogacy are not conducted for the purpose of experimentation; however, the sensitivity and personal risks involved in organ donation and experimentation are significantly similar, and thus the level of information and type of consent required should apply to the context of organ donation, including ova donation and surrogacy.

<sup>xxxi</sup> European Parliament Resolution on the Planned Trading of Human Egg Cells by Great Britain and Romania, B6-0205/2005.