The Royal Australian and New Zealand College of Obstetricians and Gynaecologists

Excellence in Women's Health

Surrogacy in Australia and New Zealand

This statement has been developed and reviewed by the Women's Health Committee and approved by the RANZCOG Board and Council.

A list of Women's Health Committee Members can be found in Appendix A.

Disclosure statements have been received from all members of this committee.

Disclaimer This information is intended to provide general advice to practitioners. This information should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient. This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The document has been prepared having regard to general circumstances.

First endorsed by RANZCOG: July 2011
Current: July 2017
Review due: July 2020

Background: This statement was first developed by Women's Health Committee in July 2011 and most recently reviewed in July 2017.

Funding: The development and review of this statement was funded by RANZCOG.

1. **Surrogacy** The first surrogate pregnancy following IVF conception was reported in the USA in 1985.[1] Since then, many countries around the world have allowed surrogacy while others have not. There is no one legal definition of surrogacy as the definition and associated laws are regulated by individual States and Territories.

2. **Gestational surrogacy.** This involves the surrogate acting as a "gestational carrier". Embryos are created by in vitro fertilisation (IVF) techniques from the sperm and oocytes of the commissioning parents; the resulting embryos are transferred to the uterus of the surrogate. The pregnancy outcome for babies has been comparable or better than standard IVF pregnancies.[2-5] Follow up of the experience of the commissioning parents[6], and surrogate mothers[7, 8] has been generally favourable. There is limited reported long term follow up of the surrogate mothers and even less of babies born to date.[9-11]

3. **Legislation regarding surrogacy** varies across jurisdictions. Each State in Australia, the A.C.T and New Zealand have their own laws.[12] It is essential that practitioners are aware of the legislation that applies in the jurisdiction in which they practice. Uniformity and clarity of legislation would benefit both the health practitioners and women for whom they care. In New Zealand altruistic surrogacy is permitted.

   While altruistic surrogacy in general is allowed and "commercial" surrogacy is not, the restrictions governing this practice vary across jurisdictions and are usually subject to some form of regulatory approval condition or consent.

4. Surrogacy may allow those parents who are otherwise unable to conceive or carry a child to realise their desire to become parents. Legislation does not usually define for which patients' surrogacy may be used. Patients for whom it may be appropriate include:

   - Women for whom the uterus is the cause of their infertility or inability to carry a pregnancy (e.g. previous hysterectomy, Asherman's syndrome or müllerian agenesis).

   - Women with certain medical conditions, such as severe heart disease, which might threaten the life of the woman should she become pregnant, provided she is considered fit enough to look after the child after birth and her life expectancy is reasonable.

   - Surrogacy has also been used successfully for women with multiple miscarriage or repeated failure of IVF. Expert opinion should be sought in these circumstances.

5. The issues involved in surrogate pregnancy are complex and expert counselling regarding the legal, social/ethical and psychological dimensions will be required for the involved parties.

   RANZCOG members may become involved with any or all of the following areas: pre-pregnancy counselling, evaluation of fertility, management of the IVF cycle and the management of the pregnancy and delivery.

   Pre-pregnancy counselling of the surrogate should occur as per RANZCOG guidelines (see link below). In particular, the surrogate would need advice regarding lifestyle and medical issues which could affect the pregnancy outcome, and medical risks to which she will be exposed by the pregnancy, so that she may give informed consent to participate. The usual treatment and professional obligations will also apply, including informed consent of all parties.

6. Those establishing a surrogacy service would be prudent to consider protocols of management used at centres which have established surrogacy programs,[13-15] with regard to protocols of management - medically, legally, and psychologically before, during and after a surrogate pregnancy. The status of approval by an independent ethics committee, and the inclusion of a cooling off period after approval and before proceeding have merit.

References

1. Utian WH, Sheean L, Goldfarb JM, Kiwi R. Successful pregnancy after in vitro fertilization and embryo transfer from an infertile woman to a surrogate, N Engl J Med. 1985;313(21):1351-2.

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3. Marrs RP, Ringler GE, Stein AL, Vargyas JM, Stone BA. The use of surrogate gestational carriers for assisted reproductive technologies, Am J Obstet Gynecol. 1993;168(6 Pt 1):1858-61; discussion 61-3.

4. Parkinson J, Tran C, Tan T, Nelson J, Batzofin J, Serafini P. Perinatal outcome after in-vitro fertilization-surrogacy, Human Reproduction. 1999;14(3):671-6.

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7. Blyth E. "I wanted to be interesting. I wanted to be able to say 'I've done something interesting with my life'": Interviews with surrogate mothers in Britain, Journal of Reproductive and Infant Psychology. 1994;12(3):189-98.

8. Jadva V, Murray C, Lycett E, MacCallum F, Golombok S. Surrogacy: the experiences of surrogate mothers, Hum Reprod. 2003;18(10):2196-204.

9. Ethics Committee of the American Society for Reproductive Medicine. Consideration of the gestational carrier: a committee opinion, Fertility and Sterility 2013;99(7):1838-41.

10. Golombok S, Blake L, Casey P, Roman G, Jadva V. Children born through reproductive donation: a longitudinal study of psychological adjustment, J Child Psychol Psychiatry. 2013;54(6):653-60.

11. Jadva V, Blake L, Casey P, Golombok S. Surrogacy families 10 years on: relationship with the surrogate, decisions over disclosure and children's understanding of their surrogacy origins, Hum Reprod. 2012;27(10):3008-14.

12. Victorian Assisted Reproductive Treatment Authority. Relevant acts and regulation - other states 2014 [Accessed http://www.varta.org.au/relevant-acts-and-regulation-other-states/.

13. Appleton T. Surrogacy, Current Obstetrics and Gynaecology. 2001;11(4):256-7.

14. Brinsden PR. Gestational surrogacy, Hum Reprod Update. 2003;9(5):483-91.

15. Devine B. An overview of surrogacy in Australia, O&G magazine. 2010;12(3):38-9.

Links to other College statements

Evidence-based medicine, obstetrics and gynaecology (C-Gen 15)

Consent and provision of information to patients in Australia regarding proposed treatment (C-Gen 02a)

Consent and provision of information to patients in New Zealand regarding proposed treatment (C-Gen 02b)

Pre-pregnancy Counselling (C-Obs 3a)

Routine Antenatal Assessment in the absence of pregnancy complications (C-Obs 03b)

Patient information

A range of RANZCOG Patient Information Pamphlets can be ordered via:

https://www.ranzcog.edu.au/Womens-Health/Patient-Information-Guides/Patient-Information-Pamphlets

Appendices

Appendix A Women's Health Committee Membership

Name	Position on Committee
Professor Yee Leung	Chair
Dr Joseph Sgroi	Deputy Chair, Gynaecology
Associate Professor Janet Vaughan	Deputy Chair, Obstetrics
Associate Professor Ian Pettigrew	EAC Representative
Dr Tal Jacobson	Member
Dr Ian Page	Member
Dr John Regan	Member
Dr Craig Skidmore	Member
Associate Professor Lisa Hui	Member
Dr Bernadette White	Member
Dr Scott White	Member
Associate Professor Kirsten Black	Member
Dr Greg Fox	College Medical Officer
Dr Marilyn Clarke	Chair of the ATSI WHC
Dr Martin Byrne	GPOAC Representative
Ms Catherine Whitby	Community Representative
Ms Sherryn Elworthy	Midwifery Representative
Dr Amelia Ryan	Trainee Representative

Appendix B Overview of the development and review process for this statement

i. Steps in developing and updating this statement

This statement was originally developed in July 2011 and was most recently reviewed in July 2017. The Women's Health Committee carried out the following steps in reviewing this statement:

- Declarations of interest were sought from all members prior to reviewing this statement.
- Structured clinical questions were developed and agreed upon.
- An updated literature search to answer the clinical questions was undertaken.
- At the July 2017 face-to-face committee meeting, the existing consensus-based recommendations were reviewed and updated (where appropriate) based on the available body of evidence and clinical expertise. Recommendations were graded as set out below in Appendix A part iii)

ii. Declaration of interest process and management

Declaring interests is essential in order to prevent any potential conflict between the private interests of members, and their duties as part of the Women's Health Committee.

A declaration of interest form specific to guidelines and statements was developed by RANZCOG and approved by the RANZCOG Board in September 2012. The Women's Health Committee members were required to declare their relevant interests in writing on this form prior to participating in the review of this statement.

Members were required to update their information as soon as they become aware of any changes to their interests and there was also a standing agenda item at each meeting where declarations of interest were called for and recorded as part of the meeting minutes.

There were no significant real or perceived conflicts of interest that required management during the process of updating this statement.

iii. Grading of recommendations

Each recommendation in this College statement is given an overall grade as per the table below, based on the National Health and Medical Research Council (NHMRC) Levels of Evidence and Grades of Recommendations for Developers of Guidelines. Where no robust evidence was available but there was sufficient consensus within the Women's Health Committee, consensus-based recommendations were developed or existing ones updated and are identifiable as such. Consensus-based recommendations were agreed to by the entire committee. Good Practice Notes are highlighted throughout and provide practical guidance to facilitate implementation. These were also developed through consensus of the entire committee.

Recommendation category		Description
Evidence-based	A	Body of evidence can be trusted to guide practice
	B	Body of evidence can be trusted to guide practice in most situations
	C	Body of evidence provides some support for recommendation(s) but care should be taken in its application
	D	The body of evidence is weak and the recommendation must be applied with caution
Consensus-based		Recommendation based on clinical opinion and expertise as insufficient evidence available
Good Practice Note		Practical advice and information based on clinical opinion and expertise

Appendix B Full Disclaimer

This information is intended to provide general advice to practitioners, and should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient.

This information has been prepared having regard to general circumstances. It is the responsibility of each practitioner to have regard to the particular circumstances of each case. Clinical management should be responsive to the needs of the individual patient and the particular circumstances of each case.

This information has been prepared having regard to the information available at the time of its preparation, and each practitioner should have regard to relevant information, research or material which may have been published or become available subsequently.

Whilst the College endeavours to ensure that information is accurate and current at the time of preparation, it takes no responsibility for matters arising from changed circumstances or information or material that may have become subsequently available.