Guidelines for Surrogate Pregnancy

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Contents

Aim

The purpose of this guidance is to provide a clear framework within which Midwives, obstetricians, Neonatologists and the wider professional team can best support surrogate women whilst appreciating the position of the commissioning / intended parents. This guidance applies to all health professional irrespective of grade, level, location or staff group.

Definitions

1.1 Surrogacy is the practice whereby a woman (the surrogate mother) carries a child for another person with the intention that the child should be handed over at birth. The commissioning couple or intended party to raise the child as theirs.

1.2 **Surrogate**: the woman who carries the pregnancy

1.3 **Commissioning / intended parents (IP's):** those who wish to bring the child up after birth

Types of surrogacies

- **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 or artificial insemination at home. In this situation, the baby is biologically related to the intended father and the surrogate.

- **Host** (gestational surrogacy): This method uses the egg of the intended mother and the sperm of the intended father (husband / partner / donor). In this case, an IVF clinic is always required. A child conceived by this method has no biological connection to the surrogate.

Legal aspects of surrogacy

Surrogacy is legal in the UK although, a surrogacy agreement cannot be enforced by law. The development of the surrogacy legal framework 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 legislative stance on surrogacy in which:

- No money other than expenses should be paid in respect of the surrogacy arrangement.
- It is illegal to advertise as, or for a surrogate.
- The surrogate is the child's legal parent at birth.
- If the surrogate is married or in a civil partnership their spouse or civil partner will be the child's second parent, unless they did not give their permission.
- Legal parenthood can be transferred by parental order or adoption after the child is born.
- If there is a disagreement about who the child's legal parents should be, the courts will decide based on the best interests of the child.
- Following birth, there is a legal process – the parental order process – to transfer legal parenthood from the surrogate to the IP's.

- To apply for a parental order and transfer legal parenthood, at least one of the IP's must be genetically related to the baby.
- Couples must apply for the Parental Order before the child reaches six months of age.
- The surrogate parents must consent to the making of the order.

Parental Orders: Were established by The Human Fertilisation and Embryology (HFE) Acts as the route to legal parenthood. Firstly, for married intended parents (1990), later (2008) to unmarried and same sex couples and further regulation in (2018) allowed single people to apply for parental Orders.

There are several non-profit organisations that can lawfully assist surrogacy and support both surrogates, intended parents and health care staff: *Childlessness Overcome Through Surrogacy / Surrogacy UK / Brilliant beginnings / My Surrogacy Journey Website.*

Preconception

The RCM (2021) states the Department of Health and Social Care advocates for written surrogacy arrangements ideally made before conception. Although this is not a legal document, it sets out how parties intend to conceive and manage the pregnancy, birth and care for the baby post-natally. It should also cover all eventualities and decision-making events.

Antenatal Care

- Once aware of the surrogacy the booking midwife should alert the Safeguarding midwife. This will allow the midwife to access supervision and support, plus for the safeguarding lead to contact the local authority. Making them aware that the surrogacy exists and that they are satisfied that the baby is not or will not be at risk, because of the arrangement.

- If the surrogacy is arranged through a licensed clinic, then an assessment of the family in relationship to safeguarding will have been undertaken prior to treatment. Written evidence of this is advised. If the safeguarding midwife is satisfied, that the licenced clinic has followed the code of practice then there are no requirements to inform the local authority.

Local licensed clinics

Centre for Reproduction & Gynaecology Wales (CRGW)
Wales Fertility Institute – Neath
The Fertility Home

- In circumstances where the birth or subsequent arrangements for the baby are not clear, referral to the safeguarding lead should be undertaken.

- Any safeguarding concerns should follow the normal procedure and a SIP2 should be completed.

- In the event of a surrogate mother and IP's presenting at hospital or a home birth in labour without prior booking, both the police and social services should be informed immediately.

- All antenatal care should be delivered in accordance with relevant clinical guidance, based upon individual risk assessment.

- The midwives' legal duties lie within the interest of the surrogate mother and child. It is important to consider what the surrogate wants to be called, Mother – Yes / No.

- The RCM (2021) highlight that although the surrogate may choose to include the IPs in the care and at appointments, the surrogate should be encouraged to have one or more appointments on her own. Allowing to disclose any medical or personal history and to report any concerns without fear of judgement or coercion by the IP's. The 16/40 antenatal check is possibly the best option, as this appointment does not include any fetal surveillance.

- All documentation should be recorded in the handheld notes i.e. surrogates name / address/ DOB / medical history / genetic fathers name / address / medical history and details of the commissioning parents, plus the fertility centre involved.

- Birth plans and postnatal care should be discussed and planned by a senior midwife and/or a safeguarding midwife. Most surrogates would have undertaken a birth plan as part of the surrogacy agreement. RCM recommend that this birth planning should occur around 32 weeks' gestation. The birth plan should be retained in the hospital notes. In addition to the birth plan, consent for treatment and screening of the newborn should be included. If it is anticipated that there is a need for input from the neonatal unit or additional screening it is important that the consultant paediatrician is aware of the surrogacy, and it may be appropriate that they meet the IP's.

- Although the care and consent lie with the surrogate, the IP's must always be treated as parents. It must be facilitated that they attend all ultrasound scans and appropriate appointments with the surrogate where she requests. As healthcare professionals we have the power to both positively and negatively impact on this surrogacy journey for all involved. Sensitive language must be considered and used.

- It would be of benefit for the community midwife assigned to the surrogate to involve community midwife of IP's (especially out of area). The community midwife for IP's should be aware of the surrogacy arrangement, labour and postnatal plans and should be informed immediately of concerns, birth and discharge. Thus, allowing for more sensitive, seamless care and support for the IP's.

<u>Intrapartum care</u>

- It should be clear in the birth plan who the surrogate wishes to be present in labour and immediate care of the new-born.

- The labour ward / birthing suite should facilitate both surrogate, IP's and other preferred birthing partner where able. Although in the event of an emergency normal procedures apply.

- If at any time the surrogate wishes the IPs to leave the room, then her wishes must be respected.

- The final decision rests with the surrogate.

Postnatal care

- The immediate postnatal period is a time of great emotional upheaval, and increased sensitivity maybe required in caring for both the surrogate and the IP's. It maybe suggested that a second midwife is present to support the needs of the IP's.

- The surrogate may consider her role finished after the birth. Usually, the child is cared for by the IPs after birth, therefore any parenting advice, support and decision making should be directed at the IP's. If possible two separate side rooms should be considered to accommodate the surrogate and the IP's.

- It should not be assumed that an infant of a surrogacy arrangement would not be receiving breast milk. Some arrangements want the surrogate to breastfeed the infant or to receive expressed breast milk. The intended mother may wish to stimulate her own production of breastmilk. Support from specialist infant feeding midwife maybe required.

- Two sets of postnatal notes should be used, one for the surrogate and the other for the infant.

- Check intended parents discharge details. Names, address and GP. Inform own GP, named midwife and health visitor of discharge. Thus, ensuring appropriate support on discharge.

- On discharge, inform community midwife / GP / health visitor of both surrogate mother and IP's.

- The surrogate may wish to be discharged independently of the infant, although the infant is legally hers. Discharge should take place with a senior midwife with full knowledge of the safeguarding Midwife.

- The infant should be registered in the usual way. The surrogate registering as the mother.

- If the surrogate changes her mind, the midwife's responsibility is with the surrogate. The midwife may wish to contact the safeguarding midwife/ lead Midwife for support for support.

- If the IP's change their mind with regards to taking the infant the legal responsibility is with the surrogate. If the surrogate decides against having the

child, the safeguarding midwife should be informed immediately, out of hours this will be the senior midwife on duty.

- Additional support should be offered to surrogates, as there is an increased incidence of depression during pregnancy and postpartum (Travers 2023).

Maternity Services

Checklist for Clinical Guidelines being Submitted for Approval

Title of Guideline:	Guidelines for Surrogate Pregnancy
Name(s) of Author:	Antenatal forum
Chair of Group or Committee approving submission:	Ellie Brown
Brief outline giving reasons for document being submitted for ratification	Document update
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Please indicate key words you wish to be linked to document	Surrogacy Surrogate Commissioning Fertility Parental order safeguarding
File Name: Used to locate where file is stores on hard drive	Z:\Maternity\Policies and Guidelines\Obs\2020 onwards\Surrogate pregnancy\Guidelines for Surrogate Pregnancy v1.1 Final 20.11.24.docx