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Jago, a baby born through surrogacy, shares a smile with Emma who carried him. Their story is featured in this supplement.

# Care in surrogacy: Practice, ethics and regulations

**SURROGACYUK**

# Care in surrogacy: Practice, ethics and regulations

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### SurrogacyUK ([surrogacyuk.org](http://surrogacyuk.org))

SurrogacyUK is a non-profit organisation that advocates for and supports altruistic surrogacy in the UK. We support people unable to carry their own children and those who wish to support them. Our definition of 'unable to carry' is broad and inclusive, taking in the LGBTIQ+ community, people unable to carry for medical reasons and those unable to carry for emotional or psychological reasons related, for example, to previous traumatic births or for trans men, non-binary people and people with body dysmorphia. We don't support elective surrogacy journeys. Since 2002, over 380 surrogate babies have been born to SurrogacyUK members.

### *Acknowledgement*

*Many thanks to Emma, Alan, Nic and Jago for the front cover picture.*

### *Disclaimer*

*The views expressed in this supplement represent SurrogacyUK's position and not necessarily the opinion of each individual contributor.*

# An introduction to surrogacy in the UK

The development of a legal framework for surrogacy in the UK has been concurrent with technological developments and regulation around assisted reproduction. The Surrogacy Arrangements Act (1985) established the legal and ethical basis of the UK's legislative stance on surrogacy in which:

- altruistic surrogacy - in which surrogates can only be reimbursed for reasonable expenses relating to pregnancy - is legal;
- commercial surrogacy is illegal, so agencies and brokers are prohibited from profiting from surrogacy;
- it's illegal to advertise as, or for, a surrogate;
- surrogacy arrangements or agreements are not legally enforceable;
- the surrogate and, if married or in a civil partnership, their partner, are the legal parents of the surrogate-born child at birth.

The Human Fertilisation and Embryology (HFE) Acts then established the 'Parental Order' process as the route to legal parenthood - first for married intended parents of surrogate children (1990) and later extending eligibility to unmarried and same-sex couples (2008). In 2018, further Regulations allowed single people to apply for Parental Orders.

Today, the UK's surrogacy laws can be regarded both as:

- progressive (the UK is one of relatively few countries in the world to have clear legislation and regulations governing surrogacy); and
- out-dated and in need of reform.

The Parental Order process, which can delay intended parents' recognition as legal parents for up to a year after their child's birth, is considered by UK surrogacy organisations to be in particular need of reform. This is due to the potential stress and uncertainty which the process of transferring legal parenthood from the surrogate (and the surrogate's partner) to the intended parents can cause for all parties (Nuffield, 2023).

It is hoped that reform is on its way. On 29 March, 2023, the Law Commission of England & Wales, and the Scottish Law Commission released recommendations for the reform of UK surrogacy law. Their core recommendations include:

- a new system of regulation by the Human Fertilisation and Embryology Authority (HFEA) for UK surrogacy organisations and a status of Registered Surrogacy Organisation (RSO);
- a new pathway through which legal parenthood can be achieved for intended parents from birth, subject to oversight of the surrogacy journey by an RSO;
- a new Surrogacy Register, maintained by the HFEA, that will allow surrogate-born people to access information about their origins;
- removal of the regulation that requires surrogates' partners to be named on the birth certificates of surrogate-born children.

SurrogacyUK believes that the recommendations retain the UK's distinct and progressive approach to altruistic surrogacy, strengthen measures that avoid the commercialisation of surrogacy in the UK, provide greater clarity to all parties in surrogacy arrangements and – most importantly – help to provide a secure start to children born through surrogacy, and a clear route through which they can obtain information about their origins.

The Law Commissions can only make recommendations and only Parliament can change the law. UK surrogacy organisations, and other countries interested in reviewing their own surrogacy laws, will be keenly watching to see if these recommendations lead to much-awaited legal change.

## Surrogacy: A glossary of terms and explainers

- Parents through surrogacy are referred to as 'intended parents' or IPs prior to birth. In 2018, a law change in the UK permitted single people to become parents through surrogacy; hence IPs is used where appropriate in this supplement.
- 'Teams' is used in this supplement and in many surrogacy organisations to refer to the IPs, the surrogate and the surrogate's partner.
- Traditional surrogacy (sometimes 'straight surrogacy' or 'partial surrogacy') refers to surrogacy in which the surrogate is the genetic parent of the surrogate-born baby and often doesn't involve clinic intervention (except in cases where in-utero insemination is the route to conception).
- Host surrogacy (sometimes 'gestational surrogacy' or 'full surrogacy') refers to surrogacy in which the surrogate does not have a genetic link to the surrogate-born child and in-vitro insemination is the route to conception.
- Elective surrogacy refers to arrangements in which surrogacy is chosen or 'elected' rather than required because people are unable to carry their own child.

It's an exciting time for surrogacy and a good time for healthcare professionals, and early years educators, to develop their understanding of surrogacy, and to build their confidence to provide care for surrogacy teams.

In the UK, surrogacy remains a relatively unusual way to start or grow a family. In 2021, 424 parental orders were issued in the UK, including for surrogate children born overseas. That's fewer than 1:1290 of the 625,000 live births in the UK in that year (Office of National Statistics [ONS], 2022).

To the frustration of this relatively small surrogacy community in the UK, surrogates, intended parents, and the process of surrogacy itself, are often viewed with suspicion or mistrust, exacerbated by:

- myths and media tropes, amplified by dramatic and misleading storylines in soap operas (in which the surrogate, desperate for money, takes the money and keeps the baby);
- a lack of awareness of or familiarity with surrogacy;
- a loud lobby that object to surrogacy, as they believe that, in all cases, it subjugates women;
- a divergence with individual moral, religious or ethical values.

Healthcare professionals may well at some point in their career work with surrogacy teams, and they have a particularly powerful potential to impact surrogacy journeys, both positively and negatively.

Whilst this supplement focusses on altruistic surrogacy in the UK, many of the principles of care that it considers are applicable in other jurisdictions as considered in the 'International Surrogacy' section below.

### Practice Pointers

Language is really important when providing care in surrogacy. For example:

- Surrogates generally prefer the term 'surrogate' rather than 'surrogate mother', including when they have a genetic link to the child. Surrogates don't consider themselves to be the baby's parent and being referred to as 'mother' can make them and the intended parents feel uncomfortable.
- Avoid making references to the 'real parent' when talking to or about intended parents. In UK law, in order to get a Parental Order, one of the IPs must have a genetic link to the surrogate-born child, but establishing which IP has that genetic link should be done sensitively and carefully.

## International and Commercial Surrogacy

Internationally, the legalities and practicalities of surrogacy are very varied. Whilst the principles of care are likely to be similar, it's important for healthcare professionals and early years educators – and the Journal's international readership – to understand how surrogacy differs internationally, and to consider some of the underlying ethical issues.

What follows is not an exhaustive list or guide to international surrogacy. A more comprehensive list of international surrogacy laws is maintained by Surrogacy360 and available in the references section at the end of this supplement.

### A GLOBAL SUMMARY

Many countries do not have a clear regulatory framework for surrogacy. That doesn't mean that surrogacy doesn't happen – it may take place in private arrangements in communities and families – but, outside of a legal and regulatory framework, surrogacy arrangements in those countries are less likely to be ethically sound. Reputable surrogacy organisations would not consider supporting international surrogacy arrangements in those countries, and 'repatriating' a child born in one of those jurisdictions to the UK, for example, would be complicated.

Several countries that used to permit foreign nationals to pursue surrogacy arrangements including Cambodia, India, Thailand and Nepal, have recently made 'surrogacy tourism' illegal due to ethical concerns (see section on 'ethical considerations').

### SURROGACY IN EUROPE

Perhaps surprisingly for countries that are often regarded as socially liberal, surrogacy is also illegal in Norway and Sweden. Those countries are home to vocal lobbying groups that equate surrogacy with prostitution. They campaign against surrogacy from a radical feminist perspective, arguing that the process subjugates and exploits women. This is contrary to the views of SurrogacyUK surrogates who feel proud, empowered and rewarded by the opportunity to help other people become parents.

Some countries permit some forms of surrogacy but not others. In Denmark, for example, altruistic, traditional surrogacy is the only form of legal surrogacy. In the Netherlands, both traditional and host altruistic surrogacy are legal, but age limits and stipulations around genetic links are in place for host surrogacy arrangements. The Republic of Ireland is currently considering new legislation relating to surrogacy.

Elsewhere in the European Union, surrogacy is generally illegal, but processes are in place through which citizens can become legally recognised as the parents of children born through surrogacy overseas (often via legal processes designed for adoption).

Russia, Belarus, Georgia and Ukraine have previously been destination countries for international 'commercial' surrogacy, but are restricted to heterosexual married couples. In 2022, Russia's parliament banned non-Russian-nationals from pursuing surrogacy in Russia and, due to the war, Ukraine is neither a safe nor viable option. The ethics of pursuing surrogacy in those countries has always been a point of contention; UK surrogacy organisations that support international surrogacy have varied views (see 'Ethical Considerations').

### **SURROGACY IN NORTH AMERICA**

Altruistic surrogacy is legal in Canada, including for non-Canadian-nationals. The laws relating to surrogacy and the acquisition of parenthood vary between provinces. Quebec, for example, is currently considering legislation that will recognise surrogacy agreements in law, whereas those agreements have long been recognised in British Columbia.

Surrogacy in the USA is under state, rather than federal, jurisdiction and, in most states, is either legal or unregulated. To take a few examples:

- it's illegal in Idaho, Michigan and Indiana;
- both traditional and host surrogacy are legal and regulated in Washington State and Colorado (amongst others); and
- host surrogacy is legal and regulated in New York, Texas and California (amongst others).

Surrogacy in the USA is generally commercial and, where it's legal and regulated, there are clear frameworks and significant legal protections for all parties in place.

### **SURROGACY IN AUSTRALIA AND NEW ZEALAND**

With the exception of the Northern Territories, where it's unregulated, altruistic surrogacy is legal in Australia, but only for Australian residents. New Zealand is similar, and is currently considering legislation to establish a clear framework for surrogacy (which currently relies on laws designed for adoption).

### **COMMERCIAL SURROGACY**

The 'altruistic or commercial' debate is a lively and contentious issue in the surrogacy community. It's often presented in an adversarial way and tends to be divisive. The definitions are disputed too: some people regard payments to surrogates as 'commercial'; others would only regard profit by agencies or brokers as commercial. Surrogates in North America who

receive compensation in 'commercial' surrogacy arrangements have altruistic motivations too.

For intended parents who are able to afford the higher costs of commercial surrogacy, the legal frameworks that support it can be attractive. They tend to provide more assurance and certainty around legal parenthood than jurisdictions such as the UK which allow altruistic surrogacy. Some surrogacy organisations, like SurrogacyUK, only support UK-based, altruistic surrogacy. Brilliant Beginnings and My Surrogacy Journey support members to pursue commercial surrogacy in other jurisdictions too.

The key question is: is it ethically preferable for surrogates to be paid for their services (as in 'commercial' surrogacy) or repaid for 'expenses only' (as in 'altruistic' surrogacy)?

There are good, ethical, reasons cited by proponents on either side.

The altruistic model moves surrogacy outside any perceived commodification, exploitation and 'marketplace'. It recognises that asking someone to carry a child on your behalf is a 'gift' given, not a 'service', and distances surrogacy, and surrogates, from unfair (but not uncommon) accusations that they are involved in the sale of babies.

On the other hand, the 'commercial' model recompenses surrogates for the work they do in carrying a child. It doesn't assume that women should carry children for free (as they are socially expected to) and can offer greater certainty to all parties, within a commercial contract.

### **Practice Pointers**

#### **Altruistic v commercial surrogacy**

Healthcare practitioners are encouraged to:

- familiarise themselves with the different sides of the debate without assuming that either model is better or worse;
- clarify the legal status of surrogacy in their country or state of employment and the particulars of the law and regulations in their jurisdiction;
- understand the law sufficiently to recognise illegality or abuse if they come across it.

### **ETHICAL CONSIDERATIONS**

There are a number of key factors to consider in judging how ethically sound international surrogacy laws and regulations are. Some key questions include:

- Are the rights of surrogates protected (with respect for the central principles of autonomy and consent that are considered in the next section)? Concerns over surrogacy in Ukraine relate to the identification of intended parents as parents from the point of conception rather than birth, challenging the ethical principle of the surrogate's bodily autonomy

discussed later on this page. Similarly, research into surrogacy in India (which has since banned ‘surrogacy tourism’) found that:

*Indian surrogates have no power to make decisions about the gestational and birth process, which is decided and managed by medical doctors and intended parents. The Indian situation contrasts with that in the United States, the UK or Israel, where surrogates have autonomy and the power to make decisions on the pregnancy, including on the future child (Rozée et al., 2019).*

- Are surrogates able to consent freely, or are they under (for example) financial pressures that make them subject to exploitation? Inequalities between average incomes and living standards in surrogates’ and intended parents’ home countries can generate conditions in which the surrogate’s consent may be compromised (considered further in Nuffield, 2023).
- Are the rights of children born through surrogacy protected? Is there a clear route for legal recognition of their relationship with their parents?
- Will the child have a right to access information about their origins, including information about their surrogate and their genetic origins?
- Are the rights of all parties, including IPs sufficiently protected? International commercial surrogacy, in particular in unregulated jurisdictions, can make intended parents vulnerable to abuse by brokers and agencies keen to exploit people’s desperation to become parents.

Most readers of this supplement work in jurisdictions where surrogacy is both legal and well regulated, but not necessarily very common. However, ethical issues still apply and can impact the provision of care. The next section considers those issues in more detail.

## Autonomy, consent and decision-making in surrogacy journeys

As healthcare professionals, encountering surrogacy for the first time can be daunting. Depending on how familiar you are with surrogacy, and how well prepared your organisation is from a policy and

procedure perspective, you might:

- not know what to do;
- feel vulnerable and provide care in an over-cautious way;
- allow your own preconceptions, prejudice or bias to impact the way in which you provide care.

This section explores consent and decision-making in surrogacy journeys from both a practical and an ethical perspective, and should help build your confidence and overcome the uncertainty you might experience in your first encounter with a surrogate pregnancy.

### START FROM A POSITIVE PLACE

The kind of media and soap opera tropes mentioned on page 3 can lead to suspicion or mistrust of surrogacy. That can, subconsciously, impact the provision of care and the all-important first impressions that you might make on a surrogate, their intended parent(s) (IPs) and their wider team (surrogates’ partners are often very much involved in surrogacy journeys).

So try to start from a positive place. Make professional judgements in the usual way, accommodating the particular features of surrogacy journeys as explained here, but don’t assume that just because it’s surrogacy, that there’s something wrong.

### AUTONOMY AND CONSENT

#### Bodily Autonomy

The ability of a person to make choices concerning their own bodies. These choices must be made without fear, undue pressure, violence or coercion.

Bodily autonomy and consent are central, ethical principles in healthcare, including in surrogacy. As with any pregnancy, the pregnant person – in this case, the surrogate – should retain body autonomy at all times, and should be able to make informed decisions about their treatment or care. Establishing whether patients have the capacity for autonomous choice and their ability to provide consent in healthcare normally involves considering:

- Competence (is the surrogate capable of making relevant decisions?) and
- Authenticity (is the decision genuinely theirs?)

You’re probably familiar with shorthand ways of assessing these (through capacity tests for example), and you should apply those tests in the usual way. You should also think of the journey that the surrogacy ‘team’ will have already been on because often it will help reveal a great deal of authentic decision-making as well as the particular challenges they have faced.

- For cis-gender, heterosexual couples, surrogacy is rarely a first choice: it’s one that normally follows long journeys of infertility and loss or

- congenital conditions that may have been known for a long time or recently diagnosed.
- Same-sex and trans couples may have encountered prejudice with respect to their sexuality, gender-identification or ambition to start a family. Like heterosexual couples, they've also probably carefully considered other options such as fostering and adoption, and made a positive decision for surrogacy.
  - In the vast majority of cases, surrogates will have very carefully considered their decision. It may be a life goal to become a surrogate (as in Emma's case on page 10) or an offer made to close friends or family members who are unable to conceive or carry naturally.

In addition, surrogacy journeys are time-consuming, emotional and often expensive. The people involved are likely to have spent time finding out about surrogacy, building support networks and ensuring that they are making appropriate decisions for themselves, their families and for each other. There are likely to have been barriers and challenges too, such as how long it can take to form a team, high IVF costs for the IPs, extreme reactions from family members who don't understand or agree with the choices made, and well-meaning but (sometimes) inquisitive friends, colleagues and acquaintances who want to give their opinion and advice.

Surrogacy arrangements don't happen by accident, and healthcare professionals should avoid regarding them with suspicion. But they should recognise how matters of consent, competence and authenticity need special consideration in the context of surrogacy.

Of course, if concerns do arise, the normal safeguarding processes should be applied.

### DECISION-MAKING IN SURROGACY TEAMS

Decision-making for altruistic surrogacy pregnancies and births is often done by a team, collectively, where everybody's preferences and their 'red lines' have been discussed at length, but where the surrogate's bodily autonomy is the primary factor.

Where a surrogacy journey is supported by an organisation (such as Brilliant Beginnings, COTS, My Surrogacy Journey or SurrogacyUK) it's likely that a written agreement will have been drawn up to record key decisions made by teams, through a facilitated discussion.

In the UK, those agreements are not legally-binding, but they carry moral weight and help to ensure that challenging issues are considered thoroughly in advance. Agreements are likely to record the team's decisions on:

- expenses payable to the surrogate through the pregnancy, including planning for contingencies (such as unplanned c-section incurring additional costs for the surrogate);
- expectations around future relationships including between the surrogate and the child;
- attendance at scans and appointments;

- arrangements for birth plans and birth partners;
- announcing pregnancy and birth; and
- scenarios relating to termination of the pregnancy.

Tough decisions about the termination of non-viable pregnancies or trisomy disorders shouldn't involve any surprises. It's essential that termination conversations happen before teams try to conceive. Surrogates' decisions around termination in a surrogate pregnancy might differ from those that they would make about their own pregnancies. Whatever surrogates decide, their consent must be given freely, without coercion or pressure, and reputable surrogacy organisations – and sensible surrogacy teams – will make sure that difficult conversations take place well before pregnancy.

The fact of surrogacy must not be used to coerce or put pressure on surrogates' decisions. But nor does the fact of surrogacy *imply* coercion or undue pressure on them. Healthcare professionals must satisfy themselves that the person under their care is competent and is making authentic healthcare decisions (which together indicate their autonomy), just as they would with a regular pregnancy.

### NEONATAL DECISION-MAKING

Neonatal decision-making is an area where existing UK law can be at odds with the wishes of everyone involved in a surrogacy team. As described on page 3, surrogates and their spouses or civil partners (if they have one) are the legal parents at birth for surrogate children. That means that the surrogate has legal responsibility for decisions about post-natal care until the point when a parental order is issued.

However, guidance from the UK's Department of Health & Social Care (DHSC) entitled 'Care in Surrogacy' (2021) contains clear and pragmatic advice for healthcare professionals covering this:

*Postnatal care related to a surrogate birth will usually be very different to other births. Often the surrogate will consider her role to be finished after the birth and wish to be discharged independently of the child. Usually the child will be fully cared for by the IP(s) from birth and so parenting support, advice and decision making should be directed to them until they are discharged with the child.*

The written consent of the surrogate should be provided which delegates treatment-related decision-making to the IP(s) and this should be clearly recorded in the medical notes, again taking into consideration the legal framework for who can legally make those decisions (DHSC, 2021).

The provision of uninformed or overly cautious care-giving post-birth is likely to be upsetting for both surrogates and intended parents. Again, unless there's specific cause

for concern about your patients, after applying your normal safeguarding checks, start from a positive place in your application of post-natal care-giving for surrogates, intended parent(s) and their newborns.

### Practice Pointers

- Educate and inform yourself so that you don't experience the 'fear factor' when you meet your first surrogate or surrogacy team.
- Start from a positive place; don't assume coercion or vulnerability until you see evidence of it.
- Read the Department of Health & Social Care's 'Care in Surrogacy' guidance if it's applicable (DHSC, 2021).

## Dealing with loss and complications

There's a popular misconception that surrogates particularly enjoy pregnancy or have enjoyed easy, natural births in the past. None of these things are generally true and, of course, all pregnancies carry risk. Reputable surrogacy organisations will make every effort (through implications counselling or similar) to ensure that all parties are aware of the risks, that complications are managed and that support is provided where loss occurs.

Breaking bad news and dealing with pregnancy complications are often challenging for healthcare professionals. Surrogacy journeys have added complexity and require extra attention to ensure that all parties are treated inclusively, and communicated with effectively.

### MINIMISING RISK

As part of its vetting process, SurrogacyUK seeks to ensure that potential surrogates have completed their own families before they undertake a surrogacy journey. SurrogacyUK does, however, allow surrogates who don't wish to have children themselves to become surrogates if they're at least 25 years old and are very clear in their own mind.

Reputable surrogacy organisations (and all clinics) will also seek assurance from healthcare professionals to minimise risk in surrogacy journeys, including testing of surrogates and IPs for sexually transmitted and heritable diseases.

### DISCUSSING LOSS AND COMPLICATIONS

Surrogacy agreements, discussed in the previous section, will often cover complications in pregnancy and birth such as:

- extreme side-effects during pregnancy, and their treatment;
- abnormalities found during scans and non-

invasive prenatal testing (NIPT); and

- abnormalities that only become clear in later scans or after birth.

Surrogacy teams should have had difficult conversations about termination before trying to conceive. Healthcare professionals should respect that and recognise that surrogacy teams are likely to make decisions collectively, even though their primary duty of care will be for the surrogate.

It's important to recognise that loss can occur before surrogates are involved in surrogacy journeys too. Host surrogacy journeys start when intended parents attempt to create embryos. Events and procedures that are routine for clinicians will be high-stakes, life events for intended parents. Failure at any stage of the process can be painful, and costly. Surrogacy journeys are particularly expensive when IVF is involved.

### MISCARRIAGE

Miscarriage is always devastating. Surrogacy teams tend to test for pregnancies early and often, and opt to take reassurance scans, so they may be more likely to be aware of early term miscarriages than couples who try to conceive naturally.

Clinic teams, sonographers and support staff should keep this in mind when working with surrogacy teams. They should also make sure that:

- there are clear policies and practices around who's able to be in scan rooms and at consultations;
- appropriate consents are signed;
- where there's a choice, that test results (for example for NIPT) are sent to the right team member (which may be the intended parents rather than the surrogate).

Where care-providers have to share bad news, it's important to recognise that, whilst the surrogate will suffer physically, all parties will grieve. Unfortunately, surrogates often feel added 'guilt' and a sense of responsibility for the loss of what they consider to be the intended parents' child.

Dealing appropriately with grief will be especially important in cases of stillbirth, or if a baby passes soon after birth. Specially trained staff, including midwives, should provide support to the whole surrogacy team, including the IPs, ensuring that they are recognised as the baby's parents in terms of access to the bereavement suite and with respect to their wishes for the baby's body.

It is vital that – within the parameters of law and policy – professional judgement, flexibility and compassion are exercised and that the special circumstances of surrogacy pregnancies and births are accommodated.



# Children of surrogacy

Any discussion about surrogacy is incomplete unless it also considers the impact of surrogacy on children. ‘Children of surrogacy’ is intended as a broad term, taking in not just children born through surrogacy, but also children whose lives are affected by surrogacy. That includes surrogate’s own children, and children with siblings or cousins born through surrogacy. There’s a small but growing body of research exploring the impact that surrogacy has on children and asking questions such as:

- Is there an emotional, psychological or developmental impact on children born through surrogacy?
- What do children born through surrogacy think about parenthood?
- What do children think about the law in this area?

## A LONGITUDINAL STUDY

Professor Susan Golombok from the University of Cambridge’s Centre for Family Research has led the UK’s only longitudinal study into the wellbeing of children born through surrogacy. Some of her earlier research into ‘lesbian mother families, and on families formed through IVF and donor conception, had shown that the widely held assumption that these families would experience problems was wrong’ (Golombok, 2020:135). Professor Golombok was keen to explore the impact that ‘being separated from the women who gave birth to them, some of whom were their genetic mothers’ (p135) would have on children born through surrogacy.

The study started in 2000 and included 42 surrogacy families. It’s very accessibly summarised in Golombok’s, ‘We are family: what really matters for parents and children’ (2020). In brief:

At age one, ‘Parents through surrogacy showed greater warmth and enjoyment in their babies than the parents who had conceived naturally. They were also more emotionally involved with their babies...’ (Golombok, 2020:135).

At age three, ‘The surrogacy families appeared to be doing better [than those where children were conceived naturally] because the parents were so pleased to have children after all they had been through to make it happen’ (Golombok, 2020:136).

The only ‘blip’ in development appears at age seven when ‘some of the surrogacy children showed an increase in emotional and behavioural problems’ (Golombok, 2020:136) but these psychological problems had ‘disappeared by the time we re-visited the families when the children were aged ten’ (Golombok, 2020:136).

Professor Golombok suggests that the ‘most likely explanation for this phenomenon...is that these children have to cope with issues relating to their identity at a younger age than most other children’ (Golombok, 2020:136).

The study found that, as children approach adulthood, the children’s origins in surrogacy matter less to them and the majority were largely uninterested. That’s a useful reminder that the things that adults worry about regarding their children, aren’t necessarily important to the children they’re worrying about. But we need to ask children to know that.

## CHILDREN’S VOICES IN SURROGACY LAW (CVSL)

Dr Katherine Wade, Dr Kirsty Horsey and Zaina Mahmoud have done exactly that in an innovative, empirical project that aims to gather and analyse children’s views on surrogacy law (Wade et al., 2023). Children’s Voices in Surrogacy Law (CVSL) is being undertaken concurrently with the review of UK surrogacy law and aims to engage children of surrogacy in that reform.

Facilitating research with children presented challenges for the team which they overcame by using focus groups with illustrated card games and artwork to gather children’s views on law reform. Phase 1 involved 25 children (aged 8-17) who were either born through surrogacy, their mother was a surrogate or their family member had had a child through surrogacy. Phase 2 involved children from schools. The research is ongoing, but preliminary findings from Phase 1 are very interesting for anyone involved in surrogacy, and in providing care and education for children of surrogacy. It was found that:

- Care, love, support, and responsibility were central to how participants viewed parenthood.
- Most participants thought that intended parents should automatically become parents following surrogacy.
- Most participants expressed a strong dislike towards payments for surrogates.
- Some participants were concerned that intended parents would be under pressure to pay large amounts.
- Many participants were very open about surrogacy in their lives, while others only spoke about it when relevant, or where it was brought up. (Wade et al., 2023)

Beyond surrogacy, and potentially across healthcare, CVSL provides a model for the engagement of children as agents in the co-production of laws and regulations that impact their lives.

To bring the content of the supplement to life, the final section considers a traditional surrogacy journey, from start, to birth.

## My surrogacy journey - Emma Kenwright

For as long as I can remember, I wanted lots of children and loved the idea of having a large family. Not being able to have children would have been devastating to me but I've been lucky – I have six children of my own and have always conceived easily. The urge to become a surrogate – and to help someone else to start or grow their family – became stronger as my own family grew, to the point that it became a life goal. I joined SurrogacyUK in 2018 after the birth of my youngest child. The organisation has a 'friendship first' approach which appealed to me and I chose traditional surrogacy because I didn't want to go through a clinical process – my conceptions and births have all been natural and, although I was approaching 40 when I joined, I felt confident in my health and fertility.

### CHOOSING INTENDED PARENTS

In SurrogacyUK, surrogates make 'offers' to people they want to support (never the other way round). Some organisations do things differently but this was an important part of me feeling secure and in control. The first offer I made was to a heterosexual couple; after getting to know them, and a few months of trying to conceive, we didn't fall pregnant and the team broke down. Something hadn't felt quite right anyway. I think that surrogates can put pressure on themselves to make progress, and with hindsight, I wish I'd waited a bit longer to choose.

The choice is so important because surrogacy is a journey that you take your whole family on (and a lot of your friends). I was open-minded about who to help but I did need them to be geographically close, have things in common with me and my family, and I needed to feel a connection to them.

The second offer I made, in October 2019, was to Nic and Alan, a same-sex couple who live about an hour's drive away from me. When I saw their profile online, there was just something about them that drew me. I didn't expect to fall in love with them so much, but they just slotted into my family and it feels like they have always been a part of our lives.

### TRYING TO CONCEIVE (THROUGH A GLOBAL PANDEMIC)

In total, we tried to conceive nearly 20 times. The Covid-19 pandemic complicated our journey, and we also experienced some early losses. They were hard: they were my first (known) miscarriages and would have been upsetting in any circumstances, but everything about surrogacy is loaded with added complexity and emotion. Sharing news of positive test results with my IPs was one of the joys

of my journey; sharing news of our miscarriages with them was awful. It's difficult as a surrogate to avoid feeling responsible, but Nic and Alan were great about it and we kept each other positive.

The hardest period for us was a run of about nine months without a positive test at all; maintaining hope and optimism through that period was a challenge. Doubts about my own fertility started to creep in, and I know that Alan (whose sperm we used) had begun to worry about his. We were worrying about each other's fertility too; we communicated really well as a team, but it's easy to see how surrogacy journeys break down through doubt, mistrust or paranoia.

I'm pleased and proud that, at a time when Nic and Alan were ready to give up, it was my belief and determination that encouraged them to try a few more times, resulting in the birth of their son, Jago, in October 2022, just over three years after we met.

### RELATIONSHIPS IN SURROGACY

Surrogacy is as much about managing relationships, expectations and emotions as it is babies. Strong surrogacy teams support each other, and are able to seek support from outside the team too. As a woman, and a qualified midwife, I was able to help inform my IPs about aspects of menstruation, conception and pregnancy that they, as gay men, didn't know. They also helped me to manage the pressure I put on myself to carry a baby for them.

As a nurse, I'm used to providing care not just to my patients, but to their families too. Surrogacy, to me, seems like a 'special case' of that kind of care. If you meet a surrogacy team, I think it's important to understand everything that they've already been through, and the potential that you have to disrupt – or improve – the relationship that they've built and the journey that they're on.

### CARE ACROSS OUR SURROGACY JOURNEY

From the start, I wanted Nic and Alan to attend all appointments and scans and to experience as much of the pregnancy as they could. We were clear on where they would be included (as much as possible!) because my attitude was, whilst it's my body, it's our pregnancy and it's their baby.

We had a few cases where care in our surrogacy journey could have been better. The first was at an early scan. As soon as 'surrogacy' was mentioned, the receptionist's attitude towards us seemed to change. It was subtle, but we all felt it. Perhaps it was prejudice, or perhaps it was just unfamiliarity and fear of doing something wrong, but either way, it soured what should have been a positive experience. The sonographer on that occasion was great, but every point of healthcare contact has the potential to impact a journey.

A later scan in our final and successful pregnancy was a point of poor care too. The sonographer wouldn't let both Alan and Nic into the room, so Alan missed out on hearing his baby's heartbeat for the first time. It's a simple fact about surrogacy

that, often, three people want to be in the room where you'd normally expect two! I know, as a nurse, that we can work within guidance, adapt to the situations we see and make positive decisions for our patients. That wasn't what happened on this occasion and we went into every scan from that point on in fear of confrontation, rather than with the excitement of seeing the baby. We asked for a note to be put on our file, so it didn't happen again; that simple action made a big difference.

### LABOUR AND BIRTH

At 38 weeks and with slight hypertension, I was put under considerable pressure to be induced. A routine scan ended up with a trip to the labour ward, and I didn't see my family again for four days. It wasn't a surrogacy thing but because of my age and I didn't feel listened to by the people providing my care. My IPs didn't put any pressure on at all with regards to the induction decision; in fact, they offered to leave the consultation room at this point – but it made me realise the pressure that surrogates could feel, faced with difficult choices about their body, and someone else's baby.

There were many positives about our care too. The midwife who delivered Jago was exceptional and most of the people we met from that point onwards were fabulous. People generally used inclusive language with my IPs, referring to them as 'the dads' and not referring to me as Jago's 'mother'. They were also sensitive to the fact that I was carrying someone else's baby, and to the birth plans we'd made together in which:

- My IPs were my birth partners (whilst my husband looked after the family at home);
- Alan would cut the cord (after a delay if possible);
- Nic would have the first cuddle; and
- I would do the first feed if I was well enough to.

As it happened, after Jago's birth I had a major postpartum hemorrhage. This brought out the best in everyone; the care provided to us as a team was superb. The team sought my informed consent throughout, recognised the role that I'd asked my IPs to play (as my advocates in exactly this kind of situation) and kept them informed whilst I was in theatre.

### POLICY AND PRACTICE

Through my labour, our midwifery team had been battling against a lack of hospital policy regarding surrogacy. At one point, we were told that I wouldn't be allowed to leave hospital before the baby (a common surrogacy myth!) and we were all a bit dismayed that our care team were having to do their own research into the 'legalities' of surrogacy throughout my delivery and the baby's first few hours of life. It put our care-givers in a really difficult position and jeopardised what had been very positive relationships. It was all resolved eventually, but only when the hospital's legal department got involved.

I think all hospitals and healthcare organisations

should have policies for surrogacy; we had good treatment because we had good, kind, people providing our care, but they should be supported by existing policy and documentation.

### PRIDE IN SURROGACY

Helping Nic and Alan to start a family has made me immensely proud to be a surrogate. Every day they send me photos and videos of Jago. I don't feel maternal towards him, but I love him and enjoy spending time with him. I'm proud to work in a healthcare system that, for the most part, understands surrogacy and in a country where altruistic surrogacy operates in a clear legal framework. I now volunteer for SurrogacyUK providing support for other surrogates through their journeys.

#### Practice Pointers

As a surrogate and a healthcare professional, my practice pointers are:

- Check whether you have a surrogacy policy in place and if you haven't, do something about it; consider how you'll feel if a surrogacy team walk into your ward or clinic tomorrow!
- Don't be scared of surrogacy; take an interest in the people you meet and the journey they've been on.
- Ignore soap opera story lines and negative press about surrogacy. This has been an empowering and amazing experience for me: no one made me do it, but I'll be forever happy that I have!

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