Crossing Borders for Reproductive Care: A Systematic Review and Meta-Synthesis of Intended Parents' Experiences

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TABLE OF CONTENTS

List of Figures

List of Tables

Abstract

Cross border reproductive care (CBRC) is a growing global phenomenon where individuals travel abroad seeking assisted and third-party reproductive services. Infertility rates are rising, and the increased accessibility of travel has produced global 'hubs' where intended parents seek fertility treatment to fulfil their parenthood desires. While CBRC has faced social commentary fraught with ethical and moral debate, less attention has been paid to exploring intended parents’ experiences, with much of this understanding remaining fragmented and providing only a partial account of CBRC. Consequently, this research explored intended parents’ experiences embarking on their treatment abroad, their care overseas and their navigation of ethical concerns, by systematically reviewing and synthesising existing CBRC qualitative literature. Seven databases were searched, with 24 included studies synthesised using a meta-aggregative approach following screening and quality appraisal. Key findings concerning the experience of CBRC included: exhaustion of local options for family formation; varied care and assistance from local clinicians; a reliance on peer support to facilitate CBRC; trust as core to the experience of care abroad; overall satisfaction with care abroad; and dissatisfying aspects of overseas care. Additionally, key findings relating to intended parents’ navigation of ethics included: disillusion with and rejection of the exploitation discourse; and attempts to identify, minimise and avoid exploitation. Going beyond the scope of discrete studies, the findings from this meta-synthesis reveal the overall landscape of CBRC and helps inform future practice for all stakeholders, including policy makers and clinicians, to maximise support and positive outcomes throughout the CBRC experience.

Key words: cross-border reproductive care, intended parents, assisted reproduction, meta-synthesis

Declaration

This report contains no material which has been accepted for the award of any other degree or diploma in any university and, to the best of my knowledge, contains no materials previously published except where due reference is made. I give permission for the digital version of this thesis to be made available on the web, via the University of Adelaide’s digital thesis repository, the Library Search and through web search engines, unless permission has been granted by the School to restrict access for a period of time.

27th September 2021

Contribution Statement

In writing this thesis, my supervisor and I collaborated to generate research questions of interest and design the appropriate methodology, before developing and pre-registering the study protocol. I generated the search terms with my research supervisor and in consultation with an experienced research librarian. I conducted the database searches and after I removed all duplicates co-screened a proportion of studies against the inclusion/exclusion criteria with my supervisor, before undertaking the remainder of the screening alone. The reporting quality of a proportion of eligible articles was assessed by myself, my supervisor and an additional student researcher; I then assessed the remainder. I completed data extraction and analysis with guidance from my supervisor and wrote up all aspects of the thesis.

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Crossing Borders for Reproductive Care: A Systematic Review and Meta-Synthesis of Intended Parents' Experiences

Overview

Cross border reproductive care (CBRC) is a growing global phenomenon seeing individuals travel abroad to seek specific assisted and third-party reproductive services (Paulson, 2017; Salama et al., 2018). This behaviour occurs within a broader context of globalisation and technological advances that have paved the way for innovative and alternative conception methods, moving away from the assumption that reproductive care will occur locally with regulated services (Hudson et al., 2011; Jackson et al., 2017). Infertility rates are rising and international travel has become increasingly accessible, invoking the rapid development of commercial infrastructure to support international travellers and service providers throughout their reproductive journey (Inhorn & Patrizio, 2012). Consequently, particular locations have become global ‘hubs’ or epicentres for specific reproductive services, including intracytoplasmic sperm injection (ICSI), in-vitro fertilisation (IVF), sperm donation, egg donation, embryo donation, sex selection or commercial surrogacy (Salama et al., 2018). The implications of CBRC are far reaching, with potential consequences for physical, psychological and social health, as well as broader policy formation. Despite its growing global occurrence, there remains minimal understanding of the experiences that occur for those who undergo CBRC. Therefore, this thesis aims to enhance knowledge by systematically reviewing and synthesising current understandings of the CBRC user experience.

Language and Terminology

The growth of CBRC has been paralleled by a steady increase in social and academic discourse. It is important to note that these discourses often rest on underlying and highly loaded assumptions and misinformation about the parties involved in CBRC. Consequently, there has been much debate surrounding the appropriate terminology to describe CBRC. “Procreative tourism” was a term first coined by Knoppers and Lebris (1991), later shifting to “reproductive tourism” in response to the wider occurrence of international travel for medical care (Martin, 2011). However, an emerging stance suggests that describing reproductive care with such connotations is incongruent with the reality of the physical and emotional hardships for involuntarily childless people seeking assistance (Hudson et al., 2011). Therefore, several commentators (Hudson et al., 2011; Pennings et al., 2008; Shenfield et al., 2011) have endorsed the term cross-border reproductive care. Accordingly, this thesis utilises cross-border reproductive care (CBRC) for the neutrality and dignity it affords all stakeholders. The term intended parent(s) will be used to refer to individuals engaging in CBRC.

Incidence of CBRC

As of 2019, it is estimated that 5% of the European assisted reproduction market derives from CBRC, consisting of 11,000 to 14,000 patients and 24,000-30,000 cycles of treatment (Ferber et al., 2020; Hudson et al., 2011). In the United States of America (USA), approximately 4% of all fertility treatments facilitated are for non-American residents, while 16% of the USA surrogacy market consists of international intended parents (Hudson et al., 2011). The scope of CBRC is expanding, and its incidence is rising, creating an industry worth more than US$22.3 billion globally (Global Market Insights, 2016; Pennings, 2010; Salama et al., 2018).

However, care must be taken when gauging the incidence of CBRC. The complexities of logistical and legal variation between the home country and the country of care make it unclear where the responsibility for data collection lies. After attempting to capture the incidence of CBRC, Hughes et al. (2016, p.789) concluded, "clinicians are not motivated to collect even the simplest of data regarding CBRC patients". Consequently, the rather disjointed insights into the incidence and scope of CBRC underscore the need to establish national registries and unified data collection to quantify the occurrence of CBRC accurately.

Current Understandings of CBRC

Underlying Motivations for CBRC

While the current literature is incomplete, it simultaneously captures the complex factors driving people to seek CBRC. Ultimately, the common thread between those seeking CBRC stems from infertility. Traditionally, infertility is a biological phenomenon defined as failure to achieve a pregnancy after 12 months or more of regular unprotected sexual intercourse (Gurunath et al., 2011). Beyond this definition, however, there is recognition of social-based infertility encompassing LGBTQ+ (lesbian, gay, bisexual, transgender & queer +) couples who cannot conceive without assistance from a third-party, or single individuals wishing to conceive (Ireni-Saban, 2016). Despite the World Health Organisation (WHO) and the International Committee for Monitoring Assisted Reproductive Technologies (ICMART) declaring that infertility should be classified as "a disease of the reproductive system", the literature reflects that infertility is not a disease but rather a condition largely influenced by social, cultural and psychological factors (Crozier & Martin, 2012; Ireni-Saban, 2016).

The factors influencing infertility and the heterogeneity of CBRC seekers are captured in the observations of Inhorn and Patrizio (2009), who identify seven discrete factors motivating CBRC: [1] countries prohibiting specific services for religious or ethical reasons; [2] unavailability of specific services relating to lack of expertise, infrastructure or technology; [3] a ruling that a service is unsafe or the risks are unknown; [4] certain groups of people may be excluded from services based on age, marital status or sexual orientation; [5] unavailability of services as demand outweighs supplies, resulting in shortages and long waitlists; [6] service affordability overseas; and [7] travelling to preserve privacy in the home country. While these motivations are echoed throughout the literature, the varying significance of these factors remains speculative (Inhorn & Patrizio, 2009; Ethics Committee of the American Society for Reproductive Medicine, 2016). Indeed, much of the empirical work has drawn from clinician accounts rather than patients' perspectives of motivations behind travelling for reproductive care (Hudson et al., 2011).

Controversies and Concerns Surrounding CBRC

Meeting at the intersection of politics, sociology, religion and law, CBRC is surrounded with contentious debate (Couture et al., 2019; Hudson et al., 2011; Ikemoto, 2009; Jackson et al., 2017; Pennings et al., 2008). Many celebrate the advantageous aspects of CBRC, such as improved access and reduced costs of care, circumventing discrimination in domestic care, and generating revenue for local economies in abroad (Ethics Committee of the American Society for Reproductive Medicine, 2013). However, innovations in reproductive technologies, increased accessibility via the Internet, and the development of highly competitive global economies remains a source of ambivalence for many commentators.

The rapid expansion of CBRC has left industry bodies, human rights representatives and scholars urging reform and restraint to manage the potential commercialisation, commodification and exploitation of patients, donors and surrogates (Bromfield & Rotabi, 2014; Ferber et al., 2020; Damelio & Sorensen, 2008). Much of the attention is directed towards third-party reproduction, such as surrogacy and gamete donation, where critics contend that power imbalances between third-parties and intended parents leads to the exploitative relationships between women in low-income settings and wealthy intended parents (Ballantyne, 2014). Additionally, feminist scholars have criticised third-party reproduction as commodifying women's reproductive capacity (Markens, 2012).

Other commentators express concern for the safety and wellbeing of intended parents during CBRC. It appears that intended parents largely facilitate cross-border arrangements online and sidestep professional support in their home country; owing to the negative connotation of law evasion and taboo surrounding CBRC (Blyth, 2010; Blyth et al., 2011; Hudson et al., 2011; Rodino et al., 2014). Consequently, doubts have been raised about the standards of overseas clinics, quality of care, provision of patient support, as well as language barriers, and how these factors may compromise the safety of intended parents (Blyth et al., 2011; Ferraretti et al., 2010; Pennings et al., 2008; Shenfield et al., 2011).

These concerns for patients are exacerbated by the exceedingly bewildering and ambiguous legal environment that CBRC occurs within, typically involving mismatches between laws in the respective jurisdictions of residence and service provision (Jackson et al., 2017). Domestic legal regimes simultaneously prohibit the very services forcing people to travel to fulfil their procreative desires yet facilitate the arrangements through citizenship and parentage provisions (Jackson et al., 2017). As a result, patients often find themselves navigating an extraordinarily grey area of the law. In the face of negligence, travellers may lack protection in destination countries without medical malpractice laws and restricted jurisdictional reach (Blyth et al., 2011).

Reported Experiences of CBRC Intended Parents

Despite the concerns surrounding CBRC, the emerging evidence suggests a disjunction between broader commentary and intended parents' experiences. In 2011, Hudson et al. reviewed the CBRC literature, which addressed the experiences of participating parties, including intended parents. While some of the concerns noted above were raised, ultimately, those who had accessed CBRC reported a generally positive experience and were satisfied with shorter waiting times and donor availability (Hudson et al., 2011). Notably, Shenfield et al.'s (2010) study reported that 90% of participants felt they received satisfactory information in their language; contrary to concerns raised by commentators in the literature (Hudson et al., 2011). However, the authors highlighted the shortcomings of the existing literature on patient experiences, noting that studies often adopted predefined survey questions lacking the nuance to thoroughly capture many aspects of CBRC (Hudson et al., 2011). Indeed, only five of the ten papers pertaining to CBRC experiences used qualitative methods.

Following this review, Inhorn and Gürtin (2011) outlined a future research agenda for CBRC and emphasised the need for more rigorous data collection relating to CBRC experiences and outcomes. Subsequently, there has been a growing effort to centre patient voices and capture experiences of CBRC. Hudson et al. (2016) and Rodino et al. (2014) explored CBRC experiences in the United Kingdom (UK) and Australia/New Zealand, respectively. Both studies found patients viewed CBRC more favourably than care in their home country. Notably, intended parents reported regaining a sense of control over their treatment, negotiating their care pathway more liberally and that communication overseas was more favourable compared to prior domestic experiences (Hudson et al., 2016; Rodino et al., 2014).

Issues in the CBRC Research

The published data regarding CBRC experiences is scarce, meaning CBRC remains shrouded in mystery. To date, much of the literature comprises investigative journalism and scholarly commentary centred on the problematisation of wealthy, 'Western' clients obtaining services in lower-income countries (Jacobson, 2020). However, the emerging evidence suggests a substantial disjunction between the general representation of CBRC patients in the literature and their reported experiences of accessing CBRC and its associated hardships (Payne et al., 2020). Of particular concern is the number of scholars who draw from press reports to bolster their claims about CBRC (Hudson et al., 2011).

Although CBRC is a significant point of discussion, it remains under-theorised and under-researched. While empirical investigations and commentaries have offered important perspectives concerning a range of issues that can arise in CBRC, much of this work has been fragmented and, at times, lacks a substantial evidence base. Without robust, empirical data, it is difficult to correctly distinguish between commentators’ speculative hypotheses and intended parents’ lived experiences. Emerging research exploring experiential perspectives appears to complicate and, at times entirely, contradict the longstanding assumptions that dominate CBRC discussions. The CBRC industry involves many stakeholders, including intended parents, doctors, brokers, and third-parties. For too long, speculation by outside parties has dominated perceptions of CBRC, with little attention given to those at the forefront of the industry – intended parents. Given the scope of CBRC and its occurrence as an important life event globally, a more cohesive effort to understand the experiences of intended parents is warranted.

Research Aims

This study’s primary purpose is to capture firsthand experiences of CBRC and illuminate the common perspectives, considerations and dilemmas that arise. By synthesising the existing qualitative literature, this thesis aims to offer a more comprehensive interpretation of the CBRC experience beyond the scope of discrete studies to reveal the overall landscape of CBRC for intended parents. By drawing from intended parents’ voices, results from this systematic review and meta-synthesis may inform future practice and due diligence for all stakeholders, including regulators and policymakers, to maximise support and positive CBRC outcomes. With this overarching aim guiding the research, the following questions will be addressed:

1) What are intended parents’ experiences as they come to embark on CBRC?
2) What are intended parents’ experiences throughout their care abroad?
3) How do intended parents experience and navigate the ethical contentions associated with CBRC?

Method

Design

Qualitative syntheses are proliferating health and medical research, allowing researchers to examine participant experiences and perspectives, not only at an individual level but more broadly, by integrating studies from various contexts and populations (Lachal et al., 2017). When synthesising qualitative evidence, the meta-aggregative approach is particularly favoured due to its similarities with the Cochrane process of systematic reviewing used for quantitative studies (Pearson & Hannes, 2012). Meta-aggregation reflects a rigorous process centred on transparency, auditability and reliability that is sensitive to the complexity of interpreting and understanding qualitative research (Hannes & Lockwood, 2011). Consequently, the current study adopted a meta-aggregative approach.

The defining feature of meta-aggression is its alignment with the philosophy of pragmatism, whereby meanings are drawn across qualitative studies to deliver synthesised practical statements or "lines of action" that transcend theory production and are grounded in the voices of relevant stakeholders (Hannes & Lockwood, 2011; Pearson et al., 2011). In this sense, meta-aggregation is appropriate when faced with heterogeneity across studies, as the findings are pooled to inform, develop, implement and evaluate health interventions and practices, regardless of methodology (Hannes & Lockwood, 2011; Munn et al., 2019). Thus, meta-aggregation is not focused on the re-interpretation or re-analysis of primary data but seeks to categorise data based on similarity in meaning before synthesising them into a single comprehensive set of findings (Pearson et al., 2011). This meta-synthesis was preregistered (PROSPERO ID: 260213).

Search Strategy

The *Preferred Reporting Items for Systematic Reviews and Meta-Analyses* (PRISMA) guidelines were adhered to throughout the review process (Page et al., 2021). Seven databases (Pubmed, PsycINFO, Embase, CINAHL, Scopus, Sociological Abstracts and Web of Science) were systematically searched from database inception until April 2021 to identify qualitative studies examining intended parents’ experiences of CBRC, with identified articles imported and screened in Endnote. Additionally, databases alerts were created to identify studies indexed or published after the initial search and assess them for possible inclusion. Working with a research librarian, a search strategy combining controlled vocabulary, free-text search terms and Boolean logic (Table 1) was developed according to each database (Appendix A), including terms such as "cross-border", "reproductive treatment", "qualitative research", "lived experience" and appropriate variants. Finally, reference lists of articles that satisfied inclusion criteria were checked manually for eligible articles.

Eligibility Criteria and Study Selection

Studies were selected for inclusion if they (i) explored intended parents’ experiences of CBRC; (ii) reported primary data; (iii) reported qualitative data (mixed method studies were eligible if qualitative data was reported separately and in sufficient detail for analysis); (iv) were published in English in a peer-reviewed journal. Data was deemed qualitative if it was obtained through qualitative collection methods, such as interviews or ethnographies, or analysed using qualitative methods, such as thematic analysis. Exclusion criteria were letters, editorials, conference abstracts and unpublished dissertations. For this thesis, studies that only reported the experiences of other CBRC stakeholders (e.g., clinicians, surrogates, donors) were excluded.

Table 1

Search Terms and Boolean (Logical) Operators used in the Database Searches

AND ⇨

OR ⇩

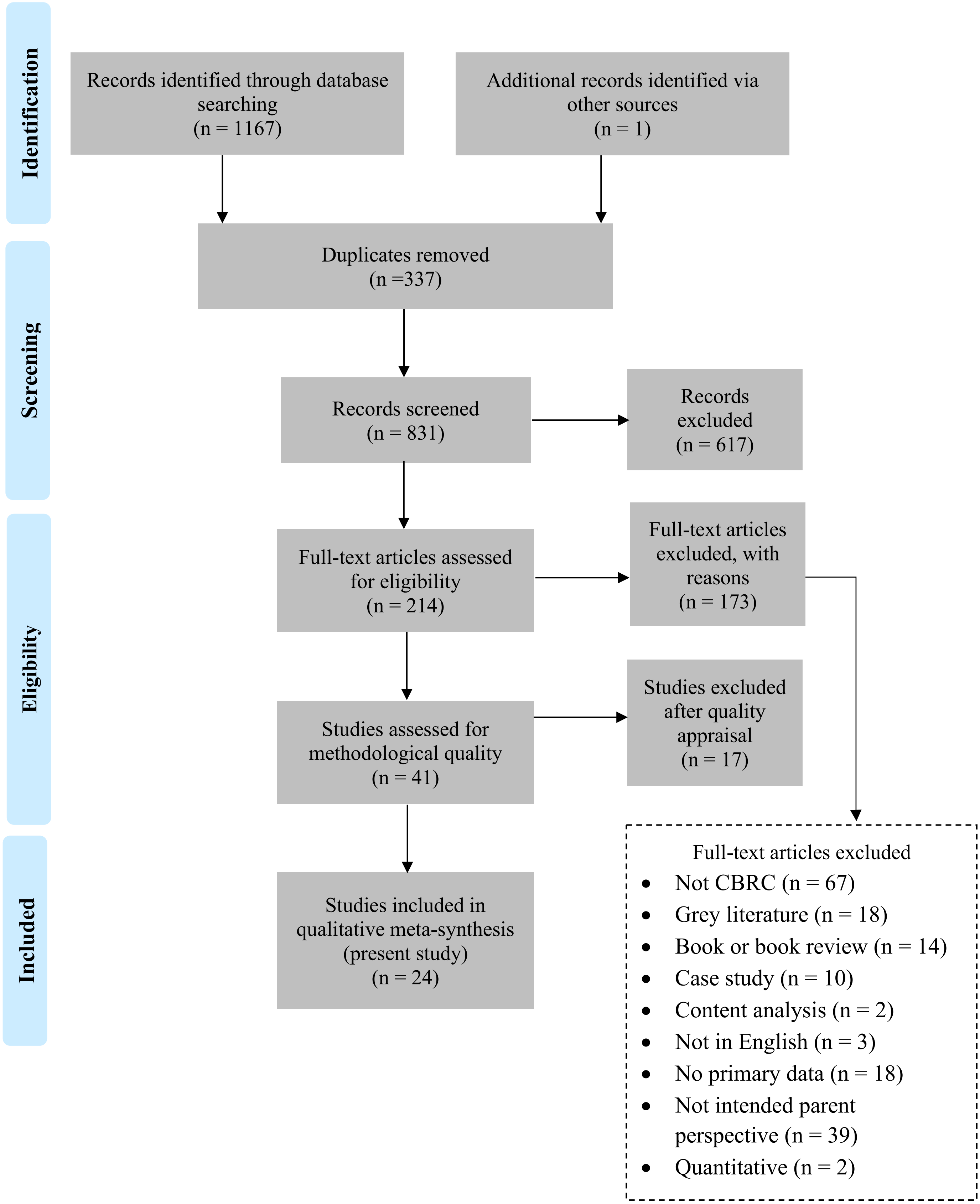
Reproductive Treatment	*Cross-Border*	*Qualitative*
assisted reproduction fertility treatment infertility treatment reproductive technolog* reproductive technique egg donation sperm donation embryo donation gamete donation oocyte donation surrogacy ICSI IVF in vitro fertili?ation sex selection third-party reproduction reproductive treatment	Medical tourism[mh] OR cross-border international transnational foreign reproductive tourism reproductive travel fertility tourism procreative tourism fertility tourist reproductive tourist circumvention tourism	qualitative* focus group* interview* thematic analys* content analys* lived experience* personal experience* interpretative phenomenology* analys* ethnograph* case stud* narrative*

Note. Search terms included stated terms in both singular and plural forms.

The initial search yielded 1167 citations (see Figure 1). After the removal of 337 duplicates, 831 studies were screened by title and abstract Additionally, one further study was added for inclusion after searching study reference lists. The author and the research supervisor co-screened a randomly selected sample of 95 articles for eligibility (approximately 10% of citations for title and abstract screening) to minimise data selection bias. Interrater agreement was high (99%, $K = .95$, $p<.05$) and disagreements were resolved through consensus discussion. The full texts of 214 potentially eligible articles were examined according to inclusion/exclusion criteria, resulting in 41 studies assessed for methodological reporting quality. Seventeen studies were excluded based on the quality assessment; consequently, the meta-synthesis comprised 24 studies.

Figure 1

PRISMA Flowchart of Study Selection Process for Comprehensive Systematic Review (Page et al., 2021)



Quality Appraisal

Critical appraisal forms an integral part of the meta-aggregative approach, allowing researchers to consider the features of a published article contributing to its methodological rigour and subsequently influence the quality of the resultant synthesis (Lachal et al., 2017; Pearson, 2004). The *QualSyst Quality Assessment Checklist* (Kmet et al., 2004) was adopted to evaluate the rigour of eligible papers for this meta-synthesis. The checklist was utilised by the author, a second student researcher and the research supervisor to co-appraise a proportion of papers before the author appraised the remainder.

Each study was appraised on the extent to which it met 10 item-specific criteria on a three-point scale (*yes* = 2, *partial* = 1, *no* = 0). Summary scores were calculated for each study by summing the total score obtained across checklist items and dividing by the total possible score of 20, yielding a possible score of 0-1, whereby higher scores pertained to superior quality. Variances in the appraisal process were resolved through reviewer discussion. The authors of QualSyst recommend a liberal cut-off score of .55/1.0 and a conservative score of .75/1.0 (Kmet et al., 2004). Only 24 high-quality studies that met the conservative cut-off were included in the current study; scores ranged between .75 and .95 (Appendix B for full assessment).

Data Extraction and Synthesis

PRISMA guidelines informed data extraction techniques, with a study-specific data extraction sheet (Appendix C) developed to gather study characteristics and relevant findings from included studies. This research also followed the Enhancing Transparency in Reporting the Synthesis of Qualitative Research (ENTREQ; Tong et al., 2012) framework, a 21-item checklist used to report the synthesis of qualitative health research (Appendix D). Data extracted consisted of (i) sample characteristics (e.g., sample size, gender, age; home country); (ii) CBRC characteristics (e.g., type of care sought, country of care); (iii) study characteristics (e.g., study aim, design, recruitment source) and (iv) lived experience.

Using a deductive meta-aggregative approach, primary data from included studies were categorised according to the research questions, based on similarity in meaning and synthesised into a set of comprehensive findings (Pearson et al., 2011). Preliminary extraction was supplemented by verbatim identification of categories and themes from the authors of the included studies. These were supported by accompanying illustrative extracts. In the event of a publication with no author-identified themes, findings in the form of definitive statements made by primary authors were extracted from the narrative following a discussion between the author and research supervisor.

Reflexivity Statement

Integral to qualitative research, self-reflexivity is an introspective process that promotes self-awareness and authenticity with one's self, research and audience (Tracy, 2010). Mindful of this, the author is a young, white, cisgender woman from a high-income country (Australia) with no lived experience of family formation, infertility, nor CBRC. Caution was taken throughout the research to minimise bias via discussion with the research supervisor. It is hoped that the distant position of the author from the topic has afforded a sense of neutrality and open-mindedness regarding CBRC.

Results

Study Characteristics

The key characteristics of the 24 included studies are provided in Table 2. The studies were published between 2011 and 2021 and documented the experiences of intended parents from a range of countries, with most studies drawing from intended parents originating from Australia ($N_{studies} = 8$), the UK ($N_{Studies} = 6$) and the USA ($N_{Studies} = 4$). Similarly, the destinations/country of care also comprised various countries, with most examining India ($N_{Studies} = 13$) and the USA ($N_{Studies} = 11$; see Figures 2 and 3 for a detailed breakdown of the countries of origin and care). Meanwhile, despite the included literature documenting several forms of CBRC, commercial surrogacy featured in over half of the studies ($N_{Studies} = 15$) (Figure 4). Qualitative data were collected via interviews ($N_{Studies} = 17$) and ethnographies ($N_{Studies} = 7$), and most adopted thematic analysis ($N_{Studies} = 19$).

Participant Characteristics

The sample comprised 677 individuals who had or were in the process of accessing CBRC ($N_{Studies} = 24$; see Table 3). Participants were aged between 25 and 60 years, based on 198 participants ($N_{Studies} = 7$), with a mean age of 38.3 years, according to the data from 222 participants ($N_{Studies} = 7$). The standard deviation for participant age was 5.5 years ($N_{Studies} = 2$). The sample contained 189 females ($N_{Studies} = 10$) and 187 males ($N_{Studies} = 13$). Most participants were partnered, based on 251 participants ($N_{Studies} = 14$), while 13 were single ($N_{Studies} = 4$). One-hundred and ninety-three participants were heterosexual ($N_{Studies} = 9$), 79 were gay ($N_{Studies} = 7$), 30 were lesbian ($N_{Studies} = 2$), and 1 was bisexual ($N_{Studies} = 1$).

Table 2

Characteristics of Included Studies

Lead Author (Year)	Country (Origin)	Country (Destination)	Type of CBRC	Sample Size (n =)	Recruitment Source	Methodology		QualSyst Summary Score
						Data Collection	Data Analysis	
Arvidsson (2015)	Sweden	India, USA, Northern Europe	Commercial Surrogacy	30	Infertility NGOs, snowball sampling & word of mouth.	Semi-structured interviews	Thematic Analysis	.90
Carone (2016)	Italy	USA, Canada	Commercial & altruistic Surrogacy	30	Snowball sampling within main Italian LGBTQ+ parenting & planning association.	Interviews	Interpretive phenomenological Analysis	.95
Couture (2019)	Canada	Unspecified	Assisted reproduction (without donation), sperm donation, oocyte donation	17	Purposeful selection during fieldwork, supplemented through treating physicians and other stakeholders connected to CBRC intended parents.	Ethnography	Thematic Analysis	.80
Deomampo (2013)	USA, Australia, Norway, France, Canada, Israel, Netherlands	India	Commercial Surrogacy	39	Referral from fertility clinic staff in India, supplemented with snowball sampling following initial contact.	Ethnography	Thematic Analysis	.85

						Methodology		
Lead Author (Year)	Country (Origin)	Country (Destination)	Type of CBRC	Sample Size (n =)	Recruitment Source	Data Collection	Data Analysis	QualSyst Summary Score
Gezinski (2018)	Germany, Australia, USA, Israel, UK	Mexico, Thailand, India, USA	Commercial Surrogacy	10	Purposeful sampling via staff of various international surrogacy networking non-profits and Facebook groups.	In-depth interviews	Interpretative Phenomenological Analysis	.90
Hanefield (2015)	UK	Czech Republic, Ukraine, Sweden, Spain, Cyprus	IVF, ICSI, egg donation, sperm donation	9	Advertisement on the medical tourism research project website, posts made to online support or information forums, media contact & patient testimonials.	Interviews	Thematic Analysis	.90
Hovav (2020)	Unspecified	Mexico	Commercial Surrogacy	26	Multi-sited, iterative approach using snowball sampling of sites, including fertility clinics, surrogacy agencies & surrogacy conferences.	Ethnography	Abductive Analysis	.80
Hudson (2013)	UK	Unspecified	Egg donation, sperm donation, IVF (donor gametes)	44	Referral from professionals in the field knowledgeable about patients who had either been abroad or were considering having treatment outside their own country.	In-depth interviews	Systematic Thematic Coding	.75

Lead Author (Year)	Country (Origin)	Country (Destination)	Type of CBRC	Sample Size (n =)	Recruitment Source	Methodology Data Collection	 Data Analysis	 QualSyst Summary Score
Hudson (2016)	UK	Spain, Czech Republic, Ukraine, Greece, South Africa, Cyprus, Russia, USA, Barbados, Norway, India, Hungary, Denmark	IVF (donor gametes), oocyte donation, sperm donation, embryo donation	51	Online patient forums; support group newsletters and mailings; media coverage about the project; word of mouth; overseas clinics; and UK clinics.	In-depth Interviews	Thematic Analysis	.80
Hudson (2017)	UK	Spain, Czech Republic, Ukraine, Greece, South Africa, Cyprus, Russia, USA, Barbados, Norway, India, Hungary, Denmark	IVF (donor gametes), oocyte donation, sperm donation, embryo donation	29	Online patient forums; support group newsletters and mailings; media coverage about the project; word of mouth; overseas clinics; and UK clinics.	In-depth Interviews	Thematic Analysis	.75

						Methodology		
Lead Author (Year)	Country (Origin)	Country (Destination)	Type of CBRC	Sample Size (n =)	Recruitment Source	Data Collection	Data Analysis	QualSyst Summary Score
Jackson (2017)	Australia	India, Thailand, Mexico, Greece, Canada & USA	Commercial surrogacy, egg donation	28	Multi-method recruitment process using clinical avenues and broader advertising to the public	Semi-structured interviews	Thematic Analysis	.90
Machin (2018)	Angola	Brazil	Unspecified	14	Non-probabilistic sampling	Semi-structured interviews	Thematic Analysis	.90
Millbank (2019)	Australia	India, Thailand, Nepal, Mexico, Spain, South Africa, Greece, Canada & USA	Commercial surrogacy, egg donation, embryo donation	39	Unspecified	Semi-structured interviews	Thematic Analysis	.85

Lead Author (Year)	Country (Origin)	Country (Destination)	Type of CBRC	Sample Size (n =)	Recruitment Source	Methodology		
						Data Collection	Data Analysis	QualSyst Summary Score
Nebeling Petersen (2018)	Denmark	USA, India, Thailand	Commercial surrogacy	15	Private surrogacy Facebook groups and word of mouth.	Interviews	Feminist Analysis[1]	.80
Pande (2015)	Unspecified	India	Commercial surrogacy	12	Surrogacy clinic in India.	Ethnography	Ethnographical Analysis	.85
Riggs (2015)	Australia	India	Commercial surrogacy	12	Flyer circulated to members of the advocacy group Surrogacy Australia via the group's administrator.	Interviews	Thematic Analysis	.75
Rudrappa (2015)	Australia, USA	India	Commercial surrogacy	20	Online surrogacy blogs, supplemented with snowball sampling through intended parents.	Semi-structured interviews	Thematic Analysis	.75

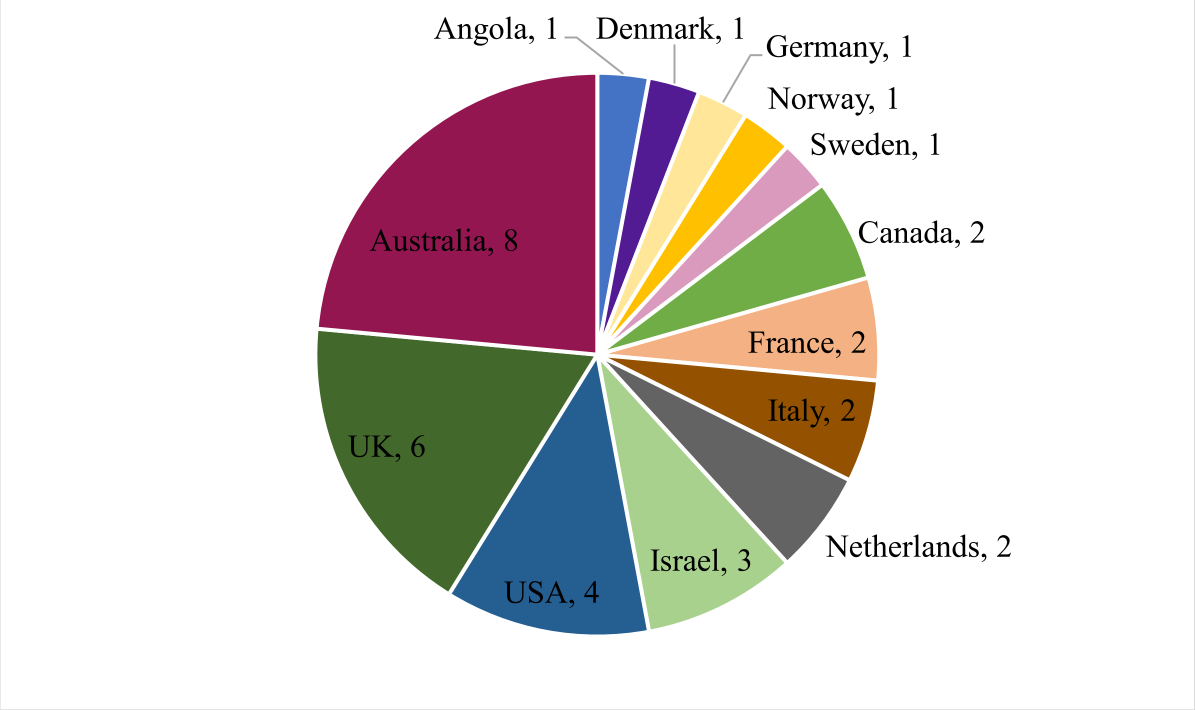
						Methodology		
Lead Author (Year)	Country (Origin)	Country (Destination)	Type of CBRC	Sample Size (n =)	Recruitment Source	Data Collection	Data Analysis	QualSyst Summary Score
Schurr (2018)		Mexico	Commercial surrogacy	19	Contact facilitated by surrogacy agencies and fertility clinics, Facebook groups, surrogacy fairs and snowball sampling.	Ethnography	Thematic Analysis	.75
Smietana (2021)	USA, Australia, Western, Northern & Southern Europe	India, USA, Russia	Commercial surrogacy	65	Contact through surrogacy and ART clinics as well as associations formed by surrogacy families.	Ethnography	Thematic Analysis	.80
Stuhmcke (2021)	Australia	USA, India, Thailand, Nepal, Mexico, Spain, South Africa, Greece, Canada	Commercial surrogacy, egg donation	56	Unspecified	Interviews	Thematic Analysis	.85
Van Hoof (2014)	Netherlands	Belgium	ICSI, IVF, IUI with sperm donation	32	Purposeful sampling from a Belgian IVF clinic based on age, number of previous treatments and distance from clinic.	Semi-structured Interviews	Thematic Analysis	.90

						Methodology		
Lead Author (Year)	Country (Origin)	Country (Destination)	Type of CBRC	Sample Size (n =)	Recruitment Source	Data Collection	Data Analysis	QualSyst Summary Score
Van Hoof (2015)	France	Belgium	IVF with sperm donation	24	Purposeful sampling at the department of reproductive medicine at Ghent university hospital.	Semi-structured interviews	Thematic Analysis	.90
Zanini (2011)	Italy	Spain, Denmark, Belgium, Czech Republic, Greece, Ukraine, Canada	Unspecified	40	Specialised websites and online forums; gay family associations; word-of-mouth advertising during a 1-month ethnographic stay in an IVF clinic in Barcelona, where incoming patients were interviewed.	Ethnography	Thematic Analysis	.75
Ziv (2015)	Israel	India, USA	Commercial surrogacy	16	Clients of two Israeli agencies that provide surrogacy services overseas.	In-depth structured interviews	Thematic Analysis	.80

Note. ART = Assisted Reproductive Technology

Figure 2

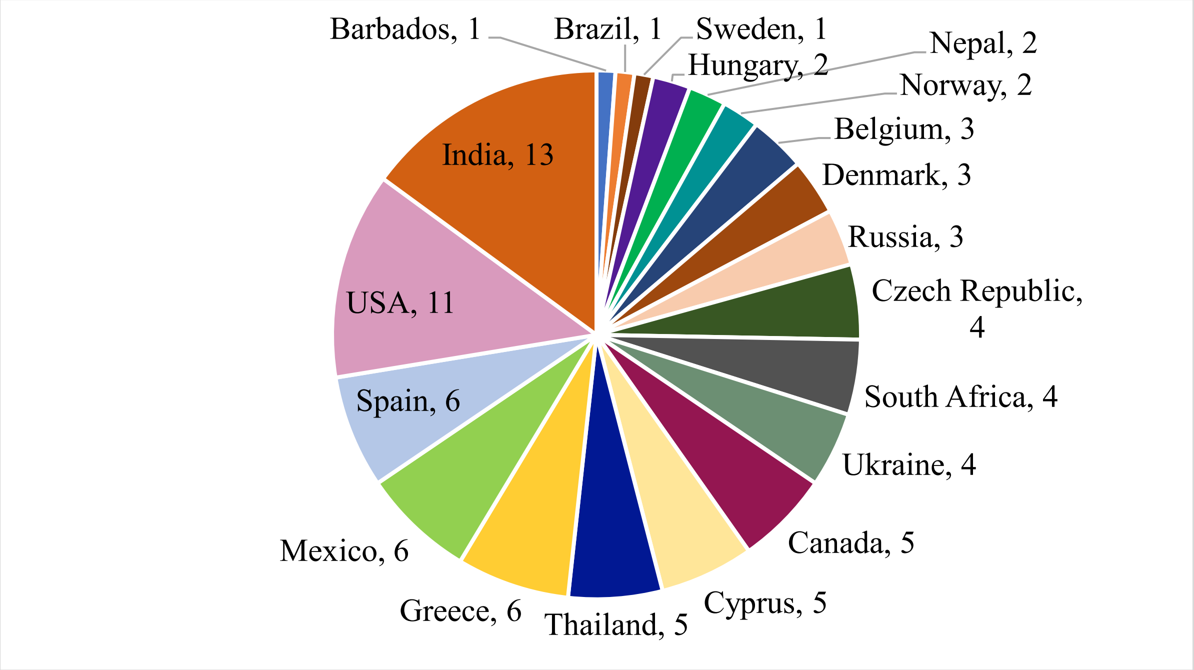
Intended Parents' Country of Origin (by $N_{studies}$)



Note. $N_{studies}$ = number of studies

Figure 3

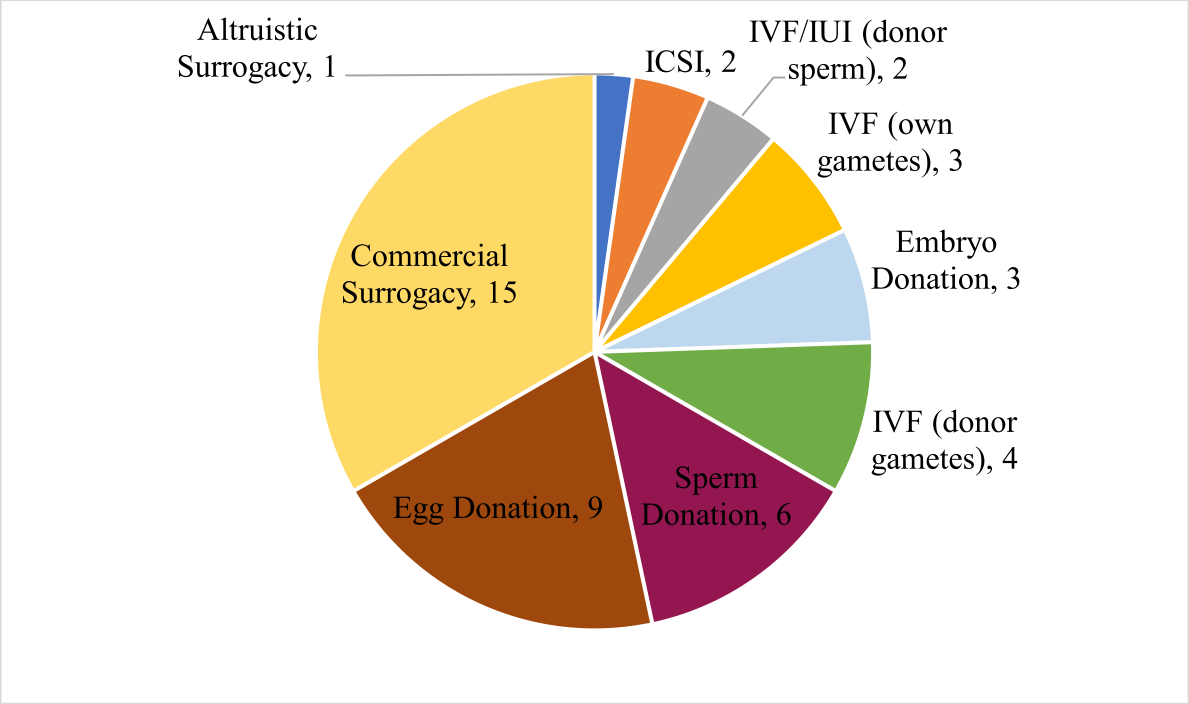
Intended Parents' Country of Care (by $N_{studies}$)



Note. $N_{studies}$ = number of studies

Figure 4

Type of Cross-Border Care Sought (by $N_{studies}$)



Note. $N_{studies}$ = number of studies; *ICSI = Intra-Cytoplasmic Sperm Injection; IVF =In Vitro Fertilisation; IUI = Intrauterine Insemination*

Table 3

Participant Characteristics of Included Sample (N = 677)

Variable	$N_{studies}$	$N_{participants}$	M	SD	Range
Intended Parents	24	677			
Age (years)	7	222	38.3		
	2			5.5	
	7	198			25-60
Gender					
Female	10	189			
Male	13	187			
Relationship status					
Partnered	14	251			
Single	4	13			
Civil Partnership	1	1			
Sexuality					
Heterosexual	9	193			
Gay	7	79			
Lesbian	2	30			
Bisexual	1	1			

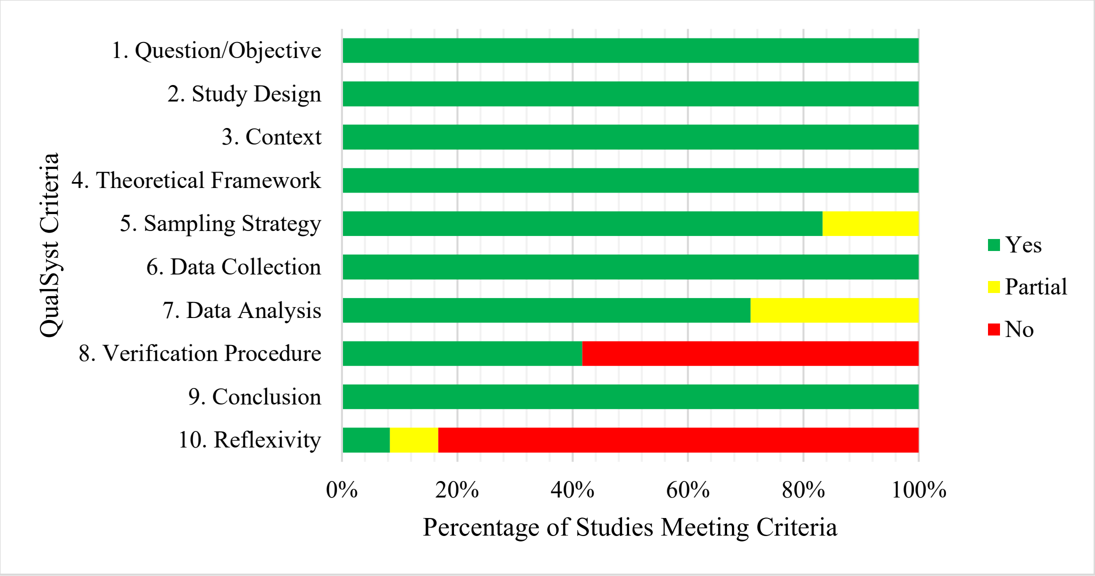
Note. $N_{studies}$ = number of studies; $N_{participants}$ = number of participants; M = Mean; SD = standard deviation

Reporting Quality of Included Studies

The 24 included studies were of high quality and possessed scores ranging from .75 to .95, with most studies at least partially fulfilling 8 of the 10 criteria (see Figure 5). All studies comprehensively addressed and detailed the study objective, design, context, theoretical framework, data collection methods and conclusion (*Items1-4, 6* and *9*: 100% fulfilled). Most studies adequately detailed the sampling strategy used (*Item 5*: 83% fulfilled) and fully described data analysis (*Item 7*: 71% fulfilled). Additionally, many studies detailed their verification procedures (*Item* 8: 42% fulfilled), while few studies comprehensively reported the use of reflexivity (*Item* 10: 8.33% fulfilled).

Figure 5

QualSyst Criteria Scores by Percentage of Included Studies



Synthesised Findings

Overview

From experiences reported in the 24 included studies, three synthesised findings relating to the research questions were generated (see Table 4). The meta-synthesis resulted in eight categories: exhaustion of local options for family formation; varied care and assistance from local clinicians; a reliance on peer support to facilitate CBRC; trust as core to the experience of care abroad; overall satisfaction with care abroad; dissatisfying aspects of overseas care; disillusion with and rejection of the exploitation discourse; and attempts to identify, minimise and avoid exploitation.

Intended Parents' Experiences Preparing for CBRC

The meta-synthesis of intended parents' experiences that led them to embark on CBRC was derived from 15 studies, grouped into three categories (Table 4) to generate the overall synthesised finding: *After exhausting local fertility service options, intended parents turn to CBRC as a last resort and embark on their overseas fertility journey with minimal support from local care providers, instead relying on unofficial peer guidance.*

Exhaustion of Local Options for Family Formation. For most intended parents, CBRC came after exhausting local treatment options. Available treatment options varied across jurisdictions, however logistical and legal barriers typically constrained intended parents’ access to domestic care (Arvidsson et al., 2015, Deomampo, 2013; Gezinski et al., 2018; Stuhmcke, 2021; Van Hoof et al., 2014; Zanini, 2011). For many intended parents, the decision to undertake CBRC followed local fertility care marked by health complications and unsuccessful conception attempts (Arvidsson et al., 2015; Gezinski et al., 2018):

Table 4

Synthesised Findings and Component Categories of Experiences of CBRC among Intended Parents

Experiences Preparing for CBRC: After exhausting local fertility service options, intended parents turn to CBRC as a last resort and embark on their overseas fertility journey with minimal support from local care providers and subsequently rely on unofficial peer guidance.

- Exhaustion of local options for family formation prior to embarking on CBRC
- Varied care and assistance from local clinicians to prepare for CBRC
- A reliance on peer support and information to inform CBRC

Experiences of Care Abroad: CBRC relies on a trusting relationship between intended parents and facilitators of care abroad, leading to positive experiences characterised by a sense of control, individualised care and professionalism, as well as negative experiences associated with navigating an unfamiliar environment, a loss of control and poor post-birth support.

- Trust as core to intended parents' experiences of care abroad
- Overall satisfaction with care abroad
    - A sense of control and empowerment in decision making
    - Individualised care provision
    - Professional and informative care provision

- Poor care provision compromising CBRC experiences
    - Lack of familiarity with surroundings and language barriers
    - Loss of control and disconnection from the pregnancy
    - Limited follow-up and poor post-birth support

Experiences Navigating the Ethical Contentions Associated with CBRC: Intended parents reject the exploitation discourse and actively work to minimise the potential for exploitation through their choice of CBRC destination, framing surrogacy as a "win-win" and advocating for law reform.

- Disillusion with and rejection of the exploitation discourse
- Attempts to identify, minimise and avoid exploitation
    - Choice of destination mediating exploitation risk
    - Reframing CBRC as a win-win
    - Advocating for legislative change in the home country

> *I had six attempts here in Australia with IVF, and . . . I had two miscarriages and an ectopic pregnancy by this stage. . . . [The physician] said that my adenomyosis was so severe . . . my uterus was never going to stretch beyond nine weeks.* (Gezinski et al., 2018, p.178)

These experiences of local treatment prior to CBRC were often depicted as lengthy, convoluted and unexpected (Gezinski et al., 2018; Stuhmcke, 2021; Zanini, 2011):

> *We've gone from hoping we could do it ourselves, to needing an egg donor, to needing a sperm donor, to using overseas eggs, to being fortunate enough to have access to some donor embryos, to possibly considering a surrogate, to considering a surrogate overseas.* (Stuhmcke, 2021, p.11)

For other intended parents, CBRC was a solution for long waiting times or unsuccessful attempts locally (Hanefield et al., 2015; Hudson et al., 2016; Van Hoof et al., 2014; Van Hoof et al., 2015). In these instances, travelling abroad offered increased ease and preference for treatment access, particularly for intended parents who felt biological time pressure to conceive:

> *I also have to say that we actively went looking for a solution to our problem because if you look for a certain recognition of your preferences and well there is a chance of disappointment that it is not available to you nearby, but I think it is an attitude. I think we are very active and keep on looking for solutions.* (Van Hoof et al., 2014, p.190)

Ultimately, intended parents emphasised that CBRC was the last resort in their quest for family formation (Arvidsson et al., 2015, Deomampo, 2013; Gezinski et al., 2018; Stuhmcke, 2021; Van Hoof et al., 2014; Zanini, 2011): *"I reached the point where my body said 'Enough, no more now'. Knowing that I've done all that I can, made me feel reassured about taking that decision [regarding surrogacy]"* (Arvidsson et al., 2015, p.5). As a last resort, the decision to access CBRC was carefully considered over time (Arvidsson et al., 2015; Gezinski, 2018): *"…We wanted to reach the conclusion that this is actually defensible and the right thing to do. So this was a big process as well"* (Arvidsson et al., 2015, p.5).

In contrast to heterosexual intended parents who exhausted local options before CBRC, for many gay and lesbian intended parents, CBRC was their only option for family formation (Arvidsson et al., 2015; Deomampo, 2013; Gezinski et al., 2018; Nebeling Petersen, 2018; Stuhmcke, 2021). For these intended parents, there was no exhaustion of local options because their sexuality precluded treatment access altogether: *"They don't recognize our child wish, not in France at least. Because of our sexual orientation we do not have the right to have children. So yes, I agree, they fail to recognize our wish…"* (Van Hoof et al., 2015, p.393). Many expressed frustrations with the hypocrisy of local laws forcing them abroad for family formation (Van Hoof et al., 2015; Zanini, 2011):

> *The fact that you must to go to another country to get reproductive assistance makes you think. [...] This is unfair. Really unfair. It makes me so angry, because I am considered an Italian citizen, I must pay taxes and when I'll send my child to kindergarten we'll be both considered in the household, from the point of view of our incomes. So why should they consider my partner's income, if we don't even have the right to be a couple? These things drive me crazy.* (Zanini, 2011, p.569)

More broadly, intended parents described CBRC as their only chance to fulfil lifelong desires for parenthood (Nebeling Petersen, 2018; Schurr, 2018; Zanini, 2011; Ziv & Freund-Eschar, 2015): *"For as long as I can remember, I wanted to have children. It's just been something I always wanted. It just took time to find a way. Not an easy way, but we were sure we wanted kids"* (Nebeling Petersen, 2018, p.707).

Varied Care and Assistance from Local Clinicians. As intended parents prepared for CBRC, they attempted to solicit advice and care from local clinicians. While intended parents had established relationships with clinicians during their local treatment, their clinicians' input on treatment abroad varied. Some local clinicians willingly offered assistance and, at times, actually recommended CBRC (Jackson et al., 2017; Millbank, 2019; Zanini, 2011): "*[My fertility doctor] straight up [said] that you can go to various clinics over-seas, because the waiting lists are very, very long…She suggested to me three countries at that stage*" (Millbank, 2019, p.377). Furthermore, clinicians gave informal suggestions to intended parents seeking third-party gamete donation (Millbank, 2019; Zanini, 2011): "*They recommended us one centre in Ukraine. They happened to know people there…they told me that people are very good there, that they are particularly well prepared [...] so, I go there*" (Zanini, 2011, p.570).

At times, local care was necessary for intended parents who needed diagnostic and preparatory treatment such as cycle monitoring, ultrasounds and hormonal stimulation (Jackson et al., 2017; Millbank, 2019; Van Hoof et al., 2015). Finding a local clinician willing to help with these procedures was instrumental (Millbank, 2019; Van Hoof et al., 2015, p.395): *"But we were lucky. He agreed and even prescribes us, you know, for reimbursement"* (Van Hoof et al., 2015, p.395). For some, seeking local care meant complex navigation of grey areas of the law, as one intended parent from Australia explained:

> *I could get the [diagnosis and treatment] procedure done in Western Australia, but it couldn't be under the care of somebody who was helping me to get pregnant ... So I had to just go to my GP and I had to get a referral. She understood what was going on. But I had to get a referral to a gynecologist surgeon . . . for. . . a couple of those procedures. She did the procedure and she knew what was going on, but neither of them were helping me to get pregnant and working directly with [the US clinic]. I was the one who had to get the instructions from [the US] and then go to my doctor about it. I couldn't go through . . . the IVF clinic.* (Millbank, 2019, p.382)

Other intended parents found this process relatively straightforward:

> *So how we coordinate it is that he tells me what I need. He writes it down for me. I take it to my GP who's fully aware of my journey. ... I just tell him a little bit about the background to why we're doing it and then he'll write me an Australian script for it, so that's how we're coordinating it at the moment.* (Jackson et al., 2017, p.43)

When intended parents had cooperation from local clinicians, they could access the preparatory support they needed:

> *I just rocked into a GP and said, this is what I'm doing and this is what I need.... The GP did that without any issue at all - whereas . . . some fertility specialists . . . they perceive it as them helping us break the law if they actually enable that.* (Millbank, 2019, p.385)

When local support was available, it provided intended parents with validation, security, safety and continuity of care (Jackson et al., 2017; Millbank, 2019; Van Hoof et al., 2014; Van Hoof et al., 2015; Zanini, 2011). One intended parent described the three-way relationship between themselves and their local and overseas clinicians:

> *He knows him very well professionally, so we had that continuity of care so [my IVF doctor] would talk to him and he could talk to [her] directly. . . they could share information. She knew that I would be well cared for in South Africa. Conversely [the South African] doctor knew that I would be well cared for in Australia when I got back, so there was absolutely no issues with me going.* (Millbank, 2019, p.377)

Despite cooperation from some clinicians, many intended parents described a contrasting experience, characterised by discouragement, refusal and judgement from local clinicians (Hudson et al., 2016; Jackson et al., 2017; Millbank, 2019; Van Hoof et al., 2014; Van Hoof et al., 2015). In these instances, intended parents struggled to find clinicians that would facilitate care when they disclosed their CBRC plans:

> *It's just that in the Netherlands it is hard to find a clinic to do the ultrasounds. I have called different places for hours until I found a place. Clinics don't want to do that in the Netherlands…Not even in the clinic where we've been known for five years, they were not willing.* (Van Hoof et al., 2014, p.190).

Difficulty accessing assistance was particularly common for intended parents undertaking cross border surrogacy (Jackson et al., 2017; Millbank, 2019): "*As soon as you say the word surrogacy they just kind of shut you down. Even one of the nurses who I became quite friendly with, she said "do not say that word in our offices"* (Millbank, 2019, p. 378). These encounters were often characterised by hostility and discouragement:

> *I mentioned it to her just to get her idea and she said 'oh that's terrible. These are women that are terribly exploited and you'll go over there and you'll get a disease and you'll be in some terrible baby factory and what not'.* (Jackson et al., 2017, p.41)

At times, uncooperative local clinicians inhibited CBRC, as one intended parent from the UK recalled trying to access their local treatment records to send overseas:

> *…it took me a long time to get from them. They wanted to charge me for it, it was just ridiculous, the English clinic, getting my information from them. In the end I threatened them and said 'I'm entitled to this information, I don't want my full file, just give me a synopsis.* (Hudson et al., 2016, p.105)

Intended parents who struggled to access local support felt excluded and as if their CBRC was devious and ethically corrupt (Hudson et al., 2016; Millbank, 2019; Van Hoof et al., 2014):

> *That was really awkward, and really weird, because ... I managed to get an appointment with [a doctor at an IVF clinic] and she basically said to me, "look, don't tell anybody that I'm doing this for you. We're not allowed to do it, and I don't - don't tell anybody. We're not allowed to do it. I don't like what you're doing. But*

> *you're here now, so let's have a look." She was not impressed with the whole surrogacy. . . we didn't talk a lot about it because I was there for 10 minutes. . . . I didn't go back to her because I thought: that's completely crazy.* (Millbank, 2019, p.384)

For some intended parents considered "socially infertile", accessing local care was unnecessary. Gay men and single individuals who always knew they were infertile (e.g., women born without a uterus) could sidestep interactions with local clinicians (Millbank, 2019; Stuhmcke, 2021). As one gay intended father described: *"I didn't seek out any medical information because it wasn't relevant I think to my situation"* (Stuhmcke, 2021, p.14).

A Reliance on Peer Support to Facilitate CBRC. Often left with little support from local clinicians, intended parents turned to external information and support to facilitate CBRC. Sources of information and support included surrogacy agencies, healthcare providers and surrogacy conferences (Gezinski et al., 2018; Hanefield et al., 2015; Van Hoof et al., 2014; Zanini, 2011). However, intended parents primarily relied on the Internet and word of mouth to conduct "research" and seek advice from experienced CBRC users (Gezinski et al., 2018; Hanefield et al., 2015; Hudson, 2017; Jackson et al., 2017; Machin et al., 2018; Van Hoof et al., 2014; Zanini, 2011): *"I tried to find another centre, always consulting the website and the forum and then checking [...] with women who were in the same situation as I was"* (Zanini, 2011, p.570).

At times, information came from those who had previous encounters with local fertility services and knew barriers to access in the home country: *"With regard to the egg donation I was told [by a friend] there's a five year waiting list at that time for eggs*" (Hanefield et al., 2015, p.359). Likewise, broader members of the community also informed intended parents: "*How did we find out about South Africa? Oh, we asked around, and as we* *are from a church, the pastor there recommended someone. We were guided by the pastor of our church…"* (Machin et al., 2018, p.11).

Word-of-mouth recommendations were instrumental when often no official sources of CBRC information were available and helped gauge experiences and success rates (Hanefield et al., 2015; Jackson et al., 2017; Machin et al., 2018):

> *Because obviously going to another country I had absolutely no idea. You don't know whether the websites are actually legitimate…Even having a Skype conversation or a telephone conversation you've got no guarantee. So I felt I would not have gone overseas unless I knew someone who had been at that clinic.* (Jackson et al., 2017, p.38)

Peer testimonies could override clinician input and ultimately determine the course of travel (Jackson et al., 2017; Van Hoof et al., 2015; Zanini, 2011):

> *[Y]ou do your own research. You get on the websites and you get on the blogs and all that sort of stuff and that provides you with far more of an education, be it right information or not — far more education and reassurance than any doctor's given me; because you're talking to other women that have been there, done that...* (Jackson et al., 2017, p.38)

Intended Parents' Experiences of Care Abroad

The meta-synthesis of intended parents' experiences of care abroad was derived from 18 studies grouped into three categories and six subcategories (Table 4), to provide the overall synthesised finding: *Cross border reproductive care relies on a trusting relationship between intended parents and overseas care providers, leading to positive experiences characterised by a sense of control, individualised care and professionalism, as well as negative experiences associated with navigating an unfamiliar environment, a loss of control and poor post-birth support.*

Trust as Core to the Experience of Care Abroad. Across the included studies, trust was a central and reoccurring point of discussion for intended parents. As intended parents navigated treatment overseas, they had to evaluate the trustworthiness and safety of foreign and unfamiliar clinicians and medical systems. At times this unfamiliarity evoked uncertainty and ambivalence for intended parents, particularly regarding the information received, the safety of overseas clinics and their decision-making process (Hudson et al., 2016; Stuhmcke, 2021). One intended parent described her ambivalence towards CBRC: *"You're putting your trust in donors that are overseas and they're not being regulated by your own government so you're not sure if everything is done above board"* (Stuhmcke, 2021, p.19). For some, this uncertainty eased after initial consultations with overseas care providers, allowing intended parents to subjectively appraise a clinic as trustworthy (Riggs et al., 2015; Van Hoof, 2014): *"…When we visited the clinic the lead doctor really put my mind at ease"* (Riggs et al., 2015, p.50).

Overall Satisfaction with Overseas Care. Intended parents largely described overall satisfaction with care abroad. Satisfaction with care was distilled into three subcategories: a sense of control and empowerment in decision making, individualised care, and professional and informative care provision.

A Sense of Control and Empowerment in Decision Making. From the outset, the availability of treatment in destination countries offered greater control and increased choice for some intended parents. Compared to experiences in their local jurisdiction, intended parents reported increased control regarding protocols, timing and selection of a donor (Hudson & Culley, 2013; Hudson et al., 2016; Van Hoof et al., 2014). As one intended parent expressed:

> *I think we were well informed, it was more transparent, [we had] more control. Any questions that we had were answered quickly, fully, without being patronising, and we*

> *felt that they weren't being answered according to an NHS textbook, which is how we felt [in the UK].* (Hudson et al., 2016, p.104)

Experiences abroad afforded intended parents autonomy and control, in contrast to local care, where intended parents felt local clinicians were 'playing god' by dictating treatment: *"Yes, Sam [partner] said to me one time 'they are playing god' and I think that's a nice way to put it"* (Van Hoof et al., 2014, p.188). As a result, some intended parents reported feeling more empowered during their overseas care as they could access the treatment and care they desired and provide input along the way (Hudson et al., 2016; Van Hoof et al., 2014).

Individualised Care. Similarly, intended parents felt that overseas fertility treatment offered a more individualised experience. Individualised care went beyond meeting physical needs and was characterised by attention to intended parents' emotional needs (Hudson et al., 2016; Riggs et al., 2015; Van Hoof et al., 2014; Van Hoof et al., 2015). Many intended parents felt that overseas clinicians had their best interests at heart and were truly invested in their success (Hudson et al., 2016; Riggs et al., 2015; Van Hoof et al., 2014; Van Hoof et al., 2015).

Furthermore, intended parents reported that overseas care was more considerate and inclusive of their circumstances. One intended parent highlighted how her male partner only felt like an equal contributor when care occurred abroad: *"He's found the process overseas much better because he's invited into the treatment room as an equal person, they don't just talk to me, they do talk to him"* (Hudson & Culley, 2013, p.258). Similar experiences were expressed by LGBTQ+ intended parents, who believed overseas health professionals treated them as a 'regular case', free from moral objection (Van Hoof et al., 2015). As one lesbian intended parent from France stated: *"We're not treated like aliens when we arrive here [overseas treatment facility]"* (Van Hoof et al., 2015, p.394).

Professional and Informative Care Providers. Experiences of overseas fertility care were marked by professionalism and informative communication between care providers and intended parents. For intended parents, these interactions were instrumental in facilitating a positive experience. Specifically, positive experiences were distinguished by clinician willingness to dedicate greater amounts of time and regular opportunities to discuss treatment (Hudson 2016; Gezinski et al., 2018; Riggs et al., 2015; Van Hoof et al., 2014): *"It is a time in your life when you are working intensely towards this goal and well yes, it's just nice here, you feel like everyone at the clinic is here for you"* (Van Hoof et al., 2014, p.189). This communication was characterised as informative, empathetic and open, and was conducted in person, via email or by telephone (Hudson et al., 2016; Van Hoof et al., 2014; Van Hoof et al., 2015): *"... the physicians here are very progressive and we're treated like anybody else, not like we're sick…I think the main reason we pulled through all the challenges is because we were treated so good here"* (Van Hoof et al., 2015, p.394). At times, communication was sustained well beyond the gestational and post-birth period, as mentioned by one intended parent: *"The support we received was fantastic. We still keep in contact with our doctor. Whilst we probably only hear from her every few months, it is very caring..."* (Riggs et al., 2015, p.50).

Additionally, intended parents believed overseas care providers were more thorough and offered more routine testing, experience and expertise than care providers in the home country (Machin et al., 2018; Van Hoof et al., 2014). As one intended parent expressed:

> *After our third treatment cycle in the Netherlands they told us 'sorry, that's it for you' and then you arrive here and through thorough testing they find out why exactly it didn't work and if that's something they can treat, then you feel recognized as a patient, like they take you seriously.* (Van Hoof et al., 2014, p.189)

For intended parents, these factors pointed to the professionalism of overseas care: *"The clinic's been extremely professional. Any questions or hesitations I've had they've dealt with"* (Riggs et al., 2015, p.50). As one Australian intended parent elaborated: *"I did not come away feeling that this was a third-rate country at all. On the contrary . . . they're quite advanced"* (Gezinski et al., 2018, p.179).

Dissatisfying Aspects of Overseas Care. Despite the positive aspects of overseas care, several negative factors surfaced for some intended parents. These negative factors can be understood through three subcategories: a lack of familiarity with surroundings, a loss of control over the pregnancy, and poor post-birth follow up and support.

Lack of Familiarity with Surroundings and Language Barriers. Being in an unfamiliar environment, often with language barriers, was challenging for some intended parents. During face-to-face consultations, intended parents felt unsettled when staff talked amongst themselves in another language and at other times had to rely on translators during conversations with staff: *"It was a bit more daunting. There's the language and the Cyrillic script and then it was a totally unknown culture and there are dodgy dealing going on in [Ukraine]"* (Hudson et al., 2016, p.106). Language barriers generated a sense of foreignness amongst intended parents that reinforced the reality that accessing their fertility treatment required travelling to culturally unfamiliar destinations and navigating unknown medical systems (Couture et al., 2019; Riggs et al., 2015): "*I think they could have picked up a bit on that, especially when you're in a foreign country, because you're actually quite isolated there"* (Riggs et al., 2015, p.11).

For some, travelling to a foreign country was framed as a dangerous or "terrifying" undertaking (Pande, 2015; Stuhmcke, 2021): *"I came all the way here. Look outside, who in their right minds would come to a place like this! I did and all alone… in a strange land, away from my family"* (Pande, 2015, p.57). This cultural dissonance directly influenced intended parents' experience of care overseas (Couture et al., 2019; Hudson et al., 2016; Riggs et al., 2015): *"It was incredibly nice in [Spain] but everything feels foreign I suppose and it emphasizes the strangeness of everything"* (Hudson et al., 2016, p.106).

Loss of Control and Disconnection from the Pregnancy. While some intended parents expressed an increased sense of control during treatment abroad, others noted the contrary, reporting an absence of control. From the outset, some intended parents described a monopoly of few treatment providers that offered little scope for choice:

> *It's quite clear that there's no sympathy involved… every piece of the puzzle has got an extravagant fee, even for the ethics panel there was a fee… it just seemed to be different economy in terms of pricing as well. You have no option there, you're limited in terms of the number of providers in the case. So you're sort of well, okay, I need to bear that cost.* (Stuhmcke, 2021, p.16)

Consequently, intended parents expressed feeling as though they relinquished their autonomy to overseas care providers who ultimately controlled their treatment (Stuhmcke, 2021; Riggs et al., 2015): *"I felt that I was a pawn in their goal of increasing success rates, rather than as someone on a journey to becoming a parent"* (Riggs et al., 2015, p.51). In one case, the lack of autonomy went as far as care providers making decisions during a surrogacy arrangement without consulting the intended parents: "*The clinic did not tell us that they were going to induce labour and just induced the baby… they just rang us and said come to the hospital as the baby was born"* (Riggs et al., 2015, p.51).

More frequently expressed, however, was the loss of control intended parents felt during surrogacy arrangements due to physical distance from the pregnancy. The implications of this distance and lack of control evoked anxiety, powerlessness and emotional detachment from the unborn child (Carone et al., 2016; Ziv & Freund-Eschar, 2015). As one intended parent described:

> *Pregnancy is nine months of uncertainty, we're waiting every month to get an update regarding the pregnancy's development. If there was a woman next to me, I could stroke her belly, see that she eats and rests enough ... we trusted to fate when we provided our sperm. However, since then we are at the mercy of others. We are not updated or asked for anything.* (Ziv & Freund-Eschar, 2015, p.16)

During treatment, intended parents relied on staff overseas to mediate connections between them and their surrogate. For some intended parents, staff encouraged this connection, enabling them to regain a sense of control during CBRC (Arvidsson et al., 2015; Carone et al., 2016; Gezinski et al., 2018):

> *Before I was in contact with [surrogate's name] everyday, before I could trust her, for me the pregnancy meant only that something which was mine was growing somewhere else, in someone else's house. . . She was amazing in involving us, she wrote down every aspect of the pregnancy in a diary and she sent it to us weekly by mail. She made us feel completely part of the story.* (Carone et al., 2016, p. 185)

However, other intended parents were directly discouraged, and at times prohibited, from communicating with the surrogate (Arvidsson et al., 2015; Gezinski et al., 2018; Hovav, 2020; Rudrappa, 2015): *"I really wanted to have a much closer relationship with my surrogate, and it just makes me sad that she will never know that"* (Gezinski et al., 2018, p.179). This experience was particularly evident in surrogacy arrangements in India, Mexico and Thailand, where intended parents reported minimal contact with the surrogate; versus experiences of surrogacy in the USA and Israel, where close and ongoing relationships with the surrogate were common (Arvidsson et al., 2015; Carone et al., 2016; Gezinski et al., 2018; Hovav, 2020; Rudrappa & Collins, 2015; Smietana, 2021): "*We don't want to cut the ties with her at all, and we hope she feels the same*" (Carone et al., 2016, p.186).

Limited Follow-Up and Post-Birth Support. Poor post-birth support was another negative aspect of overseas care. For some intended parents, follow up care was fragmented or absent throughout CBRC (Millbank 2019; Riggs et al., 2015). Intended parents undertaking surrogacy believed overseas care providers offered less support and interest in their treatment once they returned home: *"... it's quite confusing when you get back because you've never kind of got the continuity of care which is quite hard"* (Millbank, 2019, p.22). This occurrence led intended parents to suggest that overseas clinics were more interested in their money than their treatment outcomes: *"The only emails that I've received from them were asking for a written testimonial for their website. Not any 'How are you going?' not any follow up"* (Riggs et al., 2015, p.51). Another intended parent recounted:

> *Once the children were born I found the clinic to be not as involved…They were fairly good in a lot of respects but I think the follow on was lacking. It would have been nice if you'd seen the doctor you've dealt with a bit more* (Riggs et al., 2015, p.51).

Additionally, lack of support was particularly noted following pregnancy loss for intended parents engaging in surrogacy; exacerbating the already significant toll on intended parents (Millbank, 2019; Riggs et al., 2015):

> *When it came to a late-term pregnancy loss, the clinic straight away started talking about finding us another surrogate who had a high success rate. The grief we went through at the time was rarely acknowledged; they didn't really help us running around, there were lots of things we had to organise in terms of bringing ashes home and organising the funeral and that kind of thing and we didn't have help with any of that. I think they wanted the whole problem to go away in a sense, 'cos it was one of their worst nightmares.* (Riggs et al., 2015, p.51)

Intended Parents' Experiences Navigating the Ethical Contentions Associated with CBRC

The meta-synthesis of intended parents' experiences navigating the ethical contentions associated with CBRC was derived from 15 studies that were grouped into two categories and three subcategories (Table 4), to provide the overall synthesised finding: *Intended parents reject the exploitation discourse and actively work to minimise the potential for exploitation through their choice of CBRC destination, framing surrogacy as a "win-win" and advocating for law reform.*

Disillusion with and Rejection of the Exploitation Discourse. Throughout the included studies, intended parents appeared disillusioned with and rejected the exploitation discourse surrounding CBRC. Much of this discourse is directed towards cross border surrogacy and fuelled by media coverage and social commentary. For intended parents, this discourse tended to weigh heavily on the decision-making process and even temporarily dissuaded them from committing to surrogacy altogether (Arvidsson et al., 2015; Rudrappa & Collins, 2015). For example, after watching a documentary on surrogacy in India, an intended parent described their shock and discomfort:

> *Then we felt like, we're not getting into this process, so actually we put it on ice. Yes, we completely shut it out of our minds. And then a few months went by until we were babysitting another couple's children and started thinking about it again.* (Arvidsson et al., 2015, p.5)

At times, media portrayals of surrogacy were adverse enough to prevent intended parents from reaching out to their support networks in fear of a negative response; particularly in countries where all forms of surrogacy were illegal and negative perceptions were felt to be more pervasive (Arvidsson et al., 2015; Gezinski et al., 2018).

Intended parents were soon reassured about their participation through conversations with others who had undertaken surrogacy overseas and later went on to reject the discourse entirely following their own surrogacy experience abroad (Arvidsson et al., 2015; Gezinski et al., 2018; Stuhmcke, 2021): *"[w]e're not trying to work the system, we're trying to create a family"* (Stuhmcke, 2021, p.20). In addition, others noted the hypocrisy of the exploitation discourse: *"People say it is exploitation, but it is just as much exploitation to purchase a backpack [produced by an Indian woman in a sweatshop], but people in that case are not nearly half as grateful"* (Arvidsson et al., 2015, p.7).

Attempts to Identify, Minimise and Avoid Exploitation. In response to the exploitation discourse, many intended parents attempted to identify, minimise and avoid situations where they felt potential exploitation could occur.

Choice of Destination Mediating Exploitation Risk. For some intended parents, the choice of destination country was perceived to negotiate exploitation risk. This choice was typically based upon a distinction of social class and origin, ultimately dividing intended parents into two groups. The first group consisted of intended parents who felt that high-income destination countries were the least exploitative route for CBRC (Couture et al., 2019; Nebeling Peterson, 2018; Stuhmcke, 2021). In their eyes, CBRC in high-income destination countries provided some guarantee of medical and legal protection for surrogates and donors: *"At least in Spain, I saw the girls coming in the back door themselves. It was more open. There are laws that govern this relationship. That's important"* (Couture et al., 2019, p.45). Similarly, an intended parent who travelled to the USA explained her choice of CBRC destination:

> *They're not being regulated by your own government so you're not sure if everything is done above board. That's why I chose America, because I thought it would be less likely for there to be a lot of dodgy things going on.* (Stuhmcke, 2021, p.19)

For these intended parents, choosing a high-income country was a way to minimise exploitation risk: *"I'm not saying that India is exploitation of the poor. But the possibility is there, and that's enough for us to not choose it"* (Nebeling Petersen, 2018, p.700).

The second group of intended parents believed choosing a low-income destination country was the more ethical option, highlighting the relative significance of financial compensation for low-income donors and surrogates (Couture et al., 2019; Rudrappa & Collins, 2015; Smietana et al., 2021; Stuhmcke, 2021). Several intended parents argued that compensation for surrogacy in high-income countries had relatively minimal effect on the lives of third parties: *"It's probably a nice windfall of cash, but that's it"* (Rudrappa & Collins, 2015, p.950). Whereas for surrogates in low-income countries, compensation was seen as "fundamentally" life-changing and more meaningful: *"[in the USA], you maybe help somebody pay off their credit cards, but there, you may be helping them move into the middle class or something"* (Rudrappa & Collins, 2015, p.950).

One intended parent referred to the situation of surrogates in low-income countries as follows: *"The opportunities are so limited. [. . .] If they then have the ability to carry a child for nine months and get a whole new life, why cannot people accept it?"* (Arvidsson et al., 2015, p.6). Others expressed their disagreement with the assumption that women in low-income countries had less autonomy and suggested there is more nuance to the issue of exploitation in CBRC (Couture et al., 2019; Rudrappa & Collins, 2015): *"I fell into my own trap: thinking these women are less empowered to make their own decisions for themselves. They are intelligent—they can make the decision that they can get this money to help their kids or start a new business or buy a new house or whatever—so I don't consider it exploitation"* (Rudrappa & Collins, 2015, p.949).

Reframing CBRC as a Win-Win. Regardless of the destination country, intended parents frequently framed third-party CBRC as a win-win situation. For some intended parents, this win-win characterised CBRC as an altruistic act, whereby intended parents receive "a gift of life" and third parties fulfil their desire to help childless people (Arvidsson et al., 2015; Carone et al., 2017; Smietana et al., 2021; Rudrappa & Collins, 2015). As one intended parent explained: *"There is no price for what she did. She wanted to give life and she did it"* (Carone et al., 2017, p.186). At times, the win-win benefit was simply a matter of supply and demand: *"I don't have a problem with supplying demand. If I wanted that Harvard graduate to be my donor, and she says to me: OK, I'll do it for you for 50 000 dollars"* (Couture et al., 2019, p.45).

For other intended parents, not only did CBRC provide them with a child but also provided third parties with increased autonomy and liberation (Arvidsson et al., 2015; Couture et al., 2019, p.45; Smietana et al., 2021; Stuhmcke, 2021; Rudrappa & Collins, 2015). This was particularly the case for surrogacy arrangements in low-income countries, where financial compensation for surrogacy was framed as an opportunity to improve women's livelihoods:

> *A woman is helping another woman, one who does not have the capacity to have a baby and the other who lacks the capacity to lead a good life… [surrogate mothers are] able to buy a house, educate their children and even start a small business.* (Smietana et al., 2021, p.9)

This perspective was echoed across various accounts by intended parents: "*Oh, I really felt that it was mutual… She does it as a nice gesture, and at the same time we know that she will have financial security in the future"* (Arvidsson et al., 2015, p.6). As another intended parent who travelled to India stated: *"there are a whole lot of winners here. No one was hurt"* (Rudrappa & Collins, 2015, p.950).

Advocating for Legislative Change in the Home Country. For several intended parents, avoiding exploitation consisted of advocating for legalising fertility services in their home country. Despite engaging in CBRC, intended parents were vocal about local law reform to guarantee a safer and more ethical option for CBRC stakeholders (Arvidsson et al., 2015; Couture et al., 2019; Jackson et al., 2017; Van Hoof et al., 2015). Several intended parents noted their preference to access treatment in their home country (Arvidsson et al., 2015; Van Hoof et al., 2014):

> *No one would be happier than us if we had been able to do it in Sweden in an orderly manner… Then we could go to the hospital and arrange everything. That would have been much better than all those agents and intermediaries, which is of course not optimal.* (Arvidsson et al., 2015, p.7)

Several intended parents were highly critical of local laws that permit altruistic surrogacy but prohibit commercial arrangements. For these intended parents, altruistic regimes were viewed as constraining, coercive and unethical in the sense that they may pressure women into "helping" intended parents by being their surrogate (Couture et al., 2019; Jackson et al., 2017):

> *… you'd have a bit of hinting going on, wouldn't you? If it's altruistic here and it's in-family there's a lot of hinting; aunties are talking to sisters, friends are saying 'would you do it for them, what about them, why don't you help them', or whatever.* (Jackson et al., 2017, p.28)

Indeed, for some intended parents, the imperative of altruism was inconceivable after knowing first-hand the physical and emotional toll of fertility treatment:

> *While I was taking hormones, I had headaches, I felt dizzy. The needles were big. So, at one point I was full of bruises on my stomach. I could not stand anything on my stomach. And asking someone to do it for free [...].* (Couture et al., 2019, p.43)

Ultimately, several intended parents wanted local laws re-examined and suggested that, with safeguards, services such as commercial surrogacy and commercial egg donation could be a solution (Arvidsson et al., 2015; Couture et al., 2019; Jackson et al., 2017). As a Swedish intended parent explained:

> *If it is done properly, it can turn out well. [. . .] But it can also be done in the wrong way. As it works now, I think there is a big risk that it could turn out very wrong for all parties concerned. [. . .] That's why it is so important for Sweden to thoroughly investigate this issue and come to a conclusion on how to handle it.* (Arvidsson et al., 2015, p.7)

Discussion

Overview

CBRC is an increasingly complex and multifaceted experience for intended parents. To the author's knowledge, this is the first meta-synthesis exploring intended parents' experiences of CBRC. Findings from the included studies were aggregated into eight categories and nine subcategories to produce three synthesised findings related to intended parents' experiences embarking on CBRC, experiences of care abroad, and experiences navigating the ethical contentions associated with CBRC. Guidelines for health professionals who care for intended parents considering or in the process of CBRC are also provided.

Summary of Findings

The decision to undergo CBRC is not a choice but an inevitable step following the exhaustion of local options. For some intended parents, local options were non-existent. For others, CBRC was a final option following many physically, emotionally and financially draining domestic treatment attempts. This well documented pattern ultimately underscores how legal, social, economic and cultural factors act as barriers to local care but simultaneously push intended parents towards CBRC to fulfil their conception desires (Gurtin & Inhorn, 2011; Levine et al., 2017; Rodino et al., 2014).

Concerningly, as intended parents pursue CBRC, local care provision was inadequate or refused altogether. Earlier research has highlighted the bypassing of traditional doctor-patient dynamics, resulting in varying but typically negligible support for intended parents undergoing CBRC (Blyth, 2010; Culley et al., 2011). For example, Hammarberg et al. (2015) found that less than half of intended parents sought information or discussed cross-border surrogacy with local IVF practitioners and those who did reported perceived negative reactions. Meanwhile, Rodino et al. (2014) revealed that as few as 5.8% of intended parents sought information from professional sources, such as local fertility clinics, during CBRC arrangements.

Despite this lack of engagement with local services, clinicians acknowledge their key role in educating local patients about the potential challenges associated with CBRC, the importance of passing professional judgements about treatment options abroad and monitoring CBRC intended parents during preparatory and follow-up treatment (Culley et al., 2013; Van Hoof et al., 2016). Moreover, clinicians have voiced their opposition to containing or interfering with CBRC locally (Culley et al., 2013). However, based on the intended parents' experiences in the present sample, a disjunction exists between what clinicians theorise is best practice for intended parents versus how they manage these matters in practice. For intended parents who attempted to discuss CBRC with local providers, legal grey areas and ambiguous practice guidelines impinged on free-flowing information exchange. Clinicians must grapple with competing obligations: prioritising patient care by facilitating support and information provision, or not appearing to endorse "immoral" behaviour and consequently shutting the door on patients seeking CBRC advice.

The consequences of this shift in the patient-doctor dynamic are significant. If intended parents seldom seek reproductive advice from health professionals, they are left navigating a "wild west" of online and word-of-mouth health information. Blyth (2010) found that over 75% of intended parents organised their CBRC arrangements, with most relying on the Internet (64%) or the media (20%) for information. Despite burgeoning resources aimed at supporting intended parents, verifying their accuracy can be impossible (Horsfall et al., 2013; Snyder et al., 2011; Stuhmcke et al., 2020). Nevertheless, as observed in the current findings, the value intended parents place on these informal information sources is unequivocal and can ultimately determine the course of treatment.

Consequently, it has been suggested that intended parents do not necessarily view technical data or professional opinion as the sole indicator of high-quality care but instead turn to first-person narratives for reassurance and quasi-professional knowledge about CBRC (Payne, 2015; Jackson et al., 2017). This occurrence is not unique to CBRC; it is observed in the broader healthcare landscape through the emergence of online social networks between experientially similar others (Gage, 2013). These networks enable widespread information exchange between patients without the constraints of traditional healthcare and can shape the healthcare experience (Benetoli et al., 2018; Gage, 2013; Griffiths et al., 2012; Kotsilieris et al., 2017).

Despite preliminary complications for intended parents, this meta-synthesis has affirmed previous findings and depicted a nuanced but broadly positive experience of CBRC (Blyth, 2010; Hudson et al., 2011; Inhorn & Patrizio, 2012; Rodino et al., 2014). Yet, many commentators continue to speculate that CBRC is invariably more risk-laden than treatment in the home country, implying the quality of local treatment reigns superior (Culley et al., 2013; De Sutter, 2011; Waller et al., 2017). Here, the experience of intended parents diverges, and it becomes apparent that these speculations are made in the absence of strong evidence to confirm or refute them (Culley et al., 2013).

Although intended parents from this sample raised concerns about several aspects of CBRC and reinforced the documented existing challenges of CBRC, including language barriers and poor post-birth support, their perspectives point to a larger debate about what constitutes best practice in health care. While the factors constituting positive and negative experiences of CBRC in this study are discrete, they are simultaneously intertwined and describe a preference for person-centred care (PCC).

No universally agreed definition of PCC exists; however, it is driven by a paradigm that recognises individuals as a biopsychosocial whole (Delaney, 2018; Pelzang, 2010). In this sense, PCC is respectful of and responsive to patient preferences, needs and values, particularly concerning clinical decision-making (Dancet et al., 2010). Increasingly, governments, the WHO and broader health policy organisations have advocated for and recognised the need to emphasise the individual in healthcare (Australian Commission on Safety and Quality in Health Care, 2011; WHO, 2007). Additionally, several professional bodies in the fertility industry have begun to endorse PCC in CBRC contexts. The European Society of Human Reproduction and Embryology produced a good practice guide for CBRC, where patient-centredness was a key principle (Shenfield et al., 2011). Similarly, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG, 2016) suggested that during CBRC, intended parents' autonomy needs to be upheld by providing appropriate information and counselling to make an informed decision.

PCC has consistently benefited consumers and healthcare organisations by reducing stress, increasing empowerment, increasing patient satisfaction, improving clinician-patient alliance, decreasing hospital stays and readmission and improving overall health outcomes (Bertakis & Azari, 2011; Delaney, 2018; Ekman et al., 2012). In reproductive contexts, individuals with infertility attach significant value to PCC (Dancet et al., 2010; van Empel et al., 2010). Indeed, van Empel et al. (2011) found that fertility patients were willing to trade-off up to a third of the pregnancy success rate for more PCC during treatment. Furthermore, Dancet et al.'s (2012) research on fertility patient perspectives showed that conceptualisations of PCC remain strikingly similar across international contexts. Provision of information, communication and health professional competence were integral to fertility patients' PCC (Dancet et al., 2012). Similarly, emotional support and shared decision making were considered key facets contributing to PCC (Dancet et al., 2012). These findings closely resemble the experiences of intended parents in the meta-synthesis, who emphasised the centrality of individualisation, control, communication and emotional support during CBRC.

Thus, the universality of PCC is evident, and its importance for intended parents during local and overseas treatment is underscored. However, again, a disconnect appears between what is overwhelmingly recognised as best practice and intended parents' experiences of inconsistencies within their care both locally and abroad.

During an already emotionally tumultuous time accepting infertility, intended parents receive varied care and support while traversing a landscape of social and bioethical debate. As the present sample demonstrated, intended parents face stigma from local care providers and harsh criticism in the broader social and scholarly sphere. While commentators raise some warranted qualms about CBRC, they often remain fixated on reducing intended parents to ruthless exploiters of third-party donors and surrogates to "passive objects at the mercy of global capitalism" (Nahman, 2008, p.67). In the process, commentators essentially deny third parties' agency and dismiss donors' and surrogates' lived experiences.

This is interesting to consider when global CBRC destinations are rapidly undergoing stricter regulation, often banning foreigners' use of fertility services. For example, 2015 saw the Thai government criminalize commercial surrogacy, while the following year, India prohibited commercial surrogacy for non-citizens (Hibino, 2020; Rudrappa, 2018). If commentators are correct in their speculation and the moral scrutiny intended parents face is justified, then logically, it would follow that commercial bans on surrogacy would grant third parties improved livelihoods and reprieve from exploitation. However, Huber et al. (2018) and Pande (2020) interviewed Indian surrogates following the ban and revealed Indian women felt that a reliable and substantial income opportunity had been removed, with no consideration for what would become of their livelihoods. Interestingly, while many of the women interviewed still received income via surrogacy with domestic Indian intended parents, there was a general perception that foreigners offered substantially more for their services (Huber et al., 2018).

The ethical assumptions made about commercial arrangements underpinning CBRC has led to the emergence of a hierarchy, where altruistic arrangements are distinguished as ethically superior. Policymakers in some jurisdictions, including Australia and the UK, entrench this distinction by legislatively accommodating altruistic surrogacy and gamete donation while shunning paid arrangements as “deviant” and “criminal” (Stuhmcke, 2015).

It is compelling to consider that, within "altruistic" reproductive arrangements, there is no moral questioning regarding the payment doctors receive for facilitating embryo creation and transfer, or for the paid care nurses provide, nor the fees lawyers charge for reproductive contracts. Cognisant of this, intended parents in the present sample considered an absence of compensation for third parties reprehensible and unethical. Furthermore, broader samples of intended parents utilising altruistic arrangements have expressed moral discomfort and discontent about not compensating surrogates for their time, labour and inconvenience (Jackson et al., 2017).

A further argument made by many feminist commentators is that commercial third-party arrangements are conducive to the commodification and objectification of donors and surrogates (Tieu, 2009; Tangri & Kahn, 1993). However, reports in this meta-synthesis indicate intended parents desire, actively facilitate and attempt to sustain meaningful relationships with surrogates; surrogates are not reduced to a temporary "incubator" per se but are considered an important and long-standing part of intended parents' and their children's lives. Moreover, when there was limited opportunity to forge such relationships, intended parents reported distress. Previous research by Ciccarelli and Beckman (2005) suggested the quality of the relationship with intended parents largely determines the surrogate's satisfaction. While Jadva et al. (2003) found that surrogates felt an ongoing and special bond towards the child they carried. In effect, third-party reproduction is not a matter of "objectifier" versus "objectified", but rather a shared experience with the potential for satisfaction for all involved.

Ultimately, commentators have become mired in a debate of bioethics rather than considering intended parents’ plight and representing the desires of third-party donors and surrogates. Ethical assumptions made about CBRC are flooded with symbolic and theoretical rhetoric that adopt a ‘Western’ cultural lens and erase the lived experiences of donors and surrogates in non-western countries, as well as the perspectives of intended parents who seek such arrangements (Blazier & Janssens, 2020). Ironically, these assumptions are made by commentators who claim to advocate for the protection of CBRC stakeholders; yet intended parents in the present sample noted the stigma and stress fuelled by such commentary. It is well acknowledged that minimising harm to all parties involved in CBRC can be avoided through government regulation, rather than criminalisation (Ekberg, 2014; Pande, 2021; Wilkinson, 2016). Indeed, experiences in this meta-synthesis highlight the contradictions and failings of prohibitive laws in some jurisdictions that paint all commercial CBRC arrangements with the same brush. Rather, more considerate and nuanced regulations may ensure positive outcomes for third parties, intended parents, local healthcare systems and systems abroad.

Methodological Considerations

The methodological rigour of qualitative meta-syntheses is comparable to that of systematic reviews, in terms of consistency, reliability and generalisability (Pearson et al., 2011). The rigour of the current meta-synthesis was bolstered by opting for a high threshold on the QualSyst quality checklist (Kmet et al., 2004), ensuring only the highest-quality studies were included and assisting in producing a high-quality synthesis. During this process, co-screening with an additional researcher further verified the quality standard of eligible articles. Additionally, this meta-synthesis included all forms of CBRC across a range of settings, ensuring the breadth of the included studies offers a more complete insight into CBRC than discrete studies focusing on one form of reproductive care in specific countries.

While this meta-synthesis aimed for comprehensive sampling, the present sample was primarily derived from ‘Western’, educated, industrialised, rich and democratic (WEIRD) populations and, subsequently, may have skewed the inferences drawn from the data. This represents a broader issue in psychological research and generalising findings to the population at large should be done cautiously (Rad et al., 2018). Although a robust search strategy was used, potentially relevant studies may have been missed, and the representation of CBRC in the meta-synthesis may be incomplete. Additionally, an absence of researcher reflexivity and secondary verification in most included studies means the extent to which author biases skewed data collection and interpretation of the included findings is unknown. To avoid such biases influencing the present study, the author strived to engage in their own process of reflexivity and remain impartial during research.

The social stigma surrounding CBRC and the laws that prohibit and, at times, criminalise it may have influenced intended parents’ involvement in the included studies; perhaps altering their disclosures out of fear for judgement or retribution. Finally, the constant upheaval of CBRC legislation means a significant proportion of the included studies featured intended parents travelling to India and Thailand for surrogacy – countries which have since banned CBRC. Consequently, it is unknown whether the current findings still stand in alternative countries used for CBRC.

Future Research

In light of the changed legal status of service provision across once-popular CBRC destinations, there is a need to explore intended parents’ experiences in newer CBRC countries such as Ukraine. Whether legislation changes have altered intended parents’ experience remains to be seen. Additionally, a more direct investigation into intended parents' psychosocial wellbeing using quantitative and qualitative approaches is warranted to raise awareness of the emotional toll associated with CBRC, provide further insight into the impacts of stigma surrounding CBRC and gauge further the emotional impact mediated by a connection, or lack of, between intended parents and surrogates. Likewise, there is a need to develop and research PCC interventions; specifically, investigating the direct effect PCC has in CBRC contexts and whether this mediates CBRC experiences.

CBRC has not escaped the far-reaching impact of the COVID-19 pandemic. Indeed, early in the pandemic, assisted reproduction ceased almost entirely and international travel halted (Tsakos et al., 2020). As a result, intended parents have had their fertility treatment interrupted and, in some instances, been unable to access their gametes frozen overseas or collect their newborn children in overseas surrogacy arrangements (Keaney & Moll, 2020). The biologically time sensitive nature of fertility treatment adds further pressure to this process (Simopoulou et al., 2020). Given the ongoing uncertainty of the pandemic and the consequences it has held for intended parents, CBRC in a COVID-19 world is situated to be a particularly ripe area for future research.

Implications

Although the results from this study form three discrete findings, they point to a broader, inter-related, cyclical picture. The moral panic associated with CBRC influences how intended parents prepare for their overseas fertility quest, shaping the subsequent experience of care abroad. As intended parents are often alone in this journey, CBRC remains hidden and the taboo surrounding the practice intensifies. Consequently, CBRC is unequivocally complex, multifaceted and misunderstood, and any proposed legislative agenda must be sensitive to this.

The global nature of CBRC suggests it cannot be considered in isolation within a single country, as legislation in one country has cross-border implications. Simultaneously, the moral and legal diversity regarding CBRC makes global legislative harmonisation beyond reach. To date, attempts to curtail intended parents seeking care abroad have failed. The speculative "risks" of CBRC are not eliminated by strict legislation but are simply relocated (Crockin, 2013; Stuhmcke, 2015). Instead, a more nuanced approach considers how local and international healthcare systems can act to ensure harm minimisation (See Table 5).

Ultimately, domestic legislators need to desist from the legislative creep that seeks to dictate the nature and content of clinician interactions with intended parents. Clinicians have a duty to uphold intended parents’ safety, autonomy and best interests, and blunt legislation that compromise these (Weinberger et al., 2012). In addition, PCC needs to be prioritised in fertility care contexts. The viability of benchmarking PCC in such contexts needs investigation to ensure consistent and adequate care provision (Dancet et al., 2010). Part of this process should encourage shared care across borders to foster continuity of care and support networks for intended parents. In turn, increased collaboration and transparency regarding CBRC may invoke a social shift, where commentators cease speculating sensationalised non-issues and all CBRC stakeholders can participate without fear of judgement.

Table 5

Implications and Practice Guidelines for CBRC Stakeholders

Intended Parents Should:

- Be aware of the potential risks of CBRC, such as language barriers, cultural differences and differences in care provision, to ensure they are accounted for when choosing destination countries and care providers.
- Recognise that infertility can be a stressful and emotionally burdensome experience, potentially compounded by overseas care, distance from support networks and associated stigma of CBRC and commercial third-party reproduction. It is important to prepare for these factors and have appropriate support available such as counselling or ongoing, regular communication with support networks.
- Find a local clinician who is supportive, transparent and understanding towards CBRC to ensure accurate information provision, continuity of care and contribute to a more positive experience of CBRC.
- Be aware that online peer support and resources are useful for support and validating CBRC experiences, but caution must be taken regarding the accuracy of the information and, particularly, medical advice regarding fertility treatment.
- Understand that while some ‘socially infertile’ intended parents (such as gay men) may not require medical assistance in the home country for CBRC, it may still be useful to seek fertility information from local healthcare providers and to foster a support network in the home country.

Home Country Clinicians Should:

- Uphold a commitment to protecting intended parents’ safety by providing information and support on CBRC to ensure harm minimisation.
- Recognise that without support, intended parents are likely to rely on online, typically unverified information regarding fertility treatment overseas.

- Provide care that is person-centred and recognise the hardships associated with infertility, the individualised emotional needs of intended parents and the importance of shared decision making with intended parents.
- Recognise the stigma associated with CBRC and commercial third-party reproduction and ensure their interactions with intended parents do not exacerbate this by refraining from judgement and condemnation.
- Increase understanding of local legislation to ensure conversations with intended parents can occur safely within legal boundaries.
- Make efforts to facilitate shared care between themselves and overseas care providers to best support intended parents.
- Advocate for legislative change that ensures clinicians can uphold their healthcare duties and keep patients safe through information provision without government interference.

Overseas Clinicians Should

- Uphold principles of person-centred care to ensure intended parents have a positive experience of CBRC:
    - Care provision must go beyond physical needs and also attend to the emotional needs of intended parents undertaking CBRC.
    - Decisions relating to care and treatment must always be discussed and made in conjunction with intended parents. To do so, it is important to actively seek intended parents’ perspectives and ensure they feel heard in the care process.
    - Recognise there are often language and cultural differences between intended parents and overseas care systems. Additional reassurance and support may be necessary for intended parents, as they may feel isolated overseas.
    - Information provision must be thorough and timely, ensuring dedicated efforts are made to discuss treatment and care with intended parents.

  - Extra care and support must be provided in the case of pregnancy/child loss during care abroad. This experience requires direct attention to intended parents’ emotional needs and should not be medicalised nor minimised for intended parents using surrogates.
  - Follow-up care is central for a positive care experience, and efforts should be made to contact intended parents after they arrive back in their home country.
- Make efforts to facilitate shared care between themselves and intended parents' local care providers in the home country.
- Recognise it is integral that intended parents are allowed to communicate and form connections with surrogates, as this appears to be increasingly important for intended parents, mediating a positive experience of CBRC where distress is minimised.

Policy Makers Should

- Develop legislation that removes ambiguity for local care providers who encounter intended parents undertaking CBRC, ensuring clinicians can openly engage in dialogue and uphold their duties to patients without fear of legal reprimand.
- Recognise that prohibitions of fertility care will not eliminate their occurrence, only relocate such care elsewhere.
- Recognise that not all commercial third-party reproductive arrangements are exploitative and that altruistic arrangements are undesirable for some intended parents that require surrogacy for family formation.
- Ensure harm minimisation is at the forefront of local and overseas laws, whereby patient safety and wellbeing is always kept at the forefront.
- Make efforts to develop benchmarking for person-centred care that fosters training and ensures adherence to person-centred principles amongst clinicians.

Note. *CBRC = Cross Border Reproductive Care*

Conclusion

This systematic review and meta-synthesis of intended parents' experiences of CBRC has revealed an increasingly complex phenomenon, woven together by distinct common threads from a local, international and ethical standpoint. Going forward, first-person narratives such as those featured in this meta-synthesis will assist in informing healthcare provision and broader social attitudes to improve the safety, satisfaction and wellbeing of all involved in CBRC. The time for speculation and misinformed assumptions has come to an end. If legislators, healthcare professionals and broader commentators are truly concerned about the best interests of CBRC stakeholders, they will realise that current policy and practice is too often doing more harm than good. The evidence and insights into the realities of CBRC are on the table; it is now time to act upon them.

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Appendices

Appendix A

Logic Grids for Database Searches

Pubmed	Reproductive Treatment AND →	Cross-Border	AND → Qualitative
	"reproductive techniques, assisted"[mh] OR infertility therapy[tiab] OR assisted reproduction[tiab] OR fertility treatment[tiab] OR reproductive treatment[tiab] OR infertility treatment[tiab] OR reproductive technolog*[tiab] OR reproductive technique*[tiab] OR egg donation[tiab] OR sperm donation[tiab] OR embryo donation[tiab] OR directed tissue donation[mh] OR directed tissue donation[tiab] OR gamete donation[tiab] OR oocyte donation[tiab] OR surrogacy[tiab] OR ICSI[tiab] OR intracytoplasmic sperm injection[tiab] OR IVF[tiab] OR in vitro fertilization[tiab] OR in vitro fertilisation[tiab] OR intrauterine insemination[tiab] OR IUI[tiab] OR intracervical insemination[tiab] OR artificial insemination[tiab] OR "sex preselection"[mh] OR sex selection[tiab] OR third party reproduction[tiab] OR "surrogate mothers"[mh] OR surrogate[tiab] OR gestational carrier[tiab] OR birth mother[tiab] OR birth parent[tiab]	"medical tourism"[mh] OR medical tour*[tiab] OR cross-border[tiab] OR cross border[tiab] OR international[tiab] OR transnational[tiab] OR trans-national[tiab] OR foreign[tiab] reproductive tour*[tiab] OR reproductive travel[tiab] OR fertility tour*[tiab] OR procreative tour*[tiab] OR circumvention tour*[tiab]	"qualitative research"[mh:noexp] OR qualitative*[tiab] OR "focus groups"[mh] OR focus group*[tiab] OR interview*[tiab] OR thematic analys*[tiab] OR content analys*[tiab] OR lived experience*[tiab] OR personal experience*[tiab] OR interpretative phenomenolog*[tiab] OR ethnograph*[tiab] OR case stud*[tiab] OR narrative*[tiab]

PsycINFO	reproductive technology.sh,ti,ab OR assisted reproduction.ti,ab OR infertility therapy.ti,ab OR reproductive technolog*.ti,ab OR reproductive treatment.ti,ab OR ferility treatment.ti,ab OR infertility treatment.ti,ab OR reproductive technique*.ti,ab OR egg donation.ti,ab OR sperm donation.ti,ab OR embryo donation.ti,ab OR gamete donation.ti,ab OR oocyte donation.ti,ab OR directed tissue donation.ti,ab OR surrogacy.ti,ab OR ICSI.ti,ab OR intracytoplasmic sperm injection.ti,ab OR IVF.ti,ab OR in vitro fertili?ation.ti,ab OR IUI.ti,ab OR intrauterine insemination.ti,ab OR intracervical insemination.ti,ab OR artificial insemination.ti,ab OR sex preselection.ti,ab OR sex selection.ti,ab OR third party reproduction.ti,ab OR surrogate.ti,ab OR gestational carrier.ti,ab OR "surrogate parents (humans)".sh OR birth mother.ti,ab OR birth parent.ti,ab	cross-border.ti,ab OR cross border.ti,ab OR international.ti,ab OR transnational.ti,ab OR trans-national.ti,ab OR foreign.ti,ab OR reproductive tour*.ti,ab OR reproductive travel.ti,ab OR fertility tour*.ti,ab OR procreative tour*.ti,ab OR medical tour*.ti,ab OR circumvention tour*.ti,ab	qualitative measures.sh,ti,ab OR qualitative methods.sh,ti,ab OR qualitative*.ti,ab OR focus group.sh OR focus group*.ti,ab OR interview.sh OR interview*.ti,ab OR thematic analys*.ti,ab OR content analys*.ti,ab OR lived experience*.ti,ab OR personal experience*.ti,ab OR interpretative phenomenolog*.ti,ab OR ethnograph*.ti,ab OR case stud*.ti,ab OR narrative*.ti,ab
Embase	"infertility therapy"/syn OR "reproductive technolog*":ti,ab OR "assisted reproduction":ti,ab OR "infertility therapy":ti,ab OR "reproductive treatment":ti,ab OR "fertility treatment":ti,ab OR "infertility treatment":ti,ab OR "reproductive technique*":ti,ab OR "egg donation":ti,ab OR "sperm donation":ti,ab OR "embryo donation":ti,ab OR "gamete donation":ti,ab OR "oocyte donation":ti,ab OR "directed tissue donation":ti,ab OR "surrogacy":ti,ab OR ICSI:ti,ab OR "intracytoplasmic sperm injection":ti,ab OR IVF:ti,ab OR "in vitro fertili*ation":ti,ab OR IUI:ti,ab OR "intrauterine insemination":ti,ab OR "intracervical insemination":ti,ab OR "artificial insemination":ti,ab OR sex selection/syn OR "sex	"medical tourism"/syn OR "medical tour*":ti,ab OR cross-border:ti,ab OR "cross border":ti,ab OR international:ti,ab OR transnational:ti,ab OR trans-national:ti,ab OR foreign:ti,ab OR "reproductive tour*":ti,ab OR "reproductive travel":ti,ab OR "fertility tour*":ti,ab OR "procreative tour*":ti,ab OR "circumvention tour*":ti,ab	qualitative/de OR qualitative*:ti,ab OR focus group*:ti,ab OR interview/de OR interview*:ti,ab OR "thematic analysis"/de OR "thematic analys*":ti,ab OR "content analysis"/de OR "content analys*":ti,ab OR "personal experience"/de OR "lived experience*":ti,ab OR "interpretative phenomenolog* analys*":ti,ab OR ethnograph*:ti,ab OR "case stud*":ti,ab OR narrative*:ti,ab

	selection":ti,ab OR "sex preselection":ti,ab OR "third party reproduction":ti,ab OR "surrogate":ti,ab OR "gestational carrier":ti,ab OR "birth mother":ti,ab OR "birth parent":ti,ab		
CINAHL	MH "reproduction techniques+" OR TI "reproductive technique*" OR AB "reproductive technique*" OR TI "infertility therapy" OR AB "infertility therapy" OR TI "assisted reproduction" OR AB "assisted reproduction" OR TI "fertility treatment" OR AB "fertility treatment" OR TI "infertility treatment" OR AB "infertility treatment" OR TI "reproductive technolog*" OR AB "reproductive technolog*"OR TI "reproductive treatment" OR AB "reproductive treatment" OR TI "egg donation" OR AB "egg donation" OR TI "sperm donation" OR AB "sperm donation" OR TI "embryo donation" OR AB "embryo donation" OR TI "gamete donation" OR AB "gamete donation" OR TI "oocyte donation" OR AB "oocyte donation" OR TI "directed tissue donation" OR AB "directed tissue donation" OR TI Surrogacy OR AB surrogacy OR TI ICSI OR AB ICSI OR TI "intracytoplasmic sperm injection" OR AB "intracytoplasmic sperm injection" OR TI IVF OR AB IVF OR TI "in vitro fertili?ation" OR AB "in vitro fertili?ation" OR TI IUI OR AB IUI OR TI "intrauterine insemination" OR AB "intrauterine insemination" OR TI "intracervical insemination" OR AB "intracervical insemination" OR TI "artificial insemination" or AB "artificial insemination" OR MH "sex preselection" OR TI "sex selection" OR AB "sex selection" OR TI "third-party reproduction" OR AB "third-party reproduction" or TI "third party reproduction" OR	MH "medical tourism" OR TI cross-border OR AB cross-border OR TI "cross border" OR AB "cross border" OR TI international OR AB international OR TI transnational OR AB transnational OR TI trans-national OR AB trans-national OR TI foreign OR AB foreign OR TI "medical tour*" OR AB "medical tour*" OR TI "reproductive tour*" OR AB "reproductive tour*" OR TI "reproductive travel" OR AB "reproductive travel" OR TI "fertility tour*" OR AB "fertility tour*" OR TI "procreative tour*" OR AB "procreative tour*" OR "circumvention tour*" OR AB "circumvention tour*"	MH "qualitative studies" OR TI qualitative* OR AB qualitative* OR MH "focus groups" OR TI "focus group*" AB "focus group*" OR MH interviews OR TI interview* OR AB interview* OR MH "thematic analysis" OR TI "thematic analys*" OR AB "thematic analys*" OR MH "content analysis" OR TI "content analys*" OR MH "life experiences" OR TI "lived experience*" OR AB "lived experience*" OR TI "personal experience*" OR AB "personal experience*" OR TI "interpretative phenomenolog* analys*" OR AB "interpretative phenomenolog* analys*" OR TI "case stud*" OR AB "case stud*" OR TI narrative* OR AB narrative*

	AB "third party reproduction" OR TI "surrogate" OR AB "surrogate" OR TI "gestational carrier" OR AB "gestational carrier" OR TI "birth mother" OR AB "birth mother" OR TI "birth parent" OR AB "birth parent"		
Scopus	TITLE-ABS-KEY (Infertility therapy OR "reproductive technolog*" OR "reproductive technique*" OR "assisted reproduction" OR "reproductive treatment*" OR "fertility treatment*" OR "infertility treatment*" OR "egg donation" OR "sperm donation" OR "embryo donation" OR "gamete donation" OR "oocyte donation" OR "directed tissue donation" OR surrogacy OR ICSI OR "intracytoplasmic sperm injection" OR IVF OR "in vitro fertili?ation" OR IUI OR "intrauterine insemination" OR "intracervical insemination" OR "artificial insemination" OR "sex selection" OR "sex preselection" OR "third party reproduction" OR "surrogate" OR "gestational carrier" OR "birth mother" OR "birth parent")	TITLE-ABS-KEY ("medical tour*" OR cross-border OR "cross border" OR international OR transnational OR trans-national OR foreign OR "reproductive tour*" OR "reproductive travel" OR "fertility tour*" OR "procreative tour*" OR "circumvention tour*")	TITLE-ABS-KEY ("qualitative research" OR qualitative* OR "focus group*" OR interview* OR "thematic analys*" OR "content analys*" OR "lived experience*" OR "personal experience*" OR "interpretative phenomenolog* analys*" OR ethnograph* OR "case stud*" OR narrative*)
Sociological Abstracts	NOFT("infertility therapy" OR "reproductive technolog*" OR "reproductive technique*" OR "assisted reproduction" OR "reproductive treatment*" OR "fertility treatment*" OR "infertility treatment*" OR "egg donation" OR "sperm donation" OR "embryo donation" OR "gamete donation" OR "oocyte donation" OR "directed tissue donation" OR surrogacy OR ICSI OR "intracytoplasmic sperm injection" OR IVF OR "in vitro fertili?ation" OR IUI OR "intrauterine insemination*" OR "intracervical insemination*" OR "artificial insemination*" OR "sex selection" OR "sex preselection" OR "third party	NOFT("medical tour*" OR cross-border OR "cross border" OR international OR transnational OR trans-national OR foreign OR "reproductive tour*" OR "reproductive travel" OR "fertility tour*" OR "procreative tour*" OR "circumvention tour*")	NOFT("qualitative research" OR qualitative* OR "focus group*" OR interview* OR "thematic analys*" OR "content analys*" OR "lived experience*" OR "personal experience*" OR "interpretative phenomenolog* analys*" OR ethnograph* OR "case stud*" OR narrative*)

	reproduction" OR "surrogate" OR "gestational carrier" OR "birth mother" OR "birth parent")		
Web of Science	TS=("infertility therapy" OR "reproductive technolog*" OR "reproductive technique*" OR "assisted reproduction" OR "reproductive treatment" OR "fertility treatment" OR "infertility treatment" OR "egg donation" OR "sperm donation" OR "embryo donation" OR "gamete donation" OR "oocyte donation" OR "directed tissue donation" OR surrogacy OR ICSI OR "intracytoplasmic sperm injection" OR IVF OR "in vitro fertili?ation" OR IUI OR "intrauterine insemination" OR "intracervical insemination" OR "artificial insemination" OR "sex selection" OR "sex preselection" OR "third party reproduction" OR "surrogate" OR "gestational carrier" OR "birth mother" OR "birth parent")	TS= (cross-border OR "cross border" OR international OR transnational OR trans-national OR foreign OR "medical tour*" OR "reproductive tour*" OR "reproductive travel" OR "fertility tour*" OR "procreative tour*" OR "circumvention tour*")	TS=("qualitative research" OR qualitative* OR "focus group*" OR interview* OR "thematic analys*" OR "content analys*" OR "lived experience*" OR "personal experience*" OR "interpretative phenomenolog* analys*" OR ethnograph* OR "case stud*" OR narrative*)

Appendix B

QualSyst Evaluation of Methodological Quality of Included Studies ($N_{studies} = 24$)

QualSyst Criteria										
Lead Author (Date)	Question/ Objective	Study Design	Context	Theoretical Framework	Sampling Strategy	Data Collection	Data Analysis	Verification Procedure	Conclusion	Reflexivity	TOTAL
Arvidsson (2015)	●	●	●	●	●	●	●	●	●	○	18 = .90
Carone (2017)	●	●	●	●	●	●	●	●	●	◖	19 = .95
Couture (2019)	●	●	●	●	●	●	●	○	●	○	16 = .80
Deomampo (2013)	●	●	●	●	●	●	◖	○	●	●	17 = .85
Gezinski (2018)	●	●	●	●	●	●	●	●	●	○	18 = .90
Hanefield (2015)	●	●	●	●	●	●	●	●	●	○	18 = .90
Hovav (2020)	●	●	●	●	●	●	●	○	●	○	16 = .80
Hudson (2013)	●	●	●	●	◖	●	●	○	●	○	15 = .75
Hudson (2016)	●	●	●	●	●	●	●	○	●	○	16 = .80

	QualSyst Criteria									
Lead Author (Date)	Question/ Objective	Study Design	Context	Theoretical Framework	Sampling Strategy	Data Collection	Data Analysis	Verification Procedure	Conclusion	Reflexivity	TOTAL
Hudson (2017)	●	●	●	●	◖	●	●	○	●	○	15 = .75
Jackson (2017)	●	●	●	●	●	●	●	●	●	○	18 = .90
Machin (2018)	●	●	●	●	●	●	●	●	●	○	18 = .90
Millbank (2019)	●	●	●	●	◖	●	●	●	●	○	17 = .85
Nebeling Peterson (2018)	●	●	●	●	●	●	◖	○	●	◖	16 = .80
Pande (2015)	●	●	●	●	●	●	◖	○	●	●	16 = .85
Riggs (2015)	●	●	●	●	●	●	◖	○	●	○	15 = .75
Rudrappa (2015)	●	●	●	●	●	●	◖	○	●	○	15= .75
Schurr (2019)	●	●	●	●	●	●	◖	○	●	○	15= .75

	QualSyst Criteria									
Lead Author (Date)	Question/ Objective	Study Design	Context	Theoretical Framework	Sampling Strategy	Data Collection	Data Analysis	Verification Procedure	Conclusion	Reflexivity	TOTAL
Smietana (2021)	●	●	●	●	●	●	●	○	●	○	16= .80
Stuhmcke (2021)	●	●	●	●	◖	●	●	●	●	○	17= .85
Van Hoof (2014)	●	●	●	●	●	●	●	●	●	○	18= .90
Van Hoof (2015)	●	●	●	●	●	●	●	●	●	○	18= .90
Zanini (2011)	●`	●	●	●	●	●	◖	○	●	○	15= .75
Ziv (2015)	●	●	●	●	●	●	●	○	●	○	16= .80

Appendix C

Data Extraction Sheet

READER	**DATE**	**YEAR OF PUBLICATION**
TITLE		
AUTHOR		
ADDITIONAL PUBLICATIONS FROM SAME STUDY		
STUDY DESIGN/DESCRIPTION		
STUDY DESIGN		
RESEARCH QUESTION/PHENOMENA OF INTEREST		
METHOD OF DATA ANALYSIS		
STUDY LOCATION **Residence:** **Destination:**	**SAMPLE SIZE**	
RELATIONSHIP STATUS (% or N) & SEXUALITY	**GENDER**	
ETHNICITY	**AGE** **Range:** **Mean:** **SD:**	
TYPE OF CBRC	**MOTIVATION FOR CBRC**	

<table>
<tr><th colspan="2">FINDINGS/OUTCOMES</th></tr>
<tr><td colspan="2"></td></tr>
<tr><td>FINDING/THEME</td><td>EVIDENCE</td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td colspan="2">SUMMARY/NOTES</td></tr>
</table>

Appendix D

ENTREQ Checklist

Item	Guide and description	Reported on page #
Aim	State the research question the synthesis addresses	15
Synthesis methodology	Identify the synthesis methodology or theoretical framework which underpins the synthesis, and describe the rationale for choice of methodology (e.g. metaethnography, thematic synthesis, critical interpretive synthesis, grounded theory synthesis, realist synthesis, meta-aggregation, meta-study, framework synthesis).	Title & 16
Approach to searching	Indicate whether the search was pre-planned (comprehensive search strategies to seek all available studies) or iterative (to seek all available concepts until theoretical saturation is achieved).	16-17
Inclusion criteria	Specify the inclusion/exclusion criteria (e.g. in terms of population, language, year limits, type of publication, study type).	17
Data sources	Describe the information sources used (e.g. electronic databases (MEDLINE, EMBASE, CINAHL, psychINFO, Econlit), grey literature databases (digital thesis, policy reports), relevant organisational websites, experts, information specialists, generic web searches (Google Scholar), hand searching, reference lists) and when the searches were conducted; provide the rationale for using the data sources.	16-17
Electronic search strategy	Describe the literature search (e.g. provide electronic search strategies with population terms, clinical or health topic terms, experiential or social phenomena related terms, filters for qualitative research and search limits).	17-18 and Appendix A
Study screening methods	Describe the process of study screening and sifting (e.g. title, abstract and full text review, number of independent reviewers who screened studies.	18-19
Study characteristics	Present the characteristics of the included studies (e.g. year of publication, country, population, number of participants, data collection, methodology, analysis, research questions).	23-29
Study selection results	Identify the number of studies screened and provide reasons for study exclusion (e.g. for comprehensive searching, provide numbers of studies screened and reasons for exclusion indicated in a figure/flowchart; for iterative searching describe reasons for study exclusion and inclusion based on modifications t the research question and/or contribution to theory development).	18-19
Rationale for appraisal	Describe the rationale and approach used to appraise the included studies or selected findings (e.g. assessment of conduct (validity and robustness), assessment of reporting (transparency), assessment of content and utility of the findings).	20-21
Appraisal items	State the tools, frameworks and criteria used to appraise the studies or selected findings (e.g. Existing tools: CASP, QARI, COREQ, Mays and Pope [25]; reviewer developed tools; describe	20

	the domains assessed: research team, study design, data analysis and interpretations, reporting).	
Appraisal process	Indicate whether the appraisal was conducted independently by more than one reviewer and if consensus was required.	20
Appraisal results	Present results of the quality assessment and indicate which articles, if any, were weighted/excluded based on the assessment and give the rationale.	19, 33 and Appendix B
Data extraction	Indicate which sections of the primary studies were analysed and how were the data extracted from the primary studies? (e.g. all text under the headings "results /conclusions" were extracted electronically and entered into a computer software).	20-21 and Appendix C
Software	State the computer software used, if any.	17
Number of reviewers	Identify who was involved in coding and analysis.	21
Coding	Describe the process for coding of data (e.g. line by line coding to search for concepts).	21
Study comparison	Describe how were comparisons made within and across studies (e.g. subsequent studies were coded into pre-existing concepts, and new concepts were created when deemed necessary).	21
Derivation of themes	Explain whether the process of deriving the themes or constructs was inductive or deductive.	
Quotations	Provide quotations from the primary studies to illustrate themes/constructs, and identify whether the quotations were participant quotations or the author's interpretation	34-56
Synthesis output	Present rich, compelling and useful results that go beyond a summary of the primary studies (e.g. new interpretation, models of evidence, conceptual models, analytical framework, development of a new theory or construct).	34-56