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September 2021

Surrogacy briefing statement

Key messages:

- Surrogacy is when a woman carries a child for someone who is unable to conceive or carry a child themselves. It is an established and legal way of creating a family. However, there is no national data collection of how many babies and children have been born to surrogates.

- In the UK it is not a commercial industry but normally undertaken on an altruistic basis (expenses only). Surrogacy through commercial means is illegal in the UK. It is an offence for an individual or agency to act on a profit-making basis to organise or facilitate surrogacy for another person.

- The actions and attitudes of healthcare staff can have a significant impact on the experiences of surrogates and intended parents. Training for midwives, support workers and others working in maternity services will help to reduce stigma and help to ensure compassionate care (DHSC, 2021).

- Most surrogacy cases are straightforward, positive and rewarding experiences; disputes between parties are very rare (DHSC, 2021).

- Legal parenthood lies with the surrogate and her partner (if she has one) until it is transferred to the intended parents through legal process. This currently can only be applied for from six weeks after the birth, although the law is due to change.

- Best practice is for a pre-conception agreement between the surrogate and intended parents which outlines their wishes (although this is not legally enforceable) and for complete transparency at the booking appointment.

Legal framework

Surrogacy in the UK is governed by the Surrogacy Arrangements Act 1985 and the Human Fertilisation and Embryology Act 2008. Altruistic surrogacy is an established and legal way of creating a family in the UK and allows for a surrogate to receive reasonable pregnancy-related expenses from intended parents, as assessed by the family court. The surrogate is the legal mother of the surrogate child from birth until legal parenthood is transferred to intended parents through a parental order made by a family court. If the surrogate is married or in a relationship, her partner will also assume legal parenthood status of the child from birth until the parental order is made. Intended parents can start the process to obtain a parental order from six weeks until six months after the birth. The parental order process is normally straightforward, and it is usual for a child to be cared for by the intended parents from birth (with the surrogate's consent). The Law Commissions of England, Wales and Scotland will publish a report (expected early 2022) following a consultation on surrogacy law reform and provide government with a proposed draft bill which will allow legal parenthood from birth.

Surrogacy through commercial means is illegal in the UK (Surrogacy Arrangements Act 1985), unlike in other countries, such as the USA and India. Potential surrogates and intended parents make contact through a variety of support groups, non-profit surrogacy agencies (links in resources at the end of this document) and by word of mouth. Where staff have suspicions that there is a commercial arrangement, they should contact their Lead for Safeguarding Children for further advice and guidance.

When the conception in a surrogacy arrangement takes place in a licenced clinic and the appropriate consent forms are completed, an intended parent who provides the sperm can be registered as the legal father on the birth certificate if the surrogate is not married. A parental order would still be necessary to transfer the legal

parenthood of the second intended parent if there are two. For more information see Surrogacy: legal rights of parents and surrogates: Become the child's legal parent - GOV.UK (www.gov.uk)

Pre-conception

The Department of Health and Social Care ((DHSC) 2021) advocates for written surrogacy agreements, ideally made before conception. Whilst not a legal document, a surrogacy agreement sets out how the parties intend to conceive and manage the pregnancy and birth and care for the baby postnatally. A comprehensive surrogacy agreement would cover all eventualities and decision-making events, for example how a termination of a pregnancy would be handled. A surrogacy agreement should be treated by the maternity team with sensitivity and as confidential.

The Human Fertilisation and Embryology Authority (HFEA) Code of Practice (2019) explains that all parties involved in the surrogacy arrangement should be offered counselling to discuss the implications and potential challenges faced by them when undergoing complex treatment cycles.

In cases where surrogacy arrangements have taken place without the aid of a fertility clinic, then counselling by a suitably qualified professional is recommended to both surrogate and intended parents (including the surrogate's partner if applicable) at the antenatal stage.

Maternity Care

Antenatal care

The surrogate should be the focus of maternity care from their midwife and others in the maternity team. The surrogate may choose to include the intended parent/s in her care and at appointments however, she should be encouraged to have one or more appointments on her own. This allows confidential disclosure of medical and personal history and any current concerns without fear of judgement or coercion by

the intended parent/s. Vulnerability can be experienced by both the surrogate and the intended parent/s; the surrogate, for example, if there is socio-economic inequality (and no written agreement) and the intended parent/s who have no legal rights to the baby. If a written surrogacy agreement has not yet been prepared, or if it does not adequately cover antenatal care, then the surrogate and intended parent/s should be encouraged to create one. The team should be satisfied that the surrogate consents to the attendance and sharing of personal information at appointments.

It is important to record the names and address of the intended parent/s, who may live in another part of the country. As well as their contact details, local hospital, GP and midwifery contact details should be recorded in the antenatal records to enable a smooth discharge to community care for the baby.

Antenatal Screening

The surrogate should be offered the routine screening tests during pregnancy and it is her decision whether to have them. Her results should be directed to her and only shared with the intended parent/s if she consents. If the surrogate gives consent, the intended parent/s should be included in counselling, decision-making and information sharing.

When treatment is provided in licensed fertility clinics, infection disease screening of the surrogate and egg or sperm donor will have taken place. They will have been screened for blood karyotyping, cystic fibrosis and other applicable genetic tests.

With self-insemination there is a risk of transmission of infection to the surrogate and/or unborn baby. It is therefore important that the surrogate (and her partner if she has one) is advised of this and offered testing, prior to or after conception. The intended parent/s should be included in counselling and decision-making if the surrogate has given consent (DCSC, 2021).

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If a transmittable disease is identified, it cannot be shared with the intended parents without the consent of the surrogate as this breaches confidentiality. The surrogate should be counselled of the risks of transmission of infection to the baby and any recommended steps at birth to minimise the risk of transmission.

Sickle Cell and Thalassaemia Screening.

Haemoglobinopathy screening will depend on the following scenarios.

Scenario	Screening process
Surrogate's own eggs intended father's sperm	Complete the Family Origin Questionnaire (FOQ) and offer screening as normal.
Donor egg, intended father's sperm	Screening cannot be offered to the surrogate as she is not genetically related to the fetus. Complete the FOQ and send with the FBC ticking the donor egg box. Refer to the screening team who will offer the intended father testing.
Both the intended parent's egg and sperm	If IVF has been undertaken in the UK those providing gametes will have already undergone screening. If not offer the intended mother screening, send an FBC sample with completed FOQ.
Intended mother's egg and donor sperm.	If IVF has been undertaken in the UK those providing gametes will have

	already undergone screening. If not, offer the intended mother screening, send an FBC sample with completed FOQ. Tick appropriate box for donor sperm

(Reproduced with kind permission from Hampshire Hospitals, 2018)

Termination of Pregnancy

Where a termination of pregnancy is being considered and the relevant legal conditions are met, the surrogate makes any final decision about a termination. If the surrogate discloses that she is considering termination, then she should be referred to a counsellor and the relevant healthcare professionals in accordance with the gestation period of the pregnancy. The intended parent/s should be included in this counselling, information sharing and decision making only if the surrogate has given consent.

Planning for the birth

There are surrogate birth plan templates available through the national altruistic surrogacy organisations (Surrogacy UK, COTS and Brilliant Beginnings – see resources at the end of this briefing). A birth plan is normally part of the surrogacy agreement prepared by the surrogate and intended parent/s. This sets out the many issues commonly found in birth plans, such as place of birth and who would be present at the birth. Every effort should be made to accommodate all reasonable requests, making sure that other existing policies and procedures do not have the unintended consequence of blocking the wishes of the surrogate and intended parent/s.

The birth plan should include the wishes of the surrogate and intended parent/s for situations such as transfer to theatre for instrumental or emergency caesarean birth.

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However, under these circumstances, it should be accepted that the health professionals will make the decision about who can be in attendance in accordance with clinical care needs.

A care planning meeting should be held from 32 weeks gestation between the midwife, surrogate and intended parent/s to discuss the birth plan and early postnatal care. The birth plan should be retained in the hospital notes.

Intrapartum care

The surrogate should have the birth companions of her choice as any woman. This may include the intended parent/s for some or all the labour or birth. Information about the birth should only be given to intended parent/s with the surrogate's consent.

Staff should recognise that intended parent/s can feel vulnerable and anxious at this time as they have no legal standing and their relationship with the surrogate can vary. The birth may also be a time of psychological distress to some intended parent/s due to personal history of fertility or loss.

It is helpful to consider:

- whether the surrogate wishes to see or touch the baby at birth
- if the intended parents are not present at the birth, when the baby will meet them
- who wishes to cut the cord and announce the baby's gender
- who will give skin to skin contact to the baby?

Postnatal care and discharge

Postnatal care related to a surrogate birth can 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 baby. If this occurs, care should be transferred to the local community team. The surrogate should be given postnatal care to suit her clinical and emotional needs. Ideally, she should have continuity of care and be seen at home.

Usually, the baby will be fully cared for by the intended parent/s from birth and so parenting support, advice and decision making should be directed to them until they and the baby are discharged. It is important that the postnatal ward staff are clear about the wishes of the surrogate and the involvement of the intended parent/s. Wherever possible, surrogates and intended parent/s should be accommodated away from each other and from other mothers on the postnatal ward to maintain privacy at a sensitive time. The need for the baby to be cared for by one or both intended parent/s, should not be limited by normal visiting hours or restrictions on overnight stays (DHSC, 2021).

If there are concerns about the welfare of the baby, they should be raised and actioned in accordance with the appropriate safeguarding policies.

Written consent of the surrogate should be documented if the child is to be discharged with the intended parent/s. If the baby and surrogate are discharged at different times and the baby is not already being cared for by the intended parent/s, transfer of the baby to the intended parent/s should happen in an appropriate place on the hospital premises. They should not be forced to leave the premises to complete the transfer. Hospital policy needs to be clear regarding discharge of baby and surrogate. If the policy requires the surrogate and baby to be discharged together, the surrogate and intended parent/s should be informed ahead of time to minimise upset or delay. If this is required, the surrogate can return to the hospital for this to happen.

Under no circumstances should the baby be discharged with the intended parent/s without the surrogate's consent. There is no need to inform a social worker or lead for safeguarding unless there are safeguarding concerns.

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Once discharged, the intended parent/s and baby will require care from the community midwifery team. This may be an out of area discharge, so it is vital that during the antenatal period the intended parent/s' address, telephone number, local hospital and GP details are recorded in the surrogate's antenatal records. If the baby is discharged with the intended parent/s, there needs to be written consent from the surrogate for a healthcare professional to perform screening tests such as the NIPE test, newborn blood spot, hearing test and vaccinations.

Treatment of a sick baby

Where the surrogate has given her consent for the intended parent/s to care for the baby, it is usual practice for the intended parent/s wishes to be considered by staff regarding the treatment of a sick baby. The intended parent/s should be included in any important decisions regarding the health of the baby, whilst recognising that the surrogate has the overall responsibility until a parental order has been issued (British Medical Association, 2008).

Recommendations

- Hospital trusts and Boards should publish local guidelines for surrogate pregnancies, based on the Department of Health and Social Care 2021 guidelines.

- Hospital trusts and Boards should have an identifiable lead for surrogacy who can provide expertise, advice and support to health care professionals.

- Electronic records should be able to record surrogate pregnancies for better data collection.

- There should be more research into how surrogates and intended parent/s should be best cared for and supported by midwives and other maternity

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staff.

- Midwives, MSWs and others in the maternity team should receive education and training on surrogacy.

Key terminology

Intended parents
These are individuals or couples who are using surrogacy to become a parent. They may be heterosexual or same-sex couples in a marriage, civil partnership or living together/co-habiting or individuals regardless of their relationship status. Intended parents generally prefer to be referred to as the parent/s of the child.

Surrogate
This is the preferred term for women who are willing to help intended parents to create families by carrying a baby for them. A surrogate may or may not have a genetic relationship to the baby that she carries. Surrogates generally prefer not to be referred to as the mother or parent of the baby.

Types of surrogacies
Traditional surrogacy (also known as genetic or partial) is when the surrogate provides her own eggs to achieve the pregnancy. One of the intended parents, or the intended parent in the case of an individual applicant, provides a sperm sample for conception through either self-insemination away from a licenced setting or artificial insemination (or in vitro if there are fertility issues) with the help of a fertility clinic. Self-insemination carries risks if the sperm has not been screened for infections.

Gestational surrogacy (also known as host) is when the surrogate does not provide her own egg to achieve the pregnancy. In such pregnancies, the embryos are created in vitro and transferred into the uterus of the surrogate using the gametes of at least one intended parent, or the intended parent if an individual applicant,

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plus the gametes of the other intended parent or a donor, if required.

References

British Medical Association (2008) Parental responsibility – Guidance from the British Medical Association

Department of Health and Social Care (DHSC) (2021) Care in surrogacy: guidance for the care of surrogates and intended parents, in surrogate births in England and Wales Care in surrogacy: guidance for the care of surrogates and intended parents in surrogate births in England and Wales - GOV.UK

Human Fertilisation and Embryology Act (2008) Human Fertilisation and Embryology Act 2008

Human Fertilisation and Embryology Authority (HFEA) (2019) Code of Practice 2019-12-03-code-of-practice-december-2019.pdf

Human Fertilisation and Embryology Authority (HFEA) (2019) Surrogacy and legal parenthood FAQs

Surrogacy Arrangements Act (1985)

Surrogacy organisations in the UK:

Brilliant Beginnings - Surrogacy in the UK and abroad
COTS Surrogacy UK | Home
Surrogacy UK
The Children and Family Court Advisory and Support Service (Cafcass) Surrogacy - Children and Family Court Advisory and Support Service