Aneurin Bevan University Health Board

Care in Surrogacy Guideline

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

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Introduction

Surrogacy is an arrangement, often supported by a legal agreement, whereby the surrogate agrees to become pregnant and give birth to a child for another person(s) (the intended mother/father/parents).

Surrogacy is legal in the UK when reasonable expenses, only, are paid to the surrogate. This can vary, as every person's expenses will be different.

Policy Statement

It is recommended that all professionals caring for a people in a surrogacy arrangement will make themselves aware of the law relating to surrogacy https://www.gov.uk/legal-rights-when-using-surrogates-and-donors.

Aims

To provide support and guidance for health care professionals caring for people who are involved in surrogacy arrangements.

Scope

This policy applies to all professionals working within maternity services for ABUHB.

Roles and Responsibilities

All staff involved in the management of pregnant people involved in surrogacy arrangements must adhere to this policy.

Equality

An equality impact assessment been carried completed during the completion of this document**.**

1. UNDERSTANDING SURROGACY

There are two types of surrogacy:

a) **Straight** (partial or traditional surrogacy): This method uses the egg of the surrogate and the sperm of the intended father. This can be performed in an IVF clinic, but more often the technique of artificial insemination happens at home. In this situation the baby is biologically related to the intended father and the surrogate.

b) **Host** (gestational surrogacy): This method uses the egg of the intended mother combined with the sperm of the intended father (her husband/partner or a donor). In this case an IVF clinic is always required. A child conceived by this method has no biological connection to the surrogate. The surrogate, however, is legally responsible for the child until such time as the intended parent(s) (IP) or seek a parental order.

For more information see https://www.gov.uk/legal-rights-when-using-surrogates-and-donors/become-the-childs-legal-parent.

Disputes in surrogacy are rare and health care professionals should always attempt to work with the surrogate and the IP (s). However, in the event of an unresolvable dispute the surrogate's wishes must be respected. It is important to be aware that surrogacy arrangements are not legally enforceable, therefore if the surrogate decides to keep the child, she has just given birth to, she has the legal right to do so whether the surrogacy is straight or host.

2. THE SURROGACY PROCESS

The Royal College of Midwives (RCM) recognises that surrogacy arrangements should be the subject of strict confidentiality, with appropriate information disclosed on a 'need to know basis' and then only with the consent of the surrogate.

Once aware of a surrogate pregnancy the midwife should alert the Lead Midwife for Safeguarding to access supervision, and support. The Lead Midwife for Safeguarding will contact the local authority where the intended parents live to identify if there are any safeguarding concerns. There is no requirement to refer to social services unless there is a concern for the child's welfare.

Where possible discussion and decisions about the needs and preferences during pregnancy, labour and the puerperium should be made jointly between the surrogate and the IP (s). The midwife will facilitate, and document information on the electronic maternity notes (and handheld notes until all paper records are discontinued).

The presence of the IP(s) during labour and delivery will normally have been discussed and documented in a birth plan in the antenatal period. Midwives should make every effort to accommodate the mutually agreed wishes of both parties.

Whilst it is to be hoped that potential conflicts will have been resolved during the antenatal period some may arise during the labour. In this situation it must be remembered that the midwife's role is to care for the surrogate. Care

must be taken to ensure that the surrogates needs are always given priority and that the final decision rests with her. The immediate postnatal period is a time of great emotional upheaval, and increased sensitivity may be required in caring for both the surrogate and the IP(s). If there is conflict the midwife must focus her care on the surrogate and baby. In these situations, it is suggested that a second midwife or other health care professional may need to support the intended parents.

Postnatal care may be different to usual postnatal care as the surrogate may consider her role to be finished after the birth and may wish to be discharged independently of the child. Usually the child will be cared for by the IP (s) after the birth. Therefore, any parenting advice, support and decision making should be directed at the IP (s). The midwife should support any preferences or requests for separate accommodation between the surrogate and the IP(s) who will be caring for the child.

It should not be assumed that an infant within a Surrogacy arrangement would not be receiving breast milk. A baby as part of a surrogacy arrangement can be breast fed by the surrogate or receive expressed breast milk. The intended mother can also take medication to stimulate the production of her own breastmilk. Further advice and support may be sought from the infant feeding advisor.

The surrogate remains legally responsible for the child after birth and midwives should ensure that she consents to the surrogacy agreement and postnatal arrangements. Written consent off the surrogate should be sought if the child is to be discharged independently of her. Transfer of the child to the IP(s), can, and should take place in the hospital setting and there should not be a requirement for all parties to leave hospital together in order to

complete the transfer of the child to the IP(s). The child however should not be discharged with the IP (s) without the surrogate's consent.

If the baby is transferred out of area it is vital that the GP, Midwife, Health Visitor and New-born Screening co-coordinators in both areas are informed. Both the surrogate and the intended parents (if caring for the baby) will require a midwife to visit during the postnatal period. The intended parents may need advice on feeding and care of the baby, and this should be carried out in collaboration with the health visitor.

Consent for medication/screening of the baby **must** only be obtained from the surrogate who is legally responsible for the child until such time as the IP (s) seek a parental order. If the surrogate is married, then her spouse is automatically made the second legal parent to the child and will be entered on the birth certificate along with the surrogate. However, if the surrogate is not married the birth can be registered with the intended father's details entered on the birth certificate and he will then have joint parental responsibility and may also give consent for treatment.

If the surrogate lives outside ABUHB area and the intended parents live within area it is the responsibility of the midwife undertaking the surrogate's care to inform the Lead Midwife for Safeguarding in ABUHB that the baby will be coming to live with the intended parents.

If a New-born is transferred from another Health Board without ABUHB having prior knowledge of the surrogacy agreement, then a home visit must be carried out urgently and the family requested to share the Surrogacy Agreement. Contact must be made with the health professionals in the other area as well as the ABUHB Lead Midwife for Safeguarding. If there are any

concerns regarding the welfare of the infant, then the Wales Safeguarding Procedures must be followed, Safeguarding Wales.

The welfare of the baby will always be paramount and there is a professional duty to take account of this.