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Re/Thinking Bioethics: Reproduction and Non-Reproduction in an Intersectional Bioethics Perspective

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The article begins by reconstructing the main feminist bioethics perspective as a "new discourse" within the official bioethical discussion. It illustrates how the moral discussion and juridification have contributed to remove reproduction and non-reproduction from the personal and intimate context, reinventing them as a "states business". This process framed these issues in terms of "duties", "rights", "family planning", "demography", and "population policy". In this manner, law and morality have helped to reinforce a specific construct of fertility, motherhood, and family. By comparing two interrelated forms of Cross Border Reproductive Care (CBRC), concerning abortion and surrogacy, the article analyses how bioethical and legal frameworks – through their polarized and dichotomic discussion between law and morality – confirm and strengthen gender injustice in reproductive life. That comparison of cross-border travels highlights that surrogacy and abortion restrictions stem from a shared social and legal paradigm that relies on traditional gender roles and reveals how the stratification of reproduction is based on multiple discrimination along the lines of gender, race, and class. Finally, the article introduces an intersectional bioethics point of view on reproductive health to re-read the phenomena of non-reproductive and reproductive tourism and to propose a critique of the main global Northern feminist bioethical discourses and ethical-philosophical paradigms.

The article aims to develop an intersectional bioethics perspective on reproductive and non-reproductive care. It begins by illustrating the polarization that characterizes official bioethics, divided between bioethics of the *sanctity of life* of Judeo-Christian derivation and a secular bioethics of the *quality of life*. Therefore, the focus of our perspective pertains to the historical-philosophical and legal context of the Global North (USA and Europe). These two theoretical approaches were developed within the Western context, where the feminist bioethics critique was also developed. From the start of the article then, we aim to show how the feminist bioethics perspective has helped to unmask historical and current discriminations on reproductive health hidden behind reproductive

compromises: both legal and bioethical. Then with a comparison between two different but interconnected forms of Cross Border Reproductive Care (CBRC), that concern surrogacy and abortion, the focus of the argument moves to analyze and demonstrate how restrictive legislation, dichotomic discussion and medical control confirm and strengthen gender injustice in reproductive life. Globalization also reveals the insufficiency of critical theories that remain locked in a Western lens. In fact, surrogacy and abortion restrictions stem from a shared social and legal paradigm which depends on traditional gender roles while cross border travels reveal how the stratification of reproduction is based on multiple discrimination along the lines of gender, race, and class. The article concludes by re/reading the concept of a universal reproductive justice, introducing an intersectional bioethics point of view on reproductive health access.

1. From Bioethics to Feminist Bioethics

The interest in and attention towards the ethical and legal implications of medical practice, broadly speaking, is not characteristic of modernity. Although numerous disciplines from different perspectives have attempted to engage with this field, it was with the revolutionary changes of the 20th century that the interest in medicine and technological intervention in human life saw considerable growth.[1]

The origin of bioethics is usually traced to several historical changes. Some of the first bioethical reflections date from the 1940s, a response to the failure of traditional medical ethics. These had not been sufficient to prevent the abuses of human experimentation and the participation of physicians in extermination practices under totalitarian regimes.[2] An incisive role was also played by the social processes of democratization that, in the 1950s and 1960s, were a reason for the crises of medical paternalism. However, it was in the 1970s, following major innovations in medicine – especially in the area of genetics, embryology and gynecology – that ethical consideration of actions in the medical realm gained ground.[3] Bioethics, as it was defined in 1971 by Van Rensselaer Potter[4], stands forth as an interdisciplinary field of study involving multiple competencies and whose goal is to address and solve emerging issues of choice and decision-making in healthcare and in the broader fields capable of impacting life in all its shapes.[5] Interdisciplinarity is a distinctive feature of

[1] Borsellino, P. (1999) *Bioetica Tra Autonomia e Diritto*. Milano: Zadig.
[2] In Nazi Germany, the role of the medical landscape turns out to be central. Medical input to the regime's policies in fact took the form of the experiments carried out within the concentration camps but also in the policies of forced sterilization and abortion under the law enacted in 1933.
[3] Borsellino, *Bioetica*, 16.
[4] Potter, V.R. (1971) *Bioethics: Bridge to the Future.* N.J. Prentice Hall: Englewood Cliffs.
[5] Borsellino, *Bioetica*, 33.

bioethics and, for this reason, it is defined by a few not as a discipline – lacking the legitimacy to be qualified as critical knowledge[6] – but as a methodology: an approach based on the dialogue between several disciplines.[7] Its institutional aspect has been consolidating over the years. It has gradually been seen through not only the emergence of institutions, external and 'unofficial' bodies, and committees dedicated to it, but also in the production of national and supranational documents directed toward the development of shared practices and the recognition of rights.

Along with the development of an institutional profile, bioethics became increasingly influential on the evolution of law, and led to meaningful changes on the legal-normative level.[8] From the outset, particularly on the issues that are still most debated today, bioethical reflection polarized around two dominant theoretical models: the Judeo-Christian derived model of the *sanctity of life* and the secular-derived model of the *quality of life*, both of which are often contaminated by ideological and politically instrumentalized positioning. The *sanctity of life* model sees certain processes of life such as healing, dying, or giving birth as characterized by an order or purpose with which individuals must comply. In the traditional framework of the sanctity of life, the areas related to birth, reproduction and death are those constitutive of human nature. In relation to medically assisted reproduction (MAR), it is not only the overall principle of the unavailability of birth to be relevant, but the most specific objection that with IVF (In Vitro Fertilisation) a splitting of what is naturally connected takes place. This modality of conception 'dissociates the unitive-affective aspect of the conjugal act from its procreative and physical dimension.'[9] On the basis of this assumption, MAR, contraception and abortion are morally condemned. On the opposite side, the *quality of life* model proposed by Singer implies the development of acceptable criteria based on supportable arguments from a rational standpoint or by appealing to shared experience and empirically verifiable facts.[10] However, as argued by Donatelli, it cannot be assumed that the erosion of the previous symbolic and moral system, which assigns a natural normative order to certain fields of life, 'leaves empty the space, which it occupied for many centuries, as a surface on which modern moral principles move

[6] D'Agostino, F. (2011) *Bioetica e Biopolitica: Ventuno Voci Fondamentali.* Torino: Giappichelli.
[7] Callahan, D. (1976) 'Bioethics as a Discipline.' *Biomedical Ethics and the Law*, 1–11; Scarpelli, U. "Bioetica: prospettive e principi fondamentali" in Mori, M. (1991) *La Bioetica: Questioni Morali e Politiche per il Futuro Dell'uomo*. Milano: Bibliotechne.
[8] Borsellino, *Bioetica*, 17.
[9] Lecaldano, E. (2015) *Bioetica. Le Scelte Morali*. Bari: Laterza, kindle version, pos. 2603. Translated by the authors: 'dissocia la dimensione unitivo-affettiva dell'atto coniugale dalla sua dimensione procreativa e fisica.'
[10] Donatelli, P. (2012) *La Vita Umana in Prima Persona*. Roma-Bari: Laterza, 113. Translated by authors: "lasci vuoto lo spazio che ha occupato per molti secoli come una superficie su cui si muovono senza attrito i principi morali moderni."

without friction.'[11] In fact, assuming such a shift simply consigns these areas to the freedom, interests and movements of liberal thought, and prevents us from recognising the new opponents and new backgrounds that can take over them, 'shaping the sense of what they are to us [...] and what are the moral possibilities of thought, experience and action.'[12] Embracing the emancipation of birth, death and care from their previous paradigm of reference, in fact, does not automatically convert them into spaces for the free exercise of subjectivities, especially female ones.

Feminist bioethics was born with the aim of seeking new theoretical-applicative approaches to the issues addressed by traditional bioethics. In the 1980s feminist bioethics was developed through the incorporation of critical feminist thought within bioethical debates, which until then had almost ignored gender perspectives, adopting concepts and theoretical models that excluded female subjectivities. This critical perspective emerged from the sexual revolution and the feminist movements of the 1970s. These movements served as the main focus of their battles to claim control over their own bodies – primarily in sexual and reproductive fields – making areas such as marriage, reproduction and prostitution focal points in women's emancipation struggle.

The battles that took place in the 1960s and 1970s, and the subsequent deconstructionist debate of the 1980s, had its first major result in replacing the focus on the connections between body-mind; identity-body; and biography-biology by forcing legal discussion to rediscover the body. Before that moment, in fact, law adopted an abstract subject that did not consider the subjective implications of corporeity and existential differences. Claims in the reproductive sphere, such as the decriminalization of abortion and the demand for access to contraception, were in fact not only aimed at changes on the legislative side but were part of a broader theoretical elaboration that aimed to deconstruct the dominant paradigms and concepts. Feminist Simone de Beauvoir's (Le Deuxième Sexe, 1949) arguments come into play here as they affirm women as subjects and seek to overcome those theoretical constructions that thought her in opposition and in subordination to the male subject. Within these reflections, particular attention is paid to maternity, which is redefined not as a biological destiny that binds women to the role of mother, but as a free, conscious, and responsible choice.

[11] Donatelli, *La Vita Umana in Prima Persona*, 113. Translated by authors: 'lasci vuoto lo spazio che ha occupato per molti secoli come una superficie su cui si muovono senza attrito i principi morali moderni.'

[12] Donatelli, *La Vita Umana in Prima Persona*, 112. Translated by authors: 'plasmando il senso di ciò che sono per noi [...] e quali sono le possibilità morali di pensiero, di esperienza e di azione.'

Several authors have proposed approaches to reinterpret motherhood from a feminist perspective. Among them, it is worth mentioning the reflection of Adrienne Rich, whose work allows 'both to see how the patriarchal identification between being a woman and being a mother works and to pave the way for a recovery of motherhood and female subjectivity.'[13] Rich criticizes the institution of motherhood as a socio-cultural and symbolic patriarchal construction used to exert control over the female reproductive body. She considers the subjective experience of motherhood as a singular relationship that each woman can have with her reproductive capacities/capabilities and children. The institution of motherhood is characterized by absolute altruism, oblation, self-giving and instinctiveness, which enclose women in the maternal experience and prevent them from making their own sense of the pregnancy and maternal experience. The re-appropriation of pregnancy and motherhood by women, in terms of representation and meaning, thus becomes the main instrument in the deconstruction of the patriarchal system and the affirmation of their subjectivity. In that context, the work of Silvia Federici, Maria Rosa Dalla Costa, and Selma James highlight how, in addition to the colonial policies, the social construction of motherhood, childbearing and reproductive labour are functional to the capitalistic-patriarchal structure and economic organization of western societies.[14] The invisibilization of women within hetero-patriarchal capitalism reveals how the capitalist system necessitates gender oppression: women are delegated to reproduce and care for free individuals who represent future wage labour. Since reproduction is organized on the basis of the capitalist mode of production and accumulation, gender inequality arises as the visible effect of the devalorization of women compare to productive labour.

The political activism of the 1970s and the theoretical reflections that came along with it have helped to propagate feminist criticism in the dominant bioethical thought in the United States. Both traditional bioethics approaches, in fact, betrayed a genderized perspective that marginalized women's interests: Judeo-Christian bioethics reconfirm their natural subordination to nature and male domination and secular bioethics resorted to abstract and disembodied models marginalizing women's subjectivity and corporeity. One of the conceptual references that marked a significant turning point in the construction/deconstruction of moral reflection in this field is Carol Gilligan's 1982 work, *In a Different Voice*. Through this research, Gilligan highlights the difference

[13] Botti, C. (2007) *Madri Cattive: Una Riflessione su Bioetica e Gravidanza*. Milano: Il saggiatore, 31. Translated by authors: 'sia di vedere come funziona l'identificazione patriarcale tra l'essere donna e l'essere madre, sia di aprire la strada per un recupero della maternità e della soggettività femminile.'
[14] Federici, S. (2021) *Caliban and the Witch: Women, the Body and Primitive Accumulation*. London: Penguin Books Ltd; Dalla Costa, M. & James S. (1975) *The Power of Women and the Subversion of the Community.* Bristol: Falling Wall Press.

in developing moral reasoning which exists between women and men. This difference allows her to extrapolate two different ways of conceiving morality: the male one ascribable to respect for norms, rights, and justice (ethics of rights) and the female one ascribable to the concepts of caring for others and responsibility (ethics of care and responsibility).[15] Despite the critiques that were made of Gilligan's reflection for re-proposing the dichotomy of the sexes proper to the patriarchal vision, the subsequent feminist debate claimed the extension of the ethics of care and responsibility not only to the private dimension, but also to the political and public dimensions. The ethics of care has been an important theoretical contribution to feminist bioethics precisely because of its ability to expand and refine the rationalist and abstract approach of traditional bioethics. This approach deconstructs the myth of the autonomy of the abstract and universal subject, introducing interdependence and vulnerability as constitutive of subjectivities and moral thought. Moreover, the complementarity between ethics of care and ethics of rights promoted by Gilligan has been taken up by later bioethical thought, especially with respect to the growing relationship between bioethics and law.

Susan Sherwin presented one of the first works to advocate the inclusion of these concepts in bioethics, with a specific focus on medical care, in her book, *No Longer Patient: Feminist Ethics and Health Care*. Sherwin showed how the reflections of feminist bioethics do not only concern women's subjectivities but have general repercussions.[16] The development of the concept of relational autonomy followed in the wake of these reflections in feminist bioethics. Relational autonomy, as it is formulated by Catriona Mackenzie and Natalie Stoljar,

> does not refer to a single unified conception of autonomy but is rather an umbrella term, designating a range of related perspectives […]. These perspectives are premised on a shared conviction, the conviction that persons are socially embedded and that agents' identities are formed within the context of social relationships and shaped by a complex of intersecting social determinants, such as race, class, gender, and ethnicity.[17]

Whereas traditional bioethics had formulated individual autonomy, whose essential conditions were 'liberty (independence from controlling influences) and agency (capacity for intentional action)'[18] – relational autonomy assumes as a starting point

[15] Gilligan, C. (1991) *Con Voce di Donna: Etica e Formazione Della Personalità*. Milano: Feltrinelli.
[16] Sherwin, S. (1993) *No Longer Patient: Feminist Ethics and Health Care*. Philadelphia, PA: Temple University Press.
[17] Mackenzie, C. and Stoljar, N. (2000) *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self*. New York: Oxford University Press.
[18] Beauchamp, T.L. and Childress, J.F., (2009) *Principles of Biomedical Ethics*. New York. 58.

not only that every decision is made within a relational context, but also that the very capacities necessary for the exercise of autonomy have a relational nature and are co-constituted in interaction with others. This perspective also has important repercussions for the doctor-patient relationship since the overcoming of medical paternalism does not only occur through a shift of decision-making responsibility to the patient but implies a relationship of reciprocity and trust.

In step with the technological and biomedical developments which took place around the 1970s and 1980s in the Global North, feminist bioethics initially focused on all those issues where the extent of the inclusion of female subjectivity in the debate was most evident: abortion, assisted reproduction, motherhood, and surrogacy. The topic of reproductive technologies was and remains particularly divisive within the feminist discourse. The question that has generated the emergence of various voices in the debates however does not concern whether the use of reproductive technologies in itself is right or wrong, but whether their use results in an exercise of freedom or rearticulates oppressive systems.

Since their origins, feminist discourses on technologies were divided into two different orientations. In a preliminary perspective that we can describe as radical, the use of reproductive technologies is interpreted as a form of male control over the reproductive function, and the question is raised as to whether technology is a tool aimed at dispossessing women of control over reproduction, taking away from them the privilege of authentically experiencing their femininity. This reading was made particularly explicit in the early 1980s by Gena Corea, according to whom women's recourse to reproductive technologies is the result of an introjected aspiration to motherhood, the result of cultural conditioning that promotes other interests ascribable to the medical establishment and economic stakeholders.[19] Maria Mies denounced how, through reproductive technologies, women's reproductive power is taken away from them and compared the process to the use of a machine where women's bodies were reduced to a merely technical function.[20] It is noted how this kind of critique, which denounces the transformation of women's bodies into a 'biological-technological vehicle, may make the traditional picture that represented pregnancy as a process to be honoured appear attractive and may thus encourage a convergence with current conservative arguments, which denounce medical technologies at the beginning of life as a way of turning procreation into an

[19] Corea G. (1985) *The Mother Machine. Reproductive Technologies From Artificial Insemination to Artificial Wombs*. New York: Harper and Row.

[20] Mies, M. (2007) 'Patriarchy and accumulation on a world scale. Revisited' (Keynote lecture at the Green Economics Institute, reading, 29 October 2005). *International Journal of Green Economics*, 1(3/4), 268. doi:10.1504/ijge.2007.013059.

instrumental process.'[21] In particular, it was the IVF technique, through the decomposition of reproductive moments, that allowed not only the control over reproduction, but also its subjection to an unequal market system. This market in reproductive technologies makes reproduction accessible only to some subjectivities and not to others by re-proposing exclusionary logics with respect to economic availability and places of provenance. The central point on which criticism of reproductive technologies converges is, therefore, their capacity to reinforce systems of inequality, both gender inequality linked to the roles of the two sexes, and class and race inequality conveyed by the intervention of economic stakeholders. We will return to both of these items later.

A second perspective re-reads the technological element and gender difference from a different critical perspective. Reproductive capacity is no longer seen only as a vehicle of oppression but also as a power to be re-appropriated. Reproductive technologies can be seen as tools that can allow the realization of desires and to rethink and rewrite the social organisation that built hierarchies precisely on the coincidence of gender and biological sex. Historically, Shulamith Firestone was one of the first feminist thinkers who most deviated from the common thinking of 1970s feminists on reproductive technologies, advocating a positive reading by seeing them as potential tools for liberation from reproductive power.[22] Much later and concurrent with this line of thought, Lam points out that due to 'the application of [reproductive] technology […] the body dissolves boundaries such as those between man/woman, culture/nature, society/biology and human/machine.'[23]

On the basis of this observation, feminist bioethics proposes to identify the possible sources of oppression and exclusion on traditionally and historically marginalized subjectivities that exist on both a local and global level. Moreover, feminist bioethics, rejecting partial perspectives and having to deal with multicultural and globalized societies proposes a global perspective. The global perspective promoted by feminist bioethics has not only a geographical scope – extending its area of operation into different geopolitical contexts – but also a theoretical scope, since it implies the necessary confrontation with different cultural perspectives. As we will further highlight in the following section the contemporary reproductive injustice can only be

[21] Donatelli, *La Vita Umana in Prima Persona*, 121. Translated by authors: 'veicolo biologico-tecnologico, possa far apparire attraente il quadro tradizionale che rappresentava la gravidanza come un processo da onorare e può quindi incoraggiare una convergenza con gli argomenti conservatori attuali, che denunciano le tecnologie mediche all'inizio della vita come un modo di trasformare la procreazione in un processo strumentale.'

[22] Firestone, S. (2015) *The Dialectic of Sex: The Case for Feminist Revolution*. London: Verso Books.

[23] Lam, C. (2020) *New Reproductive Technologies and Disembodiment: Feminist and Material Resolutions*. London-New York: Routledge, 53.

understood in a global dimension.

Feminist bioethics, therefore, rejecting any dogmatic position, aims to propose a reflection that is structured on individual moral experiences, embodied and situated, and on the relational character and vulnerability of subjectivities. Despite the relevance of the theoretical framework developed by feminist bioethics, it is hardly recognised as an independent space within the scientific production, and it continues to be traced back to 'female' ethics, concerning issues that can only be attributed to female subjectivities. However, in the current context reproduction and non-reproduction do not only concern female subjectivities, requiring a broadening of feminist analysis and critique itself.

2. Cross border reproduction

In order to build on theoretical elaborations and seek concrete restitution of the subjective situations that emerge from the implementation of reproductive technologies, we will examine the phenomenon of *cross-border reproductive care*. Cross-border reproductive care (CBRC) refers to any movement from one jurisdiction to another to access reproductive technologies.[24] For there to be CBRC, the main reason for the travel must be related to access to reproductive services and the travel must involve submitting to a jurisdiction other than the original one.[25] The phenomenon will be analyzed both in relation to non-reproductive choices and therefore recourse to abortion, and to reproductive choices with particular reference to surrogacy.

The CBRC phenomenon is what best represents the fragmentation of boundaries and the need to move beyond the theoretical Western lens and adopt a global perspective. In fact, even if our theoretical frameworks mainly refer to the historical-philosophical and legal western context and the Global North remains our starting point, only when relating it to the global context it is possible to highlight how contemporary reproductive injustice is structured around racial, gender, and economic discrimination.

The CBRC presents itself as an ambivalent phenomenon: on the one hand, it opens up spaces of freedom, but on the other hand it keeps them open to forms of economic, racial and gender discrimination that act on the subjectivities that should benefit from

[24] Ikemoto, L. C. (2009) 'Reproductive Tourism: Equality Concerns in the Global Market for Fertility Services.' *Law and Inequality,* 27, 277–309.
[25] Peña López F., 'Protecting the European Medical Tourist: A New Challenge for the E.U. Law?' In Sonnenburg, S., Desmond, W. (2015) *Touring Consumption*. Karlsruhe: Springer, 186.

such freedom. Guido Pennings has highlighted how tolerance towards members of the minority who move to other countries promotes moral pluralism, because of the prevention of the clashes between the majority and the minority. He interprets this as a solution to restrictive legislation rather than a problem since it deploys a healthy degree of relativism.[26] Other authors considered the CBRC as a poor solution.[27] It arguably makes it hard to guarantee the principle of equality since it only allows access to reproductive services to those who have the economic resources for it. In addition there is an argument that it increases the psychological burden of reproductive and non-reproductive choices of those who travel abroad to access reproductive treatment. Moreover, the CBRC exposes not only a breakdown in health systems but also a breakdown in the democratic legislative process itself: instead of promoting and supporting moral pluralism, through forms of resistance to the law that could animate public debate, it produces the opposite effect. The availability of cross-border travel encourages legislators to adopt stricter bans than they would otherwise, hinging on the fact that cross-border reproductive services will temper possible resistance to the law since those who desire access to a service give little weight to the existence of a legal prohibition if it can be eluded by access to another jurisdiction.[28] Therefore, the CBRC reinforces heteronormative laws that restrict reproduction only to some subjectivities and allow others to bypass these restrictions only if they possess particular resources and characteristics.

Through two examples of CBRC we will illustrate how the transnational distribution of reproductive and non-reproductive services is framed and the need to adopt an intersectional and non-polarized approach to address it.

2.1. Abortion: cross border non-reproductive care

The polarized debate we have seen characterizing bioethics is also reflected in the legislative choices of states, with consequences for public opinion on abortion care. Although structured on different legal bases, both European and US legal systems present significant challenges with respect to guaranteeing access to abortion, necessitating interregional and interstate displacement, and thus making visible the phenomenon of CBRC.

[26] Pennings, G. (2005) «Armonizzazione legale e turismo riproduttivo in Europa». *Giorn. It. Ost. Gin.*, XXVIII.

[27] Robertson, J.A. (2004) 'Protecting Embryos and Burdening Women: Assisted Reproduction in Italy.' *Human Reproduction*, 19(8), 1693–1696. doi:10.1093/humrep/deh326.

[28] Storrow, R.F. (2010) 'The Pluralism Problem in Cross-border Reproductive Care.' *Human Reproduction*, 25(12), 2939–2943. doi:10.1093/humrep/deq270.

In Europe, abortion generally remains a criminal offense even if the law of each country provides various exceptions to this rule. The majority position on abortion laws is, in fact, partial decriminalization/criminalization with exceptions. The specific conditions for decriminalization and subsequent access to legal abortion vary widely among European countries, which establish exceptions (e.g. rape, foetal abnormality, the risk to the woman's life or health, emergency/need) and other alternative requirements, such as a gestational term, mandatory counselling and waiting periods, parental and/or court consent in the case of minors, and limitations on the type and number of health workers involved in the procedure, who may also invoke conscientious objection. Although the European situation states on 'paper' a recognition of abortion as a 'service' of the health system, in practice the vulnerability of such regulatory frameworks is evident.[29] This is seen not only in each country's access data or rates of health personnel's objections but also in the extent of need to travel across national or regional borders to access services.

Europe is far from liberalization; proof of that is the continuing convergence of some European states towards greater restrictions on access to abortion in recent years. Countries such as Poland and Hungary, followed by Italy, for example, are now the states with the most restrictions, especially in the unequal access to the service due to the abuse of conscientious objection, which in some regions means that the access to voluntary interruption of pregnancy is completely impossible. In Italy, women seeking abortion find themselves stuck in a bureaucratic maze that leads to having to move from region to region for access to abortion services. Although in most European countries pregnant people can legally have access to abortion, there is currently no broad individual right to abortion on demand. This contrasts with the situation in the United States in the fifty years following *Roe v. Wade* (1973) when the U.S Supreme Court recognised the right to abortion by anchoring it to the right to privacy and recognising it at the federal level.

The debate on displacement is not unique to the current European context. After the Supreme Court overruling of *Roe v. Wade* in June 2022 (*Dobbs v. Jackson Women's Health Organization*), both anti-abortion and pro-choice states focused on what has emerged as an interstate battle over Cross-Border Abortion and the right to travel, digital security and free speech. In our digital society in fact abortion and CBCR has also a digital dimension represented by virtual clinics and the travel of abortion pills, through the new telemedicine platforms.

[29] Pizzarossa, L. B., Hervey, T., De Ruijter, A. 'Abortion Law in Europe: The Promise and Pitfalls of Human Rights and Transnational Trade Law in the Face of Criminalization With Exceptions.' In Ziegler, M. (2023) *Research Handbook on International Abortion Law*. Cheltenham, UK: Edward Elgar Publishing.

Feminisms, in showing how reproductive control reveals the interrelationship between freedom and equality and is configured as a norm-setting device, have pushed legal reflection itself to confront its own aphorisms. Historically, they have also co-constructed models of action to protect women, moving access to health across state boundaries. An example of this is provided in the history of abortion by the Association to Repeal Abortion Laws (ARAL). When the authorities in California began a new campaign against abortion in 1966, the response was more than a simple protest. A leaflet distributed in San Francisco in June of that year included a list of doctors who performed abortions between Mexico and Japan. The illegal 'list' activities soon became a real organization beyond national borders: 'an underground feminist health agency for rights and women's health…that combined the responsibilities of a medical licensing board and a public health office.'[30] However, it is precisely the feminist vision underpinning this 'new agency', its opposition to the centuries-old criminal law on abortion, and its commitment to the transformation of the healthcare system, that make it different from a conventional state public health agency. Indeed, this effort to obtain adequate medical services is embedded within a militant movement for women's rights and sexual freedom.

Although it has not been possible for historians to trace the racial, class and educational background of ARAL or those who used the 'List', multiracial and interclass support is confirmed.[31] At one of the first press conferences advocating legislation, Patricia Maginnis, a white woman, was joined by Audrey Smith, an African-American organizer among poor blacks in San Francisco, while a Spanish-language leaflet was addressed to the Latino community that also used the ARAL 'List'. Therefore, ARAL is the first example of health activism, dissidence and civil disobedience that not only provided practical support but also contributed to the growing national awareness that the law was unable to stop the practice of abortion. It is a model of feminist health agency in theory and in practice and also a feminist political education organization. In 1969, the subsequent National Association for Repeal of Abortion Laws (NARAL) adopted, not surprisingly, the name and political perspective of the ARAL. Albeit made up of people involved in different spheres of activism (from the feminist movement but also from conservative family planning and birth control organizations), NARAL adopted a women's rights framework and a feminist abortion view from the outset.[32] NARAL therefore educated practitioners, monitored the quality of illegal abortions,

[30] Reagan, L.J. (2000) 'Crossing the Border for Abortions: California Activists, Mexican Clinics, and the Creation of a Feminist Health Agency in the 1960s.' *Feminist Studies*, 26(2), 323. doi:10.2307/3178537.

[31] Reagan, *Crossing the Border*, 2000, 323.

[32] Staggenborg, S. (1991) *The Pro-choice Movement. Organization and Activism in the Abortion Conflict*. New York-Oxford: Oxford University Press, 26.

provided women with information on pregnancy prevention and the names of competent specialists, and established clinics that offered low-cost medical and laboratory services. However, the particular aspect of its activity is the interstate connection: the American laws before *Roe* forced hundreds of thousands of women to cross the border into the illegal world to access abortion, and the ARAL 'List' directed them mostly to Mexico.[33]

Following the American example and thanks to the dialogue between feminist movements, some feminist organizations in Europe, sometimes with the cooperation of physicians, provided tools to secure out-of-state abortions and to give information about sexual and reproductive health. In Italy, for example, *Centro di Informazione Sterilizzazione e Aborto* (CISA) and *Movimento Liberazione Donna* (MLD), engaged in a campaign for the decriminalization of abortion, founded self-managed counselling, and organized trips abroad, first to the UK where abortion had been legal since 1967 and then to France after the enactment of the Veil Law.[34]

Crossing the border for abortions is again of paramount relevance today in the post-*Dobbs* era, emphasizing the historical relationship between Mexico and the United States. Even in Europe, especially in Italy, cross-border abortion is again a main topic considering the autonomy of Italian regions. In fact, in recent years many regions as Marche, Piemonte and Umbria have enacted restrictive reforms, undermining abortion access within the national health system and forcing women to cross regional boundaries. In addition, with new developments in the biotechnological scenario mobilization for access to abortion is now being restructured in connection with the biomedical and techno-informatic evolutions of the new globalized space. One of the biggest debates has concerned the spread of medical abortion, using the combination of mifepristone and misoprostol commonly known as RU-486. Threats of sabotage and other protest actions by antiabortion groups and organizations, both in the United States and in European countries, influenced decisions on drug recognition and marketing.[35]

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[33] Reagan, *Crossing the Border*, 2000.

[34] The 'Veil Law,' named for Health Minister Simone Veil, made it possible for women to terminate a pregnancy within the first ten weeks. The law was enacted following numerous collective self-reports and feminist mobilizations, and the abortion trial of Marie Claire Chevalier in Bobigny. Percovich, L. (2005), *La Coscienza Nel Corpo. Donne, Salute e Medicina Negli Anni Settanta*, Milano:FrancoAngeli; Lussana, F. (2012), *Il Movimento Femminista in Italia. Esperienze, Storie, Memorie*, Roma: Carocci editore; Perini, L. (2014) *Il Corpo del Reato. Parigi 1972-Padova 1973. Storia di due Processi per Aborto,* Bologna: BraDypUS.

[35] Clarke, A., Montini, T. (1993) 'The Many Faces of RU486: Tales of Situated Knowledges and Technological Contestations.' *Science, Technology, & Human Values*, 18(1), 42–78. doi:10.1177/016224399301800104.

In this regard, the experiences of organizations protecting access to abortion at the interstate level have also been carried forward and connected to the new non-reproductive and information technologies. The case of the organization Women on Web is peculiar to the development of a telehealth system in line with the appearance of RU-486 on the global scene. The Women on Web platform (WOW) provides information and support and online medical counselling in sixteen languages.[36] Following the *Dobbs* ruling, thirteen US states attempts were made to include bans that would simultaneously affect telemedical abortion and prevent pregnant persons from physically travelling to obtain an abortion in a state where it is still legal. Upon close examination of the Constitution and the decisions of the Supreme Court and lower courts, it is clear that these laws are unconstitutional. As interpreted by various courts, out-of-state abortion bans have no legal force because of the protections of the Commerce Clause and the Privileges and Immunities Clause of the Constitution.[37] After 24 June 2022, sexual and reproductive rights organizations continued to emphasize the impact the decision would have on all pregnant people, with a particular focus on those considered most vulnerable due to systemic discrimination, such as migrants, trans and non-binary people, and black, Latina and indigenous women. Amidst the uncertainty and legislative and social chaos unleashed by the *Dobbs* ruling, it became necessary to find an alternative: a cross-border network of collectives accompanying abortions banned in the United States. The response of states such as Mexico and Canada in welcoming people from the United States affected by the restrictive statutes represented the first clear attempt to protect the right to abortion connected to the right to travel.[38]

In the Latin American panorama, the network practices implemented by feminisms engaged in the co-construction of networks of support have in recent years configured real struggles and resistance to laws, co-constructed new narratives, and co-constituted a feminist and transfeminist model of approach to health. This can be seen in case of *Socorristas en Red*, the network born from Argentina's decision to make abortion illegal in 2014. *Socorristas en Red* challenged many Latin American states to come to terms with the dichotomies and restrictions inherent in the legal system, embedded in the patriarchal vision of sexual and reproductive health in these

[36] *Who We Are. Women on Web*. Available at: https://www.womenonweb.org/en/page/521/about-women-on-web. (Accessed: 22 May 2023).
[37] Tallmon, S. (2023) *The Post-Dobbs Legality of Out-of-State Abortion Travel Bans*, *Columbia Undergraduate Law Review*. Available at: https://www.culawreview.org/journal/the-post-dobbs-legality-of-out-of-state-abortion-travel-bans (Accessed: 22 May 2023).
[38] 'Canada and Mexico Prepare to Accept Americans Seeking Abortions' (2022) *The Guardian*. Available at: https://www.theguardian.com/us-news/2022/may/09/canada-mexico-abortions-american (Accessed: 22 May 2023).

countries.[39] On the eve of the gender backlash represented in the concrete case of *Dobbs*, the Latin American network broadened its perspective across borders, offering help to US women.[40]

In Europe, the experiences of organizations and collectives that provide support for abortion have intensified in the last few years. This has been strengthened following the legislative and judicial experiences of some countries demonstrating firm opposition to guaranteeing the service even at the expense of the fundamental right to health. In Italy, following the intensification of cases of help-seeking, many underground realities, organizations, and associations have taken steps to monitor and map conscientious objection, to provide scientific information on contraception and post-contraception devices and on abortion, and to provide accompanying paths.[41] From the Polish scenario in 2019, the Abortion Without Borders (AWB) network was activated, a trans-European initiative that aims to help people in Poland access abortions, either at home through medication abortion or abroad in clinics and hospitals by collaborating with abortion providers in England, the Netherlands, Germany and elsewhere in Europe to ensure that abortion is accessible to people forced to travel abroad.[42]

In conclusion, looking at the phenomenon of cross-border abortion, is evident that it is not only the failure to recognise the right to safe abortion that undermines reproductive rights, but also the material, economic and technological resources that people have access to.[43]

2.2. Surrogacy: cross border reproductive care

The CBRC phenomenon does not only relate to non-reproductive choice and abortion, but also reproductive choice linked to access to new technologies. In this perspective, we have chosen to use the case of surrogacy as a case study. As with debates around

[39] Maffeo, F., Santarelli, N., Satta, P., Zurbriggen, R. (2015) 'Parteras de Nuevos Feminismos. Socorristas en Red - Feministas que Abortamos una Forma de Activismo Corporizado y Sororo.' *Revista Venezolana de Estudios de la Mujer,* 20: 44, 217-227.

[40] Hernández, L. 'Organizing for Abortion Access Across Borders,' *NACLA*. Available at: https://nacla.org/abortion-access-cross-border (Accessed: 22 May 2023).

[41] The following are given as examples: on a national level the organizations Obiezione respinta, IVG-ho abortito e sto benissimo, Libere di abortire; and as regional examples the Mujeres Libres in the Emilia-Romagna region, NUDM-Transterritoriale Marche for the Marche region, and Non è un veleno based in Palermo in Sicily.

[42] 'About Abortion Support Network' (2022) Abortion Support Network. Available at: https://www.asn.org.uk/about/ (Accessed: 22 May 2023).

[43] Suk, J.C. (2022) 'A World Without Roe: The Constitutional Future of Unwanted Pregnancy,' *William & Mary Law School Scholarship Repository*. Available at: https://scholarship.law.wm.edu/wmlr/vol64/iss2/4 (Accessed: 22 May 2023).

abortion, this issue has polarized official bioethical positions, and has also led to a few criticisms from feminist positions. Surrogacy can be defined as a practice involving multiple parties within a medically-assisted reproduction process. The parties involve one or more intended parents (those who will have legal responsibility for the child) and a person (the gestational carrier) who carries the pregnancy with the aim of entrusting the child to the parents without assuming parental responsibility.

The normative responses to this practice have been divergent. If we consider the Global North (USA and Europe) from which we started our analysis, we can identify two different approaches to regulation around surrogacy. In some states of the USA, where the legal culture is characterized by seeing the contract as the privileged instrument for realizing property rights and freedom over one's own body, surrogacy has been made the subject of commercial contracts since the 1980s. In Europe, on the other hand, the donation-gratuity-compensation model has become established. However, there are forms of compensation in money that are defined as reimbursements for 'medical expenses' and for 'lost income'. To give an example 'in their recent study, the Surrogacy UK Working Group found that more than two-thirds (68.2%) of UK-based surrogates were paid between £10,000-£15,000 in expenses'. The study also refers to 16 intended parents that 'had had children through surrogacy overseas, in which the mean sum paid to the surrogate was £17,375,' and that, 'in two of the most recent High Court cases involving US surrogate mothers, the amounts paid varied from £12,850 and £14,375 to £33,737.10.[44]

In the forty years since the practice of surrogacy was introduced into the biomedical landscape, the phenomenon has become transnational. For some decades the CBRC has had as privileged destinations the states of the Global South. After India in 2012 and Thailand in 2014 began a process of restrictive regulation, allowing access only to national residents in India and penalizing commercial surrogacy in Thailand, travel for reproductive reasons started to flow to Mexico. In particular the Mexican state of Tabasco was the desired destination for surrogacy until the state also banned access to non-national residents.[45] In recent years, the market has shifted to Eastern European countries: Russia, Kazakhstan, Georgia, Albania, Armenia, Belarus and, above all, Ukraine. Emma Lamberton's studies show that Ukrainian companies control more than

[44] Jackson, E. (2016) 'UK Law and International Commercial Surrogacy: "The Very Antithesis of Sensible",' *Journal of Medical Law and Ethics*, 4, 3, 205-206.
[45] Capulli, E. (2021) Gestazione per Altri in Messico: Ricostruzione, Ratio e Problematiche Degli Attuali Scenari Normativi. *Nomos: le attualità nel diritto*, 3.

a quarter of the world market for gestational services: over the past few years, a hundred agencies have been established, at least two-thirds of them illegal.[46]

The growth in the use of surrogacy in recent decades has been possible not only because of its feasibility at the biotechnological level but also due to the gradual lowering of the costs of reproductive services and the increased possibilities of travel and information retrieval opened up by globalization.[47] Constant regulatory changes and globalization alter the geographies of CBRC, squeezing the relations between law and factual situations.

Of central importance is the way in which patients find information on reproductive services available abroad, which is mainly through the internet.[48] Thanks to global information traffic, it is very easy today for aspiring parents to turn to web channels for information on the possibilities offered by foreign clinics. However, those consulting the websites often do not have adequate information to evaluate the clinic, and very often important details concerning the procedure are left out, including the possible need for follow-up care. The problem is that, as in other areas of medicine, there is no regulation or control over the veracity and truthfulness of the data presented. It is therefore difficult to find one's way around the information available with no guarantee of reliability or objectivity. In fact, there are major differences between clinics that offer local services and those that aim to intercept clients from Western countries, both in terms of the services offered and their commercial and marketing practices. Clinics whose websites appear to be formulated to attract foreign clients correspond with those that offer low-cost services and trivialize the importance of the risks involved. Potential clients may therefore underestimate or overlook important considerations regarding the quality of care and safety of the health services offered.[49] This makes it clear how cultural background, digital literacy and access to online services affect the demand for reproductive services.

[46] Lamberton, E. (2020) 'Lessons from Ukraine: Shifting International Surrogacy Policy to Protect Women and Children,' *Journal of Public & International Affairs*.
[47] Trimmings, K., Beaumont, P.R. (2013) International Surrogacy Arrangements: Legal Regulation at the International Level. *Studies in Private International Law*. Oxford: Hart Publishing.
[48] Van Hoof, W., Pennings, G., De Sutter, P. (2015) 'Cross-Border Reproductive Care for Law Evasion: A Qualitative Study into the Experiences and Moral Perspectives of French Women who go to Belgium for Treatment with Donor Sperm.' *Social Science & Medicine*, 124, 391–397. doi:10.1016/j.socscimed.2014.09.018.
[49] Smith, E. et al. (2009) 'Reproductive Tourism in Argentina: Clinic Accreditation and its Implications for Consumers, Health Professionals and Policy Makers.' *Developing World Bioethics*, 10(2), 59–69. doi:10.1111/j.1471-8847.2009.00256.x.

Reflecting on the situation in Mexico, Caroline Shurr found that agencies shape their services and advertising campaigns to attract mainly European or US homosexual couples (who account for the highest percentage of clients, about 70-80%).[50] Also, in Spain centres have been set up exclusively for the treatment of couples from abroad. The result of this phenomenon is a massive mobilization of middle-aged Western citizens towards low-cost fertility markets. The main drivers of which, are, on the one side the consumers/aspiring parents who, faced with legislative prohibitions, resort to informal and autonomous channels to satisfy their desires, and on the other, the marketing strategies of clinics that exploit permissive national laws.

Regulatory choices regarding access to reproductive technologies do not only limit access to the reproductive health of subjectivities, but also have the function of articulating a certain family and parental model. In many European countries, access to reproductive technologies is allowed only to heterosexual couples, so reproduction, parenthood and consequently the family are structured in such a way as to reproduce both a natural paradigm of reproduction and the heterosexual family derived from it. Moreover, the European Court of Human Rights (ECtHR), called upon to express an opinion on the problem of recognising birth certificates drawn up in countries where surrogacy is prohibited, has established the necessity of recognising the filial relationship in the presence of a genetic link between the intended parent and child. However, in the requirement for a genetic connection it is possible to discern a *ratio* based on genetic essentialism, which in part conflicts with the logic that in medically assisted reproduction the voluntary element is predominant over the genetic element in the constitution of parenthood.[51] Lastly, it is also possible to discern gender discrimination, since the openings derived from the ECtHR's jurisprudence, based on the genetic connection, penalize the legal recognition of intended mothers, who in most cases of surrogacy cannot supply their own gametes.

While up to now we have been considering the issues arising from the displacements by aspiring parents in terms of individual rights and state responsibilities, we will now turn our attention to the effects of these displacements on the subjectivities that have met the demand. Many authors have highlighted how the reproductive market, especially in relation to the CBRC, has contributed to processes of social stratification

[50] Shurr, C. (2016) 'From Biopolitics to Bioeconomies: The Art of (Re-)producing White Futures in Mexico's Surrogacy Market,' *Environment and Planning D: Society and Space*, 35(2), 241–262. doi:10.1177/0263775816638851.

[51] Margaria, A. (2018) *Leggi e Giudici di Fronte Alle Nuove Realtà: Nuove Forme di Filiazione e Genitorialità*. Bologna: Il mulino, 55.

along the lines of gender, class, and race.[52] The class issue surfaces if one considers that the feminist demands discussed above, which led to the introduction of women into wage labour, did not lead to a fair redistribution of the burdens of domestic space; on the contrary, they were delegated to a cheap and racialised female labour force.[53] The reproductive labour, or as called by Melinda Cooper and Catherine Waldby 'clinical labor,'[54] realized by carriers has produced the same delegation mechanism, whereby, 'women from the Global South, through the pathways of the globalized economy, are transformed into wage substitutes for the reproduction of women from the Global North to the detriment of their own reproductive capacity/will'.[55] Some authors have used the concept of *reproductive stratification* to indicate the deep inequalities that exist globally where some categories of women are encouraged or helped to reproduce, while others are discouraged from doing so.[56] Moreover, in recent decades, although India has been a well-known destination for international surrogacy, motherhood in the country is strongly discouraged by government policies aimed to contain the birth rate and prevent overpopulation. These policies in recent years have led to mass sterilizations – four million between 2013 and 2014 – taking place in conditions completely unhygienic and medically unprotected, causing health problems and in some cases even the death of the women who underwent them.[57]

The racist western paradigm that shapes CBRC emerges if we consider that transnational diffusion of the reproductive bio-market is also oriented towards the reproduction of whiteness. This occurs through a different selection of reproductive workers whereby the market is oriented towards Eastern European states for the sourcing of oocytes, which satisfy Western phenotypic characteristics, while it is located in Southern states (India, Thailand, Nepal) in the case of surrogacy. Studying

[52] Giordano, V. (2018) *Le Regole Sul Corpo. Costruzioni Teoriche e Decisioni Giudiziarie*. Torino: Giappichelli, 88.
[53] Lafuente Funes, S. (2021) *Mercados Reproductivos. Crisis, Deseos y Desigualdad.* Pamplona: Katakrak, 190.
[54] Cooper, M., & Waldby, C. (2014) *Clinical Labor. Tissue Donors and Research Subjects in the Global Bioeconomy*. Durham: Duke University Press.
[55] Morini, C. (2010) *Per Amore o per Forza: Femminilizzazione del Lavoro e Biopolitiche del Corpo*. Verona: Ombre corte, 50. Translated by authors: 'le donne del Sud del mondo, attraverso i percorsi dell'economia globalizzata, sono trasformate in sostitute salariate della riproduzione delle donne del Nord del mondo, a scapito della propria capacità/volontà riproduttiva.'
[56] Lombardi, L., Zordo, S.D. (2013) *La Procreazione Medicalmente Assistita e le Sue Sfide: Generi, Tecnologie E Disuguaglianze*. Milano: FrancoAngeli, 20.
[57] Andrew, M. (2013) 'Inside India's Female Sterilization Camps.' Bloomberg Businessweek. Retrieved from: https://www.bloomberg.com/news/ articles/2013-06-20/inside-indias-female-sterilization-camps; Taylor, A. (2014) "Map: The Global Divide on Sterilization as Birth Control." Retrieved from: https://www.washingtonpost.com/news/worldviews/wp/2014/11/14/map-the-global-divide-on-sterilization-as-birth-control/.

the articulation of the reproductive bio-market in Mexico, Caroline Shurr highlighted the racialized division of reproductive labour within the country. Shurr reports that the director of one of the Mexican clinics gave the following answer when asked about the difference between pregnant women and ova donors: 'the egg donors are beautiful women, middle class, with some education. The surrogates are on average poorer, more *chaparritas* (short woman), most of them are single mothers.'[58]

Finally, to these observations, it is necessary to add that the reproductive bio-market is a gendered market, i.e. a market in which reproductive surrender is placed within the same logic of the free nature of care work that informed its heteronormative division within the Fordist production model. Rene Almeling is one of the most significant authors to have highlighted how the language of altruism has more clearly characterized the transfer of eggs than that of sperm.[59] Even in the United States, where both forms of donation take on a commercial character, the sale of eggs has been constructed as a gesture of love towards one's neighbour within an altruistic relationship.[60] Studies on surrogacy in the United States and Europe show how, even when it is carried out through contract, the commissioning parents prefer expectant mothers who show a sense of altruism and generosity, rather than those who admit to purely economic intentions. Thus, not only are the physical and biological burdens of reproduction placed on the expectant mothers, but also the subordinating assumption of patriarchal maternity. It should be remembered that the displacement that has allowed some women to enter the world of work has also allowed paths to be taken to redefine maternity, with the consequent emergence of rights related to self-determination with respect to reproduction, albeit called into question today. On the other hand, the subordinating elements – both to nature and to male dominance – associated with the maternal, hence instinctiveness, generosity and naturalness, have been shifted onto gestational carriers, who are either extremely *generous* women or *abnormal* women, driven by economic desperation, over whom nature will prevail.

As we have seen in the case of abortion, the articulation of the CBRC with respect to surrogacy at a global level promotes limited and conditioned possibilities of freedom. In fact, access to reproductive services is determined by multiple levels of discrimination, which encompass sexual orientation, digital literacy, and material and economic resources. Moreover, the stratification of reproduction – that involves also

[58] Shurr, C. (2017) 'From Biopolitics to Bioeconomies: The Art of (Re-)producing White Futures in Mexico's Surrogacy Market,' *Environment and Planning D: Society and Space*, *35*(2), 256.
[59] Almeling, R. (2011) *Sex Cells: The Medical Market for Eggs and Sperm*. Berkeley: University of California Press.
[60] Ibid.

global surrogacy – is structured on a racist, classist and gendered western paradigm that shape the inequal access to rights, technological development and wage.

3. From Feminist Bioethics to Intersectional Bioethics

As found through the two case studies examined above, abortion and surrogacy respectively pose the same issues: the limits of choice. Indeed, choice, in a liberal lens, implies the privilege of being able to avail oneself of it and the responsibility of being able to access it.

The rhetoric of free choice, moreover, is shown all its ambiguity: the right to safe abortion or access to surrogacy, in fact, is undermined not only by legislative gaps in recognition of reproductive rights but, as we have seen, also by the material resources people have access to, the racist matrix of Western societies and the environment in which people are situated: all features that guide a choice and that definitely do not make it free.

In this sense, both abortion and surrogacy emphasize the same mechanism of exclusion for those subjectivities whose choice is limited by a number of factors. In the globalized world ordered by neoliberal logic, choice is connoted by an individualism that reduces the concept of health to self-responsibility. Moreover, the CBRC mechanism highlights simultaneous oppressions that determine which subject is entitled to access that precise choice, making absent the multiplicity that characterizes contemporaneity.

Both in the case of abortion and in the case of surrogacy, class and race play an important role in access: the racialized person of lower economic status who cannot access the information or the service suffers from the same discrimination that leads the racialized person to choose to become a gestational carrier for financial compensation. The heterosexist paradigm prevents the trans, intersex and nonbinary person in need of abortion not only from accessing the service but, where it is possible, subjects the person to a mechanism of exclusion: it is only the woman in fact who can reproduce and, in this case, also not reproduce. The heteronormative paradigm underlies many of the surrogacy laws that push precisely for CBRC. Finally, women cannot free themselves from the oblative motherhood proper to the patriarchal construct either by accessing a non-reproductive service or by constituting themselves as pregnant women who nevertheless reject motherhood.

Re-reading the official bioethical debates through the lens of gender oppression, feminist perspectives in bioethics have undoubtedly proffered a more decentralized

reading of the moral problems related to reproduction. However, the persistence of the conception of 'difference' in feminist bioethical analysis seems to have paralyzed and polarized the discourse in the same way as in the official bioethical debate. The feminist bioethical reflection also suffers from a static perspective in that it remains conceptually bound to the terms of the more traditional moral ethical debate. As Sherwin states:

> bioethicists would do better to move away from the rigidity implicit in the foundational metaphor for ethics, appealing instead to metaphors that support more imaginative approaches to ethical deliberation (…) seek alternative metaphors that will encourage ideas of plurality and diversity in available ethical approaches.[61]

Starting from Sherwin's invitation, we therefore need to ask: how can we rethink bioethics in decentralized and situated terms, constituting it as a discourse capable of dealing with the problematic implications of the globalized and *in trouble*[62] world in which we live? How can we re-think the terms of the bioethical debate from a perspective that does not reproduce discursive paradigms steeped in anthropocentrism, where Man, understood in his meaning as a human being, remains the white, able-bodied, heterosexual man? These are the questions that underlie the necessity to regain a voice and to re-think bioethics as a space to live in, a word to be re-appropriated.

From the fundamental assumption of the existence of feminisms as opposed to the singular 'feminism', the numerous attempts to re-think bioethics in feminist terms seems not to have really produced the shift in the debate that was expected. If a good deal of responsibility can be attributed to the persistent exclusion of feminist voices as they are considered subcultures in relation to more traditionally rooted debates, an equal share of responsibility can be traced to the inability to decentralize the view and the voices of a part of this field itself.

An early critique against the feminist bioethical landscape is therefore related to the predominance of Western and white voices which, while attempting to decentralize their view have nonetheless based their analyses on a search for a 'common denominator', appealing to 'difference' rather than being enriched by it. According to Tong, the goal of 'Global Bioethics' is, 'to find ways of interacting that are respectful of

[61] Tong, R. (2019) *Globalizing Feminist Bioethics: Crosscultural Perspectives*. New York, NY: Routledge, Taylor & Francis Group, 19-20.
[62] Haraway, D. J. (2016) *Staying with the Trouble.* Duke University Press.

each other's cultural difference.'[63] However, as much as the perspective seems to hold together many of the critical points raised above with its emphasis on the intersectionality of oppressions, it still remains focused on an analysis of the situation of 'women', not really taking up the whole potential of intersectionality from which it seems to start.

The second criticism is related to holding differences in biological terms where, even assuming a deconstructed perspective, the reasoning is still held on the basis of the sexual and gender duality. This perspective seems to negate how much the injunction to reproduction is the consequence of an interweaving of science and morality on sexed bodies. The scientific grasp of the body and reproductive capacities have been 'maternalized' in the same way as they were medicalized by the scientific revolution and more fully in the political reading of Western birth in the eighteenth and nineteenth centuries. A grip that is re-articulated today in new but echoing narratives.

The proposal in this article is to re-think an *Intersectional Bioethics*, which is able to start from the intersection of different social identities, particular forms of oppression and discrimination, and their overlap. As an interdisciplinary and plural dialogue, bioethics, making the theory of intersectionality proposed by Kimberle Crenshaw its own, must re-think itself and their concepts from the interaction of multiple and simultaneous identity axes that allow unveiling the multidimensional systemic injustice and inequality.[64] Although it seems to have lost its earlier purposes by ending up as an arena of confrontation between laical and faithful thinkers (be they philosophers, physicians or jurists), the strength of bioethics remains its constitution from the outset as a plural, multifaceted and interdisciplinary debate.

Agreeing with Rosi Braidotti, we need new narratives, principles, and aspirations to avoid 'the twin pitfalls of conservative nostalgia and neoliberal euphoria.'[65] As Braidotti further argues, we need to re-articulate, in this specific context, a bioethical thought around the notion of the subject as 'a complex singularity, an affective assemblage and a relational vitalist entity.'[66]

The recent upheavals in the Global North regarding reproductive and non-reproductive techniques highlight that connection between neoliberalism and

[63] Tong, R. (2019) *Globalizing Feminist Bioethics*, 33.
[64] Crenshaw K. (1989) 'Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics.' *The University of Chicago Legal Forum*, 140, 139–167.
[65] Braidotti (2013) *The Posthuman*. Oxford: Polity Press, 11.
[66] Ibid., 171.

neoconservatism identified by Melinda Cooper. It is on the so-called 'family values' that conservative and religious social forces play a fundamental role, and it is on the re-writing of the human within the paradigms of natural law that key battles are played out, such as the access of subjectivities to reproductive and non-reproductive techniques.[67] The neoliberal paradigm inscribes medical interventions, as Adele Clarke states, no longer as operations aimed at the treatment of pathologies but as requests from patients/consumers: in this sense, care is self-responsible, individualized, and privatized.[68] The expansion of the reproductive market and of the fertility industries is, as we have seen, a paradigmatic example of that, and the conservative and fundamentalist reactions underline a re-anchoring to rhetoric which, although renewed, are somewhat 'traditional'.

The reflections of feminists such as Joan Scott, Rosi Braidotti, Donna Haraway and Judith Butler on the social-cultural construction of gender and the body are part of the radical critique of regimes of power, establishing a broad ethical reflection on the questions posed by historically marginalized human and also non-human subjectivities. Respecting the particular philosophical and methodological definitions adopted by these scholars, in general Postmodern feminism opens to plural perspectives of which none can claim objectivity, and to a located knowledge as a critical and responsible practice: no positioning is transparent, and no positioning is innocent. The nature/culture distinction as developed in the 17th century not surprisingly had to do with 'procreation' and the definition of women's 'true nature' and was used to relegate them to reproductive labour and compulsory motherhood. As Caterina Botti states, Western history is marked by the questioning and justification of the 'true nature of women', collectively defined as 'weak beings, inferior in body and mind.'[69] In an even broader perspective, it is precisely through the sexuality/reproduction connection enrolled in the nature/culture dualism that, historically, women and non-heteronormative subjectivities have been oppressed.

3.1. Shifting Bioethics

Starting from this theoretical-philosophical reconstruction and from the case studies reported, we propose four theoretical 'shifts' at the base of the elaboration of an Intersectional Bioethics.

[67] Cooper, M. (2021) *Family Values: Between Neoliberalism and the New Social Conservatism*. New York: Zone Books.
[68] Clarke, A.E. et al. (2003) 'Biomedicalization: Technoscientific Transformations of Health, Illness, and U.S. Biomedicine.' *American Sociological Review*, 68(2), p. 161. doi:10.2307/1519765.
[69] Botti, C. (2014) *Prospettive Femministe: Morale, Bioetica e Vita Quotidiana*. Mimesis Edizioni, 16. Translated by authors: 'esseri deboli, inferiori nel corpo e nella mente.'

The first theoretical shift is to re-think bioethical categories related to reproduction in the light of Spinozian materialist monism as the foundation of 'new' ethics. In doing so, mind/body becomes interconnected in a continuous relationship and interrelation. This assumption makes it possible not only to abandon binary logics of distinction but to re-think both the individual subject and the subjectivities, to emphasize interconnection and relationship, and to recognise the ontological desire of subjectivities with their responsibility and response-ability in a relational sense.[70] According to Lloyd, Spinozian 'immanentism' leads to the rejection of a universal definition of 'woman' and to a view of her as a 'process', as a multiple and relational individuality.[71] The proposal is therefore to re-think bioethical principles and categories in the light of subjectivities understood as 'intersections of a series of relationships, over time,' 'recognizing the embodied and embedded, relational and affective position of the humans.'[72] The moral subject is a concrete, situated and embodied subject, at once a corporeal dimension and an entanglement of relations. The historical objectification of women has allowed its fragmentation and consumption. As Adams states, this has also occurred in language. The reference metaphors of the long history of Western culture have reified certain subjectivities, both human and non-human, fragmenting them from their ontological meanings, constructing their existence based on representation, reiterating their annihilation as subjects in a continuous rhetorical-linguistic revisitation.[73] The fragmentation of the reproductive body, the focus on the womb and its contents, and the consumption of this for birth policies rhetoric have annihilated wills, undermined desires, and erased subjectivity. In this perspective, it is not the choice of the person who intends to have an abortion, but it is the relationship that person feels with what may or may not develop that matters. A person may not feel that connection and responsibly not want that relationship by opting for abortion. On the other hand, the pregnant person in surrogacy may responsibly wish to carry a pregnancy for others. Placing the focus on relationship and responsibility means suspending aprioristic judgment.

[70] The concept of response-ability is coined by Haraway to go beyond the liberal concept of responsibility. Response-ability includes the collective participation and care praxis instead of the individual power of 'make choice'. In addition, it includes a whole concept of care that include human and non-human. Haraway, D. J. (2008) *When Species Meet*. Minneapolis: University of Minnesota Press; (2016) *Staying with the Trouble,* Durham: Duke University Press. Tronto, J. (2020) 'Afterword,' in Bozalek, V., Zembylas, M., Tronto, J., *Posthuman and Political Care Ethics for Reconfiguring Higher Education Pedagogies*, London: Routledge.

[71] Lloyd, G. (1994) *Part of Nature: Self-knowledge in Spinoza's Ethics*. Ithaca: Cornell University Press.

[72] Botti, C. (2007) *Madri Cattive: Una Riflessione su Bioetica e Gravidanza*. Milano: Il saggiatore, 90. Translated by authors: 'intersezione di una serie di relazioni, nel tempo'; Braidotti, R. (2019) *Posthuman Knowledge.* Cambridge: Polity, 28.

[73] Adams C. J. 'Lo Stupro Degli Animali, La Macellazione Delle Donne.' Faralli C., Andreozzi M., Tiengo A. (2014) *Donne, Ambiente e Animali Non Umani. Riflessioni Bioetiche al Femminile*. Milano: LED, 143-144.

Consequently, starting from that body-mind located in a precise context that largely influences its existence and perception, the second shift is the rejection of any universalism, recognising the differences that exist of gender, race, class, and environment, which all undeniably influence people's lives and perceptions. Rejecting universalism means, first of all, assuming a posture that recognizes the partiality implied in the concept produced and imposed by the Enlightenment culture of the human being, and secondly, the responsibility that this partiality has had in colonial and imperialist projects. The problems experienced in the reproductive sphere of subjectivities, not only of women, in the globalized West, are not the same as those experienced by subjectivities in other parts of the world. The biopolitical injunction to reproduction for Western subjectivities has gone hand in hand with the necropolitical injunction for those subjectivities considered '*Other*': the universalising Western word has silenced those other perceptions that are fundamental to a discipline based on plural dialogue.

The third shift raises the question of how intersectional bioethics considers the status achieved by biotechnologies, going beyond the essentially critical conception of most feminist theories and even over the utopian one outlined by Firestone. The problematic nature of the use of technologies and biotechnologies is found in their inscription within the neoliberal paradigm, in their entanglement with oppressive and systemic power structures. The deconstruction of dualisms on which the proposal of Intersectional Bioethics is based, in agreement with Donna Haraway, blurs the boundaries between natural/artificial and organism/machine. An Intersectional Bioethics thus recognises a hybrid corporeity in that mind/body entanglement: an embodied subject is a process that is also virtual and that pushes to re-think ethical issues related to the use of technologies from new points of view that have nothing to do with the good/bad dichotomy.[74]

The fourth shift is to rethink citizenship. In a world in which capital is also biological capital, human and non-human, we are all bioethical citizens deprived, however, of bioethics that truly represents and protects the multiplicity of life. Abandoning analysis from the *bios* for a decentralized vision that embraces *zoe*[75] makes it possible to hold

[74] Haraway D.J. (1997) 'The Virtual Speculum in the New World Order.' *Feminist Review*, 55, 22–72; Haraway, D.J. (2018) *Cyborg Manifesto*. Camas Books.

[75] The ancient Western distinction between bios and *zoe* refers to the distinction between political and non-political life. Then, biopower distinguishes between beings without legal status and beings with the recognition of legal rights. Rosi Braidotti revising critical vitalism and biopolitics argues that posthuman subjectivity is a *zoe* subjectivity. Then, *zoe* represents the potentiality and transversality of all matter in connection with all the other matter. Braidotti, R. (2008). 'The Politics of Life as Bios/Zoe'

multiplicity together without having to search for a common denominator. Religious and cultural conditioning, male control of fertility, and the politics of states hinder reproductive choices and the right to have, not to have, or to limit the number of children, just as much as climate change limits the right and the desire to generate. Addressing from a bioethical point of view the limits of the rhetoric of choice dominant in any debate on reproductive and non-reproductive choices, in agreement with Gaard, this only appeals to those who have options and makes no sense to those who do not.[76] Banning abortion or convicting surrogacy by taking it out of context and out of subjects is part of the general will to deny the capability and response-ability to freely and consciously *'feel'* one's own body. But, above all, it demonstrates the wilful inability of Western societies to think in terms of a firmly recognized and equally distributed reproductive justice. To the autonomy in terms of individualist choice proper to the secular bioethical tradition of liberal derivation, an Intersectional Bioethics counterpoints a different form of autonomy that redefines the question of the right to decide, validating the ontological dimension of desire and recognising in subjective judgment a moral dimension of response-ability and a balancing capacity on the part of subjects as moral agents.

If bioethics really wants to rise to that interdisciplinary and plural dialogue for which it was born, it must therefore conceive not only of the multiple aspects that make up its field of enquiry, but first and foremost re-recognize its human and non-human citizens, embodied and located, as responsible subjects, situating itself as a multiple and positioned view. The presumed failure of interdisciplinarity and plurality of bioethics, therefore, should not necessarily be understood in a 'negative' sense: it is precisely that failure that pushes for a re-articulation of the terms of ethics, theoretical and applied, that can re-imagine, re-think, map and figure new and possible theoretical-epistemological categories and best practices.

Theories that consider the multiplicity of oppressions and analyze the links between patriarchy, heterosexism, capitalism, militarism, and economics are able to develop a cohesive and committed theory. Starting from the concept of reproduction outside the boundaries of race, gender, class, and family traditionally understood and historically/culturally constructed, allows us not only to re-interpret the concept of autonomy but also to re-think the concept of care in terms of relationship and interdependence. As the Care Collective have stated:

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in Smelik A. & Lykke N. *Bits of Life. Feminism at the Intersections of Media, Bioscience and Technology*. Washington: University of Washington press. 179-196.

[76] Gaard, G. (2010) 'Reproductive Technology, or Reproductive Justice?: An Ecofeminist, Environmental Justice Perspective on the Rhetoric of Choice.' *Ethics and the Environmen*t, 15(2), 103. doi:10.2979/ete.2010.15.2.103.

> We need to break the destructive linking of dependency with pathology and recognise that we are all formed, albeit in diverse and uneven ways, through and by our interdependencies [...] we must begin by recognising the myriad ways that our survival and our thriving are everywhere and always contingent on others.[77]

When different forms of kinship are thought, 'thought with' and also theorized, it implies a broader rethinking of the conditions necessary to create communities that truly conceive care as collective. In addition, these communities elaborate relational ethics, sharing economies and ethics of care, and in doing so and in realizing them, start again from a recognition of the precariousness and vulnerability of subjectivities. The precarious condition refers to an existential dimension. The body, a biological and social site, is exposed to a condition of vulnerability that makes it dependent on other bodies and that makes and will continue to make care work necessary. As Donna Haraway argues:

> It matters what matters we use to think other matters with; it matters what stories we tell to tell other stories with; it matters what knots knot knots, what thoughts think thoughts, what descriptions describe descriptions, what ties tie ties. It matters what stories make worlds, what worlds make stories.[78]

An Intersectional Bioethics perspective is ecofeminist, materialist, queer, postmodern, and posthuman. It extends the concept of family, accommodates alternative kinship ties and different relationships, re-thinks networks of care and bioethical language beyond the boundaries of the traditional concepts and beyond the Human as Man and its dualisms. Finally, it elaborates responsible ethical forms not only aimed at the human, but at the planet and those who are part of it.[79] An Intersectional Bioethics can help identify what is ethically justifiable and what is not through critical and deconstructive perspectives moved by the need of a reproductive justice understood in its intersectional and embodied connotation: as an entanglement between social, racial, gender and multispecies justice.

[77] The Care Collective (2020) *The Care Manifesto. The Politics of Interdependence*. London-New York: Verso, 34.
[78] Haraway, D. J. (2016) *Staying with the Trouble*. Duke University Press, 12.
[79] Clarke, A. & Haraway, D. J (2018) *Making Kin not Population: Reconceiving Generations.* Chicago: Prickly Paradigm Press.

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