Reproductive BioMedicine Online (2016) 32, 6–8

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COMMENTARY

Baby factories taint surrogacy in Nigeria

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Abstract The practice of reproductive medicine in Nigeria is facing new challenges with the proliferation of 'baby factories'. Baby factories are buildings, hospitals or orphanages that have been converted into places for young girls and women to give birth to children for sale on the black market, often to infertile couples, or into trafficking rings. This practice illegally provides outcomes (children) similar to surrogacy. While surrogacy has not been well accepted in this environment, the proliferation of baby factories further threatens its acceptance. The involvement of medical and allied health workers in the operation of baby factories raises ethical concerns. The lack of a properly defined legal framework and code of practice for surrogacy makes it difficult to prosecute baby factory owners, especially when they are health workers claiming to be providing services to clients. In this environment, surrogacy and other assisted reproductive techniques urgently require regulation in order to define when ethico-legal lines have been crossed in providing surrogacy or surrogacy-like services.

KEYWORDS: assisted reproductive techniques, baby factory, ethics, infertility, regulation, surrogacy

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The practice of reproductive medicine in Nigeria is facing new challenges with the proliferation of baby factories. These are hospitals, orphanages or homes that have been converted to places for young women to give birth to children for sale on the black market (Makinde et al., 2015). These baby factories are illegal institutions that have been linked to human trafficking rings across the world (Huntley, 2013). Since the first baby factory was discovered about a decade ago, there has been a proliferation of new ones across the southern part of the country. Between 2008 and 2014, 20 baby factories were discovered by law enforcement agents, and more than 290 pregnant or recently delivered women were found within (Makinde et al., 2015). Young women, some of whom are minor teenagers who under law should not be engaging in sex, are either willingly enrolled, or coerced, into baby factories to deliver children that are subsequently trafficked. Others are young women with unwanted pregnancies who only seek shelter in the baby factories and are unaware that their babies will be sold after birth. Some women are kidnapped and subsequently raped, impregnated and held against their will until delivery (Huntley, 2013). There are reports in the Nigerian media of various actors being involved in the baby factory business, including men, whose sole responsibility is to impregnate the women brought there without pregnancy, or to kick start another pregnancy after the delivery of a child (Onuoha, 2014).

Several ethical issues and violations occur in baby factories, including the encouragement of under-aged pregnancy,

http://dx.doi.org/10.1016/j.rbmo.2015.10.001

rape and violence perpetrated on women, trafficking of infants by the lucrative international adoption trafficking rings (Huntley, 2013; Makinde, 2015; Makinde et al., 2015), and possibly children from baby factories ending up as sacrifices in shrines (Cristiansson, 2013). Also, because baby factories are illegal institutions operating in secrecy, it is unlikely that the women in them or the children being born in these baby factories are provided with adequate healthcare services, exposing them to undue hazards and risk of death (Makinde, 2015; Makinde et al., 2015).

Baby factories are thought to have arisen to meet two needs. First, the social stigma attached to desperate teenagers with unwanted pregnancies, who are convinced to give up their babies for a financial benefit (Makinde et al., 2015). Second, the high demand for babies by infertile couples with a desire to complete their family and thereby fulfil a crucial social obligation (Makinde et al., 2015). Thus, the high burden and stigmatization of infertility in Nigeria, and the unwillingness of infertile couples to associate publicly with adoption or surrogacy, contributes to the increased patronage of baby factories (Makinde et al., 2015; Ojelabi et al., 2015). Infertile women may either pretend to be pregnant, or are fooled into believing that they are pregnant (BBC News, 2012; Makinde, 2015). Miracle performers give infertile women drugs that bloat them, giving the impression of pregnancy. They must in turn ensure that the women do not see trained physicians throughout pregnancy or are responsible for their ante-natal care, after convincing them that they carry a miracle pregnancy that will not be visible on ultrasound scans and not amenable to orthodox antenatal care (BBC News, 2012; Oberabor and Fatunde, 2014). At the time they are expected to deliver, those pretending to be pregnant knowingly procure a baby from these baby factories while those fooled are presented babies from these baby factories after being sedated during a sham labour and assisted delivery process (BBC News, 2012; Oberabor and Fatunde, 2014). The involvement of medical and allied health personnel in the operations of baby factories has been reported in national and international media (Nkrumah, 2014; Onuoha, 2014). Health workers are responsible for assisting with deliveries in the baby factories and in some cases own and operate the baby factories, thereby being complicit in the process. One of the health workers caught operating a baby factory claimed to be doing a social service by linking women carrying unwanted pregnancies with those willing to have the children (Nkrumah, 2014). However, this facility was neither registered as a fertility clinic offering surrogacy services, nor an orphanage providing adoption services, despite offering services that could be classified in that category. This case has raised questions as to where and who should be involved in providing surrogacy and adoption services within the country, especially when huge sums of money are being exchanged for these children.

There are two types of surrogacy: gestational and genetic. For gestational surrogacy, the surrogate mother is implanted with an in-vitro fertilized embryo from the parents or donors, whereas in genetic surrogacy, the surrogate mother will also be contributing the egg (Field, 2014). For some classes of surrogacy, neither the spermatozoa nor the egg are genetically linked to either the commissioning couple or the surrogate mother (Field, 2014). The choice and type of surrogacy usually depends on the underlying cause of the infertility. While these forms of assisted reproductive techniques have legally brought childbirth success to many infertile couples in developed countries, they are still evolving in developing countries, and the acceptance of, and knowledge about, these techniques is still limited (Ajayi and Dibosa-Osadolor, 2011).

The similarity in the outcome (children) of both baby factories and surrogacy is undeniably evident. However, the principles of practice are not comparable. Thus, although infants from baby factories are similar to those of the non-genetically linked surrogacy class, because the genetic makeup of the babies differs absolutely from the acquiring parents, in surrogacy, pregnancies are commissioned, whereas baby factories are criminal business ventures. Media reports that baby factories are harbouring women who are delivered of children that are sold and trafficked under shrouded circumstances locally and internationally has led to a negative campaign about such practice in Nigeria (The Guardian, 2014). This further threatens the acceptance of surrogacy, and can result in the stigmatization of anyone known to procure the services of a surrogate because of the perceived similarities between surrogacy and baby factories (BBC News, 2012; Cristiansson, 2013; Oberabor and Fatunde, 2014; The Guardian, 2014). Recent statements in the media, attributed to a public figure, that equated baby factories to surrogacy, suggests that many might be confused about the differences between the two (Omokri, 2015). At the other extreme, others believe that baby factories are human trafficking channels, and this belief has resulted in the banning of all adoptions from Nigeria by the Government of Denmark (The Guardian, 2014).

Surrogacy in Western countries is carried out under strict regulation, which requires formal agreements between the commissioning couple and the surrogate mother. Fertility specialists in these parts of the world also provide counselling and psychotherapy sessions for the surrogates to prepare them for any psychological issues that may arise as a result of the surrogacy process, services that are obviously absent in baby factories. Unlike in surrogacy, there are usually no formal agreements between the women who carry these pregnancies in baby factories and the couples that desire the babies (Onuoha, 2014). Notwithstanding, it should be noted that regulated surrogacy itself is not without its dangers. There have been well-documented instances of surrogate mothers who reneged on agreements made with commissioning couples (Field, 2014; Umeora et al., 2014).

In the absence of surrogacy regulation in Nigeria, fertility specialists practice surrogacy and other assisted reproductive techniques as they deem fit under self-crafted or adopted laws and standards (Ajayi and Dibosa-Osadolor, 2011). Criminals seize on the absence of regulation to establish centres that provide 'surrogacy-like' services. As most countries in sub-Saharan Africa do not yet have laws that regulate surrogacy or other assisted reproductive techniques (Umeora et al., 2014), the potential benefit of regulation of this practice becomes increasingly apparent, given the growing baby factory phenomenon, its similarities with surrogacy and the involvement of health workers in the operation of both (Nkrumah, 2014; Onuoha, 2014). Concern about the legal status of surrogacy has been a long-term issue. It has been referred to by some as a form of slavery, even when regulated (Allen, 1990). In these environments, it has been described as baby selling, womb renting and autonomy sharing. Surrogates have also lost self-autonomy as a result of regulation, whereby they are expected to abide by some

behaviours because of the baby that they carry (Field, 2014). Some countries, such as the UK and Israel, have not legalized *commercial* surrogacy because of concerns about the risk of exploitation and abuse of the surrogacy process (Howard, 2014). India and Thailand, where commercial surrogacy has been legalized, have recently been in the news for some sharp practices and ethical concerns, which has resulted in Thailand banning commercial surrogacy for foreigners (Field, 2014; Howard, 2014; Palattiyil et al., 2010).

Notwithstanding these criticisms, surrogacy, if practised responsibly, is respected by many as a wonderful advance in medical science for helping women with infertility. However, the proliferation of baby factories in Nigeria *is* neo-slavery and a cause for alarm. This practice, under the guise of providing a social service, emphasizes the need for all facilities and professionals providing surrogacy and adoption services in the country to be licensed and to operate under guidelines and codes of practice. Such a procedure will help to ensure that any facility that falls short of standard practice can be held accountable for its actions. There is no better time for surrogacy and other assisted reproductive techniques in Nigeria (and other African countries) to acquire regulation than now. The commodification of the birthing process in Nigeria through the baby factory phenomenon calls for increased action by professionals to become advocates for laws on assisted reproductive techniques. These laws must define who can be involved in the techniques and the guidelines for practice, and must also stipulate punishments for those that violate the rules of the practice. Furthermore, interventions that will reduce the burden of infertility in the population, such as routine screening and treatment for sexually transmitted infection before they cause irreversible damage, would be welcome. Similarly, programmes that will increase the access to assisted reproductive techniques for women and eliminate the financial barriers that characterize assisted reproductive techniques in Nigeria today are necessary. Programmes targeted at educating the population on infertility and at the same time discouraging stigmatization of infertility and encouraging surrogacy will help to reduce the pressure on infertile couples for secrecy, and will secondarily dissuade infertile couples from seeking secret children in baby factories. Baby factories are exploitative criminal manifestations that taint the advancing practice of reproductive medicine and should be publicly rejected by respected professionals in this field before it spreads beyond these current hot spots.

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Declaration: The authors report no financial or commercial conflicts of interest.

Received 5 June 2015; refereed 24 September 2015; accepted 1 October 2015.