“Birth registrations are critical in legitimizing family membership and countries differ in who they consider the legal mother of a child, which can be the gestational, genetic or social mother if donor gametes are used.”

Over the last 25 years, treatment to overcome involuntary childlessness in single women, lesbian and gay couples and infertile heterosexual couples has progressed at a momentous pace. It is highly likely that further significant changes in treatment will become available in the next 25 years and these, in turn, will be subject to the public debate and media attentions that are necessary to acculturate these practices into mainstream societies [101]. Of the various forms of treatment currently available, surrogate motherhood continues to be one that instills doubt in the minds of many people [1]. This stems, in part, from the fact that surrogates are involved in the creation and bearing of a genetically related or unrelated child, with the express purpose of giving it up upon delivery and, in part, because of fears of the overt commodification of procreation [2]. The behaviors go against the traditional norms of family formation across societies, religions and cultures [3].

The media’s continued reporting on the good, the bad and the downright ugly of surrogate motherhood, using examples of worrying arrangements from around the world [102], has had an unsettling effect. Although social science research has addressed numerous aspects of welfare, motivations and short-term outcome [4], no long-term data are available yet. A note of caution is, therefore, necessary, balancing the commissioning couples’ needs with those of the surrogate mothers and the children. Through continued monitoring and progressive debate relating to non-normative family formation and health inequalities, we should develop universal strategies for problem-free progress of surrogate motherhood practices.

**Surrogate practice**

Surrogate motherhood involves carrying and giving birth to a baby for another woman using one of two methods of conception: genetic (the surrogate uses her own oocytes and conceives using donor insemination); or gestational surrogacy (the surrogate undergoes embryo transfer using the commissioning couple’s or a donated embryo). Surrogate mothers have altruistic [5] and financial [6] reasons for being a surrogate. They tend to be of a lower socioeconomic background, with many also reporting lower educational achievements than their commissioning opposites, particularly in cross-border arrangements [7].

Worldwide, of the estimated one in seven couples who experience infertility, only a minority opt for surrogacy, despite the fact that success rates are similar to traditional IVF [8]. The commissioning mother usually has good reason to use surrogacy to overcome her inability to carry a child to term [9]. She is nearly always infertile. Gay men have also been known to commission surrogate babies. Commissioning couples invest financially and emotionally into the process of having a surrogate baby [10]. Those using embryo transfer invest a (full or partial)
Variability in surrogate practices

International surrogacy is usually carried out owing to the unavailability of surrogates in the intended couple’s country of residence, legislative issues or financial considerations. Birth registrations are critical in legitimizing family membership and countries differ in who they consider the legal mother of a child, which can be the gestational, genetic or social mother if donor gametes are used. For example, in India, clinical guidelines stipulate that the birth certificate has the genetic parents on the birth certificate [103]. A commissioning couple will have to apply for adoption in their home country if the infant was conceived using genetic surrogacy (which is relatively less common in India). In the USA, commissioning couples do not have to formally adopt; instead, they can add the infant to their passport so that it obtains US nationality just like the commissioning parents. In the UK, the regulations are stricter. It is estimated that, each year, approximately 50 applications for the formal process of Parental Orders for registration with the commissioning couples are made, most of these through UK surrogacy arrangements. Once Parental Orders have been agreed, birth certificates will record the commissioning couple as the legal parents of the child. The differential legitimization has resulted in a drive to accurately record genetic parentage on birth certificates in surrogacy and in the registration of children conceived through gamete or embryo donation, so that the children have accurate information about the circumstances of their birth [11].

“The worldwide, of the estimated one in seven couples who experience infertility, only a minority opt for surrogacy, despite the fact that success rates are similar to traditional IVF.”

The consequences of these differing surrogate motherhood practices on the surrogates, the children and the extended family remains relatively unknown [12]. For surrogacy and other forms of third-party conception, reproductive-health inequalities seem to be widening between and within developed and developing countries [13]. Surrogacy involves a triad of people, and the involvement of agencies and clinics are expensive and not routinely available to all people [2]. Instead, the more affluent are able to commission a surrogate baby, whereas the less affluent are more likely to provide a surrogate baby. Relinquished surrogates need to address the psychosocial inequalities in the triads involved in surrogacy. Healthcare professionals involved in surrogacy need to address the psychosocial circumstances within the socio-cultural settings in which these reproductive arrangements take place.

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