Auckland Women's Health Council

Te Kōpū Whāngai: He Arotake Review of Surrogacy

Submission from the Auckland Women's Health Council, 30 September 2021

Executive Summary

1. **The Commission's focus on 'respecting the autonomy' of individuals is an oversimplification of complex social, medical, ethical, biological, and genetic relations.**

   Key issues include: harmful societal discourse promoting 'family at any cost' and pro-natal ideologies; biological parenthood, e.g. maternal-fetal bonding and the needs of newborn babies; and the significant risks to both women and children associated with surrogacy involving IVF. We question the possibility of any straightforward choice for surrogates and intending parents to engage in surrogacy under these circumstances. Surrogacy law reform and practice must be supported by broader public reflection on the culture of 'parents at any cost', 'nuclear families at any cost' and the use of children as a tool for the satisfaction of adults' desire for parenthood, self-fulfilment, and self-determination. Such discussion is not evident in media coverage of Aotearoa New Zealand surrogacy law reform to date and would need to be explicitly prompted via a public health campaign.

2. **Any legal severing of the relationship between the surrogate and child is incompatible with the best interests of the surrogate-born child.**

   AWHC holds that critical consideration of surrogacy as a pathway to parenthood is essential considering issues such as maternal-fetal bonding and the needs of newborn babies for connection with the birth mother. While the Commission cites legal and discursive trends in the UK and Canada as supportive of its proposed approach, we note that discussion and practice in Nordic countries known for prioritising women's and children's health diverges considerably with bans on surrogacy in place.

   If surrogacy takes place in Aotearoa New Zealand, AWHC favours an approach that truly centralises the interests of the child, involving a requirement for shared parenting practices with terms developed as part of a comprehensive and ongoing process e.g., that provided by ECART or similar. Such processes must have an explicit directive to make the wellbeing, needs and interests of newborn babies and children paramount by involving the surrogate in the child's care.

3. **The Commission gives insufficient analytical attention to the differences between traditional and gestational surrogacy and in particular the increased risk that surrogacy involving IVF poses to the wellbeing of children and surrogates.**

   Children conceived by IVF are more likely to suffer from health issues such as higher blood pressure, adiposity, glucose levels, and more generalised vascular dysfunction than children conceived naturally. These effects seem to be related to the IVF procedure itself rather than to underlying subfertility. IVF is overused and underregulated globally, and has evolved in many parts of the world as a profit generating industry that values the money brought in by immediate gains of pregnancy and live birth over long term considerations about the health of the mothers and children. We support the judicious use of ***traditional***

surrogacy over gestational surrogacy in Aotearoa New Zealand. We can see no inherent reason why intending parents should require that the child be conceived using the egg of the intended mother. We support the establishment of new and creative family forms that prioritise the needs and interests of the child, reduce the risks to the surrogate and child, and promote full and thorough informed consent.

4. **The Commission's supposition that reform could usefully increase the pool of potential gestational surrogates in Aotearoa New Zealand is wholly inappropriate given the complexity of surrogacy situations, and physical and emotional risks to women.**

   If discouraging New Zealanders from entering surrogacy arrangements overseas is desirable, then this must be achieved by some other means. Such intervention should not put the health of New Zealand women and children at risk or play in to limited and potentially oppressive understandings of 'family' and 'parent/ motherhood'.

   The Commission's reliance on UK studies and Aotearoa New Zealand popular opinion surveys to assess the risks and acceptability of surrogacy for Aotearoa New Zealand women is inadequate. The AWHC is concerned that the perspectives of women who are, have been or are considering being surrogates have been missing from public discussion in Aotearoa New Zealand thus far. In relying heavily on the results of public opinion surveys in New Zealand the Commission appears to have slipped into the fallacy that what has been normalised (i.e. engagement in ART) in a social context is acceptable. Little research on the actual experiences of surrogacy has been carried out in Aotearoa New Zealand – this is an oversight which must be urgently corrected if all parties are to be adequately protected.

Background to the Auckland Women's Health Council

The AWHC is a feminist organisation founded 33 years ago (July 1988) just before the release of '*The Cartwright Report'*. AWHC has a special interest in patient rights, informed consent and decision-making in health care, health consumer advocacy, and the Code of Health and Disability Services Consumers' Rights.

Our vision is that all women have agency over their physical, mental, emotional and spiritual well-being and are fully informed of health services available and have access to them. Our priorities include that:

- Women have the right to make informed decisions regarding their own health care and treatment.
- Women participate in all decision-making processes for health care services.
- Women have accessible, affordable, available, and accountable health care services.

Subsequent to the Cartwright Inquiry, the AWHC played a significant role in assisting with the establishment of the National Cervical Screening Programme and in monitoring the implementation of many of the other recommendations contained in the Cartwright Report. One of our founding members was involved in several of the working groups set up following the release of the Cartwright Report and was appointed as the first patient advocate at National Women's Hospital. Subsequently, AWHC made submissions on the Health and Disability Commissioner Act 1994, then once the legislation was passed and the first Health and Disability Commissioner appointed, we made submissions and participated in consultation meetings that occurred during the development of the Code of Rights.

Over the last three decades we have been active in advocating for upholding patient/consumer rights, including making formal submissions on a wide range of health topics, such as the legislation and regulations governing various health and disability services, and in consumer representation roles relating to health and disability services.

The Law Commission's Issues Paper

The Commission proposes six guiding principles for surrogacy law reform:

1. The best interests of the surrogate-born child should be paramount.
2. Surrogacy law should respect the autonomy of consenting adults in their private lives.
3. Effective regulatory safeguards must be in place.
4. Parties should have early clarity and certainty about their rights and obligations.
5. Intended parents should be supported to enter surrogacy arrangements in Aotearoa New Zealand rather than offshore.
6. Surrogacy law should enable Māori to act in accordance with tikanga and promote responsible kāwanatanga that facilitates tino rangatiratanga.

The Commission also proposes a new legal framework to provide for the recognition of the intended parents as the legal parents of a surrogate-born child, via two alternative pathways to legal parenthood:

- Pathway 1 would apply when the surrogacy arrangement was approved by ECART. The intended parents would be recognised as the legal parents of the surrogate-born child by operation of law, without the need for a court order, provided the surrogate confirms her consent after the baby is born.
- Pathway 2 would apply whenever Pathway 1 does not apply. It would allow intended parents to apply to the Family Court after the child is born for an order recognising them as the child's legal parents.

Our Submission

1. The Commission's focus on 'respecting the autonomy' of individuals is an oversimplification of complex social, medical, ethical, biological, and genetic relations that are brought into play in surrogacy situations.

Key issues elided by this framing include harmful societal discourse promoting 'family at any cost' and pro-natal ideologies, biological parenthood, e.g. maternal-fetal bonding and the needs of newborn babies, and the significant risks to both women and children associated with surrogacy involving IVF. These issues mean that surrogacy can begin and end very differently, in ways that affect the 'intentions' and expectations of the parties and which cannot be predicted when the arrangement is first entered into. As Rhonda Shaw argues, surrogacy is much more than a legal or contractual issue (Shaw, 2020). The Commission appears to have slipped into the fallacy that what has been normalised (i.e. engagement in ART) in a social context is acceptable. The complexity and potentially fraught nature of surrogacy situations demands a more nuanced and flexible approach: "to accommodate multiple pathways to family formation without jeopardising cultural and situational diversity."(Shaw, 2020)

Decisions taken regarding fertility/infertility are intertwined with the cultural and moral environment in which people live. In Aotearoa New Zealand, ART and the relentless pursuit of parenthood have become normalised in ways that can cause people experiencing infertility great distress (Payne & Goedeke, 2009). New Zealand women may have the in-grained expectation that they will be mothers from a very young age (Walker, 2011). This environment continues to place undue pressure on couples (and particularly on women) to have children. For example, women accessing fertility treatment in one UK study described how they were driven by painful normative expectations surrounding fertility and reproductive success beginning in childhood, e.g. that "the ability to have a child was one of the "givens" I'd grew up with", how there continues to be a lack of social support for any families differing from "the 'ideal' family unit" and the social imperative of "leaving a genetic mark" (women experiencing infertility quoted by Cunningham & Cunningham, 2013).

Childlessness continues to be stigmatised in ways that discredit individuals (particularly women) and has a future negative impact on people's sense of identity and development, for example, as an adult, spouse and working colleague (Greil, Shreffler, Johnson, McQuillan, & Slauson-Blevins, 2013; Passet-Wittig & Greil, 2021; Slade, O'Neill, Simpson, & Lashen, 2007). We question the possibility of any straightforward choice for surrogates and intending parents to engage in surrogacy under these circumstances. Surrogacy law reform and practice must be supported by broader public reflection on the culture of 'parents at any cost' and the use of children as a tool for the satisfaction of adults' desire for parenthood, self-fulfillment, and self-determination (see for example, Bandelli, 2019). Such discussion is not evident in media coverage of Aotearoa New Zealand surrogacy law reform to date and would need to be explicitly prompted via a public health campaign.

2. **Any legal severing of relationship between the surrogate and child is incompatible with the best interests of the surrogate-born child.**

> *"When considering the interaction of surrogacy with both the best interests and the rights of infants it is necessary to consider surrogacy from an infant's perspective. This is because if surrogacy is examined only from adults' point of view it is far too easy to confuse a baby's interests with the empowered interests of adults who may be blinded by their own emotions, desperations and ideologies."* (Australian lawyer, adoptee and adoptee rights activist Dr Catherine Lynch in her submission to the Australian government on surrogacy law reform)

In law it is often stated that when children are involved then the 'best interests of the child are paramount.' This means that the consideration of the interests of the adult parties is not to be a balancing act but should be subordinated to the interests of the child. Furthermore, Aotearoa New Zealand is a signatory to the Convention on the Rights of the Child and so is expected to consider the rights of children when considering legislation concerning them. Under the Declaration a child "of tender years shall not, save in exceptional circumstances, be separated from his mother," and under the Convention a child has, "as far as possible, the right to know and be cared for by his or her parents." Therefore, in any consideration of surrogacy law it is imperative that the interests and rights of the child be established and protected, particularly the interests and rights of newborn infants. This is the stage in the life of a human being outside the womb when they are at their most vulnerable and are therefore most deserving of adult empathy, compassion, and care.

While the Commission cites legal and discursive trends in the UK and Canada as supportive of its proposed approach, we note that discussion and practice in Nordic countries known for prioritising women's and child health diverges. For example, Finland, a Northern European country with globally high-ranking reproductive healthcare, banned surrogacy in 2007 and continues to view the practice as "problematic to human dignity" (Eriksson, 2021). A Swedish government inquiry conducted in 2016 concluded that both altruistic and commercial surrogacy (currently illegal in Swedish healthcare) should be officially discouraged in Sweden. Justice Eva Wendel Rosberg has said that "The most important reason we do not want to allow surrogacy in Sweden is the risk of women facing pressure to become surrogate mothers. It is a big commitment, and it involves the risks associated with becoming pregnant and giving birth." (SVT Nyheter, 2016) She also says that the government should prevent Swedes from going to IVF clinics abroad to recruit surrogate mothers for this same reason. She observes (and we concur) that there are still many unknowns about surrogacy; women can be subjected to social and financial pressure to enter a surrogacy arrangement (whether altruistic or commercial), and little is known about how it affects the children themselves. Lastly, the Swedish inquiry found that legislating for altruistic arrangements had no effect on commercial surrogacy, and that women may still receive secret payment under the guise of altruism, or be pressured to become a surrogate.

AWHC holds that critical consideration of surrogacy as a pathway to parenthood is essential considering issues such as maternal-fetal bonding and the needs of newborn babies. We note that Germany also bans surrogacy entirely, placing a high importance on maternal-fetal bonding during pregnancy and considers this bond necessary to child wellbeing and successful parenthood. In Australia, Jessica Kern, herself a child born via surrogacy, has similarly critiqued the practice:

"We have so much evidence in the adoption communities that its detrimental to a child to separate them from their biology unless it's a necessity, but then we turn around and do it intentionally in this arena and we're supposed to be grateful…"

The surrogate-born child has a powerful interest in close contact with the birth mother, due to the embodiment and shared experiences of pregnancy, birth, and post-partum process between the birth mother and baby. These experiences mean that the birth mother is the biological mother of the child regardless of genetic link. A newborn baby's need for their birth mother is instinctive and innate, e.g. Dr Catherine Lynch (medical sociologist and adoptee advocate) has stated that: "every aspect, every cell, every desire of that neonate, is geared toward being on the body of the gestational mother, to suckle and seek comfort and safety" (Lynch, 2017). Newborn babies recognise and are calmed by their birth mothers' voice and heart rate. The health promoting effects of skin-to-skin bonding between birth mother and the baby are well documented, similarly access to the nutrient- and antibody rich colostrum and breastmilk produced by the birth mother and therefore specifically tailored to the child's physiology – see Adeline Allen's cogent discussion of these issues in her (2018) paper 'Surrogacy and limitations to freedom of contract: Toward being more fully human' published in the *Harvard Journal of Law and Public Policy*.

This year, the WHO endorsed new research showing that 'kangaroo mother care', which involves skin-to-skin contact and exclusive breastfeeding immediately after birth, dramatically improves a premature or low birthweight baby's chances of survival (WHO, 2021). Kangaroo care is highly relevant to surrogacy involving IVF, which results in 50-70% additional risk of preterm birth and congenital malformations (Kamphuis, Bhattacharya, Van Der Veen, Mol, & Templeton, 2014).

AWHC holds that even if the birth mother lacks an emotional bond with the baby, but the baby bonds with her, prioritising the wellbeing of the child still requires the birth mother to have a key role in the infant's life. Regardless of her 'intention', the growing science of epigenetics shows how the child is quite literally a part of the birth mother long after she has carried them in her womb and given birth. Oxytocin, a hormone present in higher quantities in pregnancy and released in labor and birth to promote bonding between mother and newborn child, is held to "imprint the baby on the mother, and the mother on the baby". Fascinatingly, scientists have also found DNA from male babies on their mothers' brains—potentially remaining there for life.

Additionally, research into the gut microbiome of vaginally delivered and Caesarean babies has found that newborn vaginally delivered babies are largely colonised by maternal bacterial communities (Tasnim et al. 2020). Podlesney and Fricke (2021) found that the largest fraction of the neonatal fecal microbiota of vaginally delivered infants were from transmitted strains from the maternal gut. Maternally transferred strains largely persisted through childhood and Podlesney and Fricke found that there was "potential life-long colonisation with maternally transferred strains". This shows a strong and persistent biological connection between birth mother and baby irrespective of any genetic relationship.

Given the above, AWHC favors an approach which truly centralises the interests of the child, involving shared parenting practices with terms developed as part of a comprehensive and ongoing process, e.g. that provided by ECART or similar. Such processes must have an explicit directive to make the wellbeing, needs and interests of newborn babies and children paramount.

3. The Commission gives insufficient analytical attention to the differences between traditional and gestational surrogacy and, in particular, the increased risk surrogacy involving IVF poses to the wellbeing of children and surrogates.

Recent analysis published in the *BMJ* shows that single embryo transfer, which involves extended embryo culture and transfer of a blastocyst, is associated with a 50-70% additional risk of preterm birth and congenital malformations (Kamphuis, Bhattacharya, Van Der Veen, Mol, & Templeton, 2014). These authors express concern about the long-term health of children born through IVF: otherwise healthy children conceived by IVF

appear to have higher blood pressure, adiposity, glucose levels, and more generalised vascular dysfunction than children conceived naturally. These effects seem to be related to the IVF procedure itself rather than to underlying subfertility. They conclude that IVF is overused and underregulated globally and that:

> *IVF has evolved in many parts of the world as a profit generating industry that values the money brought in by immediate gains of pregnancy and live birth over long term considerations about the health of the mothers and children... We owe it to all subfertile couples and their potential children to use IVF judiciously and to ensure that we are first doing no harm. (Kamphuis et al., 2014)*

Given the above, we support the judicious use of ***traditional*** surrogacy over gestational surrogacy in Aotearoa New Zealand. We can see no inherent reason why intending parents should require that the child be conceived using the egg of the intended mother. We support the establishment of new and creative family forms that prioritise the needs and interests of the child, reduce the risks to the surrogate and child, promote full and thorough informed consent while simultaneously addressing harmful societal discourse promoting 'family at any cost'.

4. **The Commission's supposition that reform could usefully increase the pool of potential gestational surrogates in Aotearoa New Zealand is wholly inappropriate given the complexity of surrogacy situations, and risks to women.**

If discouraging New Zealanders from entering surrogacy arrangements overseas is desirable, then this must be achieved by some other means. Such intervention should not put the health of Aotearoa New Zealand women and children at risk or play in to limited and potentially oppressive understandings of 'family' and 'parent/ motherhood'.

For example, the Commission relies almost solely on the findings of one UK study (the 'Cambridge Study') when asserting that surrogates' experiences are generally positive. Surrogacy involves the deliberate dislocation of the relationship between the surrogate/birth mother and the child, to reinforce normative legal family structures. The experiences of some Canadian surrogates highlight some of the emotional risks that surrogates may face, e.g. women can experience a sense of alienation from themselves, the intended parents and the child caused by fear of developing a connection with the child. Terms such as "a host", "a custodian", "an oven", and "a baby sitter" were noted in the comments in which participants described their role was to "babysit an embryo until he/she was ready to meet their parents". One woman referenced her fear of being seen as a "creepy tummy mommy":

> *"I want my intended mother to be the mother 100%. Not 99% with some creepy "tummy mommy" or "birth mother" as part of the kids' lives. No, the mother deserves to be the one and only because she is the one and only. I know I'm already taking away something that she would have killed to do." (surrogate quoted in Yee, Hemalal, & Librach, 2020)*

An ongoing quality relationship between surrogates and intended families has been found to play a crucial role in positive surrogacy experiences (Fisher, 2013). In further studies originating from the UK, many surrogates (over 40%) report feeling a 'special bond' with the child regardless of genetic links (Jadva, Murray, Lycett, MacCallum, & Golombok, 2003). Recent engagement with 184 Canadian women who had past or current experience of gestational surrogacy showed that positive and fulfilling surrogacy experiences were connected to maintaining connection with the family they helped to create: bearing witness to the intended parents' joy, happiness, love and gratitude as well as becoming good friends, 'extended family' and feeling part of a life-long relationship (Yee et al., 2020). While initial regular contact with intended families could be easy to maintain, some surrogates have reported difficulty in keeping this relationship going longer term, either through reluctance on the part of intending parents or a fear of overstepping boundaries or 'getting in the way' (Imrie & Jadva, 2014). Surrogates have linked their ill-health and psychological distress to intended parents who are

overbearing and invasive, being blamed for pregnancy or birth complications, a lack of respect for the surrogate's important role regarding the child, poor communication and a sense of 'being used':

> *"At first, I felt like we were friends, and this was going to be a wonderful journey. As soon as I was pregnant, it was all about the baby. … Furthermore, they put so much stress and anxiety on me that I ended up with hypertension and migraines throughout the pregnancy."(surrogate quoted in Yee et al., 2020)*

The AWHC is concerned that the perspectives of women who are, have been or are considering being surrogates have been missing from public discussion in Aotearoa New Zealand thus far. We support Rhonda Shaw's sociological analysis of research findings relevant to surrogacy in Aotearoa New Zealand and her conclusion that:

> *"More empirical research, documenting qualitative information from participants and service users occupying different perspectives in this domain, needs to be undertaken. Alongside surrogates and intended parents, the voices of donor-conceived persons, counsellors, psychologists and social scientists need to be heard in these debates."(Shaw, 2020)*

In the current debate, the rights of the intending parents to legal parenthood have been explicitly stressed – but not their obligations – this focus adds to the marginalising of both the child and the surrogates' rights while retaining emphasis on the surrogate's obligations. The Commission notes that some surveys of Aotearoa New Zealand public opinion on surrogacy have been conducted and, in our view, gives the views expressed by those not directly affected by the issue far too much weight. Little research on the actual experiences of surrogacy has been carried out in Aotearoa New Zealand – this is an oversight which must be urgently corrected if all parties are to be adequately protected.

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