Surrogate motherhood

Surrogacy is often a last-resort attempt for the infertile couple. It is a morally challenging method of assisted reproduction with many legal, social, ethical and psychological implications.

A surrogate mother is defined as a woman who becomes pregnant, carries and delivers a child on behalf of another couple, the commissioning parents, and at birth hands over this child to this couple.[1]

Two types of surrogacy exist, namely full (gestational/host) surrogacy and partial (genetic/straight) surrogacy. Full surrogacy occurs when both commissioning parents provide the gametes.[2] The embryo created via *in vitro* fertilisation (IVF) techniques is then implanted in the surrogate mother.[2] In this case the surrogate mother's role is purely gestational and the commissioning parents have a genetic link to the baby.[2]

Partial surrogacy occurs when an independent egg donor is used and the surrogate mother therefore undergoes IVF using the commissioning father's gamete.[2] In this case there will be three women involved, namely the genetic mother, the surrogate mother and the commissioning mother.[2] The identity of the egg donor always remains anonymous. According to the South African Surrogate Motherhood Bill,[3] the oocytes of the surrogate mother and the gametes of her husband may not be used in this regard. In the case of male factor infertility, an anonymous sperm donor is used.

Before the surrogacy arrangement the surrogate mother may be either unknown or known to the commissioning couple. Some authors argue that in the case of the unknown surrogate mother, this type of arrangement could be problematic as it depends on trust between strangers.[4] A bond must then be established between these two groups, a relationship described by the founder of a surrogacy agency as a 'forced friendship'.[5] On the other hand the surrogate mother may be known, i.e. she may be either a relative or a friend of the commissioning couple. This arrangement may complicate family dynamics.

The surrogate mother should be under the age of 40 years. She should have at least one child of her own. This will ensure informed decision-making.[3] At the time of entering into the agreement the surrogate mother should be married or divorced.[3] It is strongly recommended to transfer only one good-quality embryo.

Motivations for surrogacy vary. In some cases multiple reasons may exist. The most common motivations include wanting to help a childless couple, enjoyment of pregnancy and childbirth, self-fulfilment and financial gain.[6]

Indications

Various indications exist. These indications vary between different fertility units and countries. The most common absolute indications include patients with an absent uterus, congenital uterine abnormality, an inoperable scarred uterus, and previous total abdominal hysterectomy.[7] In 1985 Utian *et al*.[8] described the first successful surrogate pregnancy in a previously hysterectomised woman.

Relative indications for surrogacy include medical contraindications to pregnancy, namely heart or renal failure.[7] Other common indications include repetitive IVF failures, repetitive miscarriages, premature ovarian failure, and patients who received cancer treatment and previous oophorectomy.[7] In some cases surrogacy occurs for social reasons. However, this indication is controversial.

Role of the gynaecologist

Gynaecologists have no legal or moral obligation to participate in a surrogacy agreement. However, once involved the gynaecologist has three important duties to fulfil. Firstly, s/he should inform all parties involved of the moral, legal, medical, social, emotional and psychological issues involved.[7] Secondly, s/he should ensure that all the requirements and indications are fulfilled.[7] Thirdly, s/he should ensure that all involved parties receive the appropriate screening and counselling by independent specialists, including a fertility specialist, a perinatologist and a psychologist.[7]

It is advisable that the surrogate mother's family, namely spouse and children, be included in the counselling. A 'cooling-off' period should then be allowed so that all parties can think through their decision before commencing with the actual surrogacy arrangement and signing of the legal contract.[7]

Legal aspects

A surrogate motherhood agreement will only be valid if the following prerequisites are met: (*i*) the agreement must be in writing and signed by all involved parties; (*ii*) the agreement must be entered into in South Africa; (*iii*) at the time of entering into this agreement all involved parties should be living in South Africa; (*iv*) a court, within whose area of jurisdiction the surrogate mother is residing, must confirm the agreement; (*v*) the commissioning parents must be lawfully married and jointly enter into the surrogacy agreement; and (*vi*) no person may publish any facts that reveal the identity of a child born as a result of a surrogate motherhood agreement.[3]

A court will not confirm a surrogate motherhood agreement until it is satisfied that the following prerequisites have been met: (*i*) the commissioning mother must be permanently medically unsuited or incapable of giving birth to a healthy, living child; (*ii*) the commissioning parents must be physically, financially and psychologically competent to enter into the

agreement, must be suited to parenthood and must understand and accept the legal consequences involved; (*iii*) the surrogate mother must be physically and psychologically suitable, she should give informed consent and should have the informed consent of her husband; (*iv*) she should have full medical aid coverage; and (*v*) the interests of any existing children of the surrogate mother should always be protected.[3]

The court needs to confirm the surrogacy agreement before the surrogate mother may be impregnated.[3] If this process does not occur within 18 months of the court's confirmation, then the agreement lapses.[3]

Ethical principles

Regulations exist to protect all parties involved. Surrogacy results in two women with biological connections to the child.[1] Ethical principles should always be adhered to.

Autonomy. There are certain restrictions on the surrogate mother and the commissioning parents. Neither can change their minds after the pregnancy has commenced. In the case of a divorce, the commissioning parents will still be the parents. The surrogate mother would only have first choice to keep the child in the event of the death of both commissioning parents. A surrogate mother who wishes to keep the child after delivery would be guilty of abduction. In the event of the child being handicapped the commissioning parents retain responsibility.

Payment. The surrogate mother should not receive any payment for the surrogacy agreement. Reasons against payment include inappropriate coercion of vulnerable women and insult to human dignity. However, she should be financially reimbursed for pregnancy-related medical expenses and complications. Reasonable cost is another important issue. This includes travelling costs for antenatal visits and money for vitamin supplementation. Only persons who render professional services, i.e. medical or legal, in connection with the surrogate motherhood agreement may receive compensation.[3]

Informed consent. The surrogate mother has a moral obligation to take care of the child while she is pregnant. However, she and her husband have no rights or obligations towards the child. It is important to obtain the consent of the spouse of the surrogate mother. This will provide the surrogate mother with further emotional support.

Primary responsibility. All parties involved must understand that the intended parents bear primary responsibility for the child. They are the legal parents of the child and their moral responsibility starts when the surrogate agreement commences. The child must be registered as the legal child of the commissioning parents at its birth.

Safety. The surrogate mother should meet specific medical and psychological criteria before the agreement commences. Past medical, surgical and obstetric histories of the surrogate mother must always be closely scrutinised. She should be counselled about all the potential risks involved in the pregnancy. A recent retrospective study[9] reported 2 cases of severe obstetric complications in surrogate pregnancies. This is the first report ever in the literature documenting such significant findings. In the first of these cases, the surrogate underwent a late puerperal hysterectomy secondary to placenta accreta in a triplet pregnancy. In the second case, the patient underwent a hysterectomy secondary to uterine rupture. This study illustrates that potential health risks may occur during a surrogate pregnancy.[9]

Antenatal care. Mutual agreement should be reached about antenatal screening and care.[7] The surrogate mother should practise good antenatal care including screening for HIV and hepatitis as well as other appropriate antenatal tests.

Abortion. Abortion leads to the termination of the surrogacy agreement[3] and may be a cause for dissent between the involved parties. General medical and ethical principles pertaining to termination of pregnancy should be adhered to. The surrogate mother has a legal right to terminate the pregnancy against the wishes of the commissioning parents, but it would be ethically inappropriate for her to terminate a healthy pregnancy. If, however, the surrogate mother refuses a termination of pregnancy against the wishes of the commissioning couple and the baby is born with a handicap, then the commissioning parents must still comply with their obligations towards the child.[3]

Mode of delivery. The surrogate mother cannot be forced to accept any decision against her will. However, she must at all times accept the advice that will ensure the best outcome for herself and the unborn child. Closer to the time of delivery counselling must be considered again to avoid any conflict.

Psychosocial aspects

It is important to remember the psychosocial impact on all the parties involved including the commissioning parents, the surrogate mother, the surrogate's spouse and children, and the prospective child. It is recommended that counselling should include the surrogate mother's family.

A recent study[2] showed that relationships between the couple and surrogate mother were generally good, irrespective of whether the surrogate was known or unknown. After the birth of the child positive relations continued, with many couples maintaining some sort of contact with the surrogate mother, and commissioning couples perceived the surrogacy agreement as a positive experience.[2]

The media often report on the potential adverse effects of surrogacy for surrogate mothers, as described in the well-known 'Baby M' case in the USA, where the surrogate mother refused to relinquish the child to the biological father.[10]

Another recent article[11] concluded that surrogate mothers do not experience major problems in their relationship with the commissioning couple. Emotional problems experienced by

them appeared to lessen over time and they did not appear to experience psychological problems as a result of the surrogacy arrangement.[11]

The welfare of the child born as a result of a surrogacy agreement is important. However, no long-term studies exist regarding the social and psychological effects on the surrogate child. To prevent or lessen possible future emotional conflicts it is advisable for the commissioning parents to be honest with the child about the mode of conception.

Surrogacy remains a controversial and emotional topic. However, if the correct principles and legal requirements are met a surrogate pregnancy agreement can be a very fulfilling and positive experience for all parties involved.

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