Alþingi
Erindi nr. Þ 139/1410
komudagur 18.2.2011



# Tillaga til þingsályktunar um staðgöngumæðrun (þskj. 376)

*Umsögn Staðgöngu*

Með bréfi, dags. 27. janúar 2011, óskaði heilbrigðisnefnd Alþingis eftir umsögn Staðgöngu, stuðningsfélags staðgöngumæðrunar á Íslandi, um þingsályktunartillögu um staðgöngumæðrun (þskj. 376, 310. mál, 139. lggjþ.).

## Almennt um félagið Staðganga stuðningsfélag um staðgöngumæðrun á Íslandi

Félagið Staðganga var stofnað 23. nóvember 2009 og er verndari félagsins prófessor Reynir Tómas Geirsson, yfirlæknir og forstöðumaður fræðasviðs, Kvennasviði LSH. Markmið félagsins er að stuðla að umræðu um staðgöngumæðrun og að staðgöngumæðrun verði leyfð á Íslandi í velgjörðarskyni. Stofnendur félagsins eru aðilar sem eru í þeirri aðstöðu að þurfa á staðgöngumæðrun að halda til að eignast barn eða börn. Aðild að félaginu er hins vegar ekki bundin við það að þurfa á staðgöngumæðrun að halda og er hluti félagsmanna velgjörðarmenn félagsins og stuðningsfólk um staðgöngumæðrun. Meðlimir eru nú alls 51 og vinir þess eru 52, samtals 103.

## Þingsályktunartillagan og efni hennar

*Almennt um staðgöngumæðrun*

Félagið Staðganga hefur fylgst náið með allri umfjöllun um staðgöngumæðrun allt frá því það var stofnað og félagar þess margir hverjir um árabil. Það fagnar framkominni tillögu til þingsályktunar og telur að lagafrumvarp til laga sem heimili fulla staðgöngumæðrun í velgjörðarskyni muni fela í sér mikilvæga réttarfarslega bót fyrir íslenskt samfélag. Full staðgöngumæðrun á við um þegar staðgöngumóður er óheimilt að leggja til kynfrumur (egg) til staðgöngunnar og verður hún því aldrei blóðskyld barninu. Þá er rétt að árétta að þegar sé búið að stíga þau skref hér á landi með lögum sem heimila einhleypum konum og samkynhneigðum konum að undirgangast tæknifrjóvgun þannig að fósturvísi sé komið fyrir í þeim án þess þó að þær hafi erfðafræðileg tengsl við viðkomandi barn. Slíkt felur í sér sambærileg álitaefni og bent hefur verið á varðandi staðgöngumæðrun. Staðganga telur því að með því að heimila fulla staðgöngumæðrun hér á landi verði stigið skref sem er í eðlilegu framhaldi við þá réttarstöðu sem gildir hér á landi hvað tæknifrjóvganir varðar og tryggi jafnræði milli íslenskra kvenna sem glími við ófrjósemi.

Ástæður þess að kona getur ekki gengið með barn sjálf og þarf á aðstoð staðgöngumóður að halda til að eignast barn geta verið af ýmsum toga og tengjast alla jafna sjúkdómum eða fæðingargöllum. Kona getur t.a.m. misst leg vegna krabbameins í leghálsi eða leg hefur verið fjarlægt eftir fæðingu barns vegna fylgikvilla við fæðingu. Eins er þekkt að konur fæðist án legs. Að auki má nefna konur sem eru líffæraþegar eða hafa gengið í gegnum sjúkdóma og óráðlegt sé að þær gangi með barn sökum þeirra líkamlegu takmarkana. Ættleiðingar fyrir hóp þessara kvenna er ekki alltaf raunhæft úrræði.

Fjöldi kvenna á Íslandi sem þarf á staðgöngumóður að halda vegna framangreindra ástæðna er talinn vera á bilinu 0-5 á ári. Ætla má að á næstu árum og áratugum fari sú tala hins vegar

minnkandi vegna framþróunar læknavísindanna. Má hér nefna bólusetningar gegn leghálskrabbameini, möguleikann á legígræðslu eftir nokkur ár og betri lyfjameðferðir gegn krabbameini.

Áður en fjallað verður um efnistök þingsályktunartillögunnar þá vill Staðganga hvetja íslensk stjórnvöld til að vera leiðandi á Norðurlöndunum hvað varðar löggjöf um staðgöngumæðrun. Slíkt væri í takti við það sem Ísland hefur áður gert hvað varðar m.a. réttarstöðu samkynhneigðra og löggjöf í þeim efnum, sem og aðstoð við ófrjósemi einstaklinga og fleira.

## Efnistök þingsályktunartillögu – áhersluatriði sem hafa á að leiðarljósi við frumvarpsgerð

### *Í velgjörðarskyni*

Staðganga er sammála þeirri tillögu er fram kemur í þingsályktunartillögunni þ.e. að löggjöf hér á landi eigi að taka mið af því að staðgöngumæðrun sé gerð í velgjörðarskyni, þ.e. án þess að greiðsla komi til. Þó yrði eðlilegt að eðlilegur aukakostnaður staðgöngumóður yrði greiddur s.s. læknis- og lyfjakostnaður sem og mögulegt vinnutap sem skerði fjárhag staðgöngumóður. Með vel útfærðum lögum er leyfir eingöngu fulla staðgöngumæðrun í velgjörðarskyni og reglugerð sem hugsanlega yrði sett á grundvelli þeirra er auðvelt að hafa eftirlit með úrræðinu í svo litlu samfélagi, undir handleiðslu og eftirliti fagaðila þannig að komið sé í veg fyrir að staðgöngumæðrun sé gerð í hagnaðarskyni.

Í þessu sambandi þá vill félagið leggja áherslu á að ríkið taki þátt í þeim kostnaði sem hlýst af staðgöngumæðrun. Mikilvægt að þak verði sett á þann kostnað sem hugsanlega leggist á foreldrana, enda kann launamunur t.d. milli væntanlegra staðgöngumæðra verða til þess að kostnaður verður misjafn frá einni staðgöngumóður til annarrar. Slíkt gæti leitt til þess að foreldrar kjósi frekar að finna staðgöngumóður sem er í lægra launuðu starfi þar sem af því hlytist lægri kostnaður fyrir viðkomandi foreldra ef sá möguleiki er fyrir hendi.

### *Ströng skilyrði og hagsmunir aðila*

Staðganga er þeirrar skoðunar að setja verði staðgöngumæðrun ströng skilyrði þannig að tryggðir verði hagsmunir allra aðila sem þeim málum tengjast.

Mikilvægt er að hafa í huga rétt þeirra kvenna sem vilja gerast staðgöngumæður. Skýr réttur einstaklinga til upplýstrar ákvörðunar er varðar líkama þeirra er nú þegar staðfestur í íslenskum lögum til dæmis með rétti kvenna til að gefa úr sér kynfrumur (egg) og með lögum um líffæragjafir. Í báðum tilvikum tekur viðkomandi einstaklingur upplýsta ákvörðun um að taka þátt í læknisfræðilegu ferli sem fylgir viss heilsufarsleg áhætta í því skyni að láta gott af sér leiða, öðrum til handa. Í félaginu eru nokkrir félagsmenn sem hafa sér við hlið konur sem bíða eftir að þessi sjálfsagði réttur þeirra til að ráða yfir sér og sínum líkama sjálfar hvað varðar ósk þeirra að verða staðgöngumóðir sé virtur.

Tryggja þarf að hvaða kona sem er geti ekki gerst staðgöngumóðir þó hún telji sig tilbúna til þess. Það þarf til dæmis að vera tryggt að viðkomandi kona takist það ekki á hendur nema að hafa líkamlega og andlega getu til þess. Þannig mætti til dæmis binda staðgöngumæðrun því skilyrði að væntanleg staðgöngumóðir hafi áður orðið þunguð án læknisaðstoðar, meðganga verður að hafa gengið vel og án nokkurra vandkvæða og engin inngrip mega hafa verið í fæðingu. Þessi viðmið eru til að mynda viðhöfð í þeim löndum þar sem staðgöngumæðrun er

leyfð í dag. Mælt er með að félagsráðgjafi fari yfir það með væntanlegri staðgöngumóður hvað felist í öllu ferlinu frá upphafi til enda. Að öðru leyti yrði meðgangan eins og aðrar meðgöngur og tryggja ætti konunni alla þá hefðbundnu þjónustu og aðstoð er tengist meðgöngu, eins og mæðraskoðun, nauðsynleg lyf og annað slíkt.

Félagið bendir á að til eru rannsóknir virtra fagaðila eins og Prófessors Susan Golombok við Cambridge háskóla. Í einni slíkri var fylgst með staðgöngumæðrum til nokkurra ára. Í þeim var fylgst sérstaklega með líðan og aðstæðum staðgöngumæðra á meðgöngu og í kjölfar fæðingar. Niðurstöður þeirra rannsókna eru jákvæðar, staðgöngumæðrun í hag.[1]

Eðlilegt má telja að þeim konum sem vilji gerast staðgöngumæður séu sett einhver aldurstakmörk. Hins vegar er mikilvægt að þrengja aldurskilyrðið ekki um of. Mikilvægast er að tryggja að kona hafi náð fullum líkamlegum og andlegum þroska svo öruggt sé að viðkomandi kona geri sér fulla grein fyrir þeirri ákvörðun sem tekin er og hvaða áhættur eru henni samhliða. Ekki ætti heldur að setja aldurshámarkið of hátt og í þessum efnum er Staðganga hlynnt því sem fram kemur í ályktun ESHRE (European Society of Human Reproduction and Embryology) að staðgöngumóðir í tilfelli fullrar staðgöngumæðrunar geti verið allt að 45 ára.[2] Varðandi aldur foreldra má ætla að réttast sé að læknisfræðilegt mat sé lagt á hvert tilfelli fyrir sig. Kona getur t.d. verið orðin 46 ára sjálf og enn með heilbrigða kynfrumuframleiðslu (egg) eða þá átt frysta fósturvísa sem voru myndaðir fyrir legnám. Karlmenn halda einnig frjósemi sinni lengur en konur og getur verið þónokkuð aldursbil á milli hjóna.

Mikilvægt er að tryggja rétt staðgöngumóður til orlofs vegna fæðingar auk réttar til bóta, t.d. vegna vinnutaps. Taka þarf til skoðunar hvort staðgöngumóðir geti tekið fullt fæðingarorlof eða hvort sá réttur sé skertur með hliðsjón af því að barn elst ekki upp hjá viðkomandi konu. Mikilvægt er að rétturinn til bóta vegna vinnutaps sé ekki skertur með þeim hætti að það fæli konur frá því að vilja gerast staðgöngumóðir. Eigi að greiða staðgöngumóður fyrir vinnutap sem vegna meðgöngu skapast þá er lagt til að skoðað verði hvort unnt verði að gera slíkt í formi veikindaréttar sem jafnvel verði aukinn að einhverju leiti vegna aðstæðna svo almennur veikindaréttur viðkomandi konu skerðist ekki enda gæti slíkt leitt til þess að færri konur sæju sér fært að gerast staðgöngumæður.

Að meginstefnu ætti að binda heimild til þess að gerast staðgöngumóðir hér á landi við íslenskt ríkisfang eða löglega búsetu hér á landi til tiltekins tíma. Hins vegar ætti að vera mögulegt að gera undantekningar á þessu ef kona sem er erlendur ríkisborgari og/eða búsett erlendis er ættingi og hún er tilbúin til að ganga með barn fyrir einstaklinga sem að öðru leyti uppfylla skilyrði laganna um ríkisfang eða búsetu hér á landi.

Hvað foreldrana varðar þá þarf að tryggja að staðgöngumæðrun standi eingöngu þeim konum til boða sem eiga þess ekki kost að eignast eigið barn nema með aðstoð staðgöngumóður vegna til dæmis ástæðna sem að framan er vísað til. Hvað varðar samkomulagið milli þessara aðila þá þarf það að vera tryggt að það sé bindandi svo hvorugur aðili geti hætt við eftir að staðgöngumóðir er orðin þunguð. Þá þarf jafnframt að tryggja að lög skilgreini viðkomandi foreldra sem foreldra barns við fæðingu og að ekki þurfi að koma til sérstakt ættleiðingarferli

[1] Upplifun staðgöngumæðra, heiti á frummáli: Surrogacy: the experiences of surrogate mothers. Höf: Vasanti Jadva, Clare Murray, Emma Lycett, Fiona MacCallum og Susan Golombok, http://humrep.oxfordjournals.org/cgi/reprint/18/10/2196

[2] ESHRE: European Society of Human Reproduction and Embryology, Task Force on Ethics and Law 10: Surrogacy, accepted: May 19 2005, http://www.eshre.eu/binarydata.aspx?type=doc&sessionId=hucwrj45sjp4p3455oiggu55/Task_force_X_surrogacy.pdf

í kjölfar fæðingar. Að sama skapi þyrfti að gera breytingar á barnalögum þannig að gert sé ráð fyrir því að sú kona sem ali barnið sé ekki eina móðir barnsins sé um staðgöngu að ræða. Í þessu sambandi má nefna sem dæmi að tvær samkynhneigðar konur geti talist móðir eins barns þó að önnur þeirra hafi ekki fætt. Með þessu er því búið að fara út fyrir þá skilgreiningu laganna að móðir barns geti aðeins verið sú sem fæddi það. Í samræmi við það væri eðlilegt að heimila að önnur kona en staðgöngumóðir geti einnig talist móðir barns, t.a.m. sú sem lagði til kynfrumu (egg) til frjóvgunar vegna staðgöngunnar. Einnig þarf að gera breytingar á þeim ákvæðum laga sem kveða á um að faðir skuli vera sá karlmaður sem giftur er konu sem elur barn þannig að í þeim tilvikum sem staðgöngumóðir sé gift verði eiginmaður hennar ekki skilgreindur sem faðir barnsins sem hún fæðir.

Tryggja þarf væntanlegum foreldrum barns sem staðgöngumóðir gengur með fullan rétt til fæðingarorlofs auk þess sem tryggja þarf aðgang þeirra að þeirri þjónustu sem eðlilegt má teljast og rétt er að þau njóti í tengslum við fæðingu barns. Einnig þyrfti að taka afstöðu til þess með hvaða hætti þau gætu fylgst með meðgöngu staðgöngumóður og hvernig þátttöku þeirra yrði háttað t.a.m. í rannsóknum og læknaskoðunum er tengjast meðgöngu en telur Staðganga eðlilegt að staðgöngumóðirin segi til um slíkt.

Á sama hátt og varðandi staðgöngumóður ætti að binda heimild foreldranna til að fá staðgöngumóður til að ganga með barn fyrir sig við íslenskt ríkisfang eða löglega búsetu hér á landi til tiltekins tíma, allavega hina verðandi móðir. Telja má að slík tálmun teljist ekki brjóta við jafnræðisreglur alþjóðasamninga enda mætti réttlæta það með tilvísun í siðferðileg sjónarmið. Það kæmi í veg fyrir að hingað leituðu erlend pör frá ríkjum þar sem staðgöngumæðrun er ekki heimiluð.

Afar brýnt er að hagsmunir barns sem fæðist af staðgöngumóður séu tryggðir. Bent hefur verið á að siðferðileg álitaefni sem vakna hvað varðar börn sem fæðast af staðgöngumóður og rétt þeirra til vitneskju um líffræðilegan uppruna sinn. Þessu hafnar Staðganga sem raunverulegum álitaefnum og bendir á að við fulla staðgöngumæðrun leggur staðgöngumóðirin ekki til kynfrumur (egg) eins og við á um hefðbundna staðgöngumæðrun. Við fulla staðgöngumæðrun leggja almennt báðir foreldrar til kynfrumur eða annað þeirra auk kynfrumugjafa. Í undantekningartilvikum getur verið að hvorugt þeirra geti lagt til kynfrumur og eru þær þá fengnar frá kynfrumugjöfum. Í öllum þessum tilvikum verður staðgöngumóðirin ekki blóðskyld barninu enda koma kynfrumur aldrei frá henni. Fer því ekki á milli mála hver líffræðilegur uppruni barns er. Öðru máli gegnir hins vegar um ættleiðingu en þar er uppruni barna almennt óþekktur. Í tilvikum fullrar staðgöngumæðrunar getur uppruni barna því ekki orðið jafn óljós og við ættleiðingu.

Af þeim sökum má því telja að staða barns sem fæðist með fullri staðgöngumæðrun til að öðlast vitneskju um uppruna sinn sé góð enda má ætla að í meirihluta tilvika alist barn upp hjá foreldrum sem eru blóðskyldir barninu.

Taka þarf afstöðu til þess í lögum hver fari með forræði ófædds barns sem staðgöngumóðir gengur með ef til andláts foreldra kemur fyrir fæðingu. Í bindandi samkomulagi á milli staðgöngumóður og verðandi foreldra sé skýrt kveðið á um hver beri ábyrgð á barninu ef slík ógæfa dynur yfir, með vottuðu samþykki viðkomandi. Staðganga telur eðlilegast að ættingjar barnsins beri þá ábyrgð eins og venja er og taki að sér barnið við slíkar aðstæður samkvæmt vottuðu samþykki þar um. Þá komum við aftur að kosti fullrar staðgöngumæðrunar umfram

hefðbundna þar sem staðgöngumóðir verður aldrei blóðskyld barninu. Einnig þarf að kveða á um hver fari með forræði barns komi til skilnaðar foreldra fyrir fæðingu.

Hvað aðra aðila máls varðar þá þarf að taka tillit til fjölskyldu bæði staðgöngumóður og foreldranna og tryggja að hagsmuna þeirra verði gætt til hins ýtrasta. Hvað fjölskyldu staðgöngumóður varðar þá þarf staðgöngumóðir til dæmis að meta aðstæður fjölskyldu sinnar hverju sinni. Staðgöngumóðir þarf til dæmis að meta stöðu eiginmanns ef hún er í sambúð og barna sinna og afstöðu til hlutverksins með velferð allra að leiðarljósi. Ekkert bendir þó til þess að börn staðgöngumæðra taki hlutverkinu illa heldur þvert á móti fagni því góðverki sem staðgöngumæðrun er.[3]

*Samkomulag um staðgöngumæðrun verði bindandi*

Staðganga leggur áherslu á að samkomulag um staðgöngumæðrun verði bindandi enda komi slíkt í veg fyrir að aðilar geti rofið samkomulagið eftir að staðgöngumóðir er orðin þunguð. Það er lagaramminn og/eða reglugerðin sem byggir á lögunum sem ákveður hvort hlutaðeigandi aðilar geti skipt um skoðun eða ekki. Við erum fullkomlega sammála því er kemur fram í þingsályktunartillögunni að leyfa eingöngu fulla staðgöngumæðrun sem í felst að staðgöngumóðirin leggur aldrei til eigin kynfrumu (egg). Samkomulag við staðgöngumæðrun ætti að vera að fullu bindandi fyrir alla aðila. Staðgöngumóðurinni væri einnig gefið of mikið vald ef hún gæti ákveðið að halda barninu eftir fæðingu, gæti leitt til þess að hún óskar eftir greiðslu frá verðandi foreldrum fyrir að snúast ekki hugur. Slík tilfelli eru samkvæmt heimildum sjaldgæf en eitt slíkt er þekkt og kom upp í Bretlandi.

Enn komum við að mögulegum kostum fullrar staðgöngumæðrunar umfram hefðbundna í þeim skilningi að staðgöngumóðirin sé ekki blóðskyld barninu. Minnkar það líkur á því að staðgöngumóðir myndi langa til að halda barninu eftir fæðingu en bent skal á að rannsóknir þar að lútandi sýna að slík tilfelli eru afar einstök þrátt fyrir að um hefðbundna staðgöngumæðrun sé að ræða og að réttur staðgöngumóður til að halda eftir barninu sé til staðar eins og er í Bretlandi þar sem staðgöngumóðirinn má einnig leggja til kynfrumur (egg).[4]

Að sama skapi er það einnig hvernig lagaraminn er útfærður sem segir til um hvort að foreldrar geti skipt um skoðun eða ekki. Ef ekki er gert bindandi samkomulag við alla aðila þá gætu foreldrar neitað að taka við barninu eftir fæðingu. Staðgöngumóðirin situr þá eftir með barn annara sem er jafnvel ekki full heilbrigt. Við styðjum það að fullu að samkomulag við foreldra sé bindandi.

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[3] "Þó svo að neikvæðni frá einhverjum fjölskyldumeðlimum gæti (Van den Akker, 2001) sjá staðgöngumæður lífsreynsluna alla jafna sem jákvæða fyrir nánustu fjölskyldumeðlimi, sérstaklega börn þeirra (Ciccarelli, 1997) eða í versta falli segja að börnin hafi ekki hlotið neikvæða reynslu af (Hohman & Hagan, 2001) Helmingur staðgöngumæðranna í rannsókn Ciccarelli's frá 1997 skýra frá því að þær hafi orðið nánari öðrum fjölskyldumeðlimi vegna reynslu sinnar og um 3/4 tóku fram að reynslan hefði verið mjög jákvæð börnum þeirra." Heimild tekin úr skýrslu eftir Ciccarelli, Janice C.; Beckman, Linda J er birtust í Journal of Social Issues, march 2005. Tekið skal fram að rannsóknin tekur einnig til hefðbundinnar staðgöngumæðrunar þar sem staðgöngumóðir getur lagt til kynfrumu (egg) og þar með verið blóðskyld barninu.

[4] cots: http://www.surrogacy.org.uk/FAQ4.htm - í Bretlandi er enn leyfð hefðbundin staðgöngumæðrun þar sem staðgöngumóðirin leggur til egg og geta þær því ákveðið að halda barninu. Samt sem áður er fullnaðar árangur hjá COTS 98%, það er að segja eins og lagt var upp með í byrjun ferlis.

Með vandaðri lagasetningu er auðveldlega hægt að taka alveg fyrir það að slíkt geti gerst. Sjáum við ekki betur en að þannig verði staðið að málum hérlendis og erum við afar ánægð með það.

Full staðgöngumæðrun myndi einnig auka þá ábyrgð sem hvílir á væntanlegum foreldrum vegna blóðtengsla þeirra við væntanlegt barn og myndi enda tryggja að ekki skapist vilji til að hætta við gert samkomulag um staðgöngumæðrun. Sama ætti einnig við um það þegar notaðar eru gjafakynfrumur. Kynfrumur við staðgöngumæðrun verði þannig aldrei staðgöngumóðurinnar og ætíð á ábyrgð verðandi foreldra hvort heldur um þeirra eigin kynfrumur er að ræða eður ei.

*Tímasetning framlagningar frumvarps*

Staðganga leggur mikla áherslu á að frumvarp verði lagt fram sem fyrst á Alþingi. Í vinnunni framundan við smíði lagafrumvarpsins er mikilvægt að áhersla verði lögð á vönduð vinnubrögð og að litið verði til allra þeirra þátta, bæði siðferðilegra og annarra, sem málinu tengjast. Mikilvægt er að við þá vinnu verði og tekið tillit til allra þeirra sjónarmiða sem félag eins og Staðganga kann að hafa fram að færa.

Annað

*Starfshópurinn*

Í fyrirliggjandi þingsályktunartillögu er ekki tekin afstaða til þess hvaða aðilar eða fulltrúar hverra aðila skuli skipa starfshóp þann sem falið skuli að undirbúa frumvarp til laga um heimildir til staðgöngumæðrunar. Staðganga leggur áherslu á að í hópinn verði skipaðir aðilar sem á faglegum forsendum sé rétt að skipa til dæmis lögfræðingar með reynslu af frjósemis- og fjölskyldumálum, læknar og sérfræðingar á sviði kvenlækninga og frjósemishjálpar. Einnig er rétt að þar eigi setu fulltrúar hagsmunahópa sem málinu tengjast. Í þessu sambandi þá óskar Staðganga eftir því að taka þátt í starfsemi starfshópsins með setu fulltrúa félagsins í starfshópnum þannig að tryggt sé að sjónarmið félagsins og félagsmanna komi fram við þá vinnu.

*Jafnræðissjónarmið*

Rétt er að jafnræðissjónarmið séu höfð að leiðarljósi þegar heilbrigðisnefnd og þingheimur tekur afstöðu til staðgöngumæðrunar vegna afgreiðslu málsins. Staðganga berst fyrir því að allar íslenskar konur njóti sömu réttinda og fái sama aðgang að læknisfræðilegum úrræðum við sinni ófrjósemi. Jafnræði í þessum efnum er ekki til staðar eins og staðan er í dag og tryggir núverandi ástand ekki jafnræði milli íslenskra kvenna hvað varðar lausnir á ófrjósemisvanda þeirra.

Í fyrsta lagi má benda á þá mismunun sem ríkir milli gagnkynhneigðra kvenna en kona sem er án legs en með eggjastokka sem framleiða heilbrigð egg má ekki láta búa til fósturvísa og geyma. Hún má hins vegar gefa kynfrumur sínar annari konu í velgjörð. Sú kona má því fæða og eiga líffræðilegt barn þeirrar konu sem getur ekki gengið með en hefur heilbrigðar eggfrumur. Konan sem lagði til kynfrumu og er blóðskyld barninu má aftur á móti ekki ala

barnið upp sjálf. Eina leiðin fyrir konu sem ekki getur gengið með, til að koma sínu blóðskylda barni í heiminn virðist því vera sú að gefa egg og vita af því að önnur kona ali barnið upp. Í öðru lagi má líta til þess að kona sem er án eggjastokka fær alla þá læknisfræðilegu hjálp sem mögulegt er að veita í dag á meðan kona sem ekki er með leg eða má af öðrum ástæðum ekki ganga með barn fær í raun enga læknisfræðilega hjálp.

Með breytingu á lögum um tæknifrjóvgun sem gerðar voru með lögum nr. 55./2010, urðu til þær aðstæður að kona getur gengið með barn fyrir aðra konu ef þær eru í sambúð. Í breytingunni fólst að kona getur nú þegið bæði gjafaegg og gjafasæði, hvort heldur hún er í sambúð eða einhleyp. Í ljósi þessa er í ákveðnum tilvikum visst form staðgöngumæðrunar leyfilegt á Íslandi. Kona á Íslandi má í vissum tilvikum ganga með blóðbarn annarar konu en einungis ef sú kona er sambýliskona viðkomandi konu. Í samkynhneigðri sambúð eru báðar konurnar mæður barnsins, einnig sú sem fæddi það ekki og er það í mótsögn við núgildandi lög eins og áður hefur komið fram.

Gagnkynhneigð kona sem getur ekki gengið með barn en getur lagt til sitt egg má ekki þiggja staðgöngumæðrun frá konu sem vill ganga með barn fyrir hana hvort sem það er vinkona, systir eða önnur kona. Engu máli skiptir þar um þótt barnið verði blóðskylt henni og sambýlismanni hennar. Henni eru allar bjargir bannaðar.

Staðganga telur afar brýnt að gerðar verði breytingar á núverandi réttarstöðu og að lagt verði fram og samþykkt lagafrumvarp sem heimili fulla staðgöngumæðrun í velgjörðarskyni hér á landi. Þannig má girða fyrir þá mismunun milli íslenskra ófrjórra kvenna sem að framan er lýst.

*Ættleiðing*

Hugtakið staðgöngumæðrun eins og það er skilgreint í lögum nr. 55/1996 um tæknifrjóvgun og notkun kynfruma og fósturvísa manna til stofnfrumurannsókna, gerir ráð fyrir því að staðgöngumóðir láti barn af hendi eftir fæðingu til væntanlegrar ættleiðingar hjá foreldrum þeim sem samkomulag um staðgöngumæðrun var gert við. Staðganga leggur brýna áherslu á að hugtakið verði endurskilgreint með nýjum lögum og að ekki þurfi til ættleiðingu í kjölfar þess að staðgöngumóðir fæðir barn. Lög þurfa að gera ráð fyrir því að foreldrar þess teljist þeir foreldrar sem gerðu samkomulag við staðgöngumóðurina um að hún gengi með barn þeirra. Ber þá sérstaklega til þess að líta að umræddir aðilar verði í flestum tilvikum blóðskyldir viðkomandi barni.

*Tengsl milli staðgöngumóður og foreldra*

Mikilvægt er að sá hópur kvenna sem geti gerst staðgöngumæður verði ekki einskorðaður við fjölskyldu foreldranna eða nána vini. Hætt er við að slíkt geti sett ákveðinn þrýsting á fjölskyldumeðlimi. Einnig kann af einhverjum ástæðum að vera vilji fyrir því af hálfu foreldra að leita út fyrir raðir sinna nánustu ættinga og vina. Að sama skapi verður að líta til þess að ekki sé ávallt fyrir að fara nánum ættingum eða vinum sem geti á annað borð tekið það að sér að gerast staðgöngumæður t.d. vegna aldurs eða vegna barnleysis eða þar sem fyrri meðgöngur/fæðingar hafi ekki gengið vel. Eins skal líta til mikilvægis jafns réttar konu til að gerast staðgöngumóðir fyrir systir, vinkonu eða ókunnuga konu.

Staðganga ítrekar að lokum mikilvægi þess að litið verði til þess að siðferðileg álitaefni sem bent er á í tengslum við staðgöngumæðrun eru þau hin sömu og jafnvel færri en þau sem tengjast heimildum fyrir einstæðar konur til að gangast undir tæknifrjóvgun með gjafsæði og jafnvel gjafeggi. Í þeim tilvikum þekkir barn ekki ávallt til annars líffræðilegs foreldris síns og jafnvel beggja.

Svo er rétt að benda á að stærri álitamál vakna ef staðgöngumæðrun er ekki bundin í lagaramma. Þannig getur fólk til dæmis framkvæmt frjóvgun heima fyrir án eftirlits lækna og annarra sérfræðinga. Í þeim tilvikum getur kona til dæmis ákveðið að gerast staðgöngumóðir án þess að vera góður kandídat til þess og er í þeim tilvikum eftirlit ekkert og ekki hægt að fyrirbyggja að slík staðgöngumæðrun sé framkvæmd í hagnaðarskyni. Einnig ber að líta til þess að þegar Staðganga sem velgjörð er ekki leyfð er ljóst að einstaklingar munu fara erlendis til að leita sér aðstoðar, t.a.m. í þróunarlöndum þar sem eftirlit er lítið og lagaramminn veikur eða jafnvel ekki fyrir hendi. Getur það einnig orðið til þess að kostnaðurinn sem fólk þarf að bera verði afar þungbær. Verður það til þess að ekki sé hægt að koma í veg fyrir að staðgöngumæðrun eigi sér stað með vafasömum hætti. Áhrifamesta leiðin til að minnka þörfina á staðgönguiðnaði til dæmis í þróunarlöndunum er ef lönd á borð við Ísland lögleiði staðgöngumæðrun innan vandaðs lagaramma sem tekur mið af hagsmunum allra sem málinu tengjast.

Staðganga þakkar tækifærið til að gefa umsögn til Alþingis um málið. Það skal sérstaklega tekið fram að umsögn þessi inniheldur ekki með tæmandi hætti öll þau sjónarmið sem Staðganga leggur áherslu á. Félagið áskilur sér rétt til að koma frekari sjónarmiðum á framfæri við Alþingi, þá aðila sem falin verður smíði lagafrumvarps og aðra er málinu kunna að tengjast. Það ítekrar einnig að félagið er boðið og búið að veita þinginu allar þær frekari upplýsingar og alla þá aðstoð sem nauðsynleg kann að vera þörf á vegna afgreiðslu málsins. Einnig ítrekar það ósk sína til að tilnefna fulltrúa í starfshóp þann sem falið verður að semja lagafrumvarp er heimili fulla staðgöngumæðrun í velgjörðarskyni hér á landi enda sé það eðlilegt og rétt að sjónarmið félagsmanna fái að heyrast við þá vinnu enda megi telja að mikil sérþekking á málefninu sé til staðar innan félagsins.

Virðingarfyllst,
f.h. Stjórnar Staðgöngu

Íris Lind Sæmundsdóttir
Lögfræðingur

*Fylgiskjöl*

I. Fylgiskjal 1: *Upplifun staðgöngumæðra,* heiti á frummáli: Surrogacy: the experiences of surrogate mothers, höfundar: Vasanti Jadva1, Clare Murray, Emma Lycett, Fiona MacCallum and Susan Golombok, http://humrep.oxfordjournals.org/cgi/reprint/18/10/2196

  A. *Niðurstöður (þýð: Stg.)*: Staðgöngumæður upplifa yfirleitt ekki alvarleg vandamál í samskiptum sínum við verðandi foreldra, varðandi það að láta barnið af hendi né vegna viðbragða einstaklinga í kringum þær. Þau tilfinningalegu vandamál sem sumar staðgöngumæður upplifðu vikurnar eftir fæðingu virtust minnka eftir því sem leið frá fæðingu. Innskot Stg: tekið skal fram að þar sem rannsóknin var gerð er hefðbundin staðgöngumæðrun leyfð en þá má staðgöngumóðirin má leggja til sínar kynfrumur.

  B. *Samantekt (þýð: Stg.)*: Staðgöngumæður virðast ekki upplifa sálræn vandamál sem afleiðingu af staðgöngunni.

*II.* Fylgiskjal 2: *Upplifun foreldra,* heiti á frummáli: Surrogacy: The experience of commisioning couples, höfundar: Fiona MacCallum1, Emma Lycett, Clare Murray, Vasanti Jadva and Susan Golombok, http://humrep.oxfordjournals.org/cgi/reprint/18/6/1334

  *A.* *Niðurstöður (þýð: Stg.)*: Pör byrjuðu aðeins að íhuga staðgöngumæðrun eftir langt tímabil ófrjósemi eða þegar það var eini valkosturinn sem var í boði. Þegar pör rifjuðu upp kvíðatímabil á meðgöngunni þá fannst þeim kvíðinn hafi verið lítill og samband milli parsins og staðgöngumóðurinnar reyndist almennt hafa verið gott. Niðurstöðurnar voru óháðar því hvort parið hafði þekkt staðgöngumóðirina fyrir eða ekki, áður en samkomulag komst á varðandi staðgönguna. Eftir fæðingu barnsins voru áfram jákvæð samskipti hjá stórum meirihluta para við staðgöngumóður og hélst það að nokkru leyti áfram. Öll pörin höfðu sagt fjölskyldu og vinum frá staðgöngumæðruninni og höfðu ákveðið að segja barninu hvernig það kom í heiminn.

  *B.* *Samantekt (þýð: Stg)*: Verðandi foreldrar líta almennt á staðgöngumæðrunina sem jákvæða upplifun.

III. Fylgiskjal 3: *Fjölskyldur barna sem hafa verið getin án genatenglsa við báða foreldra eða með aðstoð staðgöngumóður: afleiðingar fyrir samband foreldra og barna og sálræn líðan mæðra, feðra og barna á þriðja ári, heiti á frummáli: Non-genetic and non-gestational parenthood: consequences for parent–child relationships and the psychological well-being of mothers, fathers and children at age 3*, höfundar: S.Golombok, C.Murray, V.Jadva, E.Lycett, F.MacCallum og J.Rust, http://humrep.oxfordjournals.org/cgi/reprint/21/7/1918?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=Non-genetic+and+non-gestational+parenthood%3A+consequences&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT

A. *Niðurstöður (þýð: Stg)*: Sá munur kom fram milli fjölskyldugerða að þar sem barn hafði komið í heiminn með aðstoð staðgöngu eða gjafaeggs/sæðis kom fram meiri hlýja og meiri samskipti milli móður og barns en hjá fjölskyldum sem börn voru getin á eðlilegan hátt. Hærra hlutfall staðgöngu foreldra en foreldra sem höfðu fengið gjafaegg/sæði hafði sagt börnum sínum frá hvernig getnaður þeirra hafði komið til.

B. *Samantekt (þýð: Stg)*: Það virðist vera að þótt að erfðafræðilega tengingu eða tengingu við leg móður vanti á meðgöngu þá hafi það ekki neikvæð áhrifa á samband barns og foreldra eða á sálræna líðan móður, föður eða barns á þriðja ári þess.

IV. Fylgiskjal 4: *Hvað hvetur konur til að vilja vera staðgöngumæður,* heiti á frummáli: Motivations of surrogate mothers, parenthood, altruism and self-actualization (a three year study, höfundur: Dr. Betsy P. Aigen, http://www.surrogacy.com/psychres/article/motivat.html

A. *Niðurstöður (þýð: Stg.)*: Bandarísk rannsókn á konum sem sóttu um að vera staðgöngumæður hjá " The Surrogate Mother Program of New York". Þarlendis má taka greiðslu fyrir staðgöngumæðrun. Þó að greiðsla skipti máli reynast peningar ekki vera helsta hvöt kvennanna sem valdar voru til að vera staðgöngumæður. Rannsakendur telja það sýnt að vandlegt val á konum sem vilja vera staðgöngumæður er nauðsyn og kemur í veg fyrir misnotkun. Staðgöngumæðurnar sem svo voru valdar eiga þær helst sameiginlegt að vilja hjálpa fólki að verða foreldrar og stuðla í leiðinni að jákvæðu sjálfsmati og sjálfsvitund. Konurnar tala um ást á börnum sínum, hve gefandi er að eiga börn og er það ósk þeirra að aðrir deili þessari gleði. Eiga auðvelt með nánd og tilfinnngatengsl.

B. *Samantekt (þýð: Stg.)*: Sú steka ímynd "stereotype" að þær konur sem verða staðgöngumæður séu allajafna óupplýstar, tilfinningalega kaldar og fátækar konur sem ákveða að verða staðgöngumæður peninganna vegna fær því ekki staðist.

V. Fylgiskjal 5: *ESHRE Task Force on Ethics and Law 10: Surrogacy*

A. *Abstract*
This 10th statement of the Task Force on Ethics and Law considers ethical questions specific to varied surrogacy arrangements. Surrogacy is especially complex as the interests of the intended parents, the surrogate, and the future child may differ.
It is concluded that surrogacy is an acceptable method of assisted reproductive technology of the last resort for specific medical indications, for which only reimbursement of reasonable expenses is allowed. ESHRE Task Force on Ethics and Law including, , F. Shenfield, G. Pennings, J. Cohen, P. Devroey, G. de Wert and B. Tarlatzis.

VI. Fylgiskjal 6: *Svör við ýmsum getgátum og álitamálum,* Staðganga

*A.* Í þessu fylgiskjali verður leitast við að svara eftirfarandi getgátum og álitaefnum um staðgöngumæðrun sem sett hafa verið fram meðal annars af siðfræðingum. Félagið leggur þunga áherslu á faglega og upplýsta umræðu um málefnið án þess að setja fram alhæfingar útfrá einstökum tilvikum og óstaðfestum getgátum. Eins telur Staðganga ótækt að ræða í sömu andrá staðgöngumæðrun á vesturlöndum og staðgöngumæðrun í hagnaðarskyni í þróunarlöndum.

1. Hvernig á að koma í veg fyrir staðgöngumæðrun í hagnaðarskyni?
2. Best er að fylgja Norðurlöndunum
3. Hvernig á að afmarka þann hóp sem heimilt verður að eignast barn með staðgöngumæðrun?
4. Hvernig á að tryggja réttindi barna, t.d. til að vita uppruna sinn?
5. Hvað ef staðgöngumóðir skiptir um skoðun?
6. Hvað ef verðandi foreldrar skipta um skoðun?
7. Hvernig velferð staðgöngumóður og fjölskyldu hennar verði tryggð
8. Hver á að bera kostnað af staðgöngumæðrun
9. Sú gagnrýni hefur komið upp að börnin njóti ekki brjóstagjafar
10. Unglingar segja frá því á netinu að þau séu óhamingjusöm vegna staðgöngumæðrunar því þau vita ekki uppruna sinn.
11. Siðfræðingur setti fram getgátur um að börn tilkomin með staðgöngumæðrun verði í einhverskonar limbói ef eitthvað kemur fyrir verðandi foreldra eða þá að staðgöngumóðirin verði neydd til að taka barnið að sér.
12. "Erum að fara of hratt...", "...bíðum róleg og vöndum til verka", "...ekki gott að láta eitt mál ráða ferðinni (innskot: mál Jóels)": Salvör Nordal í Návígi þriðjudaginn 15. febrúar 2011
13. "Erum að gera tilraunir": Salvör Nordal í Návígi, þriðjudaginn 15. febrúar 2011
14. "Ef þetta verður leyft núna hverning verður þetta eftir 10 ár?": Salvör Nordal í Návígi, 15. febrúar 2011

VII. Fylgiskjal 7: Samantekt úr skýrslu eftir Ciccarelli, Janice C.; Beckman og Linda J. er birtust í Journal of Social issues (march 2005) en í henni eru dregnar saman niðurstöður ýmissa rannsókna á staðgöngumæðrun (þýð: Stg.).

**Fylgiskjal 7:**

**Samantekt vegna umsagnar um staðgöngumæðrun**

Hér eru þýðingar úr hluta skýrslu eftir Ciccarelli, Janice C.; Beckman, Linda J er birtust í Journal of Social issues (march 2005) en í henni er verið að draga saman niðurstöður ýmissa rannsókna á staðgöngumæðrun. Fleiri rannsóknir hafa komið út síðan sem eru staðgöngumæðrun í hag.

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1. Fagannsóknir sýna mjög lítinn stuðning við þær háværu getgátur að Staðgöngumæðrun sé tilfinningalega skaðleg og/eða að misnotkun eigi sé stað á staðgöngumæðrum, börnum eða foreldrum." Þvert á þá vinsælu skoðun að hvöt staðgöngumæðra séu peningar þá kemur í ljós að þær segja að helsta ástæðan sé velgjörð (Ciccarelli, 1997; Hanafin, 1984; van den Akker, 2003)

   Þó að fjárhagslegar ástæður séu til staðar (innsk. í löndum þar sem leyft er að taka einhvj. greiðslu fyrir) minnstust aðeins nokkrar konur á það að fjárhagslegur ávinningur væri aðalhvötin (e.g.,Hanafin, 1984; Hohman & Hagan, 2001; Migdal, 1989; ) Undantekningar eru ein rannsókn Einwohnen 1997 er sýndi fjárhagslegan ávinning vera aðalhvötina hjá um 40% kvennanna en þó ekki sú eina og Baslington, 2002, en þar sögðust aðeins 21% kvenna að fjárhagslegan ávinningur væri helsta hvötin.

2. Sýna rannsóknir því að helsta hvötin er samúð með barnleysi og vilja hjálpa öðrum að upplifa gleði foreldrahlutverksins. Sumar vilja gera eitthvað sem er einstakt sem fyllir þær stolti (Blyth, 1994; Ciccarelli, 1997, Hanafin, 1984) eða styrkir hjá þeim sjálfsmatið (van den Akker, 2003)

3. Fræðileg umræða hefur farið inná það að tilheyra lágstétt eða hafa mjög litla innkomu geti valdið misnotkun á fátækum konum með tilliti til staðgöngumæðrunar ( e.g., Tangri & Kahn, 1993; Ciccarelli, 1997). Því er oft haldið fram að staðgöngusamkomulag geti notfæri sér ungar, einhleypar og fátækar konur (Ciccarelli, 1997).
   En rannsóknir styðja það ekki því flestar staðgöngumæður (innsk.á vesturlöndum) eru á þrítugs eða fertugsaldri, hvítar, kristnar og giftar með eigin börn (Baslington, 2002; Ciccarelli, 1997; Kleinpeter & Hohman, 2000; Ragone, 1996; van den Akker, 2003) Taka skal fram að ástæðan fyrir þessu getur verið sú að valið er úr hvaða konur geta verið staðgöngumæður af fagstofnunum. En er þetta einmitt gert til að koma í veg fyrir að fátækar, ungar konur er tilheyra minnihlutahópum séu misnotaðar (Ciccarelli, 1997)

4. Staðgöngumæður segjast alla jafna vera mjög ánægðar með reynslu sína af því að hafa verið staðgöngumóðir. Það hefur áhrif, hver reynsla er fyrir og eftir fæðingu, samskiptin við verðandi foreldra og hvort væntingum sé mætt, á það hve mikil ánægjan sé hjá staðgöngumóðurinni (Ciccarelli, 1997) Nokkrar rannsóknir sýna að staðgöngumóðirin myndar samband við verðandi foreldra frekar en barnið (Baslington, 2002; Ciccarelli,

1997; Hohman & Hagan, 2001; Ragone, 1996). Því eru það gæði sambandsins við verðandi foreldra sem á stærstan þátt í að ákvarða hve ánægð staðgöngumóðirin er með reynsluna (Baslington, 2002; Ciccarelli, 1997; Hohman & Hagan, 2001)

5. Svo að segja allar staðgöngumæður í rannsóknunum reynast eiga barn eða börn, meirihluti er giftur eða í sambúð (Baslington, 2002; Ciccarelli, 1997). Þó svo að neikvæðni frá einhverjum fjölskyldumeðlimum gæti (Van den Akker, 2001) sjá staðgöngumæður lífsreynsluna alla jafna sem jákvæða fyrir nánustu fjölskyldumeðlimi, sérstaklega börn þeirra (Ciccarelli, 1997) eða í versta falli segja að börnin hafi ekki hlotið neikvæða reynslu af (Hohman & Hagan, 2001) Helmingur Staðgöngumæðranna í rannsókn Ciccarelli's frá 1997 skýra frá því að þær hafi orðanar nánari öðrum fjölskyldumeðlimi vegna reynslu sinnar og um 75% tóku fram að reynslan hefði verið mjög jákvæð börnum þeirra.

6. Mildar neikvæðar upplifanir af staðgöngumæðrun eiga sér eflaust stað hjá flestum staðgöngumæðrum. Er þá helst verið að tala um líkamleg óþægindi þess að vera þungaður sem margar þungaðar konur finna fyrir. Konur sem ákveða að vera staðgöngumæður hafa alla jafna góða ástæður fyrir því að geta búist við eðlilegri og töluvert auðveldri meðgöngu ( innsk. því valdar eru konur sem hafa átt vandamálausar meðgöngur áður). Flestar upplifa þó hefðbunda þreytu og verki og sumar upplifa vandamál er gera meðgönguna erfiða (Ciccarelli, 1997) Það að fagaðilar veiti staðgöngumæðrum stuðning og ráðgjöf á meðan á meðgöngu stendur og eftir fæðingu er ákjósanlegt og eykur líkurnar á háu ánægjustigi hjá staðgöngumóðurinni (Ciccarelli, 1997)

7. Skoðun á gögnum sýnir að börn getin með glasafrjóvgun sýna á stigum bernsku til unglingsára sama hugræna þroskann og önnur börn, stundum meiri félagsfærni og aukna samskiptahæfileika (McMahon, Ungerer, Beaupaire, Tennant et al., 1995; Van Balen, 1998).

8. Sumar rannsóknir sýna einnig að reynsla af ófrjósemi og því að hafa fengið tæknilega hjálp við henni (ARTs) stuðli að mjög góðum tengslum milli foreldra og barns (Gibson, Ungerer, McMahon, Leslie, & Saunders, 2000; Hahn & DiPietro, 2001; VanBalen, 1996). Í rannsókn (Golombok, Murray, Brinsden, & Abdalla, 1999) þar sem bornar voru saman fjölskyldur þar sem eggjagjöf/sæðisgjöf kom við sögu, glasafrjóvgunarfjölskyldur og ættleiðing, kom ekki fram neinn marktækur munur á umönnun foreldra né nein áhrif á sálfræðilega aðlögun (psychological adjustment) barna þriggja og hálfs árs til átta ára.

9. Hjón sem leituðu til staðgöngumæðra höfðu alla jafna reynt allar aðrar leiðir til barneigna og hafa lifað með það álag sem fylgir ófrjósemi árum saman, sjá Ciccarelli and Ciccarelli.

## Hér að neðan er upprunalegi textinn í samantektinni, á frummálinu:

"Moreover, empirical data offer little support for widely expressed concerns about contractual parenting being emotionally damaging or exploitative for surrogate mothers, children or intended/social parents"

"Contrary to popular beliefs about money as a prime motive, surrogate mothers overwhelmingly report that they choose to bear children for others primarily out of altruistic concerns (Ciccarelli, 1997; Hanafin, 1984; van den Akker, 2003). Although financial reasons may be present, only a handful of women mention money as their main motivator (e.g., Hanafin, 1984; Hohman & Hagan, 2001; Migdal, 1989; for exceptions see Einwohner, 1989, in which 40% of women state the fee was their main, although not their only, motivator and Baslington, 2002, in which 21% only mentioned money as a motivator). Rather, the women have empathy for childless couples and want to help others experience the great joy of parenthood. Also, some want to take a special action and, thereby, gain a sense of achievement (Blyth, 1994; Ciccarelli, 1997, Hanafin, 1984) or enhance their self-esteem (van den Akker, 2003)"

"Scholarly discussions of social class and socioeconomic issues have deplored the potential for exploitation of poor women as surrogate mothers (e.g., Tangri & Kahn, 1993; Ciccarelli, 1997). It is often implied that surrogacy contracts could exploit poor, young, single, or ethnic minority women (Ciccarelli, 1997). Yet, the data do not support this since, in fact, most surrogate mothers are in their twenties or thirties, White, Christian, married, and have children of their own (Baslington, 2002; Ciccarelli, 1997; Kleinpeter & Hohman, 2000; Ragone, 1996; van den Akker, 2003). However, our discussions with surrogacy agencies and professionals (e.g., Center for Surrogate Parenting, H. Hanafin, personal communication, November 12, 1997) suggest that it is likely that surrogate demographics are due, at least in part, to the screening which is utilized by surrogacy agencies in selecting candidates to be surrogates. These screening procedures are specifically designed to circumvent arguments that the process could be exploitive of poor, young, ethnic women (Ciccarelli, 1997)."

"Surrogate mothers generally report being quite satisfied with their experiences as surrogate". "Nevertheless, pre- and post-birth experiences, relationship with the contracting couple, and whether expectations about surrogacy are met are important influences on the surrogate mothers' level of satisfaction (Ciccarelli, 1997). Several studies confirm that the surrogate mother generally forms a relationship with the couple rather than the child (Baslington, 2002; Ciccarelli, 1997; Hohman & Hagan, 2001; Ragone, 1996"
"Thus, it is the quality of the relationship with the couple that largely determines the surrogate mother's satisfaction with her experience (Baslington, 2002; Ciccarelli, 1997; Hohman & Hagan, 2001)"

"Almost all surrogate mothers identified in the literature have a child or children of their own, and the majority are married or with a partner (Baslington, 2002; Ciccarelli, 1997). Although family disapproval is not absent entirely (van den Akker, 2001), surrogate mothers perceived their decision to bear a child for a couple as having a positive effect on close family members, in particular their children (Ciccarelli, 1997), or at worst perceive their own children as not being negatively impacted by the experience (Hohman & Hagan, 2001). Half of the women in Ciccarelli's (1997) study reported becoming closer to a family member as the result of the surrogacy experience and nearly three-quarter of the surrogates indicated that the experience affected their own children in a positive way."

"Mild and transient negative repercussions of the surrogacy experience probably occur in varying degrees for all women. Most are general side effects of pregnancy that involve physical discomfort, experienced by all birth mothers. Women who become surrogate mothers usually have good reason to believe they will have normal, relatively easy pregnancies, but all experience routine aches and pains and some experience complications that may lead to a difficult pregnancy

(Ciccarelli, 1997)Professional support and intervention, including therapy, before and during the surrogacy process may maximize satisfaction rates among surrogates (Ciccarelli, 1997)"

"Reviews of the literature suggest that IVF children in developmental stages from infancy through adolescence show comparable cognitive functioning to other children and in some cases score higher in social and communication skills (McMahon, Ungerer, Beaupaire, Tennant et al., 1995; Van Balen, 1998). Some studies even suggest that the experience of infertility and use of Assisted Reproductive Technologies (ARTs) actually may be beneficial for parent-child relationships (Gibson, Ungerer, McMahon, Leslie, & Saunders, 2000; Hahn & DiPietro, 2001; VanBalen, 1996). One study (Golombok, Murray, Brinsden, & Abdalla, 1999) comparing egg donation, donor insemination, adoptive families, and IVF families reported no overall differences among groups in quality of parenting or psychological adjustment of children aged three and a half to eight."

"Couples who choose this option usually have exhausted more traditional alternatives, and have lived with the stress of infertility for years. As elaborated in Ciccarelli and Ciccarelli"

Ciccarelli, Janice C.; Beckman, Linda J er birtust í Journal of Social Issues, march 2005.

Human Reproduction Vol.18, No.10 pp.2196–2204, 2003 DOI: 10.1093/humrep/deg397

# Surrogacy: the experiences of surrogate mothers

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**BACKGROUND: This study examined the motivations, experiences and psychological consequences of surrogacy for surrogate mothers. METHODS: Thirty-four women who had given birth to a surrogate child approximately 1 year previously were interviewed by trained researchers, and the data rated using standardized coding criteria. Information was obtained on: (i) reasons for the woman's decision to become a surrogate mother; (ii) her retrospective view of the relationship with the commissioning couple before the pregnancy, during the pregnancy, and after the birth; (iii) her experiences during and after relinquishing the child; and (iv) how others reacted to her decision to become a surrogate mother. RESULTS: It was found that surrogate mothers do not generally experience major problems in their relationship with the commissioning couple, in handing over the baby, or from the reactions of those around them. The emotional problems experienced by some surrogate mothers in the weeks following the birth appeared to lessen over time. CONCLUSIONS: Surrogate mothers do not appear to experience psychological problems as a result of the surrogacy arrangement.**

*Key words:* experiences/motivations/psychology/surrogacy/surrogate mother

## Introduction

The practice of surrogacy, whereby one woman bears a child for another woman, is one of the most controversial procedures in the field of assisted reproduction. Media coverage of surrogacy arrangements has tended to focus on the negative aspects of surrogacy, such as the 'Baby M' case in the United States where the surrogate mother refused to relinquish the child (New Jersey Supreme Court, 1987). There are two types of surrogacy: partial (genetic), and full (gestational). With partial surrogacy, the surrogate mother is also the genetic mother of the child, and conception usually occurs by artificial insemination using the commissioning father's sperm. With full surrogacy, the commissioning couple are the genetic parents of the child and conception takes place at a clinic through IVF.

There has been considerable unease regarding the potentially adverse effects of surrogacy for surrogate mothers. For example, it has been suggested that relinquishing the child may be extremely distressing and may result in psychological problems (British Medical Association, 1996). It has also been feared that the surrogate mother may form a bond with the baby prenatally that would make it particularly difficult for her to hand over the child to the commissioning parents. On the other hand, it has been proposed that surrogate mothers may tend to distance themselves from the unborn baby, believing that the child they carry is not theirs (Ragoné, 1994). Such a detachment may make them more likely to put themselves and the unborn child's health at risk (British Medical Association, 1996). For those women who do relinquish the child, the risk of post-natal depression, as well as feelings of anger or guilt, may add further strain to the woman's psychological health. Whether or not the commissioning couple was known to the surrogate mother prior to the surrogacy arrangement, and whether or not the surrogate mother is the genetic mother of the child, are also factors that may influence the psychological well-being of surrogate mothers. Furthermore, it has been argued that surrogacy may exploit women from a more economically disadvantaged background (Blyth, 1994), such that women may enter into a surrogacy arrangement because of financial hardship without being fully aware of the potential risks (Brazier *et al.*, 1998).

Other concerns relating to surrogacy include the impact on the surrogate mother's partner, her parents and any existing children. The British Medical Association, in its review of surrogacy practice in the UK, emphasized the importance of partners of surrogate mothers giving their full support during the arrangement and after the birth of the baby. Where the surrogate mother has children of her own, the British Medical Association suggests that children should be informed about the arrangement beforehand, as the disappearance of the baby after the birth may cause them distress (British Medical Association, 1996). It has also been suggested that surrogate mothers may become ostracised or be shunned by disapproving neighbours and friends (Blyth, 1994), which may have an adverse effect on the psychological well-being of some surrogate mothers and their families.

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Very little research has been conducted on the experiences of surrogate mothers. Only a handful of studies have included interviews with women about their experiences of surrogacy and their reasons for choosing to be a surrogate mother. From a sample of 19 surrogate mothers, it was found that there were many different reasons for the decision to become a surrogate mother, such as financial gain, enjoyment of pregnancy/childbirth, and obtaining a sense of self worth and value (Blyth, 1994). It was also found that 10 of the 19 surrogate mothers experienced some form of negative response from those around them. The sample consisted of women who were at different stages of the surrogacy process; that is, some women were interviewed whilst pregnant, whereas others had given birth to a surrogate child who had reached school age. All of the women had been recruited through a United Kingdom surrogacy agency, though this may not give a true representation of all surrogate mothers as not all surrogacy arrangements are made through an agency. In some cases, surrogate mothers are relatives or friends of the commissioning couple. An American qualitative study (Ragoné, 1994) also examined the motivations for surrogate mothers deciding to embark upon surrogacy. Ragoné found that payment was not an important motivating factor. Instead, women tended to report more altruistic reasons.

The existing research on the views and experiences of surrogate mothers has tended to examine small, sometimes biased, samples. The aim of the present investigation was to obtain systematic information from a representative sample of surrogate mothers who had given birth to a surrogate child approximately 1 year prior to interview. Findings relating to the commissioning couples' experiences of the surrogacy arrangement are reported elsewhere (MacCallum *et al.*, 2003; Golombok *et al.*, submitted).

**Table I.** Sociodemographic information

| Parameter | No. of cases |
|---|---|
| Age of surrogate mother (years)[a] | 34 ± 5.44 |
| *Own children* | |
| Yes | 32 (94) |
| No | 2 (6) |
| *Marital status* | |
| Married/co-habiting | 23 (67) |
| Non-co-habiting partner | 5 (15) |
| Single | 6 (18) |
| *Social class* | |
| Professional/managerial | 4 (12) |
| Skilled/non-manual | 9 (26) |
| Skilled manual | 7 (21) |
| Partly skilled/unskilled | 14 (41) |
| *Surrogate working status* | |
| No | 14 (41) |
| Part-time | 14 (41) |
| Full-time | 6 (18) |
| *No. of previous surrogate births* | |
| 0 | 29 (85) |
| 1 | 1 (3) |
| 2 | 1 (3) |
| 3 | 3 (9) |
| *Type of surrogacy* | |
| Partial (genetic) | 19 (56) |
| Full (non-genetic) | 15 (44) |
| *Surrogate mother* | |
| Known surrogate | 7 (21) |
| Unknown surrogate | 27 (79) |

[a]Value is mean ± SD.
Values in parentheses are percentages.

## Materials and methods

### *Participants*

Thirty-four surrogate mothers of 1-year-old babies took part in the study and were recruited in two ways. Nineteen of the women were surrogate mothers for commissioning parents already participating in an ongoing study and were informed about the study by the couple. Fifteen of the women were recruited through the United Kingdom surrogacy organisation Childlessness Overcome Through Surrogacy (COTS). All surrogate mothers who were registered with COTS and had given birth to a baby approximately 1 year previously were asked to participate in the investigation.

Although it was not possible to calculate an exact response rate because of overlap between the two recruitment methods, and also because not all of the commissioning parents wished to approach the surrogate mother about the research, a response rate of 76% was obtained for those recruited through COTS. It was estimated that 68% of those approached by the commissioning couple agreed to take part.

Nineteen (56%) of the women had undergone a partial surrogacy arrangement, and 15 (44%) had had a full surrogacy arrangement. Seven women (21%) were known surrogate mothers (i.e. sister, friend, or mother), and 27 (79%) were previously unknown to the commissioning couple (i.e. met though a third party). Sociodemographic information is presented in Table I.

### *Measures*

The surrogate mothers were administered a standardized semi-structured interview in their own homes around the time of the child's first birthday. Interviews were conducted by trained researchers, and each variable was rated using strict standardized coding criteria. The interview procedure was adapted from a standardized interview developed by the same authors for a study of commissioning couples (see MacCallum *et al.*, 2003; Golombok *et al.*, submitted). The women were asked about their motivation to become a surrogate mother; their relationship over time with the commissioning couple and the child; their experiences during and after relinquishing the child; and their openness with family and friends about the surrogacy.

### *Motivations for surrogacy*

The women were asked when they had first decided to become a surrogate mother (coded in years). What had first caused them to think about surrogacy was coded into one of three categories: 'media coverage'; 'suggested by friend/family member'; and 'long-term awareness of surrogacy'. They were also asked what their reasons were for choosing to become a surrogate mother, and each of the following variables was assigned a 'yes' or 'no' rating according to the surrogate mothers responses: 'self-fulfilment'; 'wanted to help others'; 'love being pregnant'; and 'payment'. Where more than one reason had been given, this was also rated.



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### *Relationship and frequency of contact with the commissioning couple before the birth*

The surrogate mothers were asked to recall their relationship with the commissioning couple before treatment had begun, during the first few months of the pregnancy, and during the last few months of the pregnancy. For the latter two time periods, ratings were obtained separately for the relationship with the commissioning mother and father. Surrogate mothers' description of the relationship was rated according to one of three categories: 'harmonious'; 'dissatisfaction or coldness'; and 'major conflict or hostility'. 'Harmonious' was coded when the surrogate mother described a warm or friendly relationship with co-operation on both sides; 'dissatisfaction or coldness' was coded when minor disagreements had arisen between the parties or when little communication or warmth was apparent; and a rating of 'major conflict or hostility' was coded when evidence of arguments or a breakdown in communication was present. Thus, the relationship between the surrogate mother and the commissioning parents was rated on a continuum ranging from no difficulties through moderate difficulties (associated with either dissatisfaction or coldness) to severe difficulties. The frequency of contact between the couple and the surrogate mother at the start and at the end of the pregnancy was also recorded separately for the commissioning mother and father. In addition, the surrogate mother was asked how involved the commissioning mother and father had been during the pregnancy. This was rated according to one of three categories for mothers and fathers separately: 'no or little involvement'; 'moderately involved'; and 'very involved'. 'No or little involvement' was coded when the commissioning mother or father had very little contact with the surrogate mother during her pregnancy. 'Moderately involved' was coded when the commissioning mother or father showed some interest in the pregnancy by attending some scans or antenatal appointments, and a rating of 'very involved' was coded when the commissioning mother or father attended all of the scans or were aware of all the appointments and would discuss the appointments with the surrogate mother if unable to attend. Surrogate mothers were also asked whether they were happy with the level of involvement that they had received from each parent. Their responses were coded according to one of three categories for mothers and fathers separately: 'yes - happy with involvement'; 'No - too much involvement'; and 'No - not enough involvement'.

### *Experiences during and after relinquishing the child*

Data were obtained about the handing over of the child to the commissioning couple. Who decided when it should take place was rated categorically with responses being assigned to one of the following: 'mutual agreement'; 'determined by surrogate mother'; and 'determined by commissioning couple'. Whether the surrogate mother was happy with the decision was rated as either 'yes' or 'no'. In addition, whether the surrogate mother had any doubts about handing over the child was coded according to one of three categories: 'no doubts' 'surrogate had doubts'; and 'surrogate reluctant to relinquish child'.

Information was also obtained from surrogate mothers about how relinquishing the child had affected them in the year following the birth. They were asked to recount their feelings in the weeks following the birth, a few months following the birth, and how they felt currently (1 year on). These data were rated on a four-point scale, ranging from: 1, 'No difficulties', where the surrogate mother showed no sign of being upset; 2, 'Some difficulties' where the surrogate mother described having been or being upset but believed that the feelings were short term; 3, 'Moderate difficulties' where the surrogate mother described feeling very depressed or anxious, but was still able to work or manage the house; and 4, 'Major difficulties' where she felt so depressed or anxious that she was unable to function.

In addition, the surrogate mothers were asked whether they had sought medical help for psychological problems and whether they had taken any medication to treat such problems. Data were obtained separately for periods before and after the surrogacy birth. The Edinburgh Depression Scale (Thorpe, 1993) was also completed by surrogate mothers. This is a reliable and valid measure of post-natal depression where higher scores represent greater difficulties.

### *Frequency of contact with the couple and the child following the birth*

The frequency of contact with the commissioning family since the birth was obtained separately for the commissioning mother, the commissioning father and the child. The surrogate mother was also asked what role she would play in the child's life, and this was coded separately for known and unknown surrogate mothers. Known surrogate mothers were categorized according to one of two options: 'involvement appropriate to their relationship status' (i.e. not differing from their role had they not been the surrogate mother); or 'play a special role' (i.e. being the child's godmother or being involved in the child's welfare). For unknown surrogate mothers, this variable was categorized according to one of four options: 'no involvement with the family'; 'contact with the parents but not the child'; 'contact with the child'; and 'play a special role' (e.g. attending significant events in the child's life such as birthday parties). In addition, the surrogate mother was asked how she viewed the relationship between herself and the child. The relationship was rated with respect to three categories: 'no special bond' (coded when the surrogate mother reported that she had no feelings towards the child); 'special bond' (coded when the surrogate mother reported that the child was special to her). and 'like own child' (coded when the surrogate mother saw the child as her own).

### *Openness about surrogacy*

Surrogate mothers were asked whom they had told about the surrogacy arrangement, and how much they had told. Data were obtained separately for the responses of family, friends and, where applicable, the responses of their partners and children. The reactions of those who had been told were coded separately for how they felt when initially told, and how they felt currently. Responses were rated according to one of three categories: 'Positive' (when the individual was encouraging of, or pleased about, the surrogacy arrangement); 'Neutral/Ambivalent' (when the individual was unconcerned about the arrangement, or when mixed feelings were displayed); and 'Negative' (when the individual was unhappy about the arrangement, or felt hostile towards the commissioning couple or surrogate mother because of the surrogacy arrangement). With respect to surrogate mothers' partners and their own children, information was obtained about their reaction during the pregnancy and children's reactions at the time of the handover. For those women who had a partner who lived with them, information was also obtained on how supportive their partner was, and whether there were any particular difficulties for them during the surrogacy process. In addition, the women were asked to complete the Golombok Rust Inventory of Marital State (GRIMS) (Rust *et al.*, 1990); this is a reliable and valid questionnaire assessment of the quality of the marital relationship with higher scores indicating poorer marital quality.



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## Results

Results are reported as cases and percentages. For the variables relating to experiences during and after relinquishing the child and frequency of contact with the couple and the child following the birth, differences between partial (genetic) and host (non-genetic) pregnancies, and known and unknown surrogate mothers, were assessed using *t*-test and chi-square analyses. Only those comparisons that were statistically significant are reported below.

### *Motivations for surrogacy*

On average, the women had decided to become a surrogate mother 6.21 years before the time of interview, the longest time being 20 years, and the shortest 1 year. Twenty-three (68%) of the women had first heard about surrogacy from the media, five (15%) had first heard about it from a family member or a friend, and six (17%) reported a long-term awareness of surrogacy (Table II). Some women gave multiple reasons for their decision to become a surrogate mother. The most common motivation reported by 31 (91%) women was 'wanting to help a childless couple', five (15%) gave 'enjoyment of pregnancy' as a reason for opting for surrogacy, and two (6%) gave 'self-fulfilment'. Only one surrogate mother (3%) said that payment was a motivating factor.

**Table II.** Motivations for surrogacy

| Situation | Number of cases |
|---|---|
| *First heard about surrogacy* | |
| Media coverage | 23 (68) |
| Suggested by friend/family member | 5 (15) |
| Long-term awareness of surrogacy | 6 (17) |
| *Motivation* | |
| Wanting to help a childless couple | 31 (91) |
| Enjoyment of pregnancy | 5 (15) |
| Self-fulfilment | 2 (6) |
| Payment | 1 (3) |

Values in parentheses are percentages.

### *Relationship and frequency of contact with the commissioning couple before the birth*

*Relationship with couple*

The surrogate mothers' retrospective views of the relationship with the commissioning couple at three different time points are shown in Table III. Before the pregnancy, all of the surrogate mothers felt that they had a 'harmonious' relationship with the commissioning couple. At the start of the pregnancy, 33 (97%) surrogate mothers reported having a 'harmonious' relationship with the commissioning mother, with only one mother (3%) reporting her relationship as having 'major conflict or hostility'. Thirty-two (94%) surrogate mothers reported having a 'harmonious' relationship with the father at the start of the pregnancy, with one woman (3%) describing the relationship as having some 'dissatisfaction or coldness', and one woman (3%) describing 'major conflict or hostility' (the partner of the commissioning mother who also obtained this rating).

During the last few months of the pregnancy, 33 (97%) surrogate mothers felt that they had a 'harmonious' relationship with the commissioning mother, and 32 (94%) felt that they had a 'harmonious' relationship with the commissioning father. None of the women reported having a relationship characterized by 'major conflict or hostility' with either the commissioning mother or the commissioning father.

**Table III.** Relationship, frequency of contact and involvement with couple before and during pregnancy

| Situation | Relationship with couple | | | | | |
|---|---|---|---|---|---|---|
| | Before pregnancy | | First 3 months of pregnancy | | Last 3 months of pregnancy | |
| | Mother | Father | Mother | Father | Mother | Father |
| | *n* (%) | *n* (%) | *n* (%) | *n* (%) | *n* (%) | *n* (%) |
| Harmonious | 34 (100) | 34 (100) | 33 (97) | 32 (94) | 33 (97) | 32 (94) |
| Dissatisfaction/Coldness | 0 (0) | 0 (0) | 0 (0) | 1 (3) | 1 (3) | 2 (6) |
| Major conflict or hostility | 0 (0) | 0 (0) | 1 (3) | 1 (3) | 0 (0) | 0 (0) |
| | Frequency of contact with the couple during the pregnancy | | | | | |
| | Mother | | Father | | | |
| | Beginning of pregnancy | End of pregnancy | Beginning of pregnancy | End of pregnancy | | |
| | *n* (%) | *n* (%) | *n* (%) | *n* (%) | | |
| Not at all | 1 (3) | 2 (6) | 1 (3) | 3 (9) | | |
| At least once a month | 24 (71) | 24 (71) | 22 (65) | 22 (65) | | |
| At least once in 3 months | 9 (26) | 8 (23) | 11 (32) | 9 (26) | | |
| | Involvement of commissioning parents | | | | | |
| | Mother | Father | | | | |
| | *n* (%) | *n* (%) | | | | |
| No or little involvement | 0 (0) | 3 (9) | | | | |
| Moderately involved | 6 (17) | 16 (47) | | | | |
| Very involved | 28 (83) | 15 (44) | | | | |
| | Happy with involvement | | | | | |
| | Mother | Father | | | | |
| | *n* (%) | *n* (%) | | | | |
| Yes, happy with involvement | 32 (94) | 32 (94) | | | | |
| No, too much involvement | 0 (0) | 0 (0) | | | | |
| No, not enough involvement | 2 (6) | 2 (6) | | | | |



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**Table IV.** Experiences during and after relinquishing the child

| Situation | n (%) | | |
|---|---|---|---|
| Decision of when to hand over the child | | | |
| Mutual agreement | 31 (91) | | |
| Determined by surrogate mother | 3 (9) | | |
| Determined by commissioning couple | 0 (0) | | |
| Happy with decision? | | | |
| Yes | 34 (100) | | |
| No | 0 (0) | | |
| Surrogate mothers doubts or difficulties at handover | | | |
| No doubts | 34 (100) | | |
| Surrogate had doubts | 0 (0) | | |
| Surrogate reluctant to relinquish child | 0 (0) | | |
| Difficulties experienced by surrogate mothers in the year following the birth | | | |
| | Initially after handover n (%) | Few months after handover n (%) | 1 year after handover n (%) |
| No difficulties | 22 (65) | 29 (85) | 32 (94) |
| Some difficulties | 11 (32) | 5 (15) | 2 (6) |
| Moderate difficulties | 1 (3) | 0 (0) | 0 (0) |
| Major difficulties | 0 (0) | 0 (0) | 0 (0) |
| Psychological contacts | | | |
| | Before surrogacy n (%) | | After birth of the child n (%) |
| None | 31 (91) | | 30 (88) |
| General practitioner | 2 (6) | | 3 (9) |
| Outpatient clinic | 1 (3) | | 1 (3) |

*Frequency of contact*

During the first three months of pregnancy, 24 (71%) surrogate mothers saw the commissioning mother at least once a month, and a similar proportion ($n = 22$; 65%) saw the commissioning father at least once a month. One surrogate mother reported not seeing the couple at all in the first few months, and the remainder had seen the couple at least once during this time period.

Towards the end of the pregnancy, similar proportions (71 and 65%) of surrogate mothers saw the commissioning mother and father respectively at least once a month. However, the number who had not seen the couple had increased to two women (6%) not having seen the commissioning mother, and three women (9%) not having seen the commissioning father.

*Involvement*

The majority of women ($n = 28$; 83%) felt that the commissioning mother was very involved in the pregnancy, and the remainder believed that she was moderately involved. The majority ($n = 32$; 94%) were happy with the level of involvement of the mother, while the remaining two (6%), both of whom were previously unknown surrogate mothers, believed it was not enough.

In contrast, the commissioning fathers were less involved in the pregnancy. Fifteen women (44%) felt that the commissioning fathers were very involved with the pregnancy, a further 16 (47%) felt that they were moderately involved, and three (9%) felt that they had no or little involvement. Despite the lower level of involvement, the majority of women ($n = 32$; 94%) were happy with the degree of involvement of the commissioning father, with only two women (6%) believing that it was not enough.

***Experiences during and after relinquishing the child***

The results of the surrogate mothers' experiences during and after relinquishing the child are summarized in Table IV. In 31 cases (91%), the decision of when to hand the child over was the result of a mutual agreement between the couple and the surrogate mother. In three cases (9%), the surrogate mother had decided when the child was to be handed over. All of the women were happy with the decision reached about when to hand over the baby, and none had experienced any doubts or difficulties whilst handing over the baby.

How the women recalled feeling at three different time points over the following year is also shown in Table IV. Eleven women (32%) experienced some difficulties in the weeks following the handover, and one surrogate mother experienced moderate difficulties. The remainder reported no difficulties. Five women (15%) reported some difficulties a few months after the handover, and the remaining 29 (85%) reported no difficulties. The number reporting some difficulties had decreased to only two (6%) at one year on, with 32 (94%) reporting no difficulties. The comparison between known and unknown surrogate mothers showed that a significantly higher proportion of known surrogate mothers reported some difficulties at 1 year after the birth ($\chi^2 = 8.19$, $P < 0.01$). The difference in the proportion of known and unknown surrogate mothers who reported some difficulties was 0.40, representing a small to medium effect size (Rosenthal and Rubin, 1982).



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**Table V.** Frequency of contact with the couple and the child following the birth

| Situation<br>Frequency of contact | Mother<br>n (%) | Father<br>n (%) | Child<br>n (%) |
|---|---|---|---|
| Not at all | 7 (21) | 7 (21) | 8 (24) |
| At least once a month | 11 (32) | 9 (26) | 11 (32) |
| Once a month to once in the last year | 16 (47) | 18 (53) | 15 (44) |

| | n (%) |
|---|---|
| Relationship with child: known surrogate | |
| Special role | 3 (43) |
| No difference in relationship | 4 (57) |
| Relationship with child: unknown surrogate | |
| Special role | 5 (15) |
| Contact with child | 14 (52) |
| Contact with parents only | 4 (15) |
| No contact with family | 5 (18) |

| Feelings towards the child | Known surrogate mother<br>n (%) | Unknown surrogate mother<br>n (%) | |
|---|---|---|---|
| Special bond | 6 (86) | 8 (30) | Fisher's Exact, $P = 0.012$ |
| No special bond | 1 (14) | 19 (60) | |
| Like own child | 0 (0) | 0 (0) | |

| Telling child | Genetic surrogate mothers<br>n (%) | Non-genetic surrogate mothers<br>n (%) | $\chi^2$ | $P$ |
|---|---|---|---|---|
| | | | 4.05 | <0.05 |
| Should be told | 17 (90) | 9 (60) | | |
| Uncertain/uninvolved | 2 (10) | 6 (40) | | |
| Should not be told | 0 (0) | 0 (0) | | |

Before the child was born, three (9%) women had experienced psychological problems, with two (6%) having visited a general practitioner for psychological problems and one woman having had regular contact with an outpatient clinic. Since the child was born, three women (9%) had visited a general practitioner for psychological problems and one woman (the same woman as previously) made regular visits to a clinic regarding such problems.

The mean (± SD) score Edinburgh Depression Scale score for the 33 women who completed the questionnaire was 4.88 ± 3.1. The mean score for women who had undergone a full surrogacy arrangement was 4.37 ± 2.9, and that for women who had undergone a partial surrogacy arrangement was 5.57 ± 3.34. A *t*-test revealed no significant difference between these two means. None of the surrogate mothers obtained a score above cut-off indicative of clinical depression (Cox *et al.*, 1987).

### *Frequency of contact with the couple and the child following the birth*

*Frequency of contact*

The frequency of contact between the surrogate mothers and the commissioning couple and child varied greatly following the birth of the child (Table V). Eleven women (32%) had seen the mother at least once a month, and nine (26%) had seen the father at least once a month. Seven surrogate mothers (21%) had not seen the mother or the father at all. The remainder had seen the commissioning mother and father between once and once a month during the past year.

The frequency of contact with the child showed a similar pattern, with 11 (32%) of the surrogate mothers having regular contact of at least once a month with the child. Eight surrogate mothers (24%) had not seen the child at all since the birth, while the remaining 15 (44%) had seen the child between once and once a month in the past year.

*Relationship with child*

As also shown in Table V, of the seven known surrogate mothers, three (43%) expected to play a 'special role' in the child's life and four (57%) expected not to differ in their relationship with the child than had they not been the surrogate mother. Of the unknown surrogate mothers, 14 (52%) reported that they expected to have contact with the child, and four (15%) reported that they would play a 'special role' in the child's life. Four (15%) said that they would maintain contact with the parents but not with the child, and five (18%) unknown surrogate mothers said that they would have no involvement with the family.

Thirty-two (94%) surrogate mothers were happy with the level of contact with the child, but two women (6%) reported that the level of contact with the child was insufficient. In terms of how the surrogate mother felt towards the child currently, 14 (41%) reported feeling a 'special bond' towards the child, and 20 (59%) felt that there was no such 'special bond'. None of the women reported feeling that the child was like their own. Comparing 'known' to 'unknown' surrogate mothers, the former were significantly more likely to feel a special bond towards the child (Fisher's Exact test, $P = 0.012$). Six (86%) known surrogate mothers felt a special bond, in comparison with eight (30%) unknown surrogate mothers. The difference in the proportion of known and unknown surrogate mothers who felt a special bond was 0.56, representing a medium effect size (Rosenthal and Rubin, 1982).



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**Table VI.** Openness about surrogacy

| Attitude | Family | | Friends | | Partner | | | Child | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | First told n (%) | Currently n (%) | First told n (%) | Currently n (%) | First told n (%) | At pregnancy n (%) | Currently n (%) | At pregnancy n (%) | At handover n (%) | Currently n (%) |
| Positive | 16 (48) | 25 (76) | 25 (74) | 30 (88) | 12 (57) | 19 (83) | 22 (96) | 26 (81) | 28 (88) | 28 (88) |
| Neutral/ Ambivalent | 15 (46) | 7 (21) | 8 (24) | 4 (12) | 5 (24) | 3 (13) | 1 (4) | 5 (16) | 3 (9) | 4 (12) |
| Negative | 2 (6) | 1 (3) | 1 (3) | 0 (0) | 4 (19) | 1 (4) | 0 (0) | 0 (0) | 0 (0) | 0 (0) |

With regards to whether or not the child should be told about his or her origins, 26 surrogate mothers (77%) felt that the child should be told, while the remaining eight (23%) felt either uncertain or that the decision was not theirs to make. None of the surrogate mothers said that the child should not be told about the surrogacy. When comparing women who had undergone a partial surrogacy arrangement with those who had undergone a full surrogacy arrangement, it was found that 17 (90%) genetic surrogate mothers felt that the child should be told about the surrogacy arrangement compared with nine (60%) non-genetic surrogate mothers ($\chi^2 = 4.05, P < 0.05$). The difference in the proportion of genetic and non-genetic surrogate mothers who felt that the child should be told about the surrogacy arrangement was 0.30, representing a small effect size (Rosenthal and Rubin, 1982).

### *Openness about surrogacy*

#### *Openness with family*

As shown in Table VI, one surrogate mother did not have contact with her family and was therefore not included in this section of the results. The large majority ($n$ = 32; 97%) had discussed the arrangement with their family to some extent, with only one surrogate mother stating that she had not discussed the issue in this way. Two of the women reported that their family responded negatively when initially told, 15 (46%) said that their family had a neutral or mixed reactions when first told, and the remaining 16 (48%) said that their family had responded positively. The reaction of the family by the time of interview had become more positive. Twenty-five (76%) women reported that their families felt positive about the arrangement at 1 year after the birth, while seven (21%) had family members who felt neutral or had mixed feelings. Only one woman (3%) reported that her family still felt negative.

#### *Openness with friends*

The reactions of friends showed a similar pattern. When initially told, the majority of friends ($n$ = 25; 74%) responded positively, eight (24%) responded neutrally or had mixed responses, and only one friend responded negatively. By the time of interview, these values had changed to 30 friends (88%) displaying a positive reaction, and four (12%) a neutral or mixed response.

#### *Openness with partner*

Of the 23 women who had a co-habiting partner at the time of interview, two had met their partner during the pregnancy. For the 21 women who had a partner at the time of deciding to embark on surrogacy, 20 (95%) had discussed the arrangement in full with their partners, and one woman (5%) had discussed the arrangement to some extent with her partner. Twelve partners (57%) responded positively when initially told, five (24%) were neutral/ambivalent when first told, and four (19%) responded negatively.

For the remaining variables, data are reported from the 23 women who had a co-habiting partner. Nineteen (83%) reported that their partner felt positive about the surrogacy arrangement during pregnancy, three (13%) were neutral/ ambivalent, and one partner (4%) felt negative. One year on, 22 women (96%) reported that their partner felt positive towards the surrogacy arrangement, and only one woman (4%) reported that her partner felt neutral/ambivalent.

With regards to the level of support the women received from their partner, the majority ($n$ = 20; 87%) reported that their partner was very supportive and reliable during the surrogacy arrangement, and three (13%) stated that their partner was mostly supportive.

The GRIMS questionnaire yielded a mean score of 23.2. The raw scores were converted to transformed GRIMS scores, which range from 1 to 9, with higher scores indicating a poorer relationship. The mean score for the 23 women gave a transformed score of 3, which corresponds to a good, above-average relationship. Looking at the transformed scores individually, four women obtained a score of 6 (representing a poor relationship), and one woman a score of 9 (indicating very severe problems). The scores of the remaining 18 women reflected average or above-average marital satisfaction.

#### *Openness with own children*

At the time of interview, all of the 32 surrogate mothers who had children had discussed the arrangement with them to some extent, and the majority ($n$ = 29; 90%) had explained the arrangement fully. One surrogate mother had not told her child during the pregnancy as the child was too young; however, she had since discussed the issue with him. Twenty-six (81%) women reported that their children felt positive towards the surrogacy arrangement during the pregnancy, and five (16%) reported that their children's reaction was either neutral or ambivalent.

Twenty-eight surrogate mothers (88%) reported that their child reacted positively at the time of handover, and three (9%) said that their child's reaction was either neutral or ambivalent. None of the children showed a negative response. Twenty-eight surrogate mothers (88%) reported that their children felt positive about the surrogacy arrangement at the time of



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interview, and four (12%) described their children's reaction as either neutral or ambivalent.

## Discussion

The findings of the present investigation suggest that surrogacy has generally been a positive experience for those surrogate mothers interviewed, and fail to lend support to claims regarding the potentially negative outcomes of surrogacy for surrogate mothers. For example, none of the women in the present study had any doubts about their decision to hand over the child to the commissioning couple. In line with previous findings (Ragoné, 1994) which showed that surrogate mothers tended to distance themselves from the fetus, the results of the present study indicated that surrogate mothers may view the child they are carrying as not theirs, thereby facilitating relinquishment.

Furthermore, the majority of surrogate mothers did not experience major problems in their relationship with the commissioning couple during the surrogacy process. Only one woman reported major conflict early in pregnancy, and this seemed to have been resolved before the birth of the child. Indeed, she reported having a positive relationship with the commissioning mother at the time of the interview. Interestingly, no differences were observed between the known and unknown surrogate mothers with regard to the quality of the relationship with the commissioning couple. In fact, many surrogate mothers who were previously unknown to the commissioning couple maintained contact with the family after the child's birth. Although the sample of known surrogate mothers was small, these results appear to suggest that unknown surrogate mothers are just as likely as known surrogate mothers to maintain a good relationship with the commissioning couple, thus dispelling fears that such an alliance between strangers will inevitably lead to problems.

A further source of unease in relation to surrogacy is the possibility of adverse psychological consequences for the surrogate mother. Although the study showed that surrogate mothers did experience some problems immediately after the handover, these were not severe, tended to be short-lived, and to dissipate with time. One year on, only two women—both of whom were known surrogate mothers—reported feeling occasionally upset. Furthermore, the Edinburgh Depression Scale showed that none of the surrogate mothers was suffering from post-natal depression at 1 year following the birth. Thus, there was no evidence of difficulties with respect to those aspects of surrogacy that have been the greatest cause for concern.

Although the present study was based on data obtained from surrogate mothers, for 19 of the women information was also available from the commissioning couple, as they had taken part in a separate longitudinal study of surrogacy (MacCallum *et al.*, 2003; Golombok *et al.*, submitted). Thus, data from the commissioning couple could be examined to validate the surrogate mothers' reports. The surrogate mothers whose commissioning couple also took part in the research all reported a positive relationship with the commissioning mother at the beginning and at the end of the pregnancy. The commissioning mothers also all reported a positive relationship at these two time points. With regard to the relationship with the commissioning father, one of the 19 surrogate mothers reported problems. Although the respective commissioning mother did not report problems between her partner and the surrogate mother at the beginning of the pregnancy, she too reported some tension in the relationship at the end of the pregnancy.

Although it may be assumed that genetic surrogate mothers would be more likely to feel a special bond towards the child, this was not found to be the case. Genetically related surrogate mothers were, however, more likely than genetically unrelated surrogate mothers to wish the child to be told about the surrogacy arrangement. It remains to be seen how relationships will develop between the surrogate mother and the family as the child grows older, as not only will many of the children have knowledge of who their genetic or gestational birth mother is, but in many cases they will also have regular contact with her. Surrogate mothers were generally open with family and friends about the surrogacy arrangement. Although some family members and friends were negative at first, they later accepted the idea, often feeling proud of the surrogate mother. The majority of surrogate mothers reported that their partner was supportive, and that their own children reacted positively, with none of the children experiencing major problems as a result of the surrogacy arrangement.

The present investigation was based on surrogate mothers' perceptions of the surrogacy arrangement. As with any research on a controversial topic, it is not possible to rule out the risk of socially desirable responding. It is also conceivable that the aspects of the interview which relied on retrospective reporting were subject to recall bias. However, it is noteworthy that the accounts of the surrogate mothers regarding the quality of the relationship with the commissioning couple were almost identical to those of the commissioning couples themselves, suggesting that the surrogate mothers' accounts of their experiences were generally reliable. An advantage of the present investigation is that data were collected from the largest and most representative sample of surrogate mothers so far. By recruiting surrogate mothers through the surrogacy agency COTS, as well as through a parallel study of surrogacy families recruited largely through the Office of National Statistics (Office of National Statistics, 1991), the large majority of surrogate mothers in the United Kingdom whose babies were 1 year old at the time of the study were invited to participate in the research. The overall cooperation rate of over 70% thus produced a representative sample of surrogate mothers, although the possibility cannot be ruled out that those who declined to take part were experiencing greater problems than were the participants. Moreover, all of the surrogate mothers had actually given birth to children in the context of a surrogacy arrangement, whereas previous investigations have included surrogate mothers at various stages of the surrogacy process.

Overall, surrogacy appears to be a positive experience for surrogate mothers. Women who decide to embark upon surrogacy often have completed a family of their own and feel they wish to help a couple who would not otherwise be able to become parents. The present study lends little support to the commonly held expectation that surrogate mothers will experience psychological problems following the birth of the



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child. Instead, surrogate mothers often reported a feeling of self-worth. In addition, surrogate mothers generally reported positive experiences with the commissioning couple, and many maintained contact with them and the child. It cannot be assumed that the generally positive views of these surrogate mothers will be maintained over time. However, the findings provide systematic information about the feelings and experiences of surrogate mothers 1 year after the birth of their most recent surrogacy child.

## Acknowledgements

The authors are grateful to the Registrar General Office of the National Statistics and to Childlessness Overcome Through Surrogacy (COTS) for their help in recruiting families to the study. They also thank the Wellcome Trust for funding this research.

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*Submitted on March 27, 2003; Accepted on June 13, 2003*

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Human Reproduction Vol.18, No.6 pp.1334–1342, 2003 DOI: 10.1093/humrep/deg253

# Surrogacy: The experience of commissioning couples

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**BACKGROUND: Findings are presented of a study of families with a child created through a surrogacy arrangement. This paper focuses on the commissioning couples' reports of their experiences. METHODS: A total of 42 couples with a 1-year-old child born through surrogacy were assessed using a standardized semi-structured interview. Data were obtained on motivations for surrogacy, details about the surrogate mother, experience of surrogacy during pregnancy and after birth and disclosure of the surrogacy to friends and family. RESULTS: Couples had considered surrogacy only after a long period of infertility or when it was the only option available. Couples retrospectively recalled their levels of anxiety throughout the pregnancy as low, and relationships between the couple and the surrogate mother were found to be generally good. This was the case regardless of whether or not the couple had known the surrogate mother prior to the arrangement. After the birth of the child, positive relations continued with the large majority of couples maintaining some level of contact with the surrogate mother. All couples had told family and friends about the surrogacy and were planning to tell the child. CONCLUSIONS: Commissioning couples generally perceived the surrogacy arrangement as a positive experience.**

*Key words:* commissioning couples/surrogacy

## Introduction

Surrogacy is defined as "the practice whereby one woman carries a pregnancy for another person(s)... as the result of an agreement prior to conception that the child should be handed over to that person after birth" (Brazier *et al.*, 1998). In the traditional method, known as 'partial', 'straight' or 'genetic' surrogacy, the surrogate mother and the commissioning father are the genetic parents of the child and conception is through artificial insemination. However, IVF techniques mean that is now possible to implant an embryo created by the gametes of the commissioning couple in the surrogate mother. In this situation, known as 'full', 'host' or 'gestational' surrogacy, the role of the surrogate mother is purely gestational and the child is genetically related to both of the intended parents. It is also possible that a donor egg may be used, in which case the genetic mother, the gestational mother and the intended mother are three separate people. These unique aspects of surrogacy have led to it becoming the most controversial of all the assisted reproductive techniques in recent years.

The relationship between the commissioning couple and the surrogate mother is crucial to the success of the arrangement. The surrogate mother may be either a relative or friend of the commissioning couple, or may have been unknown to them prior to the surrogacy arrangement. Some argue that surrogacy with a previously unknown surrogate mother is potentially problematic (Warnock, 2002), since to some extent all of those involved are depending on trust between strangers. In other forms of assisted reproduction involving an unknown third party such as donor insemination or egg donation, the donor generally remains anonymous. However, in surrogacy cases, a bond must be established between the previously unknown surrogate mother and the commissioning couple, a relationship described by the founder of one UK surrogacy agency as a 'forced friendship' (Brazier *et al.*, 1998). On the other hand, surrogacy with a known surrogate mother presents the possibility that a relative or friend will be pressured into being a surrogate mother, and that this will complicate the dynamics within the family to a damaging extent. Indeed, in Israel it is illegal for the surrogate mother to be a relative of the commissioning couple (Benshushan and Schenker, 1997).

Whether the surrogate mother is known or unknown, potentially difficult issues arise associated with the involvement of the commissioning couple in the pregnancy and the birth, the handing over of the child to the commissioning couple and, importantly, the continuing contact after the birth between the surrogate mother and the commissioning couple. Professional advice about this contact is equivocal with the British Medical Association stating that "... while some people report benefits arising from maintaining contact between the parties after the birth, this will not suit everybody" (British Medical Association, 1996).

To some extent, the continuation of contact between the family and the surrogate mother will depend on whether the commissioning couple intend to disclose the facts of the surrogacy arrangement to the child. The disclosure or non-disclosure of the use of assisted conception is an area of much



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debate. Studies of families created by gamete donation have found that the large majority of parents do not intend to disclose the method of conception to the child (Brewaeys, 1996; 2002), although there is some evidence of a tendency towards greater openness in recent years (S.Golombok *et al.*, unpublished data). van den Akker (2000) studied 29 women at various stages of surrogacy arrangements and found that all but one of them (97%) said they would disclose the surrogacy to their child, suggesting that surrogacy families are more open than families created through other methods of assisted reproduction. However, more than half of this sample had not yet completed the surrogacy arrangement successfully.

It has been suggested that secrecy about the conception method will damage family relationships with a consequent negative impact on the child's psychological development (Baran and Pannor, 1993; Daniels and Taylor, 1993; McWhinnie, 2001)and there is some evidence that difficulties may arise when individuals discover their donor conception in adulthood (Turner and Coyle, 2000). Also, evidence from research on adoptive families shows that children are more likely to develop emotional and behavioural problems when their parents do not communicate openly about the adoption (Howe and Feast, 2000). Insofar as the surrogacy situation resembles adoption, it could be argued that children are likely to fare better when the surrogacy is disclosed to them from a young age.

As yet, there is little empirical research on the consequences of surrogacy or the experience of going through a surrogacy arrangement. In terms of child development, a review by Serafini (2001) found no verbal or motor impairment in children born after IVF (full) surrogacy at age 2. A small number of studies have been published that interviewed commissioning couples about the experience of surrogacy. From a sample of 20 commissioning parents, Blyth (1995) reported that in all cases it had been agreed that the commissioning mother would be present at the birth of the child, all parents believed that the child should be told about the surrogacy arrangement and all intended to maintain contact in some form with the surrogate mother. However, the sample included only eight sets of couples with children, and the age of the children at interview was not reported. In addition, all the participants were volunteers recruited through the UK surrogacy agency Childlessness Overcome Through Surrogacy (COTS) so cannot be considered an entirely representative sample, as not all commissioning couples have contact with COTS. Other studies in the UK (van den Akker, 2000) and the USA (Ragoné, 1994) have also used samples that include commissioning couples who have not yet become parents.

The aim of the present study was to obtain systematic information from a representative sample of surrogacy families in the UK with a child aged ~1 year old. This paper focuses on commissioning couples' reports of their experience of the surrogacy arrangement. In addition to reporting on the sample as a whole, comparisons have been made between those couples who knew the surrogate mother previously and those who did not, and between those arrangements involving full surrogacy and those involving partial surrogacy. Findings relating to the quality of parent-child relationships in surrogacy families are reported elsewhere (Golombok *et al.*, 2003).

## Materials and methods

### *Participants*

Families with a child born through surrogacy were recruited through the General Register Office of the United Kingdom Office for National Statistics (ONS). In the UK, a record is made of all families created through a surrogacy arrangement when the commissioning couple become the legal parents of the child. In the present investigation, all parents of children aged ~1-year-old who obtained legal parenthood between March 2000 and March 2002 were asked to participate in the study. A total of 58 surrogacy families were contacted. Thirty families agreed to take part, representing 60% of those who responded to the request by ONS. A total of 40% ($n$ = 20) of those who responded declined to participate in the study, and no response was obtained by a further eight families. As commissioning couples who had not yet become the child's legal parents would not have been identified by ONS, all 34 parents on the register of the United Kingdom surrogacy agency COTS with a child in the same age range were also asked to take part. Twenty-six of these families agreed to participate, representing a response rate of 76%. As 14 families who responded positively to the invitation by one organization also responded positively to the other, the total number of surrogacy families recruited to the study was 42.

The mean age of the 42 mothers studied was 35 years, with the mean age of the fathers being 40 years. There were almost equal numbers of girls and boys in the group (22 boys and 20 girls) and the mean age of the children was 10.5 months. A total of 60% of the families had only one child, 31% had two children and 9% had three children. The socioeconomic status of the families was measured by the occupation of the parent with the highest-ranking position according to a modified version of the Registrar General's classification (OPCS and Employment Department Group, 1991) ranging from 1 (professional/managerial) to 4 (partly skilled or unskilled). Seventy-six per cent of families were in the professional/managerial bracket, with the remaining families equally split between the skilled non-manual and skilled manual categories.

### *Measures*

Researchers trained in the study techniques visited the families at home. Data were obtained from the mother and the father separately by tape-recorded interview. Interviews were conducted with 100% of mothers and 69% of fathers.

The semi-structured interview focused on the couple's recall of five areas that related to their past and current experience of going through a surrogacy arrangement and each variable was rated according to strict standardized coding criteria.

#### *Motivations for surrogacy*

Information was obtained from mothers on their infertility history; i.e. how long they had been trying for a child, what diagnosis they had been given for their infertility and what first caused them to consider surrogacy. Both mothers and fathers were asked why they had opted for surrogacy rather than other fertility treatments, and whether the decision to pursue surrogacy had been reached jointly by the couple. The financial burden put on the couple by the surrogacy arrangement was also assessed.



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### *Details about the surrogate mother*

Mothers were asked for details about the surrogate mother, including whether she had been known to the couple prior to the arrangement. If the surrogate mother was known, information was obtained about; (i) who first suggested she act as a surrogate mother, and (ii) what role she would have in the child's life. If the surrogate mother was previously unknown, information was obtained about; (i) how the couple first contacted her, (ii) how long they had known her before going ahead with the surrogacy, and (iii) what role she would have in the child's life. The type of surrogacy that had been used (i.e. full or partial) was also ascertained.

### *Experience of surrogacy during pregnancy*

Parents were questioned on their retrospective recall of feelings about the pregnancy, including any anxieties and concerns, and responses were rated according to one of four categories: 'happy', 'mild apprehension', 'mixed feelings' and 'high anxiety'. This was assessed separately for recollections of the beginning and the end of the pregnancy. Both mothers and fathers were also asked about the quality of their relationship with the surrogate mother at the beginning and the end of the pregnancy. Relationship quality was rated according to one of three categories; 'harmonious', 'dissatisfaction/coldness', 'major conflict/hostility'. In addition, the frequency of contact between the couple and the surrogate mother at the beginning and the end of the pregnancy was established from the mother's interview. Frequency of contact was coded into four categories; 'more than once a week', 'once a week to once a month', 'once a month to once every 3 months' or 'not at all'.

### *Experience of surrogacy after birth*

Data were obtained about the handing over of the child to the commissioning parents, including when this took place, who decided when it should take place and whether either the surrogate mother or the couple had doubts at this point. Mothers were asked about the frequency of contact since the birth between the surrogate mother and the couple, and about the frequency with which the surrogate mother had seen the child. Frequency was coded as before, with the addition of an extra category for those couples who had seen the surrogate mother 'once or twice' only since the birth, which may be the case if they had only met in court for the granting of the parental order. Both mothers and fathers were questioned about their current relationship with the surrogate mother (rated in the same way as relationship during pregnancy) and also on their feelings about the surrogate mother's involvement with child, which was rated as 'positive', 'negative' or 'ambivalent'. Where there had been no contact between the couple and the surrogate mother, reasons for this lack of contact were ascertained. Couples were also asked whether they would recommend surrogacy to other couples experiencing fertility problems.

### *Openness about surrogacy*

Mothers were asked about the extent of their disclosure to family and friends about the surrogacy arrangement, and their reasons for disclosure or non-disclosure. Reasons for disclosure were rated by coding the following variables as 'yes' or 'no', according to the mother's responses: (i) wanted to share experience; (ii) no reason not to tell; (iii) to avoid disclosure from others; and (iv) no choice but to tell.

Both mothers and fathers were questioned about whether or not they intended to tell the child about the surrogacy and, if they intended to do so, at what age they planned to start this disclosure and what their reasons were for disclosure. As for disclosure to family, the following variables were coded as 'yes' or 'no': (i) child has right to know; (ii) to avoid disclosure from others; and (iii) no reason not to tell.

All statistical comparisons between known and unknown surrogate mother arrangements and between full and partial surrogacy arrangements were made using $\chi^2$ analyses.

## Results

### *Motivations for surrogacy*

The mean length of time for which the couple had been trying to have a child was 7.5 years. A total of 91% of women ($n = 38$) reported that the infertility had been diagnosed as a female problem, one couple had both male and female infertility problems and for three couples the reason for the infertility remained unexplained (see Table I). The most common reason for opting for surrogacy was repeated IVF failures, reported by 43% (19) of women, with the second most common reason being that the woman had no uterus (38%, $n = 16$) as a result either of a congenital abnormality or of an emergency hysterectomy. Seven per cent (three) of the women had been told that pregnancy would be life threatening, a further 7% had suffered habitual miscarriages and 5% (one) had other problems, i.e. a prolapsed uterus.

**Table Ia.** Motivations for surrogacy

| | Mothers % | n |
|---|---|---|
| Infertility diagnosis | | |
| Female problem | 91 | 38 |
| Male and female problem | 2 | 1 |
| Unexplained | 7 | 3 |
| Why surrogacy? | | |
| No uterus | 38 | 16 |
| Habitual miscarriage | 7 | 3 |
| Pregnancy is life-threatening | 7 | 3 |
| Failed IVF treatments | 43 | 19 |
| Other | 5 | 1 |
| Consider surrogacy | | |
| Media coverage | 41 | 17 |
| Suggested by clinician | 21 | 9 |
| Suggested by family/friend | 29 | 12 |
| Other | 9 | 4 |
| Financial burden | | |
| None | 66 | 27 |
| Some | 27 | 11 |
| Moderate | 7 | 3 |

**Table Ib.** Decision about surrogacy

| Decision about surrogacy | Mothers | | | | Fathers | | | |
|---|---|---|---|---|---|---|---|---|
| | Initially | | At treatment | | Initially | | At treatment | |
| | % | n | % | n | % | n | % | n |
| Male decision | 0 | 0 | 0 | 0 | 3 | 1 | 0 | 0 |
| More male than female | 9 | 4 | 0 | 0 | 10 | 3 | 7 | 2 |
| Joint decision | 48 | 20 | 81 | 34 | 59 | 17 | 90 | 26 |
| More female than male | 41 | 17 | 17 | 7 | 28 | 8 | 3 | 1 |
| Female decision | 2 | 1 | 2 | 1 | 0 | 0 | 0 | 0 |



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**Table II.** Details about surrogate mother

| | % | n |
|---|---|---|
| Surrogate mother | | |
| Not known | 69 | 29 |
| Friend | 14 | 6 |
| Sister/sister-in-law | 14 | 6 |
| Other relative | 3 | 1 |
| Known surrogate: who suggested? | | |
| Commissioning mother | 8 | 1 |
| Surrogate mother | 77 | 10 |
| Commissioning father | 0 | 0 |
| Other | 15 | 2 |
| Known surrogate: future role | | |
| Appropriate to relationship status | 77 | 10 |
| Play 'special role' | 23 | 3 |
| Unknown surrogate: future role | | |
| No involvement | 10 | 3 |
| Contact with parents, not child | 14 | 4 |
| Contact with child | 66 | 19 |
| Play 'special role' | 10 | 3 |
| Type of surrogacy arrangement | | |
| Full | 38 | 16 |
| Partial | 62 | 26 |

For 41% (17) of couples, the media coverage of surrogacy, such as TV documentaries or magazine articles, had first caused them to consider surrogacy as an option. A further 29% (12) of couples had first considered surrogacy after a suggestion by a friend or family member and 21% (nine) had been recommended surrogacy as an option by infertility specialists, with 9% (four) citing other sources.

In the main, mothers considered the decision to try surrogacy as either a joint decision between the couple (48%, $n = 20$) or as being more their decision than their husband's (43%, $n = 18$). Only 9% of mothers felt that their husband had at first been keener to attempt surrogacy than they had been. Data from the fathers followed a similar pattern, with 59% ($n = 17$) feeling it was a decision made jointly and 28% ($n = 8$) feeling that their wife had been the instigator. The remaining 13% ($n = 4$) of fathers reported that they had initially been keener than their wife had been. By the time the couples started treatment, the large majority (81% of mothers and 90% of fathers) felt that both partners were equally keen on surrogacy.

When asked about the financial burden caused by the treatment, two-thirds of couples (66%, $n = 27$) felt there had been no strain, while 27% ($n = 11$) reported some strain, requiring a general cutting down on expenses in order to afford the treatment. Seven per cent of couples ($n = 3$) reported there had been a definite financial burden, requiring measures such as taking out loans or borrowing from family, but these couples all used full surrogacy which involves potentially costly IVF cycles.

### *Details about the surrogate mother*

Of the 42 couples, 69% ($n = 29$) had not known the surrogate mother prior to the arrangement (see Table II). Of the remaining 31% ($n = 13$) of surrogate mothers, 17% ($n = 7$) were family members of the commissioning mother and 14% ($n = 6$) were friends of the couple. For the known surrogate mothers, the suggestion that she act as a surrogate mother for the couple had come from the surrogate mother herself in 77% ($n = 10$) of cases, from other people in 15% ($n = 2$) of cases and from the commissioning mother in just one case (8%). Regarding the future role of the surrogate mother, in 77% ($n = 10$) of known surrogacy arrangements, the couple and the surrogate mother agreed that she would play no special role beyond that appropriate to her relationship status with the child e.g. as aunt or family friend. For the remaining 23% ($n = 3$) of the arrangements, it was agreed that the surrogate mother would play a special role, e.g. as the child's godmother.

For unknown surrogate mothers, in all except one case, the surrogate mother and the couple had met through the surrogacy agency, COTS. Couples and unknown surrogate mothers met six times on average, and knew each other for an average of 17 weeks, before going ahead with the first attempt to conceive. Examining the two types of surrogacy separately, couples in full surrogacy arrangements had known the surrogate mother for 21 weeks on average whilst those in partial surrogacy arrangements had known her for the slightly shorter time of 16 weeks on average, but the range for both groups was the same at 2–52 weeks. Two-thirds (66%, $n = 19$) of the couples had agreed with the surrogate mother that she would have occasional contact with the child, and 10% ($n = 3$) wanted her to play a special role in the child's life, for example by attending birthday parties. A total of 14% ($n = 4$) of couples had agreed that they would keep in contact with the surrogate mother but that she would not see the child, and 10% ($n = 3$) had decided from the beginning to have no further involvement with the surrogate mother after the birth.

A total of 62% ($n = 26$) of the arrangements involved partial surrogacy and 38% ($n = 16$) of arrangements involved full surrogacy.

### *Experience of surrogacy during pregnancy*

Table III shows parental recall of concerns for two stages of the pregnancy retrospectively. At the start of the pregnancy, 72% ($n = 30$) of mothers and 81% ($n = 22$) of fathers were categorised either as 'happy', indicating no concerns, or as having 'mild apprehension', where the parent was predominantly happy or excited but had some slight concerns, for example, about how the pregnancy would progress. A higher proportion of mothers than fathers (26% versus 15%) recalled themselves as having 'mixed feelings' but their orientation towards the pregnancy was still positive, and very few parents were rated as having 'high anxiety' where anxiety was the predominant feeling about the pregnancy. By the end of the pregnancy, the general trend for both mothers and fathers was a move towards more positive feelings. Concerns about pregnancy were compared between those with known and unknown surrogate mothers and between those with full surrogacy and partial surrogacy. No significant differences were found for either comparison

In total, 98% ($n = 41$) of mothers and 90% ($n = 25$) of fathers recalled that they had a 'harmonious' relationship with the surrogate mother at the beginning of the pregnancy. When asked to remember their feelings at the end of the pregnancy, 95% ($n = 40$) of mothers and 86% ($n = 24$) of fathers rated their relationships with the surrogate mothers as 'harmonious'.



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**Table III.** Experience of surrogacy during pregnancy

| | Mothers at start of pregnancy | | Fathers at start of pregnancy | | Mothers at end of pregnancy | | Fathers at end of pregnancy | |
|---|---|---|---|---|---|---|---|---|
| | % | *n* | % | *n* | % | *n* | % | *n* |
| Parental concerns | | | | | | | | |
| Happy | 31 | 13 | 48 | 13 | 39 | 16 | 48 | 13 |
| Mild apprehension | 41 | 17 | 33 | 9 | 39 | 16 | 40 | 11 |
| Mixed feelings | 26 | 11 | 15 | 4 | 20 | 8 | 5 | 2 |
| High anxiety | 2 | 1 | 4 | 1 | 2 | 1 | 4 | 1 |
| Relationship with surrogate mother | | | | | | | | |
| Harmonious | 98 | 41 | 90 | 25 | 95 | 40 | 86 | 24 |
| Dissatisfaction/coldness | 2 | 1 | 10 | 3 | 5 | 2 | 14 | 4 |
| Major conflict/hostility | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Frequency see surrogate mother | | | | | | | | |
| More than once a week | 26 | 11 | 19 | 8 | 31 | 13 | 22 | 9 |
| Once a week to once a month | 53 | 22 | 36 | 15 | 48 | 20 | 33 | 14 |
| Once a month to once every 3 months | 19 | 8 | 38 | 16 | 21 | 9 | 38 | 16 |
| Not at all | 2 | 1 | 7 | 3 | 0 | 0 | 7 | 3 |

**Table IV.** Comparisons of frequency of contact between known and unknown surrogate mother arrangements

| | | Frequency of contact | | | | | $\chi^2$ | *P* |
|---|---|---|---|---|---|---|---|---|
| | | More than once/week | Once week–once month | Once month – once every 3 months | 1 or 2 times | Not at all | | |
| Mothers: at start of pregnancy | Known | 10 | 2 | 1 | N/A | 0 | 25.14 | <0.005 |
| | Unknown | 1 | 20 | 7 | N/A | 1 | | |
| Fathers: at start of pregnancy | Known | 8 | 3 | 2 | N/A | 0 | 22.58 | <0.005 |
| | Unknown | 0 | 12 | 14 | N/A | 3 | | |
| Mothers: at end of pregnancy | Known | 11 | 1 | 1 | N/A | 0 | 25.48 | <0.005 |
| | Unknown | 2 | 19 | 8 | N/A | 0 | | |
| Fathers: at end of pregnancy | Known | 8 | 3 | 2 | N/A | 0 | 18.62 | <0.005 |
| | Unknown | 1 | 11 | 14 | N/A | 3 | | |
| Mothers: since birth | Known | 8 | 4 | 0 | 0 | 1 | 32.25 | <0.005 |
| | Unknown | 0 | 2 | 13 | 11 | 3 | | |
| Fathers: since birth | Known | 5 | 4 | 2 | 1 | 1 | 22.68 | <0.005 |
| | Unknown | 0 | 1 | 13 | 13 | 2 | | |

Those that were not 'harmonious' were rated as having some 'dissatisfaction or coldness' in the relationship, for example, some minor conflicts or a lack or communication, but no relationship was rated as being characterized by 'major conflict or hostility'. There was no significant difference in the quality of the relationships between parents and known surrogate mothers compared to those of parents and unknown surrogate mothers. Nor was there a significant difference between the quality of relationships in full surrogacy cases and those in partial surrogacy cases.

Throughout the pregnancy, the large majority of mothers (79%, $n = 33$) saw the surrogate mother at least once a month. Fathers had less contact with the surrogate mother, with only 55% ($n = 23$) seeing her at least once a month. Three fathers (7%) did not see the surrogate mother at all during the pregnancy. Frequency of contact did not change from the start to the end of the pregnancy for mothers or fathers. Comparing known surrogate mother cases to unknown (see Table IV), parents who knew the surrogate mother had more frequent contact with her throughout the pregnancy than those who did not (e.g. at start of pregnancy, mothers: $\chi^2 = 25.48$, $P < 0.005$; fathers: $\chi^2 = 18.62$, $P < 0.005$). There was no significant difference in the frequency of contact according to the type of surrogacy, i.e. full or partial.

### *Experience of surrogacy after birth*

At the child's birth, 81% of commissioning mothers ($n = 34$) were present. The other 19% ($n = 4$) were either unable to attend or chose not to. In contrast, only 31% ($n = 13$) of commissioning fathers were present, with 40% ($n = 17$) absent through choice or circumstances. In the remaining 29% ($n = 12$) of cases, the surrogate mother requested that the commis-



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Table V. Experience of surrogacy after birth

| | Mothers | | Fathers | | Children | |
|---|---|---|---|---|---|---|
| | % | n | % | n | % | n |
| Present at birth | | | | | | |
| Chose not to/unable | 19 | 4 | 40 | 17 | | |
| Not wanted by surrogate | 0 | 0 | 29 | 12 | | |
| Present | 81 | 34 | 31 | 13 | | |
| Frequency see surrogate mother | | | | | | |
| Once a week | 19 | 8 | 12 | 5 | 19 | 8 |
| Once/week–once/month | 15 | 6 | 12 | 5 | 14 | 6 |
| Once/month–once every 3 months | 31 | 13 | 36 | 15 | 31 | 13 |
| Once or twice | 26 | 11 | 33 | 14 | 12 | 5 |
| Not at all | 9 | 4 | 7 | 3 | 24 | 10 |
| Relationship with surrogate mother | | | | | | |
| Harmonious | 91 | 38 | 89 | 25 | | |
| Dissatisfaction/coldness | 9 | 4 | 11 | 3 | | |
| Major conflict/hostility | 0 | 0 | 0 | 0 | | |
| Feelings about surrogate's involvement with child | | | | | | |
| Positive | 92 | 35 | 90 | 26 | | |
| Ambivalent | 5 | 2 | 10 | 3 | | |
| Concerned | 3 | 1 | 0 | 0 | | |
| Would recommend surrogacy | | | | | | |
| No | 2 | 1 | 0 | 0 | | |
| Uncertain | 5 | 2 | 3 | 1 | | |
| Yes | 93 | 39 | 97 | 28 | | |

sioning father not be present (see Table V). On average the child was handed over to the couple by the surrogate mother within 1 day of the birth. There was only one case of a surrogate mother having slight doubts about handing the child over, with all other surrogate mothers showing no problems. Nearly all of the commissioning mothers had no difficulty accepting the baby, although one mother (involved in a partial surrogacy arrangement) did report having minor doubts initially.

A total of 91% of commissioning mothers ($n = 38$) and 93% ($n = 39$) of commissioning fathers had seen the surrogate mother at least once since the birth, although the contact between the surrogate mother and the child was slightly lower at 76% ($n = 32$). Sixty-four per cent of mothers and children ($n = 27$), and 60% ($n = 25$) of fathers, had continued to see the surrogate mother every couple of months. In respect to the current relationship with the surrogate mother, 91% ($n = 38$) of mothers and 89% ($n = 25$) of fathers reported it still to be harmonious and there were no instances or reports of major conflict. In cases where there had been contact between the child and the surrogate mother, 92% ($n = 35$) of mothers and 90% ($n = 26$) of fathers felt positive about the surrogate mother's involvement in the child's life. Two mothers and three fathers were ambivalent towards this involvement, and one mother said that she was concerned about it.

Where there was no contact between the family and the surrogate mother, this was most likely to be either by mutual agreement or because the surrogate mother did not want contact. There were no reported cases where the primary decision to stop contact was that of the parents.

Couples who knew the surrogate mother had seen her more often since the birth than couples who had not known the surrogate mother previously (mothers: $\chi^2 = 32.25$, $P < 0.005$; fathers: $\chi^2 = 22.68$, $P < 0.005$, see Table IV), but there were no significant differences between the two groups in the quality of the current relationship between the parents and the surrogate mother. Nor were there any differences in the frequency of contact, or in the quality of the current relationship with the surrogate mother, when couples in full surrogacy arrangements were compared to those in partial surrogacy arrangements.

When asked if they would definitely recommend surrogacy to others, 93% of mothers ($n = 29$) and 97% ($n = 28$) of fathers said that they would, with only one mother stating that she would not recommend it.

### *Openness about surrogacy*

All of the commissioning couples had told both maternal and paternal grandparents about the surrogacy arrangement, although one couple had not done so until after the child's birth. When asked for their reasons for disclosure, many mothers gave more than one response resulting in a total number of responses of greater than 100% (see Table VI). The most common reasons given for telling families were: (i) 53% ($n = 22$) of couples wanted to share the experience with the family, (ii) 48% ($n = 20$) felt there was no choice but to tell, either because it would be obvious that the mother was not pregnant or because the family was aware that it was impossible for the mother to become pregnant, and (iii) 36% ($n = 15$) saw no reason not to tell. The majority of the couples' families had reacted either positively or neutrally to the news, with only 7% ($n = 3$) of couples reporting any negative reaction from family. There were no differences in the reactions of family depending on whether the surrogate mother was known or not, or on whether the surrogacy was full or partial. All of the couples had also told at least one friend.



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**Table VI.** Openness about surrogacy

| | Mothers | | Fathers | |
|---|---|---|---|---|
| | % | *n* | % | *n* |
| Reasons for telling family | | | | |
| Wanted to share | 53 | 22 | | |
| No choice but to tell | 48 | 20 | | |
| No reason not to | 36 | 15 | | |
| To avoid disclosure | 19 | 8 | | |
| Family's reaction | | | | |
| Negative | 7 | 3 | | |
| Neutral/mixed | 29 | 12 | | |
| Positive | 64 | 27 | | |
| Reasons for telling child | | | | |
| Child has right to know | 69 | 29 | 69 | 20 |
| To avoid disclosure | 64 | 27 | 48 | 14 |
| No reason not to | 41 | 17 | 45 | 13 |

All (100%) of both mothers and fathers reported that they planned to tell the child about the surrogacy in the future. The mean age at which mothers planned to start telling was 3 years old, whereas fathers planned to tell at the slightly older mean age of 5 years. The most common reason for planning to tell the child was the view that the child has a right to know the truth. This reason was given by 69% of mothers ($n = 29$) and fathers ($n = 20$). A further reason reported by 64% ($n = 27$) of mothers and 48% ($n = 14$) of fathers was to prevent the disclosure coming from anyone else, and 41% ($n = 17$) of mothers and 45% ($n = 13$) of fathers felt that there was simply no reason not to tell the child.

## Discussion

In spite of the concerns that have been commonly voiced about surrogacy, the commissioning parents had not generally found the experience of surrogacy to be problematic. However, surrogacy is by no means seen as an easy option and early fears that couples would use surrogacy 'for convenience' (HFEA, 1993) seem unfounded. The parents in this study had embarked on surrogacy either after a long period of infertility and, in many cases, repeated failed IVF treatments, or as the only way of having a child genetically related to the commissioning father when the commissioning mother had no uterus.

Media reports of surrogacy have often focused on situations where the relationship between the surrogate mother and the couple has broken down, resulting in conflict and, in extreme cases, the surrogate mother applying for custody of the child, for example the 'baby M' case (New Jersey Supreme Court, 1987). However, in this study, relationships were found to be generally good, with little sign of conflict during the pregnancy. A few couples reported having felt some dissatisfaction with the relationship in the past, for example feeling that the surrogate mother was over-exerting herself whilst pregnant, but there was no instance of this causing serious friction between them. Commissioning mothers seemed to have been more involved than did fathers with the surrogate mother during the pregnancy in that they saw her more frequently, often accompanying her to all medical appointments, and in all cases the surrogate mother was happy for the commissioning mother to be present at the birth. This is in line with Ragoné's (1994) assertion that, in the families she studied, the role of the father during pregnancy was de-emphasized while the commissioning mother formed a strong bond with the surrogate mother and was very involved in the pregnancy. It is possible that sharing the pregnancy in this way can help the commissioning mother to feel connected to the unborn child and, in the case of partial surrogacy, to come to terms with the fact that she is not the genetic mother of the child.

It has been suggested that contact with the surrogate mother after the birth might be detrimental to the family, but this does not seem to be confirmed by the findings. Nearly two-thirds of the commissioning mothers had regular contact with the surrogate mother and the large majority of parents, even where there was not regular contact, felt that their relationship was still good. There is little evidence in support of the theory that commissioning mothers may feel insecure about the surrogate mother's involvement with the child, since nearly all of the commissioning mothers were positive about this and felt that their child would benefit from it.

It should be noted that this report is based on the commissioning couples' reports only, and it is possible that they were attempting to present the situation in the best possible light. This is particularly true in light of the fact that, for some variables, couples were reporting on their memories of experiences taking place over a year ago, and may have chosen not to recall the negative aspects. The surrogate mother's perception of the arrangement may be very different, or the surrogate mother may have encountered problems that she did not share with the commissioning couple. For example,

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in Blyth's (1994) interviews with 19 surrogate mothers, five of the women studied expressed sorrow and distress about parting with the child, which the commissioning parents may not have been aware of. Therefore, in the current study the surrogate mothers themselves were interviewed where possible and data was obtained on the experience of 34 surrogate mothers (V.Jadva *et al.*, unpublished data).

All of the couples intended to disclose the facts about the surrogacy arrangement to their child at a fairly young age. This follows the pattern seen in previous studies of surrogacy (Blyth, 1995; van den Akker, 2000). In this respect, surrogacy families seem to be behaving similarly to adoptive families, where current practice is for parents to be open with the child about the adoption from as soon as the child can understand, rather than to families created through other forms of assisted reproduction, where parents tend not to be open with their child about the nature of their conception. Surrogacy families are also like adoptive families in their readiness to disclose the child's origins to their family and friends. This may be due to the fact that, as for adoptive families, the absence of a pregnancy means that the commissioning couple cannot pretend that they have had the child through natural conception. Thus, the wish expressed by some families created through gamete donation to present themselves as a 'normal' family is not an option in the case of surrogacy. Parents did not seem to see surrogacy as something to keep secret, as shown by the large numbers who reported that there was no reason not to tell the child or others.

Interestingly, there were very few differences found between the arrangements where the surrogate mother was unknown to the couple and those where she was a friend or relative. Despite couples and unknown surrogate mothers having to trust each other when they were still relative strangers, their relationship was no less likely to be harmonious than that of couples and known surrogate mothers. The fact that commissioning couples waited on average ~4 months before starting treatment suggests that both the surrogate mother and the commissioning couple were carefully considering the situation rather than hurrying into an alliance whilst still unsure Attempts to conceive began slightly sooner after meeting in partial surrogacy arrangements than in full surrogacy arrangements, possibly for practical reasons, but there was still an average of 16 weeks between the first meeting and the first insemination attempt. In situations where the surrogate mother was a relative or friend, there was little evidence of the surrogate mother being coerced by the couple, since in over three-quarters of cases, the suggestion had come from the surrogate mother herself.

In terms of the type of surrogacy used, there were no significant differences for any of the aspects of surrogacy studied between full and partial surrogacy arrangements. This suggests that the presence or absence of a genetic link between the commissioning mother and the child does not affect her experience of surrogacy or her feelings about the surrogate mother. This result is in line with other types of assisted reproductive technology involving gamete donation where the absence of a genetic link between the mother and the child does not appear to affect her feelings about motherhood (Golombok *et al.*, 1999). Similarly, adoptive mothers of children adopted in infancy have positive attachments towards their infants (Singer *et al.*, 1985).

Warnock (2002) described surrogacy as "an extremely risky enterprise and liable to end in tears". The findings of this study provide no evidence to support this claim. In fact, despite the potentially difficult nature of surrogacy, commissioning couples generally perceived the surrogacy arrangement as a positive experience and one that they would recommend to other people. However, it must be remembered that the children in these families were still in infancy so it is not yet known what the experiences and feelings of commissioning couples will be as their children grow older and develop the capacity to understand the circumstances of their birth. Nor is it known how the relationship between the commissioning couple and the surrogate mother will sustain and develop over time. This study represents the first stage of a longitudinal investigation in which families will be followed up to try to address these questions. It is only through such studies that the impact of surrogacy on families can be properly understood.

## Acknowledgements

We are grateful to the Registrar General Office of the Office of National Statistics and to Childlessness Overcome Through Surrogacy (COTS) for their help in recruiting families to the study. We would also like to thank the Wellcome Trust for funding this research.

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*Submitted on January 9, 2003; accepted on February 27, 2003*

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Human Reproduction Vol.21, No.7 pp. 1918–1924, 2006
Advance Access publication March 3, 2006.
doi:10.1093/humrep/del039

# Non-genetic and non-gestational parenthood: consequences for parent–child relationships and the psychological well-being of mothers, fathers and children at age 3

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**BACKGROUND: Findings are presented of the third phase of a longitudinal study of children conceived by assisted reproduction procedures involving surrogacy and/or donor conception. METHODS: At the time of the child's third birthday, 34 surrogacy families, 41 donor insemination families and 41 oocyte donation families were compared with 67 natural conception families on standardized interview and questionnaire measures of the psychological well-being of the parents, mother–child relationships and the psychological well-being of the child. RESULTS: The differences found between family types reflected higher levels of warmth and interaction between mothers and their 3-year-old children in assisted reproduction families than in families with a naturally conceived child. A higher proportion of surrogacy parents than donor conception parents had told their children about the nature of their birth. CONCLUSIONS: It appears that the absence of a genetic and/or gestational link between parents and their child does not have a negative impact on parent–child relationships or the psychological well-being of mothers, fathers or children at age 3.**

*Key words*: child development/donor insemination/oocyte donation/parenting/surrogacy

## Introduction

Advances in reproductive medicine since the birth of the first baby through IVF in 1978 have resulted in more than 1 million babies conceived by assisted reproduction, and it has been estimated that in some European countries up to 5% of births are now due to assisted reproduction procedures (Vayena *et al.*, 2002). In these families, it may be expected that the circumstances of the birth may influence parents' thoughts, feelings and behaviour towards their child, particularly when donated gametes and/or a surrogate mother is involved. A concern is that parents may feel or behave less positively towards a non-genetic or non-gestational child, which may have a negative effect on the child's identity and psychological well-being.

Different types of assisted reproduction have raised specific concerns arising from the different patterns of genetic and gestational relationships between parents and the child. With respect to gamete donation, fathers, in particular, have been predicted to be more distant from a non-genetic child (Daly and Wilson, 1989; Baran and Pannor, 1993). Studies of step-parent families, which are similar to gamete donation families in that there is no genetic tie between one parent and the child, point to difficult relationships between step-parents and stepchildren (Hetherington and Clingempeel, 1992; Dunn *et al.*, 1998; Hetherington and Stanley-Hagan, 2002). However, the formation of a stepfamily brings with it a number of stresses that may affect the quality of parenting that are not present in gamete donation families including the disruption of a relationship with an existing parent and the need to negotiate relationships with new family members. Interestingly, Dunn *et al.* (2000) found parents in stepfamilies that included both stepchildren and genetically related children to be less affectionate towards, and less supportive of, their stepchildren than their own biological children. Nevertheless, gamete donation families differ from stepfamilies in important ways; the parents have chosen to raise the child, have done so from birth, and generally present the child to others as their own. It cannot be assumed, therefore, that assisted reproduction parents will be like step-parents with respect to the quality of their relationship with their non-genetic child.

In the case of surrogacy, the separation of gestational parenthood from social parenthood is similar to adoption in that the mother who gives birth relinquishes the child to other parents. It might be expected, therefore, that children born through surrogacy, like adopted children, will show raised levels of psychological problems (Brodzinsky *et al.*, 1998; Brodzinsky and Pinderhughes, 2002). However, as Brodzinsky and colleagues point out, the higher rates of psychological problems shown by

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adopted children are largely associated with late placement in an adoptive family and adverse early childhood experiences. Children born through a surrogacy arrangement are more akin to early adopted children who are much less at risk for emotional or behavioural problems as they grow up. Thus, the findings of studies of adopted children should not necessarily be extrapolated to children born through a surrogacy arrangement.

The aim of this study was to provide data on the quality of parenting and the psychological development of children in assisted reproduction families where parents lack a genetic and/or gestational link with their child. In earlier phases of this longitudinal study, conducted when the children were 1 and 2 years old, data were obtained from representative samples of oocyte donation families (where the child lacks a genetic link with the mother but not the father), donor insemination families (where the child lacks a genetic link with the father but not the mother), surrogacy families (where the child lacks a gestational link with the mother, and in some cases lacks a genetic link as well) and a matched comparison group of natural conception families. It was found that the absence of a genetic and/or gestational link between a parent and the child did not jeopardize parenting or children's psychological adjustment at age 1 (Golombok *et al.*, 2004a,b) or age 2 (Golombok *et al.*, 2005, 2006). This study focuses on these families at the time of the child's third birthday just as some parents are beginning to discuss the nature of the birth with their child.

## Materials and methods

### *Participants*

Thirty-four families with a child born through a surrogacy arrangement, 41 families with a child conceived by oocyte donation and 41 families with a child conceived by donor insemination were studied in comparison with 67 families with a naturally conceived child. The surrogacy families represent 81% of the sample first recruited through the General Register Office of the United Kingdom Office for National Statistics and the United Kingdom surrogacy agency known as Childlessness Overcome through Surrogacy (COTS) around the time of the child's first birthday. The oocyte donation and donor insemination families represent 80% and 82%, respectively of the original samples recruited through nine fertility clinics in the United Kingdom when the child was around 1 year old. The natural conception families were selected through maternity ward records on the basis of stratification to maximize comparability with the oocyte donation and donor insemination families and represent 84% of the initial sample. In 59% of the surrogacy families, the surrogate mother was the genetic mother of the child (partial surrogacy) and in the remaining 41% of families, the commissioning mother was the genetic mother (full surrogacy). Nine of the oocyte donation families had conceived their child with the help of a known donor. Of the families lost to follow-up, around half could not be traced and the other half declined to participate. A detailed description of the original sampling procedures is presented in Golombok *et al.* (2004a,b).

Sociodemographic information for each group is summarized in Table I. There were similar proportions of boys and girls in each family type, and the age of the children did not differ between groups. There was a significant group difference in the age of the mothers, $F(3, 179) = 18.68$, $P < 0.001$. The oocyte donation mothers were the oldest, with a mean age of 43 years, and the donor insemination and natural conception mothers were the youngest with a mean age of 37 years. A group difference was also found for social class, $\chi^2(9, n = 183) = 24.72$, $P < 0.01$, as measured by the occupation of the parent with the highest ranking position according to a modified version of the Registrar General's classification (Office of the Population and Census Statistics and Employment Department Group, 1991) ranging from 1 (professional/managerial) to 4 (partly skilled or unskilled). This difference represented a lower proportion of donor insemination families in professional or managerial occupations. The number of siblings in the family differed significantly between groups $\chi^2(9, n = 183) = 30.41$, $P < 0.001$, with fewer siblings in the assisted reproduction families than in the natural conception families. As significant differences between groups were found for mother's age, social class and number of siblings in the family, these variables were entered into the statistical analyses as covariates.

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**Table I.** Sociodemographic information by family type

| | Surrogacy | | Donor insemination | | Oocyte donation | | Naturally conceived | | F | P |
|---|---|---|---|---|---|---|---|---|---|---|
| | Mean | SD | Mean | SD | Mean | SD | Mean | SD | | |
| Age of child (months) | 36.29 | 1.29 | 36.39 | 0.83 | 36.76 | 1.04 | 36.63 | 0.83 | 1.87 | NS |
| Age of mother (years) | 41.76 | 5.36 | 37.46 | 3.62 | 43.05 | 6.73 | 37.13 | 3.14 | 18.68 | <0.001 |
| | *n* | | *n* | | *n* | | *n* | | $\chi^2$ | P |
| Child's sex | | | | | | | | | | |
| Boy | 18 | | 24 | | 26 | | 32 | | 2.84 | NS |
| Girl | 16 | | 17 | | 15 | | 35 | | | |
| Social class | | | | | | | | | | |
| Professional/ managerial | 22 | | 16 | | 22 | | 46 | | 24.72 | <0.01 |
| Skilled/non-manual | 6 | | 11 | | 14 | | 17 | | | |
| Skilled manual | 1 | | 9 | | 3 | | 2 | | | |
| Partly skilled/ unskilled | 5 | | 5 | | 2 | | 2 | | | |
| Number of siblings | | | | | | | | | | |
| None | 15 | | 15 | | 26 | | 11 | | 30.41 | <0.001 |
| One | 17 | | 22 | | 11 | | 46 | | | |
| Two | 2 | | 4[a] | | 4 | | 10 | | | |

NS, not significant.
[a]Includes one donor insemination child with three siblings.

Researchers trained in the study techniques visited the mothers at home. Data were obtained from the mother by tape-recorded interview and questionnaires and from the father by questionnaires. Fathers were not interviewed at this phase of the study as fathers are generally less available for interview than are mothers, and the fathers participated in an in-depth interview when the child was aged 2. Information obtained by interview was rated according to a standardized coding scheme, and regular meetings were held to minimize rater discrepancy.

### Measures

*Parents' psychological state*

Mothers and fathers completed the Golombok Rust Inventory of Marital State (GRIMS) (Rust *et al.*, 1990), a questionnaire assessment of the quality of the marital relationship with higher scores indicating poorer marital quality. Split-half reliability is .91 for men and .87 for women, and the GRIMS has been shown to discriminate significantly between couples who are about to separate and those who are not. The Trait Anxiety Inventory (Spielberger, 1983) and the Edinburgh Depression Scale (Thorpe, 1993) were also completed by both mothers and fathers to assess anxiety and depression respectively. Both of these instruments, for which higher scores represent greater difficulties, have been shown to have good reliability and to discriminate well between clinical and non-clinical groups.

The short form of the Parenting Stress Index (PSI/SF) (Abidin, 1990), a standardized assessment of stress associated with parenting, was administered to mothers and fathers separately to produce a total stress score for each parent, as well as sub-scale scores of parental distress, dysfunctional interaction and difficult child, with higher scores reflecting greater parenting stress. Test–retest reliability for the total score was found to be 0.96 over a 1- to 3-month interval and 0.65 over 1 year. Concurrent and predictive validity has been demonstrated for the full-length questionnaire, and the short form has been reported to correlate very highly with the full-length version.

*Quality of parenting*

The mothers were interviewed using an adaptation of a standardized interview designed to assess the quality of parenting (Quinton and Rutter, 1988). Detailed accounts were obtained of the child's behaviour and the mother's response to it, and the following ratings were made according to strict coding criteria taking into account information obtained from the entire interview: (1) *expressed warmth* was rated on a 6-point scale from 0 (none) to 5 (high) and was based on the mother's tone of voice, facial expression and gestures when talking about the child, spontaneous expressions of warmth, sympathy and concern about any difficulties experienced by the child and enthusiasm and interest in the child as a person; (2) *emotional over-involvement* was rated on a 4-point scale from 0 (little or none) to 3 (enmeshed) and measured the extent to which family life and the emotional functioning of the mother was centred on the child, the extent to which the mother was over concerned or overprotective towards the child, and the extent to which the mother had interests apart from those relating to the child; (3) *mother–child interaction* was rated on a 5-point scale from 0 (very poor) to 4 (very high) and measured the extent to which the child and mother spent time together, enjoyed each other's company and showed affection to one another; (4) *sensitive responding* was rated on a 5-point scale from 0 (none) to 4 (very sensitive responding) and represented the mother's ability to recognize and respond appropriately to her infant's needs. This interview procedure has been validated against observational ratings of mother–child relationships in the home, demonstrating a high level of agreement between global ratings of the quality of parenting by interviewers and observers (Quinton and Rutter, 1988). Inter-rater reliabilities were calculated from 30 randomly selected interviews coded by a second interviewer who was 'blind' to family type. Agreement within one scale point for expressed warmth, emotional involvement, mother–child interaction and sensitive responding was 90%, 100%, 100% and 97%, respectively.

*Children's psychological adjustment*

The presence of behavioural or emotional problems in the children was assessed using the Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1994, 1997) administered to mothers. The questionnaire has been shown to have good inter-rater reliability, with correlations between parent and teacher scores reported to be 0.62. Evidence for validity comes from the high correlations between the total deviance score of the SDQ and the total score of the Rutter Parent Questionnaire (Rutter *et al.*, 1970) and the Rutter Teacher Questionnaire (Rutter, 1967), which were designed to assess child psychiatric disorder. In addition, the SDQ discriminates well between psychiatric and non-psychiatric samples.

*Experiences of assisted reproduction*

Mothers of children conceived by donor insemination, oocyte donation and surrogacy were administered an additional section of the interview that focused on issues directly related to the method of the child's conception. Systematic information was obtained from mothers on whether or not the parents had told or planned to tell the child about the method of his or her conception, the parents' reasons for their decision, whether or not the parents had told other people about the child's conception and disclosure to grandparents. Information was also obtained from the commissioning mothers in surrogacy families and from the oocyte donation mothers with known donors about the frequency of the family's contact with the surrogate mother or oocyte donor, their relationship with her and their feelings about her involvement with the child. The data were rated according to strict coding criteria derived from an earlier investigation (Cook *et al.*, 1995). The coding categories are described in detail in the *Results* section.

## Results

Multivariate analyses of covariance (MANCOVAs) were carried out for the questionnaire variables relating to parental psychological state for mothers and fathers separately and for the variables relating to quality of parenting derived from the interview with mothers. Analysis of covariance (ANCOVA) was conducted for the Strength and Difficulties Questionnaire. The covariates were mother's age, social class and number of children in the family. Where a significant group difference was found, Helmert contrasts were carried out to address specific questions: (1) assisted reproduction versus natural conception (AR versus NC) to establish whether the assisted reproduction families differed from the natural conception families, (2) oocyte donation and surrogacy versus donor insemination (OD/S versus DI) to establish whether families where the mother lacked a genetic or gestational link with the child differed from families where the father lacked a genetic link with the child and (3) oocyte donation versus surrogacy (OD versus S) to establish whether families where the mother lacked a genetic link with the child differed from families where the mother lacked a gestational link (sometimes in combination with the absence of a genetic link as well). For parents' experiences of assisted reproduction, comparisons between the oocyte



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donation, donor insemination and surrogacy families were carried out using chi-square tests.

### *Parents' psychological state*

Mothers' scores on the Trait Anxiety Inventory, the Edinburgh Depression Scale, the GRIMS and the PSI were entered into a MANCOVA. Wilks's λ was not significant. Similarly, fathers' scores on the Trait Anxiety Inventory, the Edinburgh Depression Scale, the GRIMS and the PSI were entered into a MANCOVA and again Wilks's λ was not significant.

### *Quality of parenting*

The expressed warmth, emotional over-involvement, mother–child interaction and sensitive responding variables from the mother's interview were entered into a MANCOVA. Wilks's λ was significant, $F(12, 452) = 1.93$, $P < 0.05$. As summarized in Table II, one-way ANCOVAs showed a significant difference between family types for expressed warmth, $F(3, 174) = 4.59$, $P < 0.01$, and mother–child interaction, $F(3, 174) = 4.31$, $P < 0.01$. For expressed warmth, the Helmert contrasts showed this difference to reflect a higher level of expressed warmth among the assisted reproduction mothers than the natural conception mothers (AR versus NC, $P < 0.001$). Regarding mother–child interaction, the Helmert contrasts identified higher levels of mother–child interaction among the assisted reproduction mothers than the natural conception mothers (AR versus NC, $P < 0.05$), and higher levels of mother–child interaction in oocyte donation and surrogacy families than in families with a donor insemination child (OD/S versus DI, $P < 0.01$).

### *Children's psychological adjustment*

There was no significant difference between family types for the total score of the SDQ (Table II).

### *Experiences of assisted reproduction*

As summarized in Table III, there was a significant difference between parents in the different family types regarding disclosure to their child about the method of their conception, $\chi^2(6, n = 116) = 40.30$, $P < 0.001$. Whereas 44% of the commissioning parents of children born through surrogacy had begun to discuss this issue with their 3-year-old child, only 7.3% of oocyte donation parents and 4.9% of donor insemination parents had begun to do so by the time of their child's third birthday. Moreover, 46% of the donor insemination parents had decided against telling their child, whereas this was true of only 22% of the oocyte donation parents and none of the surrogacy parents. The remaining parents were either undecided about whether or not to tell or planned to disclose this information to their child in the future. Those who had told or planned to tell their child were asked to give their reasons for this decision, and these were classified according to the following categories: 'Child has a right to know', 'To avoid disclosure by someone else' and 'No reason not to'. Many parents gave more than one reason for their intention to tell their child, and each was rated separately. The most commonly cited reasons were that the child has a right to know (given by 55% of surrogacy parents, 68% of oocyte donation parents and 83% of donor insemination parents) and to avoid disclosure by someone else (given by 59% of surrogacy parents, 29% of oocyte donation parents and 59% of donor insemination parents). Thirty-one percent of surrogacy parents, 21% of oocyte donation parents and 17% of donor insemination parents said that there was no reason not to tell.

The oocyte donation and donor insemination parents who had decided against telling their child were also asked for their reasons which were classified according to the following categories: 'To protect the child', 'To protect the mother' and 'To protect the father'. Twenty-two percent of the oocyte donation parents and 53% of the donor insemination parents wished to protect the child. There was also a desire to protect the non-genetic parent, with 44% of the oocyte donation parents wishing to protect the mother, and 42% of the donor insemination parents wishing to protect the father.

Regarding disclosure to other people, there was a significant difference between family types in the proportion of parents who had told at least one other person about the nature of the child's conception, $\chi^2(2, n = 116) = 14.66$, $P < 0.01$. All of the surrogacy parents had done so, whereas only 83% of the oocyte donation parents and 66% of the donor insemination parents had told someone else. There was also a difference between family types with respect to disclosure to maternal, $\chi^2(8, n = 88) = 21.13$, $P < 0.01$ and paternal, $\chi^2(1, n = 88) = 27.02$, $P < 0.001$, grandparents. The proportion of parents who had

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**Table II.** Means, SD, *F* and *P* values for comparisons of quality of parenting between family types

| | Surrogacy | | Donor insemination | | Oocyte donation | | Naturally conceived | | *F* | *P* | Contrasts | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Mean | SD | Mean | SD | Mean | SD | Mean | SD | | | AR versus NC | OD/S versus DI | OD versus S |
| Mothers | | | | | | | | | | | | | |
| Expressed warmth | 4.41 | .70 | 4.24 | .58 | 4.44 | .63 | 4.00 | .75 | 4.59 | <0.01 | <.001 | NS | NS |
| Emotional over-involvement | .32 | .53 | .27 | .54 | .41 | .54 | .20 | .44 | .41 | NS | – | – | – |
| Mother–child interaction | 3.65 | .48 | 3.39 | .54 | 3.61 | .49 | 3.42 | .58 | 4.31 | <0.01 | <.05 | <.01 | NS |
| Sensitive responding | 2.79 | .53 | 2.59 | .59 | 2.66 | .65 | 2.63 | .67 | 1.09 | NS | – | – | – |
| Children | | | | | | | | | | | | | |
| Strengths and Difficulties Questionnaire score | 7.40 | 3.6 | 7.68 | 3.7 | 7.72 | 4.1 | 6.54 | 3.8 | .177 | NS | – | – | – |

AR, assisted reproduction; DI, donor insemination; NC, natural conception; OD, oocyte donation; OD/S, oocyte donation and surrogacy; S, surrogacy.

**Table III.** Experiences of gamete donation by family type

| | Surrogacy | | Donor insemination | | Oocyte donation | | $\chi^2$ | P |
|---|---|---|---|---|---|---|---|---|
| | n | % | n | % | n | % | | |
| Telling child | | | | | | | | |
| Told | 15 | 44 | 2 | 5 | 3 | 7 | 40.30 | <0.001 |
| Plans to tell | 18 | 53 | 16 | 39 | 25 | 61 | | |
| Uncertain | 1 | 3 | 4 | 10 | 4 | 10 | | |
| Plans not to tell | 0 | 0 | 19 | 46 | 9 | 22 | | |
| Told other people | | | | | | | | |
| Yes | 34 | 100 | 27 | 66 | 34 | 83 | 14.66 | <0.01 |
| No | 0 | 0 | 14 | 34 | 7 | 17 | | |
| Told maternal grandparents | | | | | | | | |
| Told | 23 | 92 | 16 | 50 | 20 | 64 | 21.13 | <0.01 |
| Plans to tell | 1 | 4 | 0 | 0 | 2 | 7 | | |
| Uncertain | 0 | 0 | 2 | 6 | 0 | 0 | | |
| Plans not to tell | 0 | 0 | 14 | 44 | 8 | 26 | | |
| Not applicable | 1 | 4 | 0 | 0 | 1 | 3 | | |
| Told paternal grandparents | | | | | | | | |
| Told | 22 | 100 | 8 | 28 | 19 | 56 | 27.02 | <0.001 |
| Plans to tell | 0 | 0 | 1 | 4 | 2 | 6 | | |
| Uncertain | 0 | 0 | 0 | 0 | 0 | 0 | | |
| Plans not to tell | 0 | 0 | 19 | 68 | 13 | 38 | | |
| Not applicable | 0 | 0 | 0 | 0 | 0 | 0 | | |

been open with maternal grandparents was 92% for surrogacy families, 65% for oocyte donation families and 50% for donor insemination families. For paternal grandparents, the proportion who had been open was 100%, 56% and 29% for surrogacy, oocyte donation and donor insemination families, respectively.

With respect to contact with the surrogate mother, 50% of commissioning mothers, 38% of commissioning fathers and 44% of children in surrogacy families had seen the surrogate mother at least once every 3 months in the previous year, with 34, 28 and 31% of mothers, fathers and children respectively having seen her at least once per month. Most commissioning parents reported a harmonious relationship with the surrogate mother, with only 6% of commissioning mothers and 9% of commissioning fathers experiencing some dissatisfaction or coldness in the relationship, and none experiencing major conflict or hostility. Only one commissioning mother expressed some ambivalence regarding the surrogate mother's contact with the child. Of the nine sets of parents whose oocyte donation child was born with the help of a known donor, 89% of mothers, 38% of fathers and 78% of the children had seen the donor at least once every 3 months in the previous year, with 33% of mothers, 22% of fathers and 22% of children having had contact at least once per month. With the exception of one set of oocyte donation parents, all felt positive about their relationship with the oocyte donor. None of the mothers expressed concern about the oocyte donor's involvement with the child.

## Discussion

The findings of this follow up when the children were 3 years old are in line with those of earlier phases of the study in showing that the absence of a genetic or gestational link between the mother and the child does not appear to impact negatively on parent–child relationships. In fact, to the extent that differences in parent–child relationships were found between family types, these reflected higher levels of warmth and interaction between mothers and their 3-year-old children in the assisted reproduction families than in the comparison group of families with a naturally conceived child. The more positive findings for mother–child relationships in assisted reproduction families are similar to those obtained at age 1 (Golombok *et al.*, 2004a,b) and at age 2 (Golombok *et al.*, 2005, 2006). With respect to psychological well-being, no differences were identified between family types for either parents or children as assessed by standardized measures, with mothers, fathers and children found to be functioning within the normal range. The lower levels of parenting stress observed in mothers and fathers in surrogacy families at age 1 (Golombok *et al.*, 2004b) and by fathers in surrogacy families at age 2 (Golombok *et al.*, 2005) appear to have disappeared by age 3.

An issue of interest in this study was whether differences in parenting existed between families where the mother lacked a genetic and/or gestational link with the child and families where it was the father who lacked a genetic link. The only difference found was for the level of mother–child interaction, with the surrogacy and oocyte donation mothers showing higher levels of interaction with their child than the mothers of children conceived by donor insemination. This finding is surprising as it might be expected that mothers who lack a biological link with their child would interact less with their child than biologically related mothers. However, it may be that women who are unable to conceive or carry a child themselves may become especially committed to parenting when they eventually become mothers or may try to compensate for the absence of a genetic or gestational link. The DI mothers may be more akin to the natural conception mothers in this respect because they are the genetic and gestational mothers of their



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child. An alternative explanation for the significant difference between non-biological and biological mothers for mother–child interaction is that it may have resulted from chance. Although this possibility cannot be ruled out, a multivariate analysis was used to reduce the likelihood of chance effects. It should be noted that there were no differences between families where the mother lacked a biological link with the child (surrogacy and oocyte donation) and families where the father lacked a biological link with the child (donor insemination) for either the mothers', the fathers' or the children's psychological well-being.

A further question of interest was whether differences existed in parenting, or in parents' or children's psychological well-being, between the oocyte donation families and the surrogacy families, i.e. according to whether or not the mother experienced the pregnancy and birth. Although the opportunity to bond with the child during pregnancy, a process that has been associated with more positive mother–child relationships (Laxton-Kane and Slade, 2002), might lead to the prediction of more positive outcomes for the oocyte donation families, no differences were found between the oocyte donation families and the surrogacy families for any of the variables under study. This may have arisen from the fact that many of the commissioning mothers maintained contact with the surrogate mother during the pregnancy and felt highly involved.

The findings relating to parents' experiences of assisted reproduction showed that couples who had become parents through a surrogacy arrangement were much more likely to have been open with their child about the circumstances of their birth than were couples whose children had been conceived by gamete donation. Perhaps surprisingly, as it is generally believed that fathers are more sensitive about the absence of a genetic link with their child than are mothers, there was little difference between the proportions of oocyte donation and donor insemination parents who had disclosed this information to their child. In spite of the greater encouragement in recent years of parents to tell their children about the method of their conception, less than 8% of oocyte donation parents and less than 5% of donor insemination parents had begun to do so by the time of the child's third birthday. This contrasts sharply with the finding that 56% of these same oocyte donation parents and 46% of these donor insemination parents reported when their child was 1 year old that they planned to tell their child about the donor conception (Golombok *et al.*, 2004a). Although some of these parents may discuss this issue with their children as they grow older, it is generally advised that parents should begin this process at a very early age. The discrepancy between the surrogacy parents and the gamete donation parents regarding disclosure to the child most probably results from the fact that the latter experience a pregnancy and can keep the donor conception secret from family and friends whereas the absence of a pregnancy in surrogacy families increases the likelihood that the child will find out from someone else. The most common reason given by surrogacy parents for telling their child is to avoid disclosure by someone else, with 59% of surrogacy parents citing this reason. Although the same proportion of donor insemination parents gave this reason for disclosure, very few of these parents had actually told their child.

Regarding disclosure to grandparents, it is interesting to note that the surrogacy parents were most likely to tell followed by oocyte donation parents. Only half of the donor insemination parents were open about the donor conception to maternal grandparents and less than one-third told paternal grandparents. This finding suggests that donor insemination is associated with greater stigma than is oocyte donation and that the reaction of paternal grandparents to the knowledge that their grandchild is genetically unrelated to them is expected to be more negative than that of maternal grandparents. Once again, the high proportion of grandparents in surrogacy families who had been told is most likely related to the absence of a pregnancy.

Not only do the findings of this study show that the absence of a genetic and/or gestational link between parents and their child does not appear to jeopardize the development of positive family relationships but also the findings replicate those obtained from previous samples of donor insemination (Golombok *et al.*, 1995) and oocyte donation families (Golombok *et al.*, 1999) with children of a similar age. Although it was expected from their reported intentions when their child was aged 1 that more of the gamete donation parents would have begun to discuss with their children the circumstances of their birth, it seems that these intentions had not been acted upon by the time the child turned 3 years old. In contrast, many of the commissioning parents in surrogacy families had begun to discuss this issue with their child, showing that children at age 3 have at least a rudimentary understanding of the concepts of conception and childbirth. It may be the case that it is more difficult to explain gamete donation than surrogacy to a young child as an understanding of gamete donation needs a greater knowledge of the process of conception than does surrogacy, which only requires some knowledge of childbirth (Cook *et al.*, 1995; Murray and Golombok, 2003). However, it is more likely that parents with children conceived by gamete donation have not yet begun to discuss this issue because many find the topic difficult to broach, because they are concerned about the impact on family relationships, and because the presence of a pregnancy means that there is less need to tell.

## Acknowledgements

We thank the families who participated in the study and the Wellcome Trust for funding this research.

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*Submitted on August 29, 2005; resubmitted on December 22, 2005; accepted on January 9, 2006*

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# MOTIVATIONS OF SURROGATE MOTHERS:

PARENTHOOD, ALTRUISM AND SELF-ACTUALIZATION
(a three year study)

Author: Dr. Betsy P. Aigen

The public controversy over surrogate motherhood is accelerating. Because surrogacy questions cherished cultural beliefs and ideals regarding the mother-infant relationship, it inenvitably stimulates intense anxiety and discomfort. Women who choose to bear children voluntarily for someone else reap disdain, and are seen as cold, heartless, and mercenary, because they seem to so easily ìgive away their babies". Even in the absence of the issue of fee payment, there is a clear moralistic underpinning to the arguments against surrogacy, which is rarely stated overtly, that choosing to have a baby for someone else is reprehensible because it represents a ìrejection" of the infant by its biological mother. These women, who are seen as being prompted by materialistic motives, are correspondingly seen as coming from a financial and/or social ìunderclass". This is perceived as making them vulnerable to being exploited by reproductively ìprostituting" themselves. Finally, they are assumed to suffer a serious traumatic experience because of the perceived ìloss" they suffer in surrendering the infant to the couple.

Although critics have been vocal and strident, there is little actual data to substantiate these claims. This study was a preliminary effort to assess the reality of the assumptions behind this stereotype, to clarify their motives

## METHOD

### Interviews

Two hundred potential surrogates applying to The Surrogate Mother Program of New York were screened using a series of three semi-structured interviews, 90 minutes each, to assess their motivation, feelings about surrendering the baby, and a number of related attitudes. General demographic data, medical history, as well as information regarding their current and past life situation, were asked for as well, including childhood relationships. Questions also pertained to their state of emotional health, and corresponded to a traditional clinical interview. The following is a very brief summary of the results of this three year study.

## SUBJECTS

### The Rejected Group

Individuals were rejected for "emotional" reasons such as:

1. Individuals too ambivalent about becoming surrogates. Serious expressions of conflict over either the responsibility or the commitment of time, energy, and resources required; or uncertainty over whether they would feel comfortable carrying a child that was not "theirs"; or being very anxious about the possibility of social criticism.
2. Individuals overly motivated by the fee.
3.Indivials potentially experiencing too much difficulty in surrendering the baby.
4. Indiviuals likely to suffer severe loss reaction afterwards.
5. Indiviuals in the middle of a "life crisis". Crisis refers to such events as being, at the time of application, in the process of divorce, still recuperating from a divorce, mourning the recent death

of a family member or spouse, or being in the midst of an identity crisis, i.e. not knowing what to do with oneís life.
6. Indiviuals trying to use the role of surrogate as a way to deal with a traumatic situation. Efforts to "relive" abandonments suffered in childhood through "identifying" with the infant whom they see as being abandoned by themselves or given away; or unconscious conflict over another child themselves. Being a surrogate would allow the applicant to bear the child yet not keep it. The possibility exists of her changing her mind and keeping the child.
7. Individuals in poor emotional condition,depressed, immature, or unstable.
8. Judged to be dishonest and untrustworthy.

**The Accepted Group**
The accepted group includes those applicants who did not fall into any category of the rejection categories. They were (at most) minimally ambivalent about becoming surrogates not primarily motivated by the fee, and judged as having little potential difficulty in surrendering the baby. They were emotionally adequate, with no serious outstanding pathology. They were frequently judged to be honest and trustworthy.
In addition, they passed the following criteria:

1. Individuals for whom this would be a positive emotional experience, who feel they would gain by it.
2. High frustration tolerance and ìego strength". People with determination to follow through and the capacity to endure the physical and emotional demands and realities of the process.
3. A history of positive and enjoyable preganancies, both physically and emotionally.
4. Positive relationships with their children, to ensure that they have the necessary concern, understanding, and closeness to deal adequately with their childrenís questions and feelings about the choice of surrogacy.
5. The presence of a supportive home environment, i.e. spouse or significant others, to ensure an adequate environment during pregnacy.

**Demographic Characteritics and Attitudes Related to Surrogacy**
The mean age of the entire group was 26. Fifty percent were married, and 26% were single. Seventy-five percent were mothers. Forty percent had a history of one or more abortions. Sixteen percent had some relation to adoption (they or a significant family member were adopted, or they surrendered a child for adoption). As a group, they were predominantly white and either Catholic or Protestant. Almost three-fourths came from large families (three or more siblings). The average educational level was 13.3 years. Fifty percent had one or more years of college. Approximately 71% were employed (at least part-time), and 20% were either teachers or nurses. Their mean income level was above $24,000 per year. Twenty-five percent had combined family incomes above $35,000 per year. [This includes women judged to be ìfinancially desperate.] On average, applicants had been interested in being a surrogate for 1 1/2 years. Seventy-five percent wished to meet the couple.
The "average" surrogate emerges as a white mother with a fair amount of education and income. As a group, they cannot be described as destitute or living in poverty, and do not need the fee being paid them for basic survival. On average, they do not report being under serious financial pressure. Further data reflecting this is presented later on. Most of them are parents who know what the experience of bearing a child is about. There is nothing to indicate that they are naive, passive dupes who are desperate and susceptible to exploitation.

**Conclusion**
Although money is an important motive to many surrogates, it is not their primary motive. Almost all report a variety of emotional reasons for undertaking surrogacy, and many of these can be grouped together under the heading of wishes to enable parenthood, to feel self-actualized, and to

enhance their identity. It is, for these women, a particularly female experience, related to the experiences and meaning of biological functioning and motherhood. The love of their children, the gratification their children offer them, and the wish to share these experiences, were often mentioned by these women. These feelings, influenced a number of the motive categories, including empathy with the infertile wife and the drive to generate parenthood for others.
An indirect implications of all this is that these women are as "normal" as anyone else. Previous research assessing surrogates has also found them to be unremarkable and their personalities to be average. Although psychological needs may sometimes, or perhaps even often, be found underlying a number of the motives reported (e.g., guilt), we do not see that this, in an of itself, invalidates the surrogatesí choice. Such conflicts and needs, in part, fuel most "normal" choices and activities of human beings, such as marriage and career. What are "healthy" motives? We do not ban people from becoming CIA agents or test pilots because they are prompted by unresolved wishes.
This does not mean that there are no unhealthy motives for becoming a surrogate and that no discrimination is necessary. On the contrary, the fact that over 40% of our 200 applicants were rejected for emotionally-based reasons, having to do either with poor motives, general life situation, or general emotional makeup, suggests that great discrimination and caution are necessary in accepting individuals for this process. The reasons for rejection listed earlier, as well as the criteria for acceptance, can provide a useful start in the process of providing needed criteria for evaluating surrogate applicants effectively. Additionally, differences in the composition of accepted and rejected groups reflect the importance of assessing motivation and character. Those individuals and parents who are less detached, more connected to the couple, the baby, and probably to their own children and partners, seem to be the ones favored by our selection criteria. The results may also suggest that, in general, parents are better suited to be surrogates than non-parents, in terms of significant traits, motivation, and more adaptive reactions to surrendering the child.
Being a surrogate is a life experience that allows some women real success in altering their emotional state in a direction they desire and fulfilling ideal images of themselves. A very significant aspect of that image is that of being a mother and, by extension, enabling others to enjoy the pleasures of parenthood that they themselves have had. Because surrogacy involves an act of giving that is personally meaningful to the surrogate, and because what is being given is of unique value, being a surrogate mother has the potential to be a "mutative" event, an experience capable of altering and transforming identity, self-image, and existing psychic structure.
It is exactly the fact that these otherwise individuals, through their biological ability to bear children, feel that they can achieve some measure of greatness that would otherwise be beyond them, that makes being a surrogate so psychologically extraordinary. They feel this moment of greatness as a permanent possession. The memory of this action is a permanent psychological reserve against negative emotional states and events. The motives for becoming a surrogate mother cannot be glibly dismissed as mere "acting out".
In contrast to the stereotype of a heartless, misguided, impoverished woman primarily motivated by money, surrogates emerge here as average mothers, often trying to further the goals of their children and families.

*European society of human reproduction and embryology*

The official journal of ESHRE is 'Human Reproduction'. It is made up of three individual publications: Human Reproduction, Human Reproduction Update, Molecular Human Reproduction. These are published for ESHRE by Oxford University Press (OUP). OUP is a department of the University of Oxford.

## ***ESHRE Task Force on Ethics and Law 10: Surrogacy***

Received April 28, 2005.
Accepted May 19, 2005.

Abstract

This 10th statement of the Task Force on Ethics and Law considers ethical questions specific to varied surrogacy arrangements. Surrogacy is especially complex as the interests of the intended parents, the surrogate, and the future child may differ.
It is concluded that surrogacy is an acceptable method of assisted reproductive technology of the last resort for specific medical indications, for which only reimbursement of reasonable expenses is allowed. ESHRE Task Force on Ethics and Law including, , F. Shenfield, G. Pennings, J. Cohen, P. Devroey, G. de Wert and B. Tarlatzis

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http://www.eshre.eu/binarydata.aspx?type=doc&sessionid=hucwrj45sjp4p3455oiggu55/Task_force_X_surrogacy.pdf

## Svör Staðgöngu við ýmsum getgátum og álitaefnum

Hér verður leitast við að svara þeim getgátum og álitaefnum um staðgöngumæðrun sem til umræðu hafa verið að undanförnu.

*Hvernig á að koma í veg fyrir staðgöngumæðrun í hagnaðarskyni?*
Svarað í umsögn

*Best er að fylgja Norðurlöndunum*
Svarað í umsögn

*Hvernig á að afmarka þann hóp sem heimilt verður að eignast barn með staðgöngumæðrun?*
Svarað í umsögn

*Hvernig á að tryggja réttindi barna, t.d. til að vita uppruna sinn?*
Svarað í umsögn

*Hvað ef staðgöngumóðir skiptir um skoðun? (einnig tekið fyrir í umsögn)*
Það er lagaramminn og/eða reglugerðin sem byggir á lögunum sem ákveður hvort hlutaðeigandi aðilar geti skipt um skoðun eða ekki. Við erum fullkomlega sammála því er kemur fram í þingsályktunartilögunni að leyfa eingöngu fulla staðgöngumæðrun sem í felst að staðgöngumóðirin leggur aldrei til eigin kynfrumu (egg). Það er gert í þeim tilgangi að minnka flækjustig staðgöngumæðrunar og minnka líkurnar á tilfinningalegum tengslum staðgöngumóður við barnið. Samkomulag við staðgöngumóður er einnig að fullu bindandi fyrir alla aðila. Staðgöngumóðurinni væri einnig gefið of mikið vald ef hún gæti ákveðið að halda barninu eftir fæðingu, gæti leitt til þess að hún óskar eftir greiðslu frá verðandi foreldrum fyrir að snúast ekki hugur. Slík tilfelli eru samkvæmt heimildum sjaldgæf en eitt slíkt er þekkt og kom upp í Bretlandi.

Þrátt fyrir að staðgöngumóður sé leyfilegt að leggja til eigin kynfrumur (egg) er ánægja allra hlutaðeigandi samkvæmt COTS í Bretlandi um 98% en í þeim tilvikum sem þetta hefur gerst er konan allajafn að ganga með eigið barn.[1]

Staðgöngumóðir fær að halda barninu; var fyrirsögn á visir.is ekki alls fyrir löngu og aftur á visir.is og Pressan.is í febrúar .
Þetta var í Bretlandi og var þeim mikilvægu upplýsinga sleppt úr fréttinni að "staðgöngumóðirin" var að ganga með sitt blóðskylda barn og var í raun um gamaldags heimasæðingu að ræða þar sem konan sprautaði sig með sæði mannsins. Konan hafði fundið hjónin á netinu. Var ekki um staðgönguferli undir handleiðslu fagaðila að ræða. Tekið var fram af dómara að svona tilfelli séu reyndar afar sjaldgæf í Bretlandi.[2],[3]

*Hvað ef verðandi foreldrar skipta um skoðun? (einnig tekið fyrir í umsögn)*
Að sama skapi er það einnig hvernig lagaraminn er útfærður sem segir til um hvort að foreldrar geti skipt um skoðun eða ekki. Ef ekki er gert bindandi samkomulag við alla aðila þá gætu foreldrar neitað að taka við barninu eftir fæðingu. Staðgöngumóðirin situr þá eftir með barn annara sem er jafnvel ekki full heilbrigt. Við styðjum það að fullu að samkomulag við foreldra sé bindandi. Þegar þetta hefur verið rannsakað í Bretlandi reynist það vera afar sjaldgæft að foreldrar neiti að tak við barninu. Van den Akker rannsakaði 7 stofnanir er sjá um staðgöngumæðrun í Bretlandi varðandi tíðni þess að staðgöngumæður neiti að afhenda barnið eða að verðandi foreldrar neiti að taka við barni. Einungis ein stofnun tilkynnti um slíkt.[4]

Með vandaðri lagasetningu þá er auðveldlega hægt að taka alveg fyrir það að svona geti gerst. Sjáum við ekki betur en að þannig verði staðið að málunum hérlendis og erum við afar ánægð með það.

*Hvernig velferð staðgöngumóður og fjölskyldu hennar verði tryggð (einnig tekið fyrir í umsögn)*
Hluti af þessu er að staðgöngumóðirin og verðandi foreldrar geri með sér bindandi samkomulag sem skilgreint er í reglugerð um staðgöngumæðrun í velgjörðarskyni og geta verðandi foreldrar því ekki neitað að taka við eigin barni. Þess má geta að konur geta eftirlitslaust sætt sig heima með sprautu. Konan gengur þá með eigið barn fyrir hjón, hún tekur þátt í lífi barnsins eða ekki. Hér er engin leið að vita hvað var samið um. Ekki er hægt að tryggja heilsu konunnar

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[1] COTS UK: http://www.surrogacy.org.uk/FAQ4.htm - Í Bretlandi er enn leyfð hefðbundin staðgöngumæðrun þar sem staðgöngumóðirin leggur til egg og geta þær því ákveðið að halda barninu. Samt sem áður er fullnaðar árangur hjá COTS 98%, það er að segja eins og lagt var upp með í byrjun ferlis.

[2] http://www.dailymail.co.uk/news/article-1356176/Surrogate-mother-wins-case-baby-giving-birth.htm

[3] http://www.dailymail.co.uk/news/article-1349487/Surrogate-mother-changed-mind-allowed-baby.html

[4] "Olga van den Akker, "Organizational selection and assessment of women entering a surrogacy agreement in the UK" (1999) 14 Human Reproduction 262 [van den Akker, "Organizational selection"]

og almenna velferð né fær hún stuðning frá félagsráðgjafa varðandi hæfni sína til að geta gert þetta í raun. Þetta er líka gert á Íslandi í kyrrþey og leggur Staðganga áherslu á að með lögleiðingu staðgöngumæðrunar í velgjörðarskyni megi komast fyrir slík tilfelli.

Við gerum ráð fyrir því að löggjafinn skipi teymi sérfræðinga sem áður hafa komið að löggjöf er varðar réttindi hlutaðeigndi aðila í tengslum við frjósemisaðstoð. Ekki allar konur geta verið staðgöngumæður og ef eftirlit verður haft sem er í höndum fagaðila erum við fullviss um að hérlendis sé hægt að gæta réttinda og heilsu staðgöngumæðra í hvívetna.

Félagið bendir á langtímarannsóknir fagaðila eru til er taka til nokkurra ára og fylgjast með líðan og aðstæðum staðgöngumæðra á meðgöngunni sjálfri og síðar.[5] Niðurstöður eru jákvæðar fyrir staðgöngumæður og fjölskyldu hennar: (þýð: Stg.) "Þó svo að neikvæðni frá einhverjum fjölskyldumeðlimum gæti (Van den Akker, 2001) sjá staðgöngumæður lífsreynsluna alla jafna sem jákvæða fyrir nánustu fjölskyldumeðlimi, sérstaklega börn þeirra (Ciccarelli, 1997) eða í versta falli segja að börnin hafi ekki hlotið neikvæða reynslu af (Hohman & Hagan, 2001) Helmingur staðgöngumæðranna í rannsókn Ciccarelli's frá 1997 skýra frá því að þær hafi orðið nánari öðrum fjölskyldumeðlimi vegna reynslu sinnar og um 3/4 tóku fram að reynslan hefði verið mjög jákvæð börnum þeirra.".[6]

*Hver á að bera kostnað af staðgöngumæðrun*

Siðfræðingar hafa sagt að erfitt sé að stjórna kostnaði á meðgöngu við staðgöngumæðrun og viðra þær getgátur að kona væri svo ef til vill ekki í raun að gerast staðgöngumóðir í velgjörðarskyni heldur hafi hún á laun hug á að geta hagnast. "Þvert á þá vinsælu skoðun að hvöt staðgöngumæðra séu peningar þá kemur í ljós að helsta hvötin sé velgjörð" (Ciccarelli, 1997; Hanafin, 1984; van den Akker, 2003)" (þýð: Stg.).[7] Heimild tekin úr skýrslu eftir Ciccarelli, Janice C.; Beckman, Linda J er birtust í Journal of Social Issues, mars 2005. Sjá einnig: Motivations of surrogate mothers, parenthood, altruism and self-actualization (a three year study), Dr. Betsy P. Aigen.[8]

Að konur fái greitt vinnutap ef þeim er óglatt og meðgöngbuxur mun ekki breyta velgjörðarstaðgöngu á þann veg að kona sé að græða peninga, það er fráleitt. Sjáum ekki hvernig það eitt og sér sé hvati til að verða staðgöngumóðir að eygja von um óléttuklæðnað, borgaða mæðraskoðun eða að fá vinnutap greitt vegna vanlíðan. Almenn skynsemi er höfð að leiðarljósi er reglur verða settar um þetta. Við sjáum ekki að kona geti hagnast af staðgöngu í velgjörð í laun nema þá einungis ef hún hefði kúgunarvald til að neita að afhenda foreldrum barnið nema gegn greiðslu á bakvið tjöldin.

Ekki má heldur gleyma því að í ljósi þess hve fáar konur munu geta nýtt sér þetta úrræði hérlendis, 0-5 konur árlega, að við erum í mörgum tilfellum að tala um staðgöngumæður sem eru systur, frænkur eða vinkonur viðkomandi. Þeir aðilar sem þurfa á staðgöngumæðrun að halda í dag standa nú þegar frammi fyrir miklum kostnaði við tilraunir til að eignast barn/börn því sú aðstoð fæst einungis í útlöndum. Með lögleiðingu á staðgöngumæðrun í velgjörðarskyni á Íslandi verður sá kostnaður margfalt minni og eru verðandi foreldrar tilbúnir til að bera fullan kostnað af frjósemismeðferðum hérlendis ef svo bæri undir.

Í niðurstöðunni er tíundaður kostnaður við lagasetningu og framkvæmd leyfisveitingu staðgöngumæðrunar. Ef staðganga í velgjörðarsyni verður ekki lögleidd á Íslandi munu aðilar í þessum sporum standa frammi fyrir því á næstu árum að hröklast úr landi til að leita sér hjálpar. Miklir fjármunir væru þá að fara úr landi á ári hverju í þessum tilgangi og er það farsælla fyrir samfélagið að leyfa staðgöngumæðrun og rennur þá þetta fé beint til íslensks heilbrigðiskerfis.

*Sú gagnrýni hefur komið upp að börnin njóti ekki brjóstagjafar*

Sú gagnrýni nægir ekki til að hafa nein afgerandi áhrif á það hvort staðganga verði lögleidd. Ættleidd börn njóta t.a.m. ekki brjóstagjafar. Sumar konur mjólka ekki og afar hæpið er að banna þeim að eignast fleiri börn því að vitað er að þau fá ekki brjóstamjólk. Konur geta fullvel tekið þá ákvörðun að vera ekki með barn á brjósti. Sjáum ekki að þetta geti verið útgangspunktur í umræðu um staðgöngumæðrun.

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[5] Upplifun staðgöngumæðra, heiti á frummáli: Surrogacy: the experience of surrogate mothers, höfundar: Vasanti Jadva, Clare Murray, Emma Lycett, Fiona MacCallum og Susan Golombok, http://humrep.oxfordjournals.org/cgi/reprint/18/10/2196

[6] Heimild tekin úr skýrslu eftir Ciccarelli, Janice C.; Beckman, Linda J er var birt í Journal of Social Issues, mars 2005, http://www.scie-socialcareonline.org.uk/profile.asp?guid=f347f903-bba2-45f0-b8aa-5101ba5c34bc

[7] Heimild tekin úr skýrslu eftir Ciccarelli, Janice C.; Beckman, Linda J er var birt í Journal of Social Issues, mars 2005, http://www.scie-socialcareonline.org.uk/profile.asp?guid=f347f903-bba2-45f0-b8aa-5101ba5c34bc

[8] http://www.surrogacy.com/psychres/article/motivat.html

*Unglingar segja frá því á netinu að þau séu óhamingjusöm vegna staðgöngumæðrunar því þau vita ekki uppruna sinn. Kom fram hjá Ástríði Stefánsdóttur lækni og siðfræðingi á málþingi Feministafélagsins um staðgöngumæðrun*
Höfum eftir þó nokkra leit á vefnum fundið einn bandarískan ungling sem er með áberandi bloggsíðu og er ósáttur því hann veit ekki hver uppruni hans er. Staðgöngumóðirin er einnig blóðmóðir hans sem verður ekki leyfilegt hérlendis skv. þált. Drengurinn upplifir höfnun, sömu tilfinningu og getur komið upp hjá ættleiddum börnum þó það sé síður en svo algilt að þau upplifi neikvæðar tilfinningar vegna uppruna síns. Þessar hugrenningar eiga ekki við hér því í tilvikum fullrar staðgöngumæðrunar í velgjörð sem þingsályktunartillagan tekur til þá mun staðgöngumóðirin aldrei vera blóðskyld barninu eins og í þessu tilviki. Staðganga bendir góðfúslega á að óstaðfestar blogg-færslur einstaklinga á veraldarvefnum er afar hæpið innlegg í þessa umræðu.

*Siðfræðingur setti fram getgátur um að börn tilkomin með staðgöngumæðrun verði í einhverskonar limbói ef eitthvað kemur fyrir verðandi foreldra eða þá að staðgöngumóðirin verði neydd til að taka barnið að sér*
Búið er að fara yfir þetta í umsögninni. Réttindi þessara barna verða auðvitað ekkert öðruvísi en annarra. Hvað kemur fyrir börn allajafna ef báðir foreldrar látast? Skyldmenni foreldra t.d amma, systur, bræður, frænkur taka oftast barnið að sér. Ófrjósemi hjónanna hefur snert við allri stórfjölskyldunni og eru einnig systkyni, frænkur, frændur, afar og ömmur að bíða eftir óskabarninu. Hér eru kringumstæður ekkert öðruvísi en hjá öðrum börnum og verður réttur þeirra ekki verri eða öðruvísi en annara barna og er fáheyrt að halda slíku fram. Staðgöngumóðir mun aldrei ganga með eigið barn og er undarlegt að halda því fram að sú kona verði neydd af íslenskum yfiröldum til að taka að sér barnið. Íslensk yfirvöld eru fullfær um að setja fram reglugerð sem gætir réttinda allra hlutaðeigandi aðila við slíkar kringumstæður eins og endranær.

*"Erum að fara of hratt...", "...bíðum róleg og vöndum til verka", "...ekki gott að láta eitt mál ráða ferðinni (innskot: mál Jóels)": Salvör Nordal í Návígi þriðjudaginn 15. febrúar 2011*
Salvör virðist telja að vinna við þingsályktunartillöguna hafi tekið skamman tíma og sett fram eingöngu vegna máls Jóels Færseth Einarssonar sem var fastur á Indlandi. Ekkert gæti verið eins fjarri raunveruleikanum. Undirbúningur að tillögunni hefur staðið yfir í á þriðja ár hefur verið hugðarefni Ragnheiðar Elínar Árnadóttur flytjanda tillögunnar og alþingismanns um árabil. Félagar í Staðgöngu hafa margir hverjir viðað að sér fróðleik um staðgöngumæðrun í mörg ár. Konur innan Staðgöngu misstu sumar legið fyrir 7-8 árum síðan og eru því búnar að bíða eftir hreyfingu á máinu í alltof langan tíma en frjósemi þeirra er auðvitað háð aldri. Hæstvirtur utanríkisráðherra Össur Skaphéðinsson sagði við kynningu á þingsályktunartillögunni á Alþingi að hann myndi eftir umræðum um staðgöngumæðrun á Alþingi í um 10 ár.

*"Erum að gera tilraunir": Salvör Nordal í Návígi, þriðjudaginn 15. febrúar 2011*
Engin leið að finna það út að staðgöngumæðrun sé tilraunastarfsemi þegar t.d Bretar hafa leyft staðgöngumæðrun í 26 ár og hefðbundin staðgöngumæðrun hefur tíðkast eins lengi og menn muna. Það hafa verið gerðar rannsóknir og skrifað um staðgöngumæðrun allt frá árinu 1981 hið minnsta, til dagsins í dag. Staðganga hefur fundið bækur, skýrslur, álitsgerðir og rannsóknir frá árunum 1981, 1983, 1984, 1985, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1997, 1996, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009 og 2010.

*Ef þetta verður leyft núna hverning verður þetta eftir 10 ár?: Salvör Nordal í návígi, 15. febrúar 2011*
Salvör virtist í þessu samhengi ekki vera mótfallinn staðgöngumæðrun sem velgjörð nema af því að ef konur fá þann rétt að vera staðgöngumæður ef þeim hugnast það í dag þá þurfi að hafa áhyggjur af því hvert það leiði okkur á tíu árum eða næstu áratugum.

Staðganga hefur verið leyfð í t.d Bretlandi og Bandaríkjunum í tugi ára og það sem hefur helst gerst er að ferlið hefur batnað. Við erum lítil þjóð svo það eina sem verður gert hér er það sem löggjafinn ákveður að leyfa, engar breytingar verða framkvæmdar nema þær sem löggjafinn ákveður. Þróun þessara mála í þeim vestrænu ríkjum þar sem staðgöngumæðrun er leyfð er á þá leið að verið er að styrkja stöðu staðgöngumæðra og barnanna. Í því tilliti hafa sum lönd bannað staðgöngumæðrun í hagnaðarskyni og sum hafa bannað hefðbundna staðgöngumæðrun (Kanada) sem áður var leyfð (kona gengur með sitt blóðskylda barn). Eins er víða uppi umræða er takmörkun á fjölda fósturvísa er setja má upp hjá staðgöngumóður. Færri fósturvísar minnka líkur á að staðgöngumóðir gangi með fjölbura sem að sjálfsögðu eykur líkur á vandkvæðum við meðgöngu og fæðingu en þegar hún gengur með eitt barn. Salvör sagði einnig að henni hefði ekki hugnast löggjöf um eggjagjafir og rétt samkynhneigðar kvenna og einhleypra til tæknifrjóvganna og að hún væri íhaldsöm og mest hlynnt gamla staðlaða fjölskylduforminu.