

Racialized ethics of surrogacy: Transnational reproductive tourism and local surrogacy practices in Uganda

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Yuri Hibino*

Faculty of Transdisciplinary Sciences for Innovation, Kanazawa University, Kakuma-machi, Kanazawa City, Ishikawa Prefecture, 920-1192, Japan

*For Correspondence: Email: hibino@staff.kanazawa-u.ac.jp; Phone: +81 76 234 4908

Abstract

This study examines surrogacy practices in Uganda by analyzing how various actors operationalize “ethical surrogacy” in inbound and local contexts. Drawing on ethnographic fieldwork in Kampala, the study compares surrogacy programs organized by a foreign agency for Western intended parents with locally arranged surrogacy involving Ugandan agents and medical practitioners. The foreign agency promotes ethics through narratives of fair compensation and emotional connection. In contrast, local professionals articulate an ethical framework centered on strict separation to prevent emotional attachment and social conflict. These contrasting practices demonstrate that ethical surrogacy functions not as a universal moral standard, but as a situated discourse shaped by legal uncertainty, medical authority, race, and post-colonial power relations. By highlighting the management of affective labor, the study identifies multiple coexisting ethical frameworks. The findings challenge universalist bioethics and emphasize ethical pluralism as a constitutive feature of contemporary offshore reproductive practices in the Global South (*Afr J Reprod Health* 2026; 30 [19]: 41-49).

Keywords: assisted reproductive technology, global bioethics; ethical pluralism; post-colonialism; stratified reproduction

Résumé

Cette étude examine les pratiques de gestation pour autrui (GPA) en Ouganda en analysant la manière dont divers acteurs opérationnalisent la « GPA éthique » dans des contextes tant internationaux que locaux. S'appuyant sur une recherche ethnographique menée à Kampala, cette étude compare les programmes de GPA organisés par une agence étrangère pour des parents d'intention occidentaux à ceux arrangés localement par des intermédiaires et des professionnels de santé ougandais. L'agence étrangère promeut une approche éthique fondée sur des récits de compensation équitable et de connexion émotionnelle. À l'inverse, les professionnels locaux formulent un cadre éthique centré sur une séparation stricte, visant à prévenir l'attachement affectif et les conflits sociaux. Ces pratiques contrastées démontrent que la GPA éthique ne fonctionne pas comme une norme morale universelle, mais comme un discours situé, façonné par l'incertitude juridique, l'autorité médicale, la race et les rapports de force postcoloniaux. En mettant en lumière la gestion du travail affectif, cette étude identifie la coexistence de multiples cadres éthiques. Ces résultats remettent en question l'universalisme en bioéthique et soulignent que le pluralisme éthique constitue une caractéristique intrinsèque des pratiques de reproduction délocalisées contemporaines dans le Sud global. (*Afr J Reprod Health* 2026; 30 [19]:41-49).

Mots-clés: procréation médicalement assistée (PMA), bioéthique globale, pluralisme éthique, postcolonialisme, reproduction stratifiée

Introduction

African countries have long been regarded as regions where the introduction of in vitro fertilization (IVF) progressed relatively slowly; in recent years, however, IVF services have expanded significantly in several countries, including Nigeria, South Africa, Ghana, and Uganda.^{1,2} Nigeria was the first country to introduce IVF in sub-Saharan Africa in 1984. While assisted

reproductive technologies (ARTs) are rapidly growing in lower-middle-income countries such as Nigeria, Kenya, Ghana, and South Africa, emerging studies have also demonstrated their increasing presence even in low-income countries such as Uganda, Mali, Burkina Faso, Sudan, and Rwanda.³⁻⁶

In these countries, legal and regulatory frameworks governing ARTs remain underdeveloped. Fertility rates are generally high

across much of Africa, and government interest in infertility often remains limited. In societies where high fertility is the cultural norm, infertility carries a particularly strong stigma, rendering infertility treatment highly appealing despite its high cost. Soon after IVF became available, third-party reproductive technologies were also practiced at the discretion of physicians, and locally arranged surrogacy emerged as well.

Following the prohibition of commercial surrogacy in India and Thailand in the mid-2010s,⁷ surrogacy agencies began expanding their operations into Africa.⁸ Inbound surrogacy has already been introduced in several regions, including Uganda—the field site of this study. Over the past decade, international surrogacy arrangements have undergone significant geopolitical shifts due to regulatory changes, and agencies have developed global networks by recruiting gamete donors and surrogates and collaborating with IVF clinics. Their prior experiences have highlighted the importance of minimizing conflict with local communities when entering new regions.

Consequently, the introduction of offshore surrogacy into African countries has progressed in a relatively gradual manner, without major scandals such as those observed in India or Thailand. African countries have thus been quietly incorporated into a globally stratified system of reproductive labor.

Within this structure, the vast majority of intended parents are white individuals from high-income countries, whereas surrogates are predominantly local women of color. Practices of offshore surrogacy in African countries therefore unfold within contexts where post-colonial power dynamics become particularly salient. In addition to the established concept of “stratified reproduction,” scholars have described this dual exploitation—shaped by both post-colonial geopolitics and global inequalities—using terms such as the “transnational reproductive caste system”⁹ and “chains of extraction.”¹⁰

For example, Gondouin and colleagues (2024) analyze the relocation of the Indian commercial surrogacy industry to East Africa (Kenya) following regulatory tightening in India as a “reconfiguration of chains of extraction.” These chains, they argue, are complex formations in which the bodies of people in vulnerable positions—selected along lines of race, class,

geopolitics, and institutional arrangements—are targeted for the extraction of reproductive value, thereby revealing structures of exploitation in which colonial and capitalist logics converge.

This study focuses on Uganda, where offshore surrogacy has recently been introduced by a U.S.-based agent. By examining two coexisting modes of surrogacy practiced in Uganda—inbound surrogacy and local surrogacy—and by analyzing the divergent operationalizations of “ethical surrogacy,” this study explores how these practices are imbued with meaning amidst the geopolitical transformations of offshore reproduction. It investigates how global hierarchies of race, culture, and capital are reflected in the Ugandan context, specifically through the contrasting strategies of emotional intimacy and clinical detachment employed by foreign and local actors, respectively.

Methods

Fieldwork was conducted in Kampala, Uganda, during two ten-day field visits in August 2024 and March 2025. During these visits, the author carried out participant observation and conducted both formal and informal interviews with a total of 23 stakeholders. This diverse group of participants included six physicians specializing in obstetrics, gynecology, and infertility; six surrogate mothers (including prospective and former surrogates); two surrogacy agents (including a U.S.-based agency representative and local medical staff); one surrogacy coordinator; three intended parents; one policymaker; three legal experts; and one representative from bioethics and policy-oriented NGOs. Some individuals were interviewed twice across the two field visits to capture longitudinal perspectives.

All interviews were conducted in English. Interviews took place either at participants’ workplaces—such as offices, clinics, and private residences—or in cafés and restaurants. Participants tended to speak more openly in more relaxed settings where interviews were accompanied by meals or drinks.

Ethical considerations

Regarding ethical review, this study was approved by the Ethics Review Board of Kanazawa University (R6-013). In line with the ethical principles of the researcher’s home institution in

Japan, and with careful consideration of local circumstances, efforts were made to ensure the ethical integrity of the study. To prevent participants from being held accountable by local communities for their statements, all participants are referred to by pseudonyms unless otherwise specified.

This study involved qualitative interviews, and informed consent was obtained from all participants. Ethical considerations, including confidentiality and anonymity, were carefully observed throughout the research process.

Results

Brief history of IVF in Uganda

Dr. Patrick Mukasa, the first physician to successfully perform in vitro fertilization (IVF) in Uganda, trained in the United Kingdom and Kuwait before returning to Uganda to establish his own clinic in 2004. He achieved the country's first successful IVF birth in 2005, marking a significant milestone in the development of assisted reproductive technologies in Uganda. His clinic later developed into the women's hospital, which now provides not only IVF services but also comprehensive maternity and obstetric care, and has become one of the country's most prominent reproductive health centers.

Dr. Mukasa is widely recognized as a pioneer in the field of assisted reproduction in Uganda and has been invited to provide technical support in other African countries, including Kenya and Rwanda. He has also established fertility clinics in Tanzania and Zambia, contributing to the regional expansion of assisted reproductive technologies.

While Dr. Mukasa remains a central figure in the history of IVF in Uganda, the field has become increasingly diversified over time. New private clinics have been established by physicians trained through different professional lineages, and third-party reproductive technologies are now practiced in multiple facilities. As discussed later in this paper, legislation concerning assisted reproductive technologies and surrogacy is currently under development in Uganda but has not yet been enacted, and the timeline for implementation remains uncertain. Although surrogacy is not explicitly prohibited, it lacks a formal legal framework. Consequently, clinical and

operational practices are largely regulated autonomously by individual clinics and agents.

Law in Uganda

Two legislative initiatives addressing surrogacy and assisted reproductive technologies (ART) currently exist in Uganda: a private member's bill drafted by Sarah Achieng Opendi, a female Member of Parliament, and a government bill prepared by the Ministry of Health. In February 2023, Parliament approved the Surrogacy and Assisted Reproductive Technology Bill. The private member's bill has undergone multiple parliamentary readings and, at the time of writing, is awaiting presidential assent to come into force.

The bill includes several key provisions concerning surrogacy. Surrogacy may be commissioned only for medical reasons. Surrogate mothers must be at least 18 years of age; however, some experts argue that 18 is too young and recommend a minimum age of 25, as well as prior childbirth experience. While Ugandan customary law recognizes the woman who gives birth as the legal mother, the proposed legislation designates the intended parents as the legal parents. Intended parents are also required to appoint a legal guardian for the child to be born. In addition, advertising surrogacy services is prohibited, reflecting an effort to limit the expansion of commercial surrogacy.

Interviews with government officials suggest that a national hospital in Kampala is preparing to offer surrogacy services, which has generated interest among some government actors in expediting the enactment of the legislation. At the same time, surrogacy is not regarded as a high-priority policy issue. Interviewees also expressed concerns that the president—and potentially the president's spouse—may withhold assent on religious grounds. Consequently, despite ongoing parliamentary deliberations, the timing of the bill's final enactment remains uncertain.

Surrogacy practice by foreign agency

Surrogacy Agent (Agent A) is a surrogacy agency based in Uganda that provides services primarily to foreign intended parents. The agency is represented by a white American woman who has herself served as a surrogate mother on two occasions.

A distinctive feature of Agent A is its strong emphasis on conducting surrogacy in

Uganda in an “ethical” manner. The agency publicly discloses its program fees—for example, a “Base Fee of USD 15,000”—and highlights the use of an escrow account to ensure secure and transparent payments from intended parents to surrogate mothers.

Another notable characteristic of the agency is its commitment to supporting surrogate mothers not only through financial compensation but also by offering post-birth occupational training aimed at achieving long-term economic independence after participation in a surrogacy program. This support includes entrepreneurship assistance. However, this model is not entirely novel. Similar approaches were previously promoted by well-known clinics in Anand, Gujarat, India, which provided commercial surrogacy services for foreign clients. These models generated extensive debate regarding the ethics of transnational surrogacy in the Global South, and Agent A’s approach appears to draw upon these earlier precedents.

Although Uganda is still in the process of debating and drafting the Surrogacy and Assisted Reproductive Technology Bill, the agency prominently advertises the involvement of its representative in these legislative discussions. This emphasis serves to signal strong local connections and regulatory awareness, which may be reassuring to foreign clients who are unfamiliar with the Ugandan legal and social context. Uganda criminalizes homosexuality under the Anti-Homosexuality Act 2023. Reflecting this legal environment, the agency explicitly cautions that it does not recommend its surrogacy services to LGBTQ clients. Given that the agency’s clients are primarily white, English-speaking foreigners, while the surrogate mothers are local Ugandan women, this arrangement readily raises concerns regarding exploitation and post-colonial power asymmetries. For intended parents, mitigating such anxieties is highly desirable. The agency’s promotion of “ethical surrogacy” can thus be understood as a discursive strategy that directly addresses these concerns by framing the practice as socially responsible and morally justified.

What is “ethical” surrogacy? Testimonies of intended mothers and surrogates

This section examines the practices of Agent A by drawing on testimonies from intended mothers and

their Ugandan surrogates. During the author’s second stay in Kampala, two female intended parents working with Agent A were residing in the city. They were staying in serviced apartments with their newborn infants while preparing documentation and travel arrangements for their return to their home countries.

Ms. Emma, a woman in her late forties from the United Kingdom, was a single intended mother. Although she had previously been married, she had been unable to conceive. Unable to relinquish her desire to have a child, Emma decided to pursue surrogacy. She created an embryo in London using donor oocytes and donor sperm and transported it to Uganda, where it was transferred to a Ugandan surrogate. The pregnancy was successful on the first transfer; however, the embryo used was the final remaining one. Emma mentioned that she had discussed the possibility of receiving an embryo from an Australian intended mother, Ms. Rebecca (introduced below), whom she had befriended locally. Despite the long-awaited realization of motherhood, Emma appeared anxious. She confided that she did not yet “feel like a mother,” even though her baby was already three weeks old. Her own mother had accompanied her to Uganda to assist with infant care but was scheduled to return within three days, a circumstance that may have intensified Emma’s sense of unease.

Emma reported that she had met with her surrogate, Ms. Deborah, multiple times throughout the pregnancy and had been present at the delivery. The birth was a vaginal delivery, and Emma held the newborn immediately in the delivery room. She expressed gratitude for the surrogate’s endurance through the pain of childbirth.

During the pregnancy, the surrogate suggested the use of a vibration bracelet. When Deborah felt fetal movement, she touched the bracelet, allowing Emma to experience the vibration simultaneously. Emma also requested that the surrogate express breast milk for the baby. Emma stated that she felt no discomfort about this practice, believing it to be natural given that the surrogate’s blood had already “infused” the fetus during pregnancy. However, Emma reported that some friends had criticized the practice, which she interpreted as reflecting persistent stigma or misunderstanding surrounding surrogacy. The author interviewed Deborah, Emma’s surrogate, at her home. Deborah was an unmarried single mother

raising her four-year-old son. She described frequent communication with Emma throughout the pregnancy and stated that this contact provided emotional support, particularly given the absence of a husband or partner. The vibration bracelet had been her own idea, and she said she enjoyed sharing the experience with Emma.

Deborah explained that she had developed emotional attachment toward the intended mother rather than toward the baby. Because she understood the pregnancy primarily as an act of helping Emma, she felt little maternal bonding with the child. Deborah suggested that this orientation helped mitigate concerns often raised regarding the emotional difficulty of detachment after birth.

If Emma were to request future contact, Deborah stated that she could decline but would likely accept, as she did not wish to hurt Emma's feelings. Deborah described their relationship as resembling a friendship—someone with whom she could share personal matters and with whom she felt a sense of affinity. Nonetheless, Deborah emphasized that surrogacy was a temporary arrangement and that both women would now continue along separate life paths.

Ms. Rebecca, a single intended mother from Australia in her early fifties, had previously given birth to three children conceived with donor oocytes during her marriage. Through her surrogacy arrangement in Uganda, she had now become the mother of twins. When interviewed, she was breastfeeding the twins; she explained that she had undergone hormonal treatment to induce lactation in order to feed them herself.

Rebecca stated that she had maintained consistent communication with her surrogate, Ms. Dorcas, throughout the pregnancy, although she believed that Emma (the intended mother in Case 1) had developed an even closer relationship with her own surrogate. Rebecca also noted that Dorcas had children of her own and appeared occupied with her own life. She recounted that some local individuals had advised her that surrogates should undergo cesarean deliveries to prevent emotional attachment to the babies. Rebecca rejected this view, arguing that decisions regarding mode of delivery should be left to the surrogate herself.

Dorcas used the compensation from the surrogacy arrangement to purchase farmland on the outskirts of Kampala, where she had recently begun raising chickens and selling eggs and meat. The

author met Dorcas at this farm during a second interview; the first interview had taken place during her pregnancy.

Dorcas explained that she had communicated frequently with Rebecca during the pregnancy and had met her on multiple occasions. Dorcas expressed relief upon learning that the twins' passports would be issued the following day, allowing Rebecca to return home. Rebecca had told Dorcas that she hoped to visit Uganda again with the children. Dorcas described Rebecca as being "like family," but emphasized that her primary focus was her own life and her own children. As a result, she did not experience difficulty with emotional attachment to the twins she had carried.

While Dorcas appreciated Agent A's program, particularly its facilitation of direct interaction with intended parents, she emphasized that she would not feel lonely even if future contact were limited. She also noted that certain dietary preferences during pregnancy and the intended mother's presence at the birth had been specified in the contract. Because these conditions were clearly articulated in advance, she felt comfortable with them.

Local surrogacy experts and their practices

Local Surrogacy Agent (Agent B) was established in 2022 by a Ugandan entrepreneur. The founder is an influential, high-profile figure in Ugandan society, maintaining strong connections with political circles and prominent individuals. The founder's elevated social status is inferred to provide a degree of reassurance and perceived credibility to both intended parents and surrogates, even within a context where the legal status of surrogacy remains unclear.

The agency operates from a room within the founder's private residence—an expansive estate staffed by multiple domestic workers—highlighting the founder's elite socioeconomic status. According to the founder, Uganda has a large number of women who are willing to engage in gestational labor due to economic vulnerability. While acknowledging that financial motivations are central for many applicants, the founder emphasized that the agency does not recruit women who appear to pursue surrogacy solely for monetary reasons. Prospective surrogates undergo an interview process during which the agency

evaluates their motivations and perceived suitability.

Agent B has received inquiries from intended parents not only within Uganda but also from across the African continent. The founder noted that clients from West Africa are particularly drawn to the comparatively lower costs of surrogacy services in Uganda, reflecting broader economic disparities between East and West Africa. Although some white (non-African) intended parents have also expressed interest, these inquiries had not yet resulted in formal arrangements at the time of the interview.

The agency has begun establishing collaborative relationships with several clinics in Kampala. At the time of fieldwork, preparations were underway for the first embryo transfer to a surrogate. However, the agency had not yet facilitated any births and therefore had no completed surrogacy cases.

Testimonies of local surrogates

Through Agent B, the author met and interviewed four women who were either former or prospective surrogates. Ms. Dianna, a former surrogate, had delivered twins via cesarean section. She had seen photographs of the intended parents but had never met them in person. She stated that she did not wish to meet them and that, if required to be present with them at the birth, she would likely feel intense resentment. During the pregnancy, Dianna felt neglected and treated merely as a vessel for the child rather than as a full human being. Because of these negative feelings toward the intended parents, she reported that she was unable to develop affection for the fetuses during pregnancy. Dianna also expressed distrust toward the intended parents, stating that if they were unable to adequately care for the surrogate, she doubted their capacity to raise the children properly. Ms. Grace, also a former surrogate who had delivered twins via cesarean section, had never met the intended parents and did not wish to do so. She explained that meeting the intended parents might make it more difficult for her to maintain emotional detachment from the children, which she regarded as essential.

Ms. Mary was preparing for embryo transfer through Agent B, with an intended parent already involved in the arrangement. Although she had not yet met the intended parent, she expressed little concern about this. However, she stated that

she was interested in knowing whether the intended parent was happy. When asked how she would feel if the intended parent were white, her expression immediately brightened. She stated that having a white intended parent would be a source of joy and that giving birth to a child for a white person would be a great blessing—an experience she very much hoped to have.

Ms. Sarah had not yet been matched with an intended parent but expressed a desire to become a surrogate. She demonstrated a limited understanding of the surrogacy process. Although she had attempted to explain IVF to her mother, her mother appeared to have difficulty fully comprehending the concept. Sarah expressed interest in the financial compensation associated with surrogacy but had not yet formed a concrete understanding of the lived realities of the process.

Attitudes of medical doctors toward “Ethical” surrogacy practices

Dr. Charles Kibuuka has worked as a specialist in the infertility department of a general hospital since 2018 and has managed multiple cases involving local surrogacy. According to him, intended parents and surrogates should never meet at any stage of the process. He argued that mutual acquaintance is unnecessary and that direct contact may generate various complications. Although some intended parents occasionally bring surrogates to the clinic, he does not recommend this practice due to the potential for future disputes.

He regards cesarean delivery as the optimal mode of birth in surrogacy cases, as it prevents the surrogate from seeing the newborn immediately after delivery. Furthermore, breastfeeding by the surrogate is strictly prohibited, as it is believed to foster emotional attachment between the surrogate and the child. From his perspective, minimizing emotional bonds is central to what he considers “ethical” surrogacy practice.

Dr. Edward Mutumba practices at a birth facility that manages a high volume of surrogate deliveries. In cases involving local intended parents, surrogates are routinely delivered via cesarean section. The stated rationale for this practice is the prevention of emotional attachment: when general anesthesia is used, the surrogate does not hear the newborn’s cries. Despite these measures, he reported that some cases still encountered difficulties related to detachment. As

these cases were not under his direct care, further details were not available.

Dr. Edward has also managed two to three natural deliveries for surrogates working with Agent A. However, only one of these cases was followed up, and no significant problems were observed. When asked whether performing cesarean sections without medical indication is acceptable, or about the medical advantages of vaginal delivery, he responded that natural birth is generally believed to offer benefits for the newborn, including enhanced immune function and improved pulmonary adaptation.

Discussion

The findings of this study demonstrate that “ethical” surrogacy practices in Uganda are not governed by a single, unified moral framework. Instead, they are clearly bifurcated into two distinct regimes depending on whether the organizing body is a foreign-led agency or a locally managed clinical practice. This divergence suggests that “ethics” in the context of transnational reproduction is not a universal standard but a situated discourse shaped by specific socio-economic and geopolitical conditions.¹¹

Legal uncertainty as a structuring condition for normative pluralism

A primary factor shaping the surrogacy landscape in Uganda is the persistent state of legal uncertainty. While the Surrogacy and Assisted Reproductive Technology Bill was approved by Parliament in February 2023, it continues to await presidential assent, leaving a significant regulatory void in formal law. However, this study finds that such uncertainty does not lead to a mere vacuum of rules. Instead, it functions as a structuring condition that allows divergent surrogacy regimes to coexist. In the absence of state-enforced regulations, various actors—including agencies, medical specialists, and intended parents—have stepped in to develop and operationalize their own autonomous standards of “ethics.” This process effectively privatizes the moral governance of reproductive labor, where individual clinics and agents become the primary arbiters of what constitutes “responsible” practice.¹²

The relational model: Mitigating anxiety through affective engagement

In foreign-oriented arrangements, such as those facilitated by Agent A, ethicality is articulated through a “relational model” that emphasizes transparency, intimacy, and mutual recognition. This approach is exemplified by practices such as frequent communication between intended parents and surrogates, presence at birth, and the cultivation of post-birth contact. For foreign clients—predominantly white individuals from high-income countries—these practices serve as a crucial discursive strategy to alleviate deep-seated anxieties regarding post-colonial exploitation and the “commodification” of bodies.^{6,13,14}

Notably, the study observed that surrogates in this model often internalize and actively contribute to this relational framework. For instance, the case of a surrogate suggesting a vibration bracelet to allow the intended mother to share the sensory experience of fetal movement demonstrates how affective labor is used to bridge the physical gap between the parties. By reframing the pregnancy as a collaborative act of assistance toward a specific, befriended individual rather than mere maternal labor toward a child, this model facilitates a form of “ethical” detachment that sustains the surrogate's sense of moral purpose while ensuring the smooth transfer of the infant.¹⁵

The separation model: Medical authority and the technologization of ethics

In stark contrast, locally oriented surrogacy practices in Uganda conceptualize ethical conduct through the deliberate minimization of relational ties. This “separation model” is characterized by strict non-contact policies, where the intended parents and surrogates may never meet face-to-face. Medical professionals involved in these cases frequently justify such measures as essential to prevent future social or legal conflict and to protect the privacy of all involved.^{9,16}

Within this framework, obstetric interventions function not only as medical procedures but as “technologies of ethical regulation.” The routine use of elective cesarean sections under general anesthesia is specifically intended to prevent the surrogate from seeing or

hearing the newborn at the moment of birth, thereby preemptively “cutting” the potential for emotional attachment.¹⁷ Furthermore, the strict prohibition of breastfeeding serves to enforce this total affective containment. Here, ethical surrogacy is defined not by care or intimacy, but by procedural control and the successful suppression of affect, highlighting the expanding authority of medical professionals in defining moral norms through the management of the female body.

However, the medical professionals' contention that vaginal delivery fosters a stronger maternal-infant bond (attachment) compared to a cesarean section is deeply problematic, as it lacks objective, empirical evidence. In reality, unless clinically indicated by the surrogate's risk profile, a cesarean section exposes the laboring to significantly greater physical risks—such as complications and infections—than a vaginal delivery. In other words, the medical ethics concerning the surrogate's physical safety are instrumentalized here for the sake of a distinct form of “ethics” rooted in market regulation.

Racialized moral economies and global inequalities

The study further highlights how these ethical models are embedded within a “racialized moral economy.”¹⁸ The preference expressed by some local surrogates to carry children for white intended parents, described as a “blessing,” indicates how global hierarchies of race and value are internalized within the Ugandan context. In this economy, “whiteness” becomes associated with prestige and moral worth, reinforcing asymmetrical power relations even when the practice is framed as mutually beneficial. Consequently, the “ethical” discourses promoted by agencies are not neutral; they are situated responses to the inequalities inherent in transnational reproductive markets, where moral legitimacy is unevenly distributed.¹⁹

Strengths and limitations

This study is subject to several limitations. Given the constrained timeframe of the fieldwork, it is undeniable that the author may not have penetrated the deepest layers of the local community. However, the author has accumulated extensive experience conducting similar field research across global reproductive markets, cultivating a refined

methodological capacity to engage deeply with local realities even during short-term stays. Furthermore, the strategic intervention of a highly competent, locally based collaborator significantly mitigated the disadvantages associated with the brief duration of the study.

In addition, interviews were conducted within informal settings designed to optimize psychological safety. This approach successfully elicited the candid, unvarnished narratives of the participants, which often remain obscured by official institutional discourses.

Crucially, the author's racial and geopolitical positionality—being neither Black nor White—secured a relatively autonomous space when navigating both the Ugandan surrogates and the Western intended parents. This unique outsider-within position allowed the author to bypass the heightened suspicion often directed at polarized racial groups, enabling a detached and objective documentation of the intersecting power dynamics underlying both factions.

Conclusion

The coexistence of these two models reveals that “ethical surrogacy” in Uganda is a dynamic set of practices through which intimacy, distance, and responsibility are selectively produced and governed. Recognition of this “ethical pluralism” challenges universalist bioethical frameworks that evaluate surrogacy solely in terms of binary concepts like exploitation versus autonomy. Instead, ethical surrogacy must be understood as a situated practice, continuously negotiated among actors operating within the complex intersections of law, race, medical authority, and global economic disparity.

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Competing interests

No competing interest is declared.

Data availability

The qualitative data generated and analyzed during the current study are not publicly available due to

the sensitive nature of the topic and to protect the privacy of the participants, but are available from the corresponding author on reasonable request.

Authors' contributions

YH conceptualized the study, conducted the fieldwork and data analysis, and wrote the complete manuscript.

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