

Surrogacy Guideline

Document Reference No:	PTHB / MAT 098	
Version No:	1	
Issue Date:	May 2024	
Review Date:	May 2027	
Author:	Midwifery Team Lead	
Document Owner:	Head of Midwifery and Sexual Health Services	
Accountable Executive:	Executive Director of Nursing, Quality, Women and Family Health	
Approved By:	Women and Childrens Policies and Procedures Governance Group	
Approval Date:	20 th May 2024	
Document Type:	Guideline	Clinical
Scope:	PTHB Midwives	

The latest approved version of this document is online.
If the review date has passed please contact the author for advice.

Powys Teaching Health Board is the operational name of Powys
Teaching Local Health Board
Bwrdd Iechyd Addysgu Powys yw enw gweithredol Bwrdd Iechyd Lleol
Addysgu Powys

Table of Contents

Item No.	Contents	Page
	Table of Contents	2
	Version Control	2
	Engagements & Consultation	3
	Evidence Base	4
	Impact Assessment	5
	Risk Assessment Summary	5
1	Introduction	6
2	Objective	6
3	Definitions	7
4	Legal Parenthood in Surrogacy	8
5	Role of Surrogacy Agreements	8-9
6	Role of the Health Care Professionals	9-11
7	Responsibilities	11
8	Safeguarding	11
9	Monitoring Compliance, Audit and Review	12
10	References / Bibliography	12

Version Control

Version	Summary of Changes/Amendments	Issue Date
1	Initial Issue	23/05/2024

Engagement & Consultation

Key Individuals/Groups Involved in Developing this Document

Role / Designation
Powys Midwives

Circulated to the following for Consultation

Date	Role / Designation
23/01/2024	Powys Midwives
23/01/2024	Safeguarding team
23/01/2024	Women and Children's guidelines committee
13/03/2024	Legal and Risk Services

Groups Approved at

Date	Group
07/05/2024	Maternity guidelines Group
20/05/2024	Women and Children's policies and procedures governance group

Evidence Base

Please list any National Guidelines, Legislation or Health and Care Standards relating to this subject area?

Surrogacy Arrangement Act 1985.

Human Fertilisation and Embryology Act 2008

Impact Assessment

Equality Impact Assessment Summary					
	No impact	Adverse	Differentia	Positive	Statement
Age	x				<p>Please remember policy documents are published to both the intranet and internet.</p> <p>The version on the internet must be translated to Welsh.</p>
Disability	x				
Gender reassignment	x				
Pregnancy and maternity	x				
Race	x				
Religion/ Belief	x				
Sex	x				
Sexual Orientation	x				
Marriage and civil partnership	x				
Welsh Language	x				
Human Rights	x				
6. Risk Assessment Summary					
<p>Have you identified any risks arising from the implementation of this policy / procedure / written control document?</p> <p>No risks identified</p>					
<p>Have you identified any Information Governance issues arising from the implementation of this policy / procedure / written control document?</p> <p>None identified</p>					
<p>Have you identified any training and / or resource implications as a result of implementing this?</p> <p>None identified</p>					

1. Introduction

This guideline sets out a coordinated and consistent approach for health care professionals in Powys Teaching Health Board maternity services to support people involved in surrogacy. To ensure best practice, safe, positive and a rewarding experience for all.

Surrogacy is when a woman agrees to become pregnant and gives birth to a baby for another person or couple whether it is because of fertility problems or other reasons.

The UK was the first country to legislate the Surrogacy Arrangement Act in 1985. In the UK, surrogacy is not prohibited by law, but it is illegal through commercial arrangement. Surrogacy cannot be advertised or commercialized as a service, meaning you are not allowed to pay someone to be your surrogate but only claim reasonable expenses.

It is important to ensure the involvement of all parties in information-giving and decision-making wherever safe and practicable to do so, if this is something the parties have agreed to.

2. Objective

To provide support and guidance for health care professionals in providing care for families involved in surrogacy. This guideline applies to all health professionals working within Powys Teaching Health Board.

3. Definitions

Key terminology

3.1 Intended parent(s) (IP(s))

These are couples who are considering surrogacy to become a parent. They may be heterosexual or same-sex couples in a marriage, civil partnership or living together/co-habiting in an enduring relationship. To apply for a parental order (which is the way that legal parenthood is transferred from the surrogate to the IPs), at least one of the IPs in a couple must be a genetic parent of the child born to them through surrogacy. An individual may also apply for a parental order to transfer legal parenthood if they are genetically related to the child. IP(s) generally prefer to be called the child's parent(s).

3.2 Surrogate

This is the preferred term for women who are willing to help IP(s) to create families by carrying children for them. A surrogate may or may not have a genetic relationship with the child she carries for a couple. Surrogates may not prefer to be called the child's mother or parent.

3.3 Straight surrogacy

Straight (also known traditional surrogacy) surrogacy is when the surrogate provides her own eggs to achieve the pregnancy. One of the IPs, or the IP in the case of an individual applicant, provides a sperm sample for conception through either self-insemination away from a licensed setting or artificial insemination with the help of a fertility clinic. Self-insemination does carry risks if the sperm has not been screened for infections. If either the surrogate or IP has fertility issues or prefers a more clinical environment, then embryos may also be created in vitro and transferred into the uterus of the surrogate.

3.4 Host surrogacy

Host surrogacy (also known as gestational surrogacy) is when the surrogate doesn't provide her own egg to achieve the pregnancy. In such pregnancies, embryos are created in vitro and transferred into the uterus of the surrogate using the gametes of at least one IP, or the IP if an individual applicant, plus the gametes of the other IP or a donor, if required in a licensed clinic.

4. Legal Parenthood in Surrogacy

The surrogate is the legal mother of the surrogate child from birth until legal parenthood is transferred to IP(s) through a parental order made by a family court. If the surrogate is married or in a civil partnership, their partner will also assume legal parenthood status of the child from birth (unless the court is satisfied that he did not consent to the arrangement) until the parental order is made.

IP(s) can start the process to obtain a parental order from 6 weeks and must apply within 6 months of the birth of the child. Certain criteria must be met when applying for a parental order and this is set out in Section 54 and 54A of the Human Fertilisation and Embryology Act 2008 (the HFEA). Examples of the criteria to be met include, the child must be living with the IP(S), having consent of the surrogate, and her partner if they are married or in a civil relationship and at least one IP or in the case of an individual applicant, being genetically related to the child.

It is usual for a child to be cared for by the IP(s) from birth with the surrogate's consent. The surrogate is responsible for registering the birth of the child and will be registered on the birth certificate. If the surrogate is married, the spouse will be named as the legal father on the birth certificate.

If the surrogate is unmarried, the biological father of the child will be treated as a legal father, but this does not confer parental responsibility.

The permanent transfer of legal parenthood and parental responsibility to the IP(S) can only be brought about by the making of a parental order under section 54 of the HFEA.

5. Role of Surrogacy Agreements

Surrogacy agreements can be made by the intended parents and surrogate. A detailed surrogacy agreement can cover all eventualities and decision making and can be used by health care professionals to guide the provision of support and healthcare to the surrogate, intended parents and child.

A surrogacy arrangement is not legally binding and therefore not enforceable. In the UK the birth mother is the legal mother irrespective of the conception method or genetic make-up of the baby. Legal parenthood can be transferred by parental order or adoption after the baby is born and up until this point the surrogate or intended parents are free to change their mind.

A surrogacy agreement is a document often drawn up by the surrogate and IP(s) (prior to conception) that sets out how the parties intend to:

- conceive and manage the pregnancy and birth
- care for the child post-partum

A comprehensive surrogacy agreement would cover all eventualities and decision-making events, for example how the termination of a pregnancy should be handled.

The surrogacy agreement should include pregnancy, including who will attend scans and other antenatal appointments. What the intended parents and surrogates agree about the birth and who will attend. This will help to inform the birth plan and postnatal period and what everyone's expectations are around contact with the child in the long term.

A surrogacy agreement may also contain information on non-healthcare related matters and so health care professionals should handle the document with sensitivity and treat it as confidential patient information.

The guidance in this document assumes that a comprehensive surrogacy agreement has been prepared by the surrogate and IP(s) and made available to health care professionals. If this is not the case then the parties should be encouraged to prepare one and be advised that support is available, should they wish, from one of the national altruistic surrogacy organizations.

If the surrogate and the IP(s) disagree, the midwife has a duty of care to the surrogate.

6. Role of the Health Care Professionals

Where possible discussions and decisions about the needs and preferences during pregnancy, birth and the postnatal period should be made jointly by the surrogate and the IP(s). The presence of the IP(s) during the birth should be discussed and documented in the birth plan in the antenatal period between both parties. The birth plan should set out where the surrogate will give birth, handling of the child at birth, including cord cutting and skin to skin contact. The birth plan should outline who will care for the child immediately following birth, and when and where the transfer of care will take place. Midwives should make every effort to accommodate the mutually agreed wishes of both parties. The midwife's main role is to care for the surrogate and her needs and decisions are always the priority.

In the antenatal period it is good practice for the midwife to have an opportunity to see the surrogate alone to discuss domestic abuse and mental wellbeing. The midwife can then enquire about the surrogacy arrangement to ensure there is a good relationship between the surrogate and the IP(s).

Following birth, the Midwife should support any preferences for separate accommodation between the surrogate and the IP(s) who will be caring for the baby. Parenting advice, support and decision making should be directed at the IP(s).

The World Health Organization recommends that all babies receive maternal breastmilk for the first six months of their lives and then continue to have breastmilk alongside food for the first two years of life. Babies that are born within a surrogacy agreement, this may not be practically possible- dependent on the surrogate and intended parents' wishes and surrogacy agreement. The health benefits of lactation for the surrogate must be discussed by the midwife in pregnancy – as a woman who gives birth to a child but does not lactate increases their risk of multiple reproductive cancers. The health risks of a baby not receiving breast milk must also be discussed with the surrogate and the intended parents, so that they can make an informed decision around the method of feeding the baby following birth.

The surrogate and intended parents may decide that the baby should receive breastmilk, this could be directly from the surrogate, the surrogate may be willing to express breastmilk for a short or long period of time or the intended parents may decide to request donated breastmilk. If one or both, of the intended parents are born female then induced lactation may be possible via the support of an International Board-Certified Lactation Consultant or lactation specialist. This requires intensive support and medication- but it may allow one or both intended parents to provide breastmilk to their baby after birth.

The surrogate will be discharged home independently of the baby. The baby should not be discharged with the IP(s) without the surrogate's consent.

If the baby is discharged to a different Health Board to the surrogate it is essential that the GP, Midwife, Health Visitor and Newborn Screening in both Health Boards are informed by the Midwife on discharge from the hospital. Both the surrogate and IP(s) will be offered Midwifery home visits during the postnatal period. The IP(s) will also have support from the Health Visitor.

Until the parental order is complete the consent for administration of medication (for example vitamin K) and newborn screening must be obtained from the surrogate who has legal responsibility for the baby.

If the surrogate changes her mind and wishes to keep the baby, the midwife has a duty of care to respect the surrogate's wishes. If the IP(s) change their minds about taking the baby, then the surrogate will be legally responsible for the child. In the event the surrogate also refuses to take responsibility for the child then the safeguarding midwife should be contacted for advice and guidance.

7. Responsibilities

7.1 Head of Midwifery and Sexual Health

The Head of Midwifery and Sexual Health Services must:

- Ensure all staff read and understand this guideline.
- Arrange regular reviews to monitor compliance with this guideline.

7.2 Midwives

All midwives should:

Ensure they read and understand the guideline and keep updated to maintain their Midwifery qualification.

8. Safeguarding

If any safeguarding concerns or significant risk factors are identified for the unborn baby or other children, practitioners must follow Wales Safeguarding Procedures (2019) and SGP036 Safeguarding Policy [Policies & Written Control Documents - SGP 036 Safeguarding Policy.pdf \(sharepoint.com\)](#) . Advice and support concerning any safeguarding issue can be sought from PTHB Safeguarding Team via the Safeguarding Hub on 01686 252806 or email PowysTHB.Safeguarding@wales.nhs.uk (Monday-Friday 09:00-17:00, excluding Bank Holidays). Outside of office hours, Local Authority can be contacted on 0345 0544 847 or contact Silver on Call.

All registered practitioners should access appropriate safeguarding supervision and training as per guidance. [Safeguarding Supervision \(sharepoint.com\)](#)

9. Monitoring Compliance, Audit & Review

This document will be reviewed every three years or earlier should audit results or changes to legislation or practice within PTHB.

Record keeping audits are conducted regularly (10% of annual cases) and include a review of completion of handheld records, risk assessment and management plans.

10. References / Bibliography

Surrogacy Arrangement Act 1985.

Human Fertilisation and Embryology Act 2008.

GOV.UK Surrogacy: legal rights of parents and surrogates.

GOV.UK The surrogacy pathway: surrogacy and the legal process for intended parents and surrogates in England and Wales, updated 23 July 2021.

GOV.UK Care in surrogacy: guidance for the care of surrogates and intended parents in surrogate births in England and Wales, updated 23 July 2012.

Department of Health and Social Care - Care in surrogacy: guidance for the care of surrogates and intended parents in surrogate births in England and Wales, updated 23 July 2021.