To investigate the risks and benefits for infertile Australian families considering accessing Cross Border Surrogacy

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Signed,

Narelle Dickinson
Clinical and Health Psychologist, Fertility Counsellor
2015 Churchill Fellow
Dated 20/4/16
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INTRODUCTION

The purpose of the fellowship was to investigate surrogacy models of in a number of international locations utilised by infertile Australians. Although surrogacy is now legal throughout Australia, recent research has suggested that the number of Australians travelling overseas for surrogacy arrangements outweighs those who access domestic arrangements by approximately 9:1. Despite the significant numbers of families now accessing Cross Border Surrogacy (CBS), presently estimated at around 300 successful arrangements per year, Australian Intending Parents (IPs) have relatively limited access to reliable and unbiased information about the risks and implications of accessing surrogacy overseas.

This Fellowship has broadened the base of information available for families contemplating CBS by directly examining the legal, social, psychological, logistical, ethical and financial implications in countries where surrogacy arrangements are accessed by Australian IPs.

The Fellowship has increased the information available about the implications of CBS to families, directly through contact with media and online publication, and indirectly through the professional development of fertility counsellor and other fertility service providers. This report differs from the existing surrogacy literature, as it is includes direct discussion with service providers and observation of the treatment processes in each of the visited localities. My previous experience as a psychologist providing implications counselling for IPs contemplating surrogacy gave me an opportunity to directly examine:

- the laws and logistics of surrogacy
- the reproductive technology services used
- the cost of services
- the ethical and psychosocial considerations,

and thereby consider the implications for Australian families undertaking surrogacy overseas.

The primary goals of this fellowship were:

1. To provide an information and support resource for Australians contemplating surrogacy services, (either domestically or internationally) which will assist IPs to make better informed and decision about their surrogacy treatment options. Access to comprehensive and accurate information which can:
   - assist IPs to choose the legally, medically and emotionally safest treatment options for themselves
   - increase the physical, ethical and emotional protections for children who will be born as a result of surrogacy
   - reduce the risk of harm or exploitation for women agreeing to undertake surrogacy pregnancies.

2. To disseminate information to other fertility counsellors so they also have access to accurate and current information about surrogacy services overseas, and are therefore better able to also provide psycho-educative and support services to potential IPs, and help them to make informed decisions about where they plan to establish their surrogacy arrangements.
3. To influence legislative and policy change processes surrounding surrogacy. In late 2015, the Australian Federal Government announced a Parliamentary Inquiry into Surrogacy Services through the House of Representatives Standing Committee into Social Policy and Legal Affairs. The first outcome of my fellowship was to provide a submission to this inquiry based on my findings. I will continue to contribute to policy and legislative change processes as a result of the Fellowship experience. The Fellowship provided an opportunity for me to gather information and professional perspectives which are free from personal or material conflict of interest. I can provide a professional and impartial perspective, which accounts for the physical, emotional, financial, ethical and legal wellbeing of all parties involved in a surrogacy arrangement.

I wish to acknowledge:

- The Winston Churchill Memorial Trust for providing me with an opportunity to undertake this research and travel to the places currently utilised by Australians to access surrogacy arrangements. This has without doubt been a once in a lifetime opportunity to travel and undertake this research, and there is no possible way that I could have undertaken this journey without the support of the Winston Churchill Trust. I would specifically like to thank and acknowledge the Queensland Selection Committee for determining that the project was worthy and that I was a suitable candidate to receive a Churchill Fellowship: I am truly honoured.

- The support of my referees Kate Bourne, President of Australia and New Zealand Infertility Counsellors Association (ANZICA) and Stephen Page. I also acknowledge that support of Stephen Fleming in providing a reference in support of the Project.

- My husband and children for giving me the support to take seven weeks out of our normal lives and undertake this incredible experience.

- Dr Fiona Hawthorne (President of the Churchill Fellowship Association of Queensland) for her insights and guidance during the development of my Fellowship Project.

- Each of the people and organisations who agreed to meet with me during the project, and those who took time to meet with me by Skype or telephone before/during/after my travel when I was unable to arrange a face-to-face meeting.

- The families I meet within the context of my work who continue to drive themselves towards their dream of commencing/continuing a family, despite the various infertility challenges they have faced. I admire your courage and tenacity and I do hope that the project helps to make the journey towards parenthood an easier one for future families dealing with infertility.
EXECUTIVE SUMMARY

Narelle Dickinson
Clinical and Health Psychologist and Infertility Counsellor
Mobile contact: 0407118969

“To investigate the risks and benefits for infertile Australian families considering accessing Cross Border Surrogacy”

A highlight of my trip was the opportunity to meet some of the “big names” of fertility counselling in the USA. These women are amongst the top researchers and clinicians working in fertility counselling. I was stunned by their graciousness in making time for me, often at quite short notice. Particular thanks to Hilary Hanafin (Los Angeles), Dr Angela Lawson (Chicago), Dr Alice Domar (Boston) and Dr Andrea Braverman (Philadelphia), for sharing their expert knowledge and perspectives as well as their professional connections.

My visit to Boston provided another highlight when I was given an in-depth insight into the practices and processes at Circle Surrogacy, one of the largest surrogacy agencies in the USA. Staff from each facet of the organisation made the time to discuss the intricacies of patient assessment/management, escrow accounts, legal processes, and fee structures (including medical insurance). Circle Surrogacy also shared information about their ancillary programs, such as their egg donation program, and the Special Program of Assisted Reproduction service which facilitates surrogacy for HIV positive (Intending Parents (IPs)).

Key Fellowship Conclusions

- Surrogacy services are inextricably linked to egg, sperm and embryo donation services. It is impossible to properly examine CBS without a concurrent examination of donor practices.
- Counselling professionals working in surrogacy must understand the legal, medical, logistical and emotional aspects of undertaking a surrogacy arrangement both within Australia and overseas. Fertility counsellors must have capacity to prepare IPs with current and accurate information about surrogacy in Australia and overseas, provide appropriate and unbiased counselling and support ethical and safe decision making.
- Regular psychosocial counselling or “checkins” provided during the surrogacy arrangement can facilitate healthy and successful relationships between IPs and surrogates, and ensure that all parties are coping with the surrogacy.
- IPs should be provided with sufficient opportunity to undertake a domestic surrogacy arrangement, within the Australian regulatory framework. IPs and surrogates contemplating involvement in domestic surrogacy must have access to clear and comprehensive information to enable a fully reasoned decision about the process of the arrangement.
- Current Australian legislative frameworks provide insufficient and inconsistent protection for the parties involved in domestic or cross border surrogacy arrangements. Legislative change is imperative for the wellbeing of IPs, surrogates and the children who will be born from surrogacy. Regulatory reform is necessary to ensure sufficient surrogates are available domestically to meet a rapidly growing demand for surrogacy arrangements. Legislative frameworks must be consistent across Australia. Medicare funding for domestic surrogacy would increase affordability.
- CBS is a potentially unsafe form of fertility treatment: medically, ethically, psychologically and legally. For IPs who determine that they wish to engage in a cross border arrangement, it is critical that access to impartial support and advice services is available, to examine the risks of travelling overseas for surrogacy. IPs must be given sufficient information about the various CBS options, so if they do choose to engage in a cross border arrangement, they select a country which has clear regulatory frameworks which are protective of themselves and their surrogates, and is provided within treatment practices consistent with what would be offered in Australia.

- Multiple models of surrogacy exist internationally, each contributing different protections to surrogacy arrangements. Commercial surrogacy arrangements can be successfully managed without necessarily resulting in exploitation of, or harm to the involved parties. It is possible for Australians to engage in Cross Border Surrogacy (CBS) in a manner consistent with Reproductive Technologies Accreditation Council guidelines and current Australian Assisted Reproductive Technology practices.
- All surrogacy arrangements must first and foremost be designed to protect the wellbeing and interests of the child to be born through surrogacy.
# PROGRAMME

## UNITED STATES OF AMERICA

<table>
<thead>
<tr>
<th>State</th>
<th>Location</th>
<th>Name</th>
<th>Position</th>
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<tbody>
<tr>
<td>California</td>
<td>Los Angeles and Santa Barbara</td>
<td>Hilary Hanafin</td>
<td>Chief Counsellor - Center For Surrogate Parenting, Inc. (Surrogacy and Donor Agency)</td>
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<tr>
<td></td>
<td></td>
<td>Andrew Vorzimer</td>
<td>Partner - Vorzimer/Masserman Fertility &amp; Family Law Center</td>
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<tr>
<td></td>
<td></td>
<td>Robin Newman</td>
<td>Director -Global Egg Donors (Egg donor agency)</td>
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<tr>
<td></td>
<td></td>
<td>Andrea Bryman</td>
<td>Marriage and Family Therapist, Clinical Psychologist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dr Michael Feinman</td>
<td>Fertility Specialist/Associate Clinical Professor, HRC Fertility Clinic (Surrogacy and Donor agency)</td>
</tr>
<tr>
<td>Illinois</td>
<td>Chicago</td>
<td>Nidhi Desai</td>
<td>Partner - Ballard, Desai and Miller Attorneys</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nancy Block</td>
<td>Vice President of International and Major Client Relations, Fertility Source Companies (Surrogacy and donor agency)</td>
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<tr>
<td></td>
<td></td>
<td>Robin von Halle</td>
<td>Partners - Alternative Reproductive Resources (Surrogacy and Donor agency)</td>
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<tr>
<td></td>
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<td>Mary Ellen McLaughlin</td>
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<td>Antonia Granados</td>
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<td></td>
<td>Dr Brian Kaplan</td>
<td>Fertility Specialists, Fertility Centre of Illinois (Surrogacy and Donor agency)</td>
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<tr>
<td></td>
<td></td>
<td>Dr Nickey Pappas</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Dr Angela Lawson</td>
<td>Clinical Psychologist, Northwestern Memorial Hospital</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>Boston</td>
<td>Circle Surrogacy - various staff</td>
<td>Circle Surrogacy (Surrogacy and Donor agency)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dr Alice Domar</td>
<td>Executive Director of the Domar Center for Mind/Body Health, Associate Professor at Harvard Medical School</td>
</tr>
<tr>
<td>Pennsilvania</td>
<td>Philadelphia</td>
<td>Dr Andrea Braverman</td>
<td>Clinical Associate Professor of Psychiatry, Thomas Jefferson University, Philadelphia</td>
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## RUSSIA
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<tr>
<th>Location</th>
<th>Contacts</th>
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<tr>
<td>St. Petersburg</td>
<td>Professor Vladislav Korsak, Dr Elvira Isakova, Sergei Napthepcknk, Olga Shcherbakova, Taisiya Averina</td>
</tr>
<tr>
<td>Moscow</td>
<td>Multiple staff REPRIO surrogacy agency - Moscow</td>
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<td></td>
<td>Staff member NOVA Clinic - Moscow (Fertility Service)</td>
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<tr>
<td></td>
<td>Staff Member (by Skype) New Life Surrogacy Agency - Ukraine</td>
</tr>
<tr>
<td></td>
<td>Staff Member (by Skype) New Life Surrogacy Agency - Georgia</td>
</tr>
<tr>
<td>INDIA</td>
<td>Poonam Jain Director - International Star Assistance (Consultancy Evacuation, Repatriation, and Apostille Service)</td>
</tr>
<tr>
<td></td>
<td>Sonia Arora Director - New Life Delhi (Surrogacy, Donor and Fertility Service)</td>
</tr>
<tr>
<td>CAMBODIA</td>
<td>TRIP TO CAMBODIA CANCELLED AT LAST MINUTE DUE TO POOR HEALTH. No meetings, however background research and initial correspondence with Cambodian clinics was undertaken</td>
</tr>
<tr>
<td>MEXICO</td>
<td>TRIP TO MEXICO CANCELLED DUE TO CONCERNS FOR PHYSICAL SAFETY. No meetings, however, a number of Skype discussions were undertaken in November/December 2015, in preparation for the Fellowship, and background research was undertaken</td>
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MAIN REPORT

Background to Cross Border Surrogacy

Third Party Reproduction is the overarching phrase used to describe fertility treatments involving egg, sperm and embryo donation, and surrogacy. This may involve eggs, sperm, or embryos that have been donated by a third person (the donor) to enable an infertile individual or couple (the intended recipient) to become parents. Donors may be either known or anonymous to the intended recipient. Third-party reproduction also encompasses the practice of surrogacy.

Surrogacy is commonly defined as an arrangement where a woman (generally known as the surrogate, or gestational carrier) carries a pregnancy for a third party (commonly known as the Intending Parent or “IP”), with the express intention of giving up all parental and custody rights to the resulting child(ren). Surrogacy arrangements may be:

1) traditional, where the surrogate carries a child using her own eggs (fertilised with sperm from either the IP father or a third-party donor), or

2) gestational, where the surrogate is implanted with an embryo created from the eggs and sperm of the intended mother and father and/or gametes obtained from third-party donors.

Surrogacy arrangements may result in payment of fees to the surrogate (commercial/compensated surrogacy) or only involve reimbursement of out-of-pocket expenses (altruistic surrogacy). The conception can occur as a result of sexual intercourse, intrauterine insemination or In Vitro Fertilisation (IVF) treatment1.

Although surrogacy has become an accepted component of fertility treatment in many countries, the legislative structures and treatment processes by which it is undertaken varies greatly across different jurisdictions. Some countries permit only altruistic surrogacy, while others have legalised compensated surrogacy. There is considerable debate in regards what is considered to be medically acceptable or socially ethical in the management of a surrogacy arrangement.

The most contentious third party treatment is arguably Cross Border Surrogacy, (CBS) which specifically refers to surrogacy arrangements with an intra-country or international element. This may occur:

1. when an IP enters into a surrogacy agreement in another country

2. if the parties relocate from one jurisdiction which permits surrogacy to another which prohibits it or regulates it differently

3. if the intended parents and the birth mother are located in different jurisdictions.

In almost all instances, cross border arrangements involves compensation (or payment) to the surrogate. Currently, the only countries offering legal

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1 https://www.asrm.org/BOOKLET_Third-party_Reproduction/
compensated surrogacy arrangements for overseas nationals are USA (some states only), Cyprus, Georgia, Russia, Ukraine, Panama and Belarus. A number of other countries, including Laos and Cambodia and some Mexican states are also providing commercial surrogacy arrangements, but this is being undertaken without a clear legal framework. These countries attract IPs from around the world to undertake surrogacy arrangements.

The recent history of cross border surrogacy is characterised by significant upheaval and controversy. The landscape of surrogacy is unpredictable and prone to change, and very few countries have provided surrogacy over the longer term. The past couple of years have been particularly tumultuous in the international surrogacy industry.

There are some locations where CBS has been available longer term and the surrogacy industry has remained relatively stable. The USA had the first legally recognised commercial surrogacy arrangement in the mid-1980's with the famous “Baby M case”, but 30 years later there is still significant variation in surrogacy laws across the 52 US states. Commercial surrogacy programs emerged in Russia in the mid-1990s, and have been legally available since that time, and other countries in that region, including Georgia and Ukraine subsequently legalised surrogacy. Georgia commenced commercial surrogacy programs in 1992, and Ukraine first commenced surrogacy services in 2002. In response to the growing demand for surrogacy, these two countries, have more recently commenced increasingly aggressive marketing, and have rapidly acquired a large client base of foreigners seeking surrogacy.

Other countries have demonstrated far less stable surrogacy service provision. India began undertaking surrogacy arrangements around 2008, and by 2012, the industry was estimated to be generating around AUD$400million per year from domestic and overseas IPs. India had become an extremely popular location for Australian IPs as treatment was reasonably inexpensive and the distance for travel was not excessive. However, in 2013, the Indian Health Ministry announced Draft Legislation which (if enacted) would restrict same sex couples and single people from accessing surrogacy services. The uncertainty created by this caused same sex and single IPs to seek alternative locations to undertake surrogacy. In October 2015, India announced an extension to this draft legislation which would effectively prohibit any foreign national from undertaking surrogacy arrangements. Although this legislation has yet to be enacted by the Indian Government, this most recent draft effectively making India a “no-go” location for any Australian seeking surrogacy.

Clinics in Thailand had also been providing surrogacy services for some years, and Australians had been a significant part of their overseas client market, again due to comparative low costs and ease of travel. However in July 2014, in the aftermath of the now infamous “Baby Gammy” surrogacy case, the Thai Government restricted access to surrogacy services to all foreigners (with limited exceptions). It is understood that some cross border arrangements are continuing, facilitated by “loopholes” in the legislation. Currently, only Thai nationals and their partners can undertake surrogacy, so it has become a practice of some Thai clinics to arrange for the foreign male IP partner (or one of the male partners, in the case of a same sex relationship) to marry the surrogate prior to commencing the surrogacy arrangement. A divorce is arranged once the baby has been delivered and all payments finalised. In the eyes of the Thai government, this practice complies with the new legislation, but obviously this creates significant social and ethical issues. I am uncertain

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1India Seeks to Regulate Its Booming Surrogacy Industry from Reuters Health Information. 30 Sep 2013. By Nita Bhallia and Mansi Thapliyal
of the legal implications of this practice, with respect to future claim by a surrogate for either the child, or additional financial compensation.

After clinics within India were unable to provide surrogacy services to same sex and single IPs, numerous Indian owned and operated clinics established “satellite” services in neighbouring Nepal. After briefly emerging as a popular alternative to India, in late 2015 Nepal abruptly enacted legislation which ended the international surrogacy industry in that country. The Nepalese situation gained particular notoriety, as dozens of families were left in parenting limbo, uncertain whether they would even be able to exit the country with their recently delivered babies. This situation impacted at least 12-15 Australian babies who had been delivered in Nepal but had not yet returned to Australia, and for some weeks it remained unclear if they would be issued exit visas for the infants. The Nepalese Government eventually made further changes that clarified the legal situate of affected families, and at time of writing, babies were still being delivered to IPs who had commenced their Nepalese surrogacy arrangements but no new arrangements were permitted to commence.

In December 2015, Mexico enacted legislation to prevent foreign nationals from undertaking surrogacy arrangements there. Prior to this, surrogacy had been occurring in Tabasco State and had made Mexico a very popular low-cost alternative to treatment for American citizens. Following implementation of restrictions to surrogacy services in India and Thailand, Mexico had rapidly become popular for a range of other foreign nationals, as there were no restrictions on eligibility for the IP on the basis of sexuality or marital status. Numerous surrogacy arrangements had been commenced by Australians prior to the legislative change. Surrogacy arrangements for foreign nationals are now completely prohibited in Mexico, but it is understood that some cross border arrangements are continuing, illegally.

A number of other countries have emerged as popular destinations to undertake surrogacy arrangements. Cyprus, Belarus and Panama are now offering commercial surrogacy services, and in the past 12 - 18 months, Laos and Cambodia have begun providing commercial surrogacy, particularly to IPs from the Asia region. The rapidly increasing popularity of these countries for surrogacy has largely been due to their capacity to offer services much more cheaply than USA or even Russia. Like India, Thailand and Mexico, these counties offer services that cost much less, but carry diverse social and political issues (including economic unrest, political upheaval and war) that impact the capacity to offer safe and ethical arrangements. Many of these countries, particularly Laos and Cambodia, are quite inexperienced in providing fertility services, and operate within extremely questionable ethical and legal frameworks.

This background is important, as it highlights the complexity and risks of planning and undertaking a CBS arrangement in an atmosphere of upheaval and unpredictability. In most cases, a minimum of 12 months is necessary to progress from commencement of a surrogacy arrangement, to the point that an IP could expect to bring a baby home. If treatment is not immediately successful, the period of time might be far greater. The potential for instability in CBS is significant for the impact it has on IPs and their children.

**Reasons Australians seek Cross Border Surrogacy**

With surrogacy legal throughout Australia (excluding NT), and with such clear risks attached to seeking surrogacy overseas, it might be asked why any Australian would consider undertaking a CBS arrangement. The answer is
complex, but research\textsuperscript{3} suggests that IPs seek CBS arrangements over domestic surrogacy for four key reasons:

1. There is a perception of limited or no suitable surrogates in the IP’s home country. In Australia it is frequently stated that there is a lack of suitable surrogates to meet IP demand and IPs consistently state that it is excessively difficult to find suitable candidates. Certainly the restrictions on compensation for surrogates and the prohibition on advertising for surrogacy appear to play a significant role in this. Unless the IP is fortunate to have a suitably aged and gravid woman either in her family or social group, finding a woman who is prepared to carry a surrogate pregnancy for purely altruistic reasons is often difficult. The experience of countries which prohibit commercial surrogacy (such as Australia, Canada and the UK) has clearly demonstrated that there are indeed women who are prepared to act altruistically, and even for IPs who were not previously known to them. However the number of these women appears to be reasonably low, and being able to find such a person, without the capacity to publicly advertise, can be extraordinarily difficult.

\textit{Ad hoc} experience in Australian surrogacy counselling has indicated that when IPs are not able to find a suitable and willing surrogate within their family or social network, there is a tendency to seek surrogates through “underground” advertising methods such as social networking sites and webpages. This results in quite desperate and vulnerable IPs committing to any surrogate who is prepared to assist them, without necessarily having an opportunity for sound pre-matching processes.

2. There is a common perception that it is less expensive to access surrogacy (and other Assisted Reproductive Technology (ART) services) overseas. In reality, the cost of surrogacy overseas is often far greater than it would be within Australia, although this is highly dependent on the type of fertility treatment required, and which international location is accessed for those who choose to travel. Overseas IVF clinics often make promises of guaranteed success which are highly attractive for IPs who may have had years of fertility failure. The current lack of Medicare assistance for those accessing surrogacy has also resulted in domestic surrogacy being a particularly expensive fertility treatment when undertaken at home.

3. For some IPs there may be a desire to circumvent legislative and practice guideline limits on surrogacy and ART services within Australia or there may be a perception that logistical or legislative processes in Australia are excessively lengthy or complicated. There is often a misperception amongst IPs that they can avoid legislative processes overseas. In reality, IPs may be unprepared for the complex processes which must occur after delivery of the baby. If there has been a lack of opportunity to discuss international surrogacy realities with properly informed and impartial surrogacy professionals in Australia (perhaps due to efforts to keep the intended cross-border surrogacy covert), families may have accepted advice of those with vested/biased

\begin{footnotesize}
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interests and left themselves insufficiently prepared for the reality of managing the process to return to Australia with their baby.

4. For some IPs, there is a desire to keep the fact of the surrogacy, or at least the identity of the surrogate hidden (from the child or from social network). It is inevitable that some families will seek to keep their use of third party reproduction a secret. There are many complex cultural and social issues that are relevant to this. However, with proper counselling and support, it is often possible to explore the anxiety experienced about disclosure and many IPs can be encouraged to consider granting greater openness about their fertility treatment choices. Research indicates that this is in the long term best interest of the resultant children.

A recent study which examined the ART experiences of Australians engaging in CBS arrangements\(^4\) indicated that of heterosexual respondents, 65% had previously engaged with an Australian ART clinic and had already spent an average of 5 - 6 years and over AUD$30,000 undertaking fertility treatment before turning to surrogacy. The mean time spent trying to conceive (naturally and through ART) before considering surrogacy was thus 10 years.

Of the total respondents (heterosexual and same sex), over half of respondents (53%) had considered both overseas and domestic surrogacy. Of those who only considered one option, a significantly higher proportion only considered overseas compensated surrogacy (92% v 8%). 46% of these respondents expressed the view that carrying a child for no reward was unfair.

Of those who did consider uncompensated surrogacy arrangement, a significant proportion did not proceed due to either the perceived length of the process; a concern that accepting a relative or friend’s offer to be a surrogate risked damaging the relationship; the surrogate changed her mind; or a belief that the arrangement was illegal. Of those who commenced with a surrogate in Australia, around 2/3 did so through an ART clinic, and the other 1/3 undertook private, traditional surrogacy arrangements.

In Australia, the provision of all ART services is guided by the Code of Practice of the Reproductive Technologies Accreditation Council (RTAC)\(^5\) and the Ethical Guidelines of the National Health and Medical Research Council (NHMRC)\(^6\). Some states additionally have specific regulation around the conduct of assisted reproduction practice but there is state to state legislative variation in legislation. Surrogacy is the mostly highly regulated of all ART services, and there is significant regulatory complexity for those undertaking a surrogacy arrangement.

There is some general consistency across all Australian states and territories (except NT) regarding the legislation which permits domestic altruistic surrogacy:

- No compensation/payment can be made to a surrogate, although she can have her “reasonable” expenses reimbursed by the IPs (there is state by state variation in what may be reimbursed)
- All states forbid advertising or solicitation for surrogacy

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\(^6\) https://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/e78.pdf
• All IPs and surrogates must be reviewed medically, be at least 25 years of age, obtain legal advice and undertake counselling prior to undertaking a surrogacy arrangement

• Surrogacy arrangements can be either gestational or traditional

• All relevant parties are required to create a Surrogacy Agreement (written or verbal, state dependent) which governs how the surrogacy will be conducted and states the intentions of the surrogate as well as the IPs, however these agreements are not legally binding

• Following the birth of the child, the birth mother is legally viewed as the parent of the child and a birth certificate is initially issued to the surrogate and her partner

• A post birth parentage order must be obtained to establish parentage rights to the IPs.

• It is assumed that in the best interests of the child IPs will inform their child of the surrogacy, and if utilised, the fact of a donor conception.

There are also significant variations between state legislation regarding conduct of surrogacy arrangements. There are differences regarding eligibility of surrogates (generally in regards minimum age and whether she should have already had her own children). There is also variation between states which restrict IP eligibility. Some states specifically limit access to heterosexual couples, and others define medical need for surrogacy in a manner which excludes “social surrogacy”. Table 1 summarises surrogacy legislation in various Australian states.

Variations also exist between states in regards an IP entering into a cross-border surrogacy arrangement. In Queensland, NSW and the ACT it is an offence to access surrogacy overseas. Accessing CBS is not a crime in Victoria, South Australia, Tasmania or Western Australia, however, it can be difficult to obtain a parentage order on return to Australia due to the prohibition on commercial arrangements. The regulatory framework that surrounds CBS is particularly difficult, as legislators must consider both local regulations and international treaty obligations7 (of greatest relevance is Hague Convention on Protection and Co-operation in Respect of Intercountry Adoption8). Despite the restrictions, recent research suggests that around 300 families returned to Australia in 2014 with an overseas surrogate born child, and there is every indication that the numbers of Australians accessing international surrogacy is rapidly growing. Australians are now recognised as one of the highest per capita users of CBS.9

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8 https://www.hcch.net/en/instruments/conventions/full-text/?cid=69
**Learnings and outcomes of the fellowship**

The rapidly changing face of CBS significantly impacted on the planning and execution of this Fellowship. The issues that might be faced by any person considering traveling overseas to undertake a surrogacy arrangement were also encountered during the planning of the Fellowship. A preliminary itinerary had included Thailand, but was altered due to the change to legislation in that country. Subsequent planning included Nepal, however the 2015 earthquake prevented this (due to Australian Department of Foreign Affairs and Trade travel warnings) even prior to the legislation changes in that country being enacted. Travel arrangements for India had been finalised prior to the release of the most recent legislation draft in that country, and it was decided to retain this section of the Fellowship as Indian fertility clinics had demonstrated a history of moving their services extraterritorially. It was hoped that developing relationships with practitioners in that country might provide a sense of future business intentions for those clinics. I only became aware of the changes to legislation in Mexico after my departure from Australia (and only around 36 hours prior to my scheduled arrival in Mexico). At very short notice, it was decided that the travel to Mexico should be cancelled as I received multiple credible reports about potential risk to physical safety in Villahermosa. Other countries where surrogacy is currently available (including Greece, Ukraine and Georgia) were excluded either due to the political and economic upheaval currently facing those countries; an inability to guaranteed safety during travel to these

**Table 1: Summary of surrogacy legislation in Australian states**

<table>
<thead>
<tr>
<th>Category</th>
<th>QLD</th>
<th>NSW</th>
<th>VIC</th>
<th>SA</th>
<th>TAS</th>
<th>WA</th>
<th>ACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial / compensated surrogacy permitted</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>Social reason for surrogacy sufficient (such as same-sex couple)</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>yes</td>
<td>no</td>
<td>yes</td>
</tr>
<tr>
<td>Medical basis for surrogacy required*</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes*</td>
<td>no</td>
</tr>
<tr>
<td>Heterosexual married / defacto couples eligible as IPs</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Homosexual couples or single men eligible as IPs</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>yes</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>Single women eligible</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Surrogate must have had at least one child of her own</td>
<td>no</td>
<td>no</td>
<td>yes</td>
<td>no</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>An offence to enter into cross border surrogacy arrangement</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>yes</td>
</tr>
</tbody>
</table>

**Notes:**
*; age is not considered to be a sufficient medical reason
locations; or it was determined that insufficient information would be obtained to justify inclusion in the Fellowship.

The Fellowship process involved dissuasions with a broad range of individuals and services involved in coordinating and managing surrogacy arrangements regarding the models and processes of surrogacy. I met with mental health professionals, attorneys, IVF specialists, surrogacy agency staff, egg donor agency staff, migration agents and others who work within the surrogacy/donor conception and IVF industries. Unfortunately, clinics and agencies were reluctant to give me access to clients, so there was limited opportunity to speak directly with service users (either IPs or gestational surrogates). However, a number of the staff I spoke with had at some point either acted as egg donors or gestational surrogates, or had used the services of surrogacy agencies themselves as IPs, but their perspectives as service users are clearly influenced by their dual roles as consumers and providers of services.

During my interviews, I was able to build/consolidate collegial networks with a broad range of services and professionals and discussed the state of surrogacy and donor conception in Australia. My position as a Churchill fellow most certainly gave me an opportunity to ask questions frankly and without prejudice.

I explored a broad range of aspects of third party reproduction, with the particular focus on surrogacy. Discussion included (but was not limited to):

- intake/assessment/screening procedures for IPs
- intake/assessment/screening procedures for surrogates
- the “red flags”/“stop signs” during assessment
- ongoing counselling services for IPs and surrogates before, during and after the surrogacy
- trouble shooting processes if problems arise between IPs and surrogates
- special considerations for Australian IPs (i.e. organising arrangements from a distance, different time zones etc)
- the legislative frameworks relevant to each Federal/state/county area, especially in regards to pre/post birth parentage
- implications following the birth (issues such as how long an IP should expect to stay prior to issue of exit visas, birth certificates etc)
- the structure of the surrogacy agency (Who does what, and how this impacts on the IPs and surrogates)
- eligibility criteria for surrogates, common motivations, recruitment methods
- processes if a donor is also required
- capacity for an IP to bring their gametes/embryos from Australia
- processes for transport/donation/destruction of surplus embryos
- function and power of surrogacy arrangements. (including processes if there is a change of mind by either party during the process)
- processes if there are unexpected medical issues with the surrogate or the baby
- embryo management (e.g. number permitted for transfer, gender selection, use of Pre-Implantation Genetic Diagnosis (PGD))
- processes for managing multiple pregnancy (including selective termination)
• processes for management of foetal abnormality/health conditions
• management of altruistic arrangements vs commercial/compensated surrogacy
• capacity for ongoing contact between the surrogate and the IPs
• capacity for ongoing contact between the egg/sperm/embryo donor and the IPs
• treatment costs
• surrogate and donor compensation rates.
UNITED STATES OF AMERICA

The USA leg of the Fellowship encompassed the states of California, Massachusetts, Illinois and Philadelphia. Each of the services that I visited provide services to IPs and surrogates from a variety of USA states as well as numerous overseas locations (including Australia). There are estimates that between 50 - 55% of surrogacy arrangements undertaken in the USA are Cross Border arrangements involving foreign IPs (most commonly originating from France, UK, China, Sweden and Norway.

Australian IPs are estimated to be contracting approximately 4-5% of US surrogacy arrangements. It appears that around 40-45% of IPs are heterosexual couples, around 40% are same sex couples, and the remainder are either same sex or heterosexual single IPs.

There are significant differences in surrogacy practices and legislation in different parts of the USA, but because the USA services provide extraterritorial services, the USA leg of the trip will be viewed as a single entity. Although I met with representatives of more than a dozen different surrogacy agencies and affiliated services (from both the private and university based sectors), I hardly scratched the surface of surrogacy provision in the USA. There are over 150 surrogacy agencies in the USA, with around 60 based in Los Angeles alone, as well as many other professionals who provide consultant services in facilitation of surrogacy arrangements (including solicitors, counsellors and financial management services). In addition to this are 400-500 ART clinics who are available to manage the medical (IVF) aspects of surrogacy and (where necessary) donor services.

ART service providers in the USA have oversight from the American Society of Reproductive Medicine (ASRM), and a number of specific guidelines have been developed to guide the practice of clinics, agencies and professionals10111213.

However, the ASRM provides guidance only, and the practice of surrogacy service providers is governed by regulation only in a minority of states. It is generally acknowledged that there are 4 states with highly favourable surrogacy legislation (the most favourable of which is universally considered to be California), and only about six states where surrogacy is expressly prohibited.

Surrogacy arrangements are commonly undertaken in a number of other US states, with varying levels of legislative support or restriction. Surrogates, IPs and service providers are frequently located in different states from each other, so management of the varying state regulations can be complex. Table 2 summarises the different regulations for surrogacy across the USA.

11 https://www.asrm.org/uploadedFiles/ASRM_Content/News_and_Publications/Ethics_Committee_Reports_and_Statements/Consideration%20of%20the%20gestational%20carrier2013.pdf
13 https://www.asrm.org/uploadedFiles/ASRM_Content/News_and_Publications/Ethics_Commit tee_Reports_and_Statements/family_members.pdf
Table 2: Summary of surrogacy regulation in USA states.

<table>
<thead>
<tr>
<th>Highly Favourable</th>
<th>Favourable (with conditions)</th>
<th>No state law (however courts are generally favourable toward surrogacy)</th>
<th>Illegal/ Surrogacy arrangements deemed void or unenforceable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arkansas</td>
<td>Alabama</td>
<td>Alaska</td>
<td>Arizona</td>
</tr>
<tr>
<td>California</td>
<td>Connecticut</td>
<td>Colorado</td>
<td>District of Columbia</td>
</tr>
<tr>
<td>Florida</td>
<td>Delaware</td>
<td>Georgia</td>
<td>Indiana</td>
</tr>
<tr>
<td>Illinois</td>
<td>Iowa</td>
<td>Hawaii</td>
<td>Michigan</td>
</tr>
<tr>
<td>Nevada</td>
<td>(married heterosexual couples only)</td>
<td>Idaho</td>
<td>New York</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>Kansas</td>
<td></td>
<td>Nebraksa</td>
</tr>
<tr>
<td>New Jersey</td>
<td>Kentucky</td>
<td></td>
<td></td>
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<tr>
<td>North Dakota</td>
<td>Louisiana</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ohio</td>
<td>Maine</td>
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<td></td>
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<tr>
<td>Oregon</td>
<td>Maryland</td>
<td></td>
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<tr>
<td>Tennessee</td>
<td>Massachusetts</td>
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<tr>
<td>Texas</td>
<td>Minnesota</td>
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<tr>
<td>Utah</td>
<td>Mississippi</td>
<td></td>
<td></td>
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<tr>
<td>Virginia</td>
<td>Missouri</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Washington (uncompensated only)</td>
<td>Montana</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wisconsin</td>
<td>New Mexico</td>
<td></td>
<td></td>
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<tr>
<td>West Virginia</td>
<td>North Carolina</td>
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<tr>
<td></td>
<td>Oklahoma</td>
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<td></td>
<td>Pennsylvania</td>
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<tr>
<td></td>
<td>Rhode Island</td>
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<td></td>
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<tr>
<td></td>
<td>South Carolina</td>
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<td></td>
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<tr>
<td></td>
<td>South Dakota</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vermont</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Wyoming</td>
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<td></td>
</tr>
</tbody>
</table>
Models of surrogacy service provision

The surrogacy system, with its multiple models of service can be incredibly confusing for IPs accustomed to the Australian fertility system. IPs need to spend time understanding the necessary qualities of a surrogacy and/or donor agencies to help them select an agency which will provide ethical and good quality services, and provide guidance to locate appropriate legal, medical and counsellor services. Coming from the Australian surrogacy system, which has no model of surrogacy agencies, the role of an agency can be difficult to appreciate. The fees charged by agencies can be substantial and it is important to know what they might contribute to a surrogacy arrangement to justify this.

Agencies that do their job well can significantly reduce the stress for both IPs and surrogates. Agencies will generally fully screen and approve potential surrogates long before a “match meeting” with an IP, and long before an agreement is drafted. This is very different to the situation in Australia, which necessitates IPs to recruit a potential surrogate, thereby investing emotional energy into that relationship, as well as financial resources into the medical or psychological screening processes, only to be later disappointed that the surrogate is not a suitable candidate, or has changed her mind. An agency conducting this screening prior to matching with a suitable IP can serve to prevent further disappointment to IPs who may be already fatigued by previous attempts at family creation. The work of the agency is also significant in a legislative structure which permits advertising for surrogacy, and therefore increases the number of potential applicants to a surrogacy arrangement. An agency also takes the role of rematching an IP to a new surrogate if for some reason the initial surrogate is unable to proceed (e.g. change of mind, pregnancy loss, change of personal circumstances of the surrogate).

There are basically 4 different models for establishing surrogacy arrangements in the USA, ranging from independent arrangements made between IPs and surrogates, through to a one-stop-shop model of care. The four models are:

1. Independent surrogacy arrangements, where contact is established between IPs and a surrogate without the support of external parties. This may occur between IPs and surrogates with pre-existing relationships (such as family members or friends), or between parties with no pre-existing relationship. Advertising for surrogacy is permitted in the USA, and it is quite usual for IPs to use online classifieds (similar to “Gumtree” or eBay) and many IPs recruit their surrogates through internet forums, social media platforms (e.g. Facebook pages) and blogs. It is estimated that around 20% of surrogacy arrangements in the USA are arranged independently.

2. Small, so called “mom and pop” surrogacy agencies that facilitate surrogacy arrangements. There are many of these small (often single operator) agencies throughout the USA, and generally they have been established by a person who has already been through the process of a surrogacy (either as a surrogate or an IP). As a result of their own surrogacy experience, some individuals feel that they have sufficient acquired and expertise in the facilitation of surrogacy services to be able to assist others, however these individuals generally have no background in medicine, nursing, law or counselling. In reality there is a massive range in the experience and capacity of these agencies. Smaller agencies operated by individuals that don’t belong to a
regulated profession (such as medicine, psychology or law) have no external bodies enforcing their ethical practice. Although the guidelines set by the ASRM do apply to the surrogacy arrangements managed by these agencies, there is no capacity for enforcement of compliance with these best guidelines, and there is no specific regulation which applies to the practice of an agency.

3. Larger surrogacy management agencies, which rely on outsourcing of professional experts to assist with the surrogacy arrangement. The agency provides screening of surrogate candidates, and matching services. There is varying levels of support during the surrogacy and the medical, legal, financial management and psycho-social assessment services are generally outsourced to professionals with specific expertise in surrogacy. This type of agency is often engaged by IPs who have recruited their own surrogate (for example electing to use a friend or family member) but still want assistance in managing the arrangement, or want to maintain “arm’s length” management of the legal, psychological or escrow14 aspects of the surrogacy.

University based fertility and surrogacy clinics generally fall into this model of agency structure, however the vast majority of third party reproduction is undertaken by the privately owned, free standing agencies, who are less restricted by red tape and adhere more to a “free market” model.

The main advantage of this model probably lies in the consumer’s capacity to choose from a range of experts who are autonomous from, but recommended by the surrogacy agency (including counsellors, lawyers etc), but still obtain overarching management support from the agency. The core role of the agency lies in screening potential surrogates, helping an IP to be matched with a suitable surrogate woman and providing support during the surrogacy process. The agency should assist in choosing surrogates who live in “surrogacy-friendly” states, thereby facilitating the eventual parentage transfer.

The main disadvantage of this model is the varying expertise of the dozens of agencies who utilise this structure. It is incredibly difficult for a novice IP or surrogate to discern the capacity of an agency to provide them with adequate support. The model of outsourcing ancillary professionals also has potential drawbacks. It can be difficult for an IP to determine how autonomous from the agency an expert actually is, as in reality they are reliant upon agencies for their referrals (and therefore income), and there is evidence that some agencies maintain quite nepotistic interconnections with these ancillary services. IPs are reliant on agencies to recommend consultant professionals who have demonstrated surrogacy expertise, and this is particularly critical in the selection of solicitors and financial management experts. There is the potential for an agency to have a vested interest in making referrals to a specific solicitor or counsellor, without them necessarily being the most suitable practitioner.

4. “Full-service” agencies which effectively provide a one-stop shop for surrogacy management. These agencies provide all the same services as the third model (described above) but have all ancillary professional

14 A temporary pass through account held by a third party during the process of transaction between two parties
service available “in-house” (and others also available for referral as external providers). This model of service is less common, as it results in a very large and complex organisational structure, but agencies like this generally have substantial experience and capacity to provide safe surrogacy management.

The primary advantage of the full-service model is simplicity for the client in having all aspects of the surrogacy managed within the one organisation. This can be a particularly attractive option for IPs who are travelling to the USA from overseas, as they only need to maintain a single point of contact for the surrogacy. Full service agencies generally have more staff employed and work within team structures, giving increased opportunity for overseas IPs to make contact with the surrogacy agency at more flexible times which may be more convenient to their home time zones.

Possibly the main disadvantage of the larger agencies is the accompanying complex fee structures. Unsurprisingly, increased service generally results in increased costs. Some IPs feel that the fee structure of these larger agencies is unreasonable, and the same outcome will be achieved by a less integrated, cheaper agency.

Larger agencies have the capacity to establish support processes where there is one clear contact for the IPs, and a different, separate contact for the surrogates. Each agency staff member can assess, inform, educate, and advocate for their respective clients (either IP or surrogate). When it is time to match an IP with surrogate candidates, these two individuals can work together to decide who is most congruent in expectations and wishes for the surrogacy arrangement, and negotiate complex issues like location of IPs and surrogates for smooth management of interstate laws. In cases where problems do arise during the surrogacy arrangement, these two separate staff members can act as private supports and advocates and assist in repairing any ruptures which may occur in the surrogacy relationship.

Having an agency involved as intermediary, rather than managing an independent arrangement increases the opportunity for IPs and surrogates to focus on the on their relationship, rather than having to think about the planning of the surrogacy process. Some surrogacy arrangements are undertaken as a "business transaction" between the IP and the surrogate (i.e., the arrangement is established; there is minimal contact made between parties; monies are expended and the baby is collected at the end. There is no expectation of an ongoing relationship between the parties). Larger experienced agencies appear to discourage this model of surrogacy, understanding that it is not an optimal process for surrogacy to be undertaken; however it does suit some IPs, particularly those who intend to conceal their use of a surrogate from social supports or the child themselves.

Larger surrogacy agencies often also provide egg donor and sperm donor programs, or are able to source donated eggs or sperm from other agencies or gamete banks. Both anonymous and known egg, sperm and embryo donation is available in the USA, and there is a growing emphasis towards donors being known to their IPs. For multiple reasons (including the average age of heterosexual couples using surrogacy, and the high rate of same-sex couples), around 35-40% of surrogacy cases in the US also involve use of donated eggs. US services expressed interest in the Australian model of third party reproduction (e.g. establishment of donor registers, retrospective removal of anonymity for donors in some states), and seem to have increasing recognition of the benefits of open donation.

Assuming there are no complications which delay the surrogacy proceeding (such as failure to obtain insurance, or problems obtaining suitable embryos for
transfer), most large surrogacy agencies can guarantee that a surrogacy will commence within 1-5 months of initial contact.

For IPs undertaking CBS arrangements, larger agencies can also assist with logistical considerations such as travel, accommodation, and even getting around within USA. These are generally referred to as concierge services, and although there are additional fees associated with this service, it can also help to reduce the stress for IPs who travel to undertake the surrogacy arrangements.

**Financial implications of USA CBS**

There is great variation in the fees charged by agencies for surrogacy services, and there are a range of ways in which these fee structures are communicated. Some agencies quote an all in one price which provides a total estimated cost of the arrangement from surrogate screening through to the postpartum. Others have very complex financial reporting, with many itemised “lines” of fees. Most fees are indicated of an uncomplicated surrogacy arrangement, but extras costs are added if there are unforeseen complexities in the arrangement (such as multiple pregnancy, or premature delivery). This means that while some agencies may initially appear less expensive, there may be additional costs added later, or an IP will also have to pay extra costs associated with consultant services (such as solicitors and counsellors). This can lead to significant unexpected additional out of pocket expenses, so it is critical that IPs obtain as much clarification as possible about the overall fee picture.

Some agencies offer a surrogacy “guarantee” with a fixed fee quote, regardless of the number of attempts necessary to achieve a full term delivery, and even in the instance that there is a breakdown in the surrogacy arrangement leading to matching with a new surrogate. The “guaranteed” fee is a large upfront cost but has the advantage that there is no ongoing fees associated with repeated surrogacy attempts. This can be very attractive to IPs as there is generally an expectation of surrogacy taking 2-4 embryo transfers to achieve pregnancy success. Some IVF clinics also offer fee guarantees, regardless of how many egg stimulation cycles are necessary in order to achieve a pregnancy (an IVF clinic fee “guarantee” is likely to cost around USD$40,000 but provide unlimited egg retrievals and embryos transfers).

The average expected costs for an Australian accessing surrogacy in the USA would be anywhere from USD$120,000 - $160,000 (currently around AUD$170,000 - $230,000) (fee guarantee contracts would be higher again). These fees include (in US dollars):

- Surrogate fees (approximately $25,000 - 30,000) plus expenses (approximately $20,000), and additional fees may be applicable for experienced surrogates (usually a bonus $5000 for repeat surrogates), multiple pregnancies, invasive pregnancy testing procedures, caesarian section delivery etc. Payments are generally made to surrogates in 10 monthly payments, spaced throughout the pregnancy. Interestingly, surrogacy payments have been deemed not to be taxable income by the USA IRS, however, donor compensation is considered to be taxable income.
- Additional costs incurred by the surrogate such as lost wages, travel costs and child care.
- Donor fees (between $5,000 - $15,000 per cycle).
- Travel and accommodation and living costs of the IP. Most IPs would expect to make between 2-4 trips to the US (to create the embryos, to meet the surrogate, maybe to check in/attend a significant scan during
the pregnancy) and to collect their baby at the end). At delivery time, IPs need to plan to be in the USA for one to four weeks after the baby has been born, depending on when parental rights are established (pre or post birth). For same sex couples, some states make the establishment of parental rights much more complex and this generally increases the time and/or expense for IPs.

- Fertility clinic fees, which can vary enormously dependent on the fee structure of the individual IVF clinic, and how quickly treatment is successful, as each subsequent embryo transfer, or egg stimulation cycle (either for the IP herself or an egg donor) will increase the expense. Fees are likely to range around $20,000 - $25,000 for each egg retrieval leading to an embryo transfer.
- Agency fees (approximately $25,000), with extra fees for management of cross-border matters (approximately $4000-$5000).
- Legal fees and psychology assessment fees (between $7,000 and $10,000).
- Surrogate health insurance (ranging from $3000- $30,000, dependent upon state, selected plan and the surrogates existing health insurance). Some insurance companies will not cover a surrogate when a commercial arrangement is in place, and the USA insurance system is extremely complex with new policies only available for purchase between November and February each year. Waiting to buy insurance for a surrogate can add significant time periods to commencing treatment.
- Neonatal health insurance. This can be extremely expensive for cross border arrangements, and is negotiated dependent on when the parentage will transferred from the surrogate to the IP (pre or post birth). There are very few health insurers that insure neonatal health subsequent to cross-border surrogacy, and Australian health insurance policies will not cover care for the baby born in the USA. If a neonate is uninsured and requires a stay in a Neonatal Intensive Care Unit, the IP could expect to pay additional medical costs of on average $50,000 - $80,000 per baby. In the event of a neonate’s death, the IP is responsible for all costs associated with preparation and repatriation of the baby back to Australia, or burial/cremation in the USA.

The use of escrow (financial trust) accounts has become standard in USA surrogacy arrangements, due to an unfortunate history of fee mismanagement and embezzlement by some unethical providers. There are infamous cases of substantial sums of money being lost by IPs to surrogacy agencies and associated professionals. ASRM guidelines specifically recommend use of escrow accounts and as a result of some successful prosecutions of fraudulent service providers, state based surrogacy regulation (in those states which are regulated) specifically addresses the management of fee payments between the relevant parties (including the surrogate herself) via escrow accounts. A similar trust account process is also recommended for the management donor payments.

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Legal implications of USA CBS

Any baby born in the USA is automatically granted US citizenship, and is therefore automatically eligible for a US passport. The complexity for surrogacy is establishing parentage of the baby to the IPs and most IPs will hope to establish Citizenship by Descent, once the family has returned to Australia. This process has significant implications in instances whether an IP couple later separates, or there are applications for custody or inheritance. In order for these processes to be occur, an IP will require the US birth certificate, the court order granting parentage, and written statements from the IVF physician, as well as the surrogate and her partner to ensure no biological/parentage rights are ongoing for the surrogate. A comprehensive description of how the Australian Government responds to CBS is available in a Fact Sheet prepared by the Australian Department of immigration and Border Protection. Many US surrogacy Attorneys are aware of Australia’s stance on CBS and due to the complexity of the situation prefer to refer Australian IPs back to experienced solicitors in Australia.

The legal view of surrogacy is enormously variable between American states, with some states viewing surrogacy very liberally, and others completely prohibiting the practice. It is critical that a surrogate resides in a state which is favourable towards surrogacy at the time of the delivery, or the implications for transfer of parentage can be catastrophic. Services in some states, such as Illinois, will deter surrogates from interstate travel towards the end of the surrogacy gestation, as surrounding states (such as Michigan and Indiana) prohibit surrogacy, and the risk of the surrogate having an unplanned delivery there is significant when parentage order applications are to be made.

The timing of the when the parentage order is made (pre or post birth), and the process by which it occurs is also dependent upon the state in which the surrogacy lives (and delivers). In some states (California, Nevada, and Maryland), it is generally expected that application for parentage will be made in a pre-birth order, thereby granting parentage mid pregnancy (around week 22-23) to the IPs, and terminating the surrogate’s rights over the pregnancy. This ensures that the original US birth certificate is issued in the name of the IPs at the time of the baby’s delivery.

In other states, or if the case is more legally complex (such as same sex couple where only one IP is biologically related to the child), the birth certificate may be issued to the biological father and the surrogate stated as mother. Some states require DNA testing to demonstrate biological relationship between the IP and the baby. A variety of legal options are available if a simple parentage order is not possible, such as “Step parent adoption”, or an application for removal of the surrogate from the birth certificate. Failure to follow a process which formalises parentage for the child, potentially leaves the surrogate with rights and responsibilities over the baby such as custody, child support and inheritance. For an overseas IP, when there is a predictably more complex birth registration process, it must be expected that the IP and baby will have to remain in the USA for a longer period in order to finalise the necessary documentation. Some states legislation (such as California) facilitate a process of birth registration in 1-2 weeks, while others (such as Tennessee) can take 8-12 weeks, but on average it is assumed that there will be a post birth stay of 3-4 weeks.

IPs must also consider establishing a guardianship process in the event of unexpected complications occurring during the pregnancy. Often a

representative of the surrogacy agency can be appointed as the guardian for eventualities, such as a sudden preterm delivery of the baby which results in the IP to be unable to reach the USA in time for the delivery. Considerations regarding birth registration are even necessary in the event of a stillbirth or late term miscarriage as the birth certificate will be issued in the surrogate’s name if a pre-birth order has not already been granted.

**USA state specific legal implications**

**California**

A significant number of Australians travel to California each year to engage donors and/or surrogates, due to the relative proximity to Australia of the American west coast, the highly liberal surrogacy laws and ready availability of women prepared to undertake commercial donor and surrogacy arrangements. There is no requirements for a "medical basis" to the surrogacy in California, so surrogacy arrangements can be contracted for social reasons. Each of the Californian service providers I spoke with indicated that a significant proportion of their work involves Australian clients (one egg donor service reporting that 40% of her agency’s business is from Australian IPs). The number of Australian IPs has reportedly decreased somewhat in the past couple of years (possibly due to the significant cost of treatment in the USA and a poorly performing Australian dollar, but also due to the availability of other (Asian) clinics. Service providers clearly monitor these trends carefully, and consider due to recent changes in availability of surrogacy in Asia (particularly for same-sex IPs) there is a general expectation that the numbers of Australians seeking Californian surrogacy will increase again soon.

**Illinois**

Illinois has a very family friendly attitude towards third party reproduction, with the State being broadly supportive of whatever is necessary to assist people to have a family. They have had a solid State Statute in place for approximately 10 years, which provides general protections to all parties involved in surrogacy arrangements. There are minimum standards for all surrogacy arrangements which are included in the state statute and are primarily designed to protect the surrogate. These standards cover requirements for:

- legal representation
- mental health screening
- medical screening
- escrow account management
- There must be a medical basis for the surrogacy (same sex relationship is considered to be a sufficient basis)
- There must be a genetic connection between the infant and least one IP in Illinois, although there are court precedents for obtaining a parentage court order when neither IP have a biological connection to the infant.

The IPs can be recognised pre-birth as the legal parents of the child. Parentage can be recognised from the time the surrogacy contract has been signed (and the pregnancy is confirmed), but this is followed by a legal administrative process which generally formalises the parentage at around 14 weeks gestation. Despite pre-birth parentage recognition, an IP cannot force a surrogate to terminate or continue a pregnancy if problems emerge or an
abnormality is detected as they do not have rights over the surrogate’s body or medical decision making. If a pre-birth parentage over is in place, there is no capacity for the surrogate to refuse to relinquish the baby. In the event that an IP chooses not to accept the child, it will be placed in the care of the state.

Medical implications of USA CBS

There appears to be a higher rate of complicated pregnancies in the USA for surrogacy pregnancies. Although the reasons for this are not entirely clear. It is likely that there are 3 factors involved:

1. There is a higher rate of multiple pregnancies due to high rate of multiple embryo transfer in US surrogacy. It was reported that around half of IPs seek multiple embryo transfers. I am told that same sex couples are particularly likely to request transfer of more than one embryo. Although the ASRM recommends a maximum of 3 embryos per transfer, there is no legislated maximum number of embryos that can be transferred.

2. There may be factors associated with higher pregnancy risk associated specifically with surrogacy pregnancies. Under ASRM guidelines surrogate should have already completed at least one, but not more than five previous pregnancies, including her own, however there is no regulation that sets an absolute maximum number of previous pregnancies permitted for a surrogate. It may be that the higher rate of complications is associated with the fact that surrogates have, on average, completed a higher number of pregnancies.

3. There may be a higher risk of complication for a surrogate carrying a pregnancy which does not involve her own genetics. It has been noted that for many IPs seeking surrogacy arrangements, the cause of the infertility is not always completely clear. Although there is an assumption that the infertility is purely due to a carrying/uterine issue, any additional issues associated with underlying embryo quality may only become evident during the gestational surrogate process.

The increased risks associated with surrogacy pregnancy is particularly significant in cross border arrangements where the level of stress for IPs is already elevated, the perceived level of control is arguably lower, and the capacity to obtain reliable health insurance for the neonate is limited. The cost of a CBS will skyrocket if, for instance, there is a multiple order pregnancy which results in premature delivery and post birth complications. If insufficient health insurance is obtained, the out of pocket cost for IPs may reach hundreds of thousands of dollars, particularly if there are two or more neonates who require care. IPs may need to negotiate care, a long way from home and with little or no social support.

Even when a surrogacy progresses smoothly, hospitals vary in regards their familiarity with and accommodation of surrogacy arrangements, so agencies often recommend specific obstetric facilities which will facilitate a straightforward surrogacy delivery and handover of baby.

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Some clinicians undertake treatment which is broadly consistent with the Australian RTAC guidelines for ART. For example, there is an increasing number of medical practitioners who advocate for single embryo transfers in order to reduce the risks associated with multiple pregnancies. However, there are many reports of individual practitioners who take a much less conservative approach to treatment, in order to increase pregnancy success rates. There is variable use by IVF practitioners of PGD/S either for purposes of sex selection (a prohibited practice in Australia), or to increase pregnancy rates by selecting the most viable embryos. It is critically important that anyone who chooses to undertake cross-border arrangements carefully consider the medical advice they would be likely to receive from Australian fertility specialists, as this is likely to be the basis of safe ethical treatment even when overseas.

Some agencies offer specific services which facilitate surrogacy arrangements for IPs where the male partner (or both partners) are HIV positive. Specific laboratories in the USA have developed processes by which the sperm is “washed” prior to embryo creation and transfer to the surrogate. Surrogates are specifically recruited to participate in this surrogacy program, and the additional laboratory intervention adds an estimated additional USD$15,000- $20,000 to the cost of the surrogacy.

**Implications of egg donation in CBS**

Up to 40% of surrogacy arrangements in the USA involve concurrent egg donor treatment, therefore it is also important to consider the implications for egg donors. Oocyte (egg) stimulation regimes are undertaken somewhat differently in the USA (compared to Australia), with donor cycles seeking to stimulate and retrieve at least 20 eggs. Some practitioners will attempt even higher stimulation rates, seeking up to 30 eggs per cycle. Some practitioners will encourage a donor to preserve her own fertility as part of this process and retain 3-4 eggs from each donor cycle for her own future use.

Some surrogacy professionals encourage the use of PGD, to help ensure that any embryo transferred in chromosomally normal. This is sometimes encouraged even when quite young donors have been used as a way to increase pregnancy success rates for IPs. There appears to be some preference for transfer of Day 5 blastocyst embryos in US surrogacy arrangements, which is also conducive to PGD. The combination of high egg donor stimulation rates, PGD testing and multiple embryo blastocyst transfers has meant that some IVF clinics can quote surrogacy success rates of up to 93%.

There are ASRM guidelines for the management egg donation, including recommendations for psycho-educative implications counselling for the donor. In general, donors are aged between 20-32 years. Clinics indicate that most donors will undertake oocyte stimulation 2-3 times, and ASRM Guidelines recommend a maximum of 6 donations, however there is no central databasing system to track how many times a single woman has donated. Many donors will choose to donate on multiple occasions for the same family. The motivation for egg donors is generally reported to be almost purely financial in the commercial system (egg donors can expect to be paid between USD$5000 - $10,000 plus expenses) and compensation is significantly greater than the figures paid to sperm donors, (who can expect to be paid only around USD$100 per sample). The additional fees are designed to recognise the additional effort and risk sustained by egg donors.

Egg donors can elect to donate either anonymously or provide permission for identification and contact by IPs. There is great variation in estimates around the relative proportion of known to anonymous donations, with some
practitioners indicating that up to 90% of US egg donations are still by anonymous donors. However, there does appear to be a trend towards egg donors being more willing to become known to their recipient family, and Australian IPs appear to be more likely than their US or international counterparts, to want identifying information or contact with a donor when this is part of a surrogacy arrangement. There is a greater likelihood that an egg donor will become known to her recipient family than a sperm donor. Even if they decide to use an anonymous donor, IPs are entitled to a photograph of the woman, as well as information about her personal characteristics. Most IPs seek characteristics in donors such as intelligence, physical attractiveness, and positive personal and family health history.

US egg donors are recruited from all over the country as well as internationally. In some instances, donors will undertake stimulation in their own country and the cryopreserved eggs are exported to the US for the surrogacy arrangement. In some cases the donor herself will be brought to the USA for egg stimulation and retrieval. Egg donation undertaken in the USA tends to add to the expense for treatment due to comparatively expensive testing regimes and IVF clinic costs.

Screening of surrogates

Under ASRM guidelines\(^{19}\), all surrogates must undergo comprehensive medical and biopsychosocial screening. However, there is no legislative or statute requirement that this screening be undertaken, or what process/level of rigour this might involve. It is assumed by many that the risk of litigation against an agency in the instance of a problem occurring with a surrogate is sufficient to ensure that agencies properly undertake this screening, even without specific regulation of agency practice. However, it is possible that independently negotiated surrogacy arrangements or arrangements made through agencies with less established processes might not insist on such rigorous biopsychosocial screening, as a means to reduce the cost of the surrogacy.

Agencies generally undertake some initial screening processes themselves, with varying attention to factors such as:

- personal characteristics (such as minimum age of surrogate)
- obstetric history (ASRM recommends a maximum of 5 completed pregnancies, with no more than 3 previous caesarian sections)
- social circumstances (including marital status and stability, place and stability of residence, age and dependence of surrogate’s own children)
- financial status (many agencies indicated that they would refuse a surrogate who was reliant on welfare payments)
- physical health (including BMI)
- history of personal or family mental health issues
- capacity to deal with stress
- history of drug and alcohol use
- criminal history

\(^{19}\) [https://www.asrm.org/uploadedFiles/ASRM_Content/News_and_Publications/Practice_Guidelines/Committee_Opinions/recommendations_for_practices_utilizing_gestational_carriers_nonmembers.pdf](https://www.asrm.org/uploadedFiles/ASRM_Content/News_and_Publications/Practice_Guidelines/Committee_Opinions/recommendations_for_practices_utilizing_gestational_carriers_nonmembers.pdf)
• any other issues.

Women who pass this initial eligibility filter will then be assessed medically to ensure their fitness to carry a surrogacy. There are ASRM guidelines regarding the maximum number of past completed pregnancies and other medical characteristics. Women who meet the medical eligibility criteria, are subsequently required to undertake psychosocial assessment.

Most surrogacy agencies require a “clearance letter” about a potential surrogate from a fertility counsellor, as evidence that psychological screening has been undertaken, and as a means to reduce legal liability to the agency. There is variation between agencies on whether this assessment is undertaken by a counsellor employed by the agency or on an independent consultancy basis. Ideally, this assessment can be undertaken in a manner which provides information to assist the eventual surrogacy matching process.

In theory, the primary purpose of the counselling is psycho-education regarding the process and implications of the surrogacy arrangement for the surrogate, however there is generally also some psychological screening. It is important during this process to establish that the surrogate fully understands what is involved in a surrogacy, including the potential physical and emotional risks, in order to be able to obtain fully informed consent for the IVF specialist. Counsellors also noted that good pre-surrogacy counselling tends to help guarantee compliance with the surrogacy process and treatment (including medication regimes). ASRM Guidelines provide a list of issues to be considered using the counselling, and suggest that surrogates be assessed using the Personality Assessment Inventory (PAI) for psychological characteristics which may adversely impact on the surrogacy arrangement. The PAI is not generally undertaken on the surrogate’s partner, although ideally the partner would be included in discussions about the future process.

The surrogate matching process can be facilitated in counselling by gaining information about the expectations of the surrogate on critical issues such as:

• how to manage problems during the pregnancy
• numbers of embryos for transfer
• ongoing contact between the surrogate and the IP, etc.

Ethical agencies appear to really value these assessments as a means to increase the likelihood of success in a surrogacy arrangement, but there is some evidence that others may be motivated to “repackage the truth” about how well suited a woman is to becoming a surrogate in order to ensure that an arrangement proceeds.

There were numerous “red flags” identified which might exclude a surrogate candidate including:

• inability to provide informed consent
• negative / traumatic / complex past obstetric experience
• history of untreated / improperly managed perinatal depression

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• unstable home environment (including recent separation or divorce)
• unaddressed recent losses or bereavements
• a poor regard for communication and teamwork
• lack of reasonable expectations regarding the arrangement
• poor capacity to be compliant with treatment or the arrangement as a whole
• personality / psychopathology characteristics that may negatively impact on the arrangement, e.g. histrionic personality characteristics chorine or untreated depression, low levels of empathy.

A good agency will work hard to ensure that surrogates understand the risks associated with the surrogacy arrangement. Unfortunately, the worst case outcome occasionally eventuates, and for example three surrogates have died as a result of the surrogacy in the USA in the past couple of years. Surrogates must also be prepared for other adverse consequences such as foetal abnormality in the surrogate pregnancy and a subsequent request for pregnancy termination, prior to commencing a surrogacy arrangement. IPs are often unsure what they would choose to do if an abnormality is detected during the pregnancy, and this partly explains the high rate of PGD/S. Surrogates have to be able to tolerate a degree of uncertainty in how the pregnancy may be managed, although it remains their right to refuse certain medical intervention as the IP has no capacity to insist on an intrusive intervention to a surrogate’s body.

There is great variation between agencies regarding how many applicants are accepted as surrogates. Some agencies quote acceptance rates as low as 5% of women who commence the screening process. These agencies indicated that it is assumed many of the women who they reject as candidates will pursue surrogacy through other means, such as the smaller “mom and pop” agencies or private arrangements. This is greatly concerning as there is less likely to be rigorous systems of screening associated with these arrangements and candidates who are less suited to surrogacy may still proceed to commence a surrogacy arrangement which offers minimal protection for the parties involved.

Once a surrogate has completed her initial screening, medical assessment, and psychological assessment, she can be matched with an IP. The agency undertakes a selection process from the available candidates and selects one woman who is offered for consideration by the IP as a suitable candidate. IPs can accept this candidate, or reject and wait to be matched with an alternative candidate. After a match has been made, parties are encouraged to meet face to face, then an agreement can be drafted and signed. If all parties are agreeable, contact information of IP and surrogate will be shared to facilitate ongoing communication. Identifying information is not shared until the surrogacy agreement has been signed to reduce the chance that a surrogate will be coerced by the IP to proceed. Surrogates can expect the entire screening process to take between four to six weeks if undertaken comprehensively.

Some agencies have implemented processes which provide ongoing support to the surrogate throughout the surrogacy process. Some manage this by individual phone checkins while others have established systems such as face to face support group meetings for surrogates. An ideal model appears to be that which facilitates ongoing contact from the counsellor with both the IP and surrogate to regularly check that just to check in when all was going well, or act as a “buffer” when necessary. Some agencies have established a follow-up process for surrogates which may last for as long as nine months after the
surrogacy pregnancy has completed, to ensure that the surrogate has recovered both physically and emotionally.

The motivation for becoming a surrogate under the commercial/compensated US model is clearly (at least in part) financial benefit. However, agencies and psychosocial professional staff consistently indicated that women who are well suited to undertaking surrogacy also have altruistic motivation and genuinely want to help someone else create their family.

Implications for IPs

Screening processes for IPs are highly variable, with some agencies adhering closely to the American Society for Reproductive Medicine (ASRM) guidelines, in this respect\(^{22}\) and others taking a far more “relaxed approach in this regard”, and some even taking the view that assessment of IPs is inappropriate. It appears that medical screening is undertaken in a fairly consistent manner, although there are some differences (e.g. in California, there is no requirement for a medical basis for the surrogacy).

In regards emotional / mental health screening of IPs, there is great variability in practice. Many agencies choose to have some IP screening process as there is the expectation that if an agency did not assess, and there were later negative consequences arising within the surrogacy arrangement, it would most likely result in litigation. Litigation threat is often seen as a sufficient alternative to surrogacy regulation, however it was very clear that enormous variation exists in practice.

There are few consistent eligibility criteria for IPs, and even when regulated by state legislation, eligibility tends to focus on marital status, sexuality, biological connection of at least one IP, and medical basis for the surrogacy. There are not generally criteria around age or other characteristics, and for some surrogacy agencies, somewhat nominal eligibility policies are created, such as “maximum combined age of 120 years for the IP couple, with only one partner older than 60, and neither partner older than 65”. If an IP woman is older than 43 years age, some agencies will insist that an egg donor is used to increase the chance of pregnancy success. Some agencies require that IPs proceeding as a couple have demonstrated a commitment of at least 18 months duration and be living in a de facto arrangement. Some agencies will also insist that if an IP intends to proceed as a single person, they must be able to identify a support person for the duration of the surrogacy process, and this support person preferably attends some of the initial information and screening sessions.

Some agencies (commonly larger agencies employing a one stop shop model of service provision) believe that IPs benefit from ongoing support (not therapeutic counselling). This serves to “check in” on the IP and facilitate ongoing positive communication between IPs and surrogates. An ideal model of support appears to involve contact from the counsellor with both the IP and surrogate to regularly check that just to check in and confirm that all is going well, or act as a “buffer” at times there has been a rupture to the IP / surrogate relationship. This model has developed in some agencies over many years to help facilitate a positive relationship between all parties and ensure that IPs had the best possible story to tell their child about the surrogacy experience. Most agencies appear to encourage regular direct contact between the IP and the surrogate to ensure that there is a positive relationship, and IPs are encouraged

to be involved in the progress of the pregnancy (without being intrusive). Some agencies encourage contact with as much as weekly frequency, either in person (if possible) or by Skype or phone, however generally this is according to the wishes of both IP and surrogate. Contact at least once per trimester is considered a minimum by most agencies. Where possible, IPs are often also encouraged to attend ultrasound appointments (if only by Skype).

Some agencies indicated that CBS arrangements are frequently characterised by extremely anxious IPs, and this tendency for IPs to be “highly strung” can be potentially damaging to the relationship with the surrogate. Regular check-ins with the counsellor, as well as scheduled contact with the surrogate herself can assist an IP to feel more reassured about how the surrogacy is progressing, and therefore increase the chance of relaxing and enjoying the pregnancy.

Some clinics describe IPs who are mostly disengaged from the surrogate and the pregnancy and initiate minimal contact. Agencies indicated that this type of interaction is more likely to create resentment in a surrogate, or increase the chance that she becomes non-compliant with the expectations of the surrogacy. This disengagement is particularly problematic in arrangements when problems emerge (such as concern regarding the health of the foetus) as there is little or no communication in place and much greater effort is required to mediate a process which negotiates successful resolution of the dilemma being faced.

It was clearly the experience of the agencies I visited, that the majority of Australians IPs are eager to maintain an ongoing relationship with their surrogates, and often also with their egg donors (if they had one). This does not appear to be so much the case with sperm donors, but this seems to be an interesting historical trend. It was generally indicated that Australians are very open regarding ongoing contact and value the opportunity to let their child/ren grown up knowing the women who were involved in assisted in their conception and safe delivery. This was unexpected, given the research indicating that anonymity is one of the key reasons Australians use cross-border surrogacy/donor treatment.
RUSSIA

Surrogacy is a relatively common fertility service Russia and Russian clinics have become significant providers of international surrogacy services, particularly for Northern Europeans, Chinese and Americans. There are around 150 IVF clinics and 3-4 surrogacy agencies in Russia (there are many smaller agencies, but these are actually subsidiary companies of the main 3-4). 855 documented surrogacy cycles were undertaken in 2013 in Russia (the most recent published figures), of which around 380 resulted in pregnancies.

To date Russia has not been a significant provider of surrogacy services for Australians, but it was included in the Fellowship itinerary in an effort to examine the service models of countries which are emerging CBS service providers. My opportunity to investigate surrogacy in Russia was an extremely unique experience for a professional working in the Australian fertility industry, and has significantly contributed to the information available about service models in this part of the world.

Unfortunately, operationalising the Fellowship research was challenging due to the lack of existing networks between Russian service providers and Australian fertility services and patient advocate groups, and it proved quite difficult to identify reputable services who were prepared to speak with me. The majority of service providers I contacted simply never answered my emails and calls. Those who did agree to meet me were friendly and very generous with their time and information, although some were somewhat reticent with the information they were prepared to provide. I understand that a number of these agencies had previously been represented very negatively in media reports, and it appears that they were wary that speaking with any other “outsiders” wanting to ask a lot of questions may result in a similar experience.

Legal implications of Russian surrogacy

The Russian Ministry of Health Regulation 107n regulates the provision of ART services in IVF clinics, however there is no specific regulation of surrogacy agencies. In addition to the legislation around fertility treatment and surrogacy practices, Russian fertility services also have practice guidelines developed by The Russian Association of Human Fertility (RAHF), an organisation with a similar function to the Fertility Society of Australia. It is estimated that around 60% of clinics comply with the guidelines proscribed by the RAHF and as part of the Fellowship, I visited The International Centre of Reductive Medicine (MCRM), whose medical director is also the current President of the RAHF (Professor Korsak).

The Russian ART regulation permits assisted reproduction services only to married heterosexual couples and single women, and expressly prohibits services (including surrogacy) for single male IPs or same sex couples. In practice, accessing a surrogacy parentage order for a single woman, or a defacto couple is also almost impossible, and clinics indicated that they would advise unmarried IPs to consider getting married before the commencing a surrogacy arrangement to ensure the process were managed smoothly, as there were concerns that unmarried (even defacto) status would hinder the process for surrogacy parentage transfer.

Russian regulations limit IVF treatment to patients 50 years and younger, although older women may proceed with treatment at their own risk. PDG is available, but embryo sex selection is not permitted unless there are known gender-related genetic issues. The number of embryos which can be transferred during fertility treatment is limited to a maximum of two, however a third embryo can be transferred with the signed consent of the carrying woman.
Due to the high rate of multiple pregnancy in surrogacies, there is a high proportion of caesarian deliveries. Pregnancy reduction is permitted.

I was repeatedly informed that there are never cases where the surrogate refuses to relinquish the baby, even though she is entitled to under the legislation. The main reason for this is the social stigma around a surrogate carrying the pregnancy, and her failure to be reimbursed should she keep the child. However, should the surrogate refuse to relinquish the baby, there is legal precedent for the matter to be referred to a court and the IP would expect to be successful in being awarded custody of the child. Should an IP choose not to accept a child, either as the pregnancy progresses or after delivery, the baby would simply be placed for adoption. Assuming there is no contest to parentage, birth certificates are issued after the delivery of the baby, with the IPs listed as parents. IPs are then able to apply to their own consulate for the necessary paperwork to permit departure from Russia, and on average this process takes around one month.

**Surrogacy service models**

Surrogacy services are provided in two main service models. Some surrogacy agencies are completely separate from the IVF clinics and refer patients to preferred practitioners who provide fertility/IVF services, while others are part of an integrated service model (one-stop shop). Agencies generally assist IPs with all aspects of the surrogacy, including ticketing, accommodation, and making connections to IVF clinics, lawyers and any other necessary services. The pregnancy success rate for embryo transfer to surrogates in Russia is quoted to be just over 50%.

**Implications of egg / sperm donation**

IPs can use their own embryos (created at a Russian clinic, not imported from home), but if necessary, egg and sperm donors are readily available. The majority of IPs accessing Russian surrogacy services are over 40 (one source indicated that 60% of patients are over 45), so use of egg donors in surrogacy arrangements is common.

Egg and sperm donation is permitted either through anonymous or known donation, however in practice it is rare to obtain identifying information about donors, and donors are generally selected by choosing from photographs and personal descriptions. There does not appear to be any capacity for an anonymous donor to have their identity made known to a donor conceived child, and it appears that that majority of domestic IPs in Russia deliberately conceal that a donor was used.

Federal regulations limit the total number of donations per donor (seven for egg donors). Egg donors can be aged 18-35 and must have had a minimum of one child already. Donor cycles aim to stimulate around 12-14 eggs and genetic testing is not routinely recommended (although it can be arranged if requested). Egg cycle “splitting” is not permitted. Traditional surrogacy is specifically prohibited by Russian legislation.

Sperm donors are generally accessed from sperm banks and can ONLY be anonymous. Although theoretically limited by Federal regulation, the total number of sperm donations permitted could not be ascertained from discussions with services, and in fact this did not seem to be viewed as terribly important.
Surplus embryos created from donated eggs or sperm can be cryopreserved, destroyed or on-donated although egg donation is generally undertaken in fresh cycles.

Donations are almost always commercial (social or interfamilial donation is rare) and it is difficult to ascertain what kind of implications counselling a donor might receive.

**Financial implication of Russian surrogacy**

The cost of surrogacy in Russia is substantially less than one would expect to pay in the USA, with fees totalling around AUD $90,000 (presuming success within one to two IVF cycles). This includes costs such as:

- travel to Russia from Australia (two visits per surrogacy)
- accommodation for the IP
- fees to the surrogacy agency
- fees to the IVF clinic and
- compensation to the surrogate.

An IP would expect to visit Russia a minimum of twice: once to establish the cycle, and then (assuming treatment is successful) again to collect the baby. It would be expected that the first trip would involve a stay of around six weeks, and the second, about four weeks.

IPs are required to undertake contracts with the surrogacy agency, the IVF clinic and with the surrogate herself. These contracts are primarily around enforcement of fee payments. There is no “trust account” or escrow system such as exists in the USA. The total fee includes around AUD $5500 to the surrogacy agency and around AUD $3000 per IVF cycle. Fees for gender selection add around AUD $700 and Pre-Implantation Genetic Diagnosis/Screening (PGD/S) is an additional AUD $1000-$2500 (PGD/S would be recommended for an older IP hoping to use her own eggs but is otherwise not a routine treatment).

Monthly instalment payments of around AUD $370-550 to the surrogate are made either directly from the IP, or with the agency as an intermediary. The final payment (around AUD $15,000-$23,000) is made directly to the surrogate, immediately after the delivery and prior to handover of the baby, and is generally requested in cash. The fee range depends on factors such as the nationality of the surrogate, how many times she has been a surrogate, and the experience of the pregnancy itself, such as whether she requires a caesarean section, and whether she is carrying a singleton or multiple pregnancy. In Russia around 30% of pregnancies resulting from surrogacy are multiple, as it is normal practice to transfer 2-3 embryos.

**Implications for IPs**

Although surrogacy is completely legal in Russia, surrogates tend to conceal their pregnancies from the social system, and the majority live in rental accommodation away from their families for the duration of the surrogacy. Domestic surrogacy IPs commonly wear fake “bellies” to provide a pretence of pregnancy as the surrogacy pregnancy progresses. IVF centres are well equipped to support families to discretely access fertility services, even to the point of providing onsite accommodation to IPs while they are accessing active treatment. IPs are purportedly encouraged to meet their surrogates at least once during the surrogacy process, but in practice this is still not common. I was informed that the majority of surrogates want to meet their IPs, but this rarely occurs due to poor IP motivation and minimal encouragement by surrogacy.
agencies. Some psychologists do work within IVF centres to provide counselling designed to allay the common fears about how a child might react to being born as a result of donation or surrogacy, but use of third party reproduction is still viewed with negative stigma in Russian society, and the counsellors I spoke with felt that cultural change in this respect would be slow. Only around 10% of domestic surrogacies use surrogates previously known to, and recruited by the IPs.

Beyond medical screening, there is no intake/screening process for IPs, and for foreign IPs, medical screening can be done in the country of origin by one’s own doctor. Despite the regulatory limit of 50 years for eligibility to fertility treatment, there is effectively no upper age limit for IPs as older IPs can still access treatment if they sign a consent waiver.

Medical screening essentially tests the IP husband for:

- HIV, syphilis, hepatitis B and C,
- sperm count.

Medical screening of the wife includes:

- gynaecological examination with vaginal ultrasound
- blood type and rhesus
- screening for HIV, syphilis, hepatitis B and C
- gram stain smear,
- clinical blood analysis (blood count).

IPs are not required to undertake any psychological intake process, although psychologists are available on request. Some IVF clinics do have psychologists who attempt to engage with, and provide support to, domestic IPs as they progress through the surrogacy process. Unfortunately, take-up of this support is low (probably only 10-15% of IPs), and is probably reflective of the generally low acceptance of psychological services within Russian culture. There is admirable perseverance in attempting to change this treatment culture by some clinicians and real professionalism in attempting to maintain international best practice in surrogacy treatment despite cultural resistance.

**Screening and monitoring for surrogates**

The screening process for surrogates is more detailed, but medical screening remains the focus. HIV and Hepatitis C are very common in young Russian women, so rigorous medical screening of surrogates is critical. A surrogate must be aged between 20 and 30 and must have already had a child of her own. She cannot be a surrogate if she has already had a caesarian section, and she should have had no more than five to six surrogacy pregnancies in total (including her own). There was no maximum number of pregnancies, as long as the total number of deliveries does not exceed five to six.

There are also legal checks to ensure that the surrogate is suitable.

Psychological screening of surrogates primarily examines their motivation to undertake a surrogacy and the surrogate’s current social situation. Russia is currently experiencing a significant economic downturn and there are major unemployment problems emerging. Agencies clearly acknowledge that financial benefit is the primary motivation for surrogates, who generally intend to use their compensation to purchase a home, pay outstanding bills or manage some aspect of their child’s development or wellbeing. There is roughly equal
numbers of partnered and single women, however women are discouraged to commence a surrogacy if they describe relationship instability.

For those surrogates in a relationship, their partners are also assessed and undertake counselling regarding the implications of surrogacy. The majority of surrogates (around 75%) are sourced from outside of the large city centres such as St Petersburg and Moscow, and often come from smaller rural and regional centres. As a result, women are frequently housed in flats in the city centres, close to IVF clinics and obstetric services, for the duration of the surrogacy process.

Potential surrogates are generally recruited either through direct advertising or by application through internet websites. Only around 7% of applicants that apply to surrogacy agencies are considered suitable to become surrogates, although different agencies vary in the screening processes utilised and it can be assumed that longer waiting periods to be matched with a surrogate indicate more rigorous screening processes.

Prior to signing a contract, surrogates are informed of the risks of undertaking a surrogacy, with a focus on the common medical complications of surrogacy (such as miscarriage, hypertension).

Surrogate health before and during the pregnancy is monitored regularly by the clinics and surrogates are also required to undertake regular check-ins with psychologists. These checks are less to support the surrogate, and primarily to ensure she is behaving in compliance with the obligations of the surrogacy agreement. For example, surrogates are not permitted to consume alcohol during pregnancy and compliance with this is ensured by regular blood screening. If blood alcohol levels are detected during the pregnancy, the surrogate can be required to undergo a termination of pregnancy, the contract is voided and she is left without payment. If a surrogate is found to be non-compliant with the surrogacy agreement, the consequences are quite severe. Up to 12 weeks gestation (and even into later stages of pregnancy), she may be required to undergo a pregnancy termination, and would forfeit surrogacy payments.

Any additional obligations of the surrogate (as outlined by the IP) are managed within the limitations of the surrogacy agreements / contracts, and specific requests of the IPs are enforced, rather than requested. Specific wishes of the IP would be discussed during the surrogacy matching process, and although a surrogate cannot be forced to agree to unreasonable contract conditions, if she wasn’t prepared to consent to a specific condition, she simply would not be selected for that couple.

Following completion of the surrogacy pregnancy, agencies will generally provide follow-up to the surrogate for around 1 month after delivery by caesarean section (less following a vaginal delivery). If she wishes to carry another surrogacy, this process would commence around eight months following the previous delivery, and she would gain follow-up from the agency throughout this period. Around 35% of surrogates will repeat the surrogacy process.

I was pleased to investigate a model managed within a clear legislative framework, but was concerned that enforcement of many of these legal restrictions to treatment appear to be fairly relaxed (including number of embryos for transfer, use of gender selection, the number of times a single donor can donate, and concealment of donor and surrogate identity).

Perhaps of greatest concern in the Australian context is the number of donations permitted for sperm donors and the tendency to conceal that identity
of donors and surrogates. RTAC considers that the rights of a child are paramount and asserts the critical right to access donor or birth origin information for donor conceived children, and children who have been born through surrogates. Application of processes which keep information available about donors and surrogates ensures that at any time in their lives, the opportunity exists to learn more about their donors and gestational carriers, and importantly, any donor-conceived “half-siblings”. Any system which does not really operate to limit the number of donations from a single donor, or aims to keep identifying information hidden from the donor conceived child is a problem, and absolutely does not comply with the expectations RTAC places on practice at home.

Another very significant issue from the Australian perspective is the high rate of multiple embryo transfer in Russian surrogacy. The evidence surrounding risks to foetus and carrying woman associated with multiple pregnancies is indisputable. The practice of multiple embryo transfer and increased likelihood of multiple pregnancy places a heightened burden on the surrogate and the health system as a whole. There is a responsibility on any potential IP to elect for single embryo transfers, for the wellbeing of their surrogate, but also for the wellbeing of their babies.

Certainly the model ensures high compliance with surrogacy agreements, but appears to use a “stick” as well as a “carrot” approach to surrogate monitoring. Discussions with agencies left me with a sense that exploitation of surrogates was probably minimal, but coercive practices were probably fairly common. I note that in a similar manner to the USA, guidelines and even legislation are still open to “interpretation” by service providers and a serious gap in the model appears to be a lack of regulation around the practices of surrogacy agencies.

General observations of surrogacy in Russia

Travelling to Russia gave me far more than just information about specific treatments. It gave me a real insight into the culture of a country which is infrequently visited by Australians, and as I spent time there I realised how important cultural idiosyncrasies could be to a successful surrogacy. There are logistical considerations in establishing the arrangement, associated with language, and travel distance, also cultural variations in the likely expectations of IPs, surrogates, and services providers. In visiting Russia, and going about normal daily activities I discovered much more than I could have ever learned just from having meetings with service providers by Skype, or by exchanging emails.

There are significant observable differences between Russian and Australian lifestyle, and it caused me to consider some of the broader impacts of travelling to foreign locations in order to secure a surrogacy arrangement. All travelers accept risks when abroad, but in the case of surrogacy and IP must consider the potential risks to a pregnancy being carried by another person who they do not know, and will (probably) never meet.

I visited in winter and the ground was covered in snow and ice. Life in a climate such as this is extraordinarily difficult, and difficult to imagine from the relative comfort of Australia. I struggled to imagine the challenges of managing a newborn in these conditions, but this is a post birth reality for an IP, as it usual to spend at least a month in country with the baby until all of the legal and travel documentation are ready for departure. It is critical that any IP contemplating CBS be realistic about the additional logistical challenges that are likely to be faced during the arrangement.
**Georgia and Ukraine**

Although I did not directly visit the countries of Georgia and Ukraine as part of the Fellowship, I did make contact with clinics and agencies there, as these two countries are also emerging as significant providers of surrogacy services. I have included the information obtained during discussions with these agencies in the report, as it provides a useful comparison of surrogacy services in the region.

Due to the recent political upheaval in Ukraine, travelling to the Ukraine was never really an option for the Fellowship itinerary, due to the threat to physical safety. This is unfortunate, as Ukraine appears to be a rapidly growing surrogacy market for Australians. Georgia was also excluded as it is a comparatively small country, and although it is marketing itself aggressively as a provider of surrogacy services to foreigners, the population is quite small (therefore the number of women actually available to work as surrogates is quite low), and many Georgian women travel to Russia to work with Russian surrogacy agencies.

**Legal implications of surrogacy in Georgia and Ukraine**

Like Russia, Ukraine and Georgia both have legislation which are generally supportive of surrogacy. Both Ukraine and Georgia also expressly forbid surrogacy for single male IPs or same sex couples. Traditional surrogacy is not permitted. It is unclear what the legislation permits in regards limits of egg stimulation or embryo transfer, but it is assumed that limits are similar to those in Russia.

The process for transfer of parentage in Georgia is very similar to Russia. The agencies will provide advice but do not directly assist with the registration process, and it is left to the IPs to complete the process for baby registration process. Georgia issues a birth certificate within around five days of delivery, and the birth certificate carries the names of both IPs, with no reference to either the surrogate or donors (if used). The birth certificate then needs to be translated and afforded international recognition, which takes around another 10 days. At the same time, DNA testing is undertaken and results are sent to the relevant embassy to prove parentage with at least one of the IPs. There is no Australian embassy in Georgia, and IPs need to travel to Ankara (Turkey) to obtain a passport for the baby. This means that IPs must leave their newborn in Georgia and travel to Ankara, then return to Georgia with the relevant documentation.

In the event that IPs are delayed in their arrival after the baby is born (such as premature delivery), the agency will assume Power of Attorney over the infant, as the surrogate has no rights or responsibility for the child from time of delivery.

It is usual for the entire process of complete documentation to take around eight weeks from birth of the baby. During this period, agencies provide some support (concierge services) to IPs in regards accommodation, transport around Georgia and even tourism/sightseeing. While awaiting registration and travel documents, the baby remains in a maternity hospital, and IPs are only permitted to visit the baby for a maximum of two to three hours per day.

In Ukraine, surrogacy legislation has been designed such that the child belongs to the IP from the very moment of conception. Clarity around the birth registration process was not obtained during discussions.
Ukrainian clinics give a surrogacy pregnancy success rate of around 35%, however the surrogacy pregnancy rate for Georgian agencies was not provided.

**Financial implications of surrogacy in Georgia and Ukraine**

The costs of surrogacy in Georgia is even lower than Russia (around AUD $40,000 - $50,000, although it was difficult to ascertain if this fee includes costs such as travel and accommodation, and there may be additional costs). The cost of an egg donor adds around a further AUD $6000-7000. Agencies indicated that the majority of clients also use an egg donor, as the average age of IPs is high.

A Ukrainian agency quoted a “basic surrogacy package” costing around AUD $8000 but this clearly excludes an entire range of costs. It is incredibly challenging to compare services between countries (and even different agencies), making it difficult to determine exactly what a quoted fee covers.

**Implications for IPs**

There is no formal process of psychosocial screening for IPs by Georgian agencies, however IPs may be refused services if they make unreasonable requests (such as insisting on automatic foetal reduction of twins after multiple embryo transfer). Agency staff stated that it was “easy to guess the mental state” of IPs and indicated that formal screening processes were not necessary.

Georgian clinics recommend to families that two trips into the country will be required; firstly to deliver sperm for cryopreservation, and the second to collect the baby. Parents are provided with an estimated date of delivery and asked to be present in time for the birth, and agencies will assist in securing emerging travel in the event of premature delivery.

**Screening of surrogates**

Ukrainian clinics proudly assert that they have no waiting periods for IPs seeking surrogates. This leaves serious concerns about the rigour of screening processes, as more rigorous screening processes elsewhere tended to result in longer waiting periods. Although the Ukraine is a larger country than Georgia with a larger population of women potentially available for surrogacy, the recent war has led to specific legal issues in surrogacy. For married surrogates, consent must be provided by their husbands to facilitate the parentage transfer. The majority of surrogates are drawn from rural and regional areas which have been directly impacted by the war in Ukraine, and many men have been conscripted to fight. This has reduced the availability of many partners to provide consent (if the men are away at war, they cannot sign consent forms to their wives undertaking a surrogacy). The war is also significant from a personal safety perspective as the war and its social impacts (including availability of good nutrition and are house) is likely to impact on women from the regional areas of Ukraine.

Georgia is a geographically small with a relatively modest population, resulting in a fairly small number of women available to work as surrogates. Additionally, it has maintained a quite traditional culture and the practice of surrogacy is not well accepted culturally, and tends to be kept quite hidden.

The screening process for Georgian surrogates is primarily medical, and the focus of the surrogacy contracts is medical management of the pregnancy. Surrogates undertake the triple marker blood test at 17 weeks gestation and any problems in the pregnancy at that point will result in the pregnancy being terminated. IPs can request an amniocentesis, which is processed in Germany (to ensure laboratory integrity) and a pregnancy termination can occur until 24 weeks gestation in the event of chromosomal abnormality being detected.
Some psychological screening is undertaken but details of this were not provided.

Similarly to Russia, contact between IPs and either surrogates or donors in these countries is reasonably unusual. I was informed that surrogates are required to agree to contact with IPs if requested, and IPs are able to attend ultrasound scans etc if they wish. IPs can receive monthly reports from the surrogacy agencies which detail the progress of the pregnancy, and help keep the IP feeling informed about the health and wellbeing of the baby. Agencies claimed that contact between a surrogate and IP family can be facilitated later if required, but no process for this was given.

**Egg/Sperm donor implications**

As the average age of IPs using surrogacy in Georgia and Ukraine is quite high, concurrent use of egg donors is common. Egg donors in Georgia are required to provide photographs and basic physical descriptions, but do not provide their names or other identifying information. They can meet the IP if requested but this is not common practice and there is no possibility of ongoing contact, nor is the donor informed about the existence of a pregnancy.

Donor sperm is readily available through sperm banks, and donation is anonymous, at least one IP must be a biological parent to the child to facilitate a parentage order.
Surrogacy and IVF treatment has become an enormous industry in India in recent years, with over 3000 fertility clinics across the country providing services to domestic patients, as well as an increasing market of foreign IPs. Australians have been significant users of Indian surrogacy services in recent years, partly due to the low cost of services (relative to destinations such as USA), but also due to India being comparatively closer in travel times than other surrogacy destinations such as USA, Europe or Mexico.

In recent years, there has been an increasing volume of negative international media attention surrounding Indian surrogacy, with concerns focusing on the quality of services, and the potential for exploitation of the Indian surrogates. Despite these negative media reports, heterosexual couple, same-sex couples, and unpartnered foreigners were known to be travelling to India in increasing numbers for IVF, donor treatment and surrogacy.

For IPs who also required donated eggs or sperm, these could be easily obtained through either local Indian donors or overseas egg and sperm banks. Unfortunately, there have been concerns about the ethical practice of some clinics in recruitment of egg donors, and there have been known instances of extremely young women undertaking oocyte stimulation and retrieval. One very distressing example of this was the death of a 17 year old woman from complications of her third egg retrieval. The legal case surrounding this matter has recently brought attention in the international media.

The Indian Council for Medical Research (ICMR) has guidelines for ART (including surrogacy), which are designed to ensure standards of care protecting all parties, however no specific regulatory framework has yet been enacted to mandate practice. The Indian Government did draft an Assisted Reproductive Technology Bill (the Bill) in 2008 which was aimed at regulating fertility treatment (including surrogacy) in India. The draft was subsequently revised in 2010 and then again in 2013. In the 2013 draft, the Indian Health Ministry proposed the restriction of surrogacy services to heterosexual couples. Although the Bill remained in draft form, and was not enacted, this created significant uncertainty for single people or same sex couples seeking surrogacy services in India, so service provision to these groups ended. In response to the newly created gap in service provision for same sex and single clients, a number of Indian clinics quickly established “satellite” services based in Nepal, but still primarily utilising Indian surrogates. Nepal was geographically convenient for the Indian clinics to operate their services, as the country had no legislative structure in place regarding fertility treatment or surrogacy.

The situation in India changed again in November 2015 when another draft of the Bill was released, this time proposing the prohibition of surrogacy for any foreign couple (except for very specific conditions which effectively exclude almost all Australians) in India. To date, the Bill has still not been passed, but it has created a legal limbo in which it is sufficiently dangerous for any foreign persons to proceed with new surrogacy arrangements. Surrogacy remains available for Indian nationals, and domestic arrangements continue to be set in motion. For foreign families who had already commenced the process in November (including those who had a pregnancy underway) there is no impact.

25 http://icmr.nic.in/art/Chapter_3.pdf
and they will be permitted to continue the surrogacy without adverse impact, and birth certificates and other documents necessary to permit departure from India will be awarded.

The current situation is has created a particular dilemma for families who had already created and cryopreserved embryos with Indian clinics. There are currently hundreds of foreign families (reports suggest up to 500 - not all Australian) who have embryos cryopreserved in Indian clinics. They are prohibited from using the embryos in India, and they cannot have them exported to their country of residence. This is an extremely frustrating and distressing situation for IPs who were ready to commence the surrogacy process and now cannot proceed, or had already undertaken a surrogacy and were hoping to undertake a subsequent arrangement in order to have a sibling for an existing child.

There is deep division in India with respect to whether surrogacy is perceived as exploitative or advantageous.

**In opposition of Indian surrogacy**

Some assert that surrogacy is exploitative of Indian surrogates, and that women are simply being used to achieve the child creation wishes of wealthy foreigners. There is absolute evidence, at least by some clinics, of unethical practice and exploitation of Indian women. Although the guidelines exist for how a surrogacy should be managed, there is no enforceable eligibility requirements around age, health, emotional wellbeing or marital and social circumstances of the surrogate.

There is concern that many surrogates are insufficiently prepared for the obligations of the surrogacy, or have received insufficient counselling about the risks or expectations of the arrangement. A significant proportion of women who undertake surrogacies are from rural areas, some from very remote villages. Surrogates are required to sign agreements when they commence the surrogacy, in which they provide consent to the necessary medical procedures, but it is unclear whether this is always fully informed consent, particularly if the surrogate is not well educated, or illiterate and this leaves the potential for coercive practice by clinics or others who may influence a women to undertake a surrogacy.

Indian clinics generally advertise surrogacy pregnancy success rates around 60-65%, and this is due in part to the very high rate of multiple embryo transfer by Indian fertility clinics. Despite the presence of ART practice guidelines, some reports suggest that up to four embryos are commonly transferred to young surrogates, and as many as six embryos will be transferred on request, however the number appears to be quite arbitrary). The risks associated with multiple embryo transfer rate (particularly in these numbers) is a very high chance of multiple pregnancy, increasing the pregnancy risk and the likelihood of caesarean section delivery.

There is great variation in the living conditions for surrogates during their pregnancies, but there is significant use of “surrogate houses” by Indian clinics, which require the women to be absent from their own families for the duration of the surrogacy arrangement. These surrogate houses also vary in the standard of living provided, and serve two key purposes. Firstly, they increase the capacity for surrogacy clinics to monitor and regulate the health, diet and behaviour of the woman while she is carrying a surrogate pregnancy, but it also provides privacy to the woman herself while she undertakes the surrogacy. Surrogacy has become increasingly common and accepted in India in the past few years, but there is still some resistance to the practice, and some women
could expect to be stigmatised if their work as a surrogate became known in their community. It is still common for domestic IPs to conceal their use of a surrogate by “pretending” to be pregnant while they wait for their baby to be delivered. Surrogate women also receive extremely varying levels of care after their pregnancies, and there are reliable reports of surrogates dying as a result of poor or absent postpartum follow-up and care after caesarian delivery.

Unfortunately, none of the clinics visited during my Fellowship provided access to the surrogates themselves, in order to directly discuss their experiences. I assume that the lack of direct access to the surrogates is due to clinics feeling wary of external scrutiny, as there has been overwhelmingly negative reports in the International and domestic media surrounding the above issues.

**In support of Indian surrogacy**

An opposing and far more positive perspective of surrogacy was offered by others within the industry. Proponents assert that some surrogates are achieving an improvement in their social standing as a result of their surrogacy experience. There is no question that for some women, the opportunity to undertake surrogate pregnancy provides a chance to earn in nine months and income that would usually take around 10 years to earn in unskilled employment.

It has been suggested that this sudden income boost can increase their value as a wife and as a woman, and many of these women will earn far more through surrogacy than even than their husbands could hope to from normal work. If managed successfully, the money earned through the surrogacy provides the opportunity for the surrogate to educate her children, buy a property or learn new skills and start a small business for themselves. I did receive reports that amongst the loudest advocates for continuing surrogacy for foreigners, are Indian women who have undertaken surrogacies themselves, and there are some who are frustrated that they have lost significant opportunity for income.

Some clinics have established policies and procedures which are protective of surrogate women, and include eligibility requirements that the surrogates be married, have had at least one child of her own and have completed her own family.

Some clinics do permit the surrogate to remain living at home with her own family, and monitor the health of the pregnancy through practices such as “surprise visits” to ensure that the women are compliant with their surrogacy contracts. Some clinics establish surrogate houses with very positive living conditions, and the opportunity for surrogates to learn new skills such as sewing and knitting. More ethically managed “houses” permit surrogates to bring their own children with them, and provide ongoing education to the surrogate’s own children and a living expense to the surrogate for the duration of her stay. Some providers only permit a woman to act as a surrogate on one occasion, and encourage surrogates to deliver vaginally, however there is great variation in these practices between clinics.

Proponents of Indian surrogacy are supportive of government regulation of the industry in order to protect Indian women from exploitation and harm, and express great frustration that the Indian Government has failed to enact the draft Bill, even after such a long period of development. Until legislation is enacted, the medical and ethical practices of fertility clinics and surrogacy service providers remains completely dependent upon the individual clinician.

There is currently great uncertainty amongst Indian service providers about the surrogacy industry of Indian surrogacy. If the legislation is enacted in its current form, many providers will be unable to continue as there is insufficient demand
in the domestic surrogacy market alone to maintain market share. While the current legislation remains in draft form, the situation is too uncertain for providers to undertake arrangements for foreigners and issues such as what families can do with their unused embryos remain in limbo. There is potential for a further draft of the legislation to be made and enacted and under this conditions, surrogacy for foreigners may again become available. There is also an expectation that some Indian clinics will re-establish in neighbouring countries such as Sri Lanka, which have no legal frameworks around surrogacy. The precedent for offshore satellite clinics was set when Indian clinics opened up in Nepal, but this outcome would, of course leave the potential for future issues around ethical practice and changing government legislation, as occurred in Nepal.

**Nepal**

An increasing number of IPs who would have otherwise used an Indian clinic to manage their surrogacy had elected to go to Nepal over the past two to three years, but another legal dilemma suddenly developed in September 2015 when the Nepalese Government abruptly banned surrogacy altogether in that country. In Nepal the impact initially appeared completely catastrophic for families undertaking surrogacy, even for those with ongoing pregnancies, or with babies who had been recently delivered. The Nepalese Government refused to issue exit visas for any surrogate-born babies, and families were effectively unable to leave Nepal with their children. This situation was eventually rectified after round three months of active lobbying by various advocates, but in the interim period, dozens of families were stuck in Nepal with their babies, with no certainty that they would be issued the necessary documentation to permit their departure. The Nepalese Government has now permitted the completion of any surrogacies that had commenced prior to the legislation being introduced, but no further surrogacy arrangements can be commenced. Cryopreserved embryos (affecting around 300 families of various nationalities) cannot be used and exported from Nepal.
Cambodia

My travel to Cambodia was cancelled at late notice due to an illness contracted earlier in the Fellowship that resulted in my premature return to Australia. Cancellation of this leg of the Fellowship was a real disappointment, as Cambodia is one of the newest entrants to the international surrogacy industry. Despite the visit being abandoned, some background information was gained for the Fellowship.

Multiple meetings had been scheduled with Cambodian clinics, including one provider which had been advertising surrogacy services widely on the internet and in print media. The clinic managers were initially very positive and welcoming of my Fellowship, however, in the days leading up to my scheduled arrival correspondence from them ceased. Only four days before the scheduled meeting date, I received an email stating that they did not provide surrogacy services as the Cambodian Ministry of Health had not yet implemented proper guidelines for surrogacy service provision and therefore were unavailable to meet with me. I subsequently was informed by a third party that the clinic has continued to provide surrogacy services at a rate of approximately 50 embryo transfers each month, but has renamed the service “carrier pregnancy”. It is extremely concerning to find a fertility clinic which appears to be so duplicitous in their practice, and raises serious concerns about their professional ethics.

The provision of IVF and surrogacy services in Cambodia is very new, commencing only in late 2014, and the first baby was born through IVF in Cambodia in June 2015. The establishment of IVF services in Cambodia was a direct response to 2015 legislative changes in Thailand prohibiting the provision of surrogacy treatment to foreigners. A number of clinics which had previously operated in Thailand moved their operations across the border to Cambodia, and there are now at least 16 different IVF clinics operating there.

It is very difficult to determine which of these clinics are providing surrogacy services (as opposed to just IVF), but at least four clinics have been widely advertising surrogacy services. Other international providers (based in USA and Spain) are also known to have established surrogacy services in Cambodia. As at November 2015, the majority of IPs accessing Cambodian clinics were from China, but it is known that at least 20 Australian families had contracted to undertake surrogacy in Cambodia.

Legal implications of Cambodian surrogacy

The legal situation in Cambodia regarding surrogacy is very unclear, which has significant potential impacts for IPs and the surrogate children. Although no surrogacy laws have actually been enacted in Cambodia, there is an expectation that legislation will be imminently drafted by the Cambodian government. As long ago as November 2014, Cambodian authorities advised the Australian Government that the act of commercial surrogacy, or commissioning commercial surrogacy, was illegal in Cambodia with penalties including imprisonment and fines. As a result, the Australian Government issued a travel warning on their Smart Traveller website advising Australians not to travel to Cambodia for the purpose of engaging in commercial surrogacy arrangements.27

All babies born to surrogates must be reported to the Cambodian government in order to receive a birth certificate and a Cambodian passport. Under

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Cambodian law, the IP father has equal parental rights with the birth mother and is viewed as the child’s legitimate father. Paternity is established by registration of the birth under the paternal IPs name, and a signed acknowledgement by the surrogate. There is no mechanism under Cambodian law for the surrogate to surrender her parental status, so foreign (Thai, Laotian and Vietnamese) surrogates are preferred. The consent of the surrogate is required for the newborn child to leave Cambodia. Support for the parentage transfer must be provided by the IP’s embassy, and a local lawyer.

Financial implications of Cambodian surrogacy

A surrogacy arrangement in Cambodia costs approximately $AUD 40,000, making the cost comparative with services previously available in Thailand, and amongst the least expensive options for surrogacy internationally.

Medical implications of Cambodian surrogacy

Although the clinics employ Thai and western professionals to undertake the medical and embryology work, reports about service quality and ethical behaviour by Cambodian clinics are extremely concerning. Embryo production quality is considered poor, when compared to international standards. As a result, it is normal practice to undertake multiple embryo transfer to increase the chance of pregnancy. Obviously, this also increases the risk of multiple pregnancy and its associated risks.

The storage and labelling of embryos is known to not always be undertaken at international standards, resulting in increased chance of embryo “mix-ups”. There are almost endless issues for IPs and their children as a result of embryo mix-ups, but the error may not even be detected until after delivery of the surrogacy pregnancy. Embryo labelling errors are problematic for a multitude of reasons, including the right of the child to access information about their biological identity.

Before departing on my Fellowship, I received extremely concerning information about the standard of the Cambodian laboratories’ health testing. This is incredibly important for the wellbeing of all parties, not just for the creation of embryos, but also for the pre-surrogacy health screening checks. In developing countries this may be particularly important due to the high rate of sexually transmitted diseases, particularly HIV and Hepatitis B.

Screening of surrogates

Unfortunately, it was not possible to obtain reliable information about general screening processes for surrogates, covering aspects of wellbeing such as social, psychological or financial circumstances. Information regarding the social and health standards of surrogates in Cambodia has been generally difficult to obtain, but it appears that there is a preference for single women to work as surrogates in Cambodia. This increases the probability that surrogates are socially vulnerable women, with minimal education or independent financial means, and at high risk of exploitation. Due to requirements of birth registration for Cambodian mothers, some information indicates that the majority of surrogates are Thai, Vietnamese or Laotian women living in Cambodia for the duration of the surrogacy arrangement, increasing the likelihood that “surrogate houses” have been established. The practice of surrogate houses is widely criticised in the international surrogacy industry, due to the frequently negative implications for the surrogate women.

Based on the information obtained about surrogacy in Cambodian, I expect that the surrogacy industry in Cambodia will be short-lived and am very concerned that another disaster (such as the death of a surrogate, of some kind of
international furor as occurred in the Thai Baby Gammy case) will occur before legislation is eventually enacted. I would be extremely concerned for the wellbeing of any Australian families who choose to engage Cambodian surrogacy services, due to the clear risk of imminent legislative restriction to surrogacy services, and the very high probability that surrogates are being exploited or improperly prepared for their surrogacy arrangements.
MEXICO

Villahermosa (Tabasco State, Mexico) had been initially included in the original Fellowship itinerary as Mexico was a rapidly emerging location for a "budget" alternative to USA surrogacy services. Mexico was particularly popular for same sex and single IPs as there were no restrictions on who could access surrogacy there, and USA, Indian, Georgian, Russian, Ukrainian surrogacy companies are known to use Mexican surrogates, to circumvent their own country’s restrictions on IP eligibility. However, it was not until during some of my initial meetings in California (27/12/15) that I learnt that the Mexican surrogacy laws had been altered on 15th December 2015, when the Tabasco State legislature prohibited surrogacy for all foreigners.

At that point, minimal information was available, however my contacts in California were unsurprised by the change, and indicated that it had been imminent for around 12 months. There had been numerous disastrous IVF and surrogacy incidents that had garnered a great deal of unfavourable international media attention about ART practices in Mexico, and this appears to have precipitated the abrupt (although not unexpected) legal change.

Discussions with these US contacts also indicated that travelling as a single woman to Villahermosa would be extremely unsafe. I was informed that Villahermosa is a central location for the Mexican drug trade and travel is not safe for foreigners (particularly women). This information was not consistent with the information I received from Australian Department of Foreign Affairs and Trade, but did come from multiple reliable (and unconnected) American sources. The decision to cancel the Mexican part of the trip was made with extremely short notice (less than 24 hours), and physical safety was deemed the ultimate priority.

I understand that a small number of Australians had already commenced (and some had completed) their surrogacies in Mexico when legislation was enacted in December 2015, and many more were contemplating this as an option. I am informed that for those IPs who have a pregnancy underway, they will be permitted to complete the process, and there will be no complications regarding issue of birth certificates and visas. However, for anyone who had been about to start, surrogacy arrangements in Mexico are no longer legal. I understand that some surrogacy arrangements have continued to be illegally provided to foreigners, but have not been able to obtain any reliable information about how or where this is occurring.

In preparation for the Fellowship, I met with a number of providers of Villahermosa surrogacy services by Skype and established positive relationships with them. These service providers explained the processes that were in place for foreigners prior to the change to Tabasco State law. All information that follows is consistent with what was occurring prior to December 2015.

Until surrogacy for foreigners was made illegal in Tabasco State, it was the only state in Mexico where a parentage order following a surrogacy could be arranged, and even then the legality was described as “vague” and “open to interpretation”. The majority of IVF clinics are actually located in locations such as Mexico City, Tijuana and Cancun and it was normal practice for embryos to be created in these centres, or shipped to Mexico from a variety of international locations. Embryos would be transferred to surrogates in these major centres, then the surrogates would be returned to Villahermosa for the remainder of the pregnancy.
Models of surrogacy

There are at least 10 surrogacy agencies and a significant number of fertility clinics based in Mexico, many of which are part of conglomerate international companies, and others which are smaller, “boutique” providers. Marketing is generally consistent with the practices of other medical “tourism” organisations.

The Mexican Association of Reproductive Medicine (MARM) provides guidelines for fertility treatment, however compliance is not regulated and the management of IPs, surrogates as well as laboratory practices inevitably vary between providers. Discussion for the Fellowship could only be undertaken with a small number of boutique agencies, and only their agency practices have been reported here.

The model of the surrogacy providers with whom discussion were undertaken was boutique “one-stop shop”, and agencies offered integrated medical, legal, “international concierge”, private investigation and psychological screening services, and managing around 30 surrogacies each year. I understand that larger agencies could be expected to manage at least 100 surrogacy arrangements each year.

Screening for surrogates

Surrogates apply voluntarily and are required to meet three eligibility “filters”:

1. Medical suitability.
2. Understanding of the implications of undertaking a surrogacy (it is necessary for the surrogate as well as her family to properly understand the obligations of surrogacy).
3. Social environment. Surrogates are primarily recruited from the Villahermosa area, and there is a preference for women who live with their own families and have social support. It is necessary for the potential surrogate to live in an environment which will ensure her physical and emotional safety throughout the pregnancy. Psychological screening is reportedly undertaken as part of this process but details of what is involved in this screening were not provided.

It is recognised that the majority of women who will apply to become surrogates live in very traditional lifestyles, and generally reside outside the city. As a result, some surrogacy agencies also manage “foundations” or support services for surrogates, which purport to assist surrogates during and after the surrogacy arrangement, and help the women invest earnings made from the surrogacy. The foundations claim to give surrogates tools to help establish a better life, including improved housing, and opportunities to study or set up a new business.

Larger agencies are more likely to advertise for surrogates, and are more prepared to accept women from regional areas, or from out of state and require them to live in surrogate “houses”.

Implications for IPs

Psychological screening is also required for IPs, but this is only to assist in the “matching” process with the surrogate, and not to determine eligibility for surrogacy services. There are minimal eligibility requirements for IPs, apparently limited to:

- medical basis for infertility
- no criminal record
- no infection or significant health issues.

There were previously no eligibility limitations on the basis of marital status or sexuality for IPs in Mexico, making it an increasingly popular destination for same sex couples from USA and Europe. The enactment of legislation by Tabasco State has now restricted surrogacy services to heterosexual married couples. The female IP must be aged 25 to 40 and present proof that she is medically unable to bear a child. Services are limited to Mexican residents.

Contracts are made between the surrogate and the IP, which outlines all obligations and protocols of the surrogacy and claims to protect against coercion of any party. The transfer of parentage occurs prior to the delivery of the infant, and documentation is provided to the delivering hospital as proof of the IP’s parentage and to demonstrate that there is no child trafficking.

Unfortunately, in recent years there have been a significant volume of media reports emerging from Mexico in which surrogacy arrangements have ended catastrophically. These have primarily involved USA IPs, but reports also exist where other foreign nationals, including Australians, have been negatively impacted by poor clinical practices. These reports have described:

- clear cases of exploitation of surrogates
- poor housing conditions for surrogates (particularly involving the widely criticised practice of surrogate houses)
- poor laboratory practices, resulting in embryo transfer mix-ups and embryo handling resulting in unnecessary embryo destruction.

There have been credible reports that surrogates are routinely delivered preterm (at around 37 weeks gestation) by caesarean section, resulting in implications for the health of the surrogate and the neonate. There have also been multiple reports of IVF clinics and surrogacy agencies engaging in unethical practice and theft of fees. One report detailed the experience of a Brisbane couple and was published only a few weeks before Mexico outlawed surrogacy for foreigners.28

As stated, I have been informed that illegal surrogacy services continue to be available for foreigners, but have not been able to obtain any reliable information about how or where this is occurring. I have no information to specifically suggest that Australians are continuing to travel to Mexico for surrogacy, but I would be extremely concerned for the wellbeing of any Australian families who choose to engage Mexican surrogacy services, due to the clear legal risks, and the high probability of exploitation of surrogates.

CONCLUSIONS AND RECOMMENDATIONS

My beliefs and attitudes regarding surrogacy have unquestionably been challenged during the time I have worked as a surrogacy counsellor. Many of my pre-existing views about what it takes to be a gestational surrogate, what it means to be an IP, and the best/most successful means to undertake a surrogacy arrangement, have been altered by the experience of observing a wide variety of completed arrangements. My attitudes about commercial CBS have also been altered as a result of this Fellowship. The experience afforded me a far better understanding of the various models of commercial CBS, and the potential impact of introducing financial reward to a surrogacy agreement.

The Fellowship clearly demonstrated that not all surrogates involved in commercial cross-border surrogacy are exploited but it also clearly demonstrated that some surrogates due experience exploitative and coercive treatment. In order to reduce the exploitation of women in commercial surrogacy arrangements, attention should be directed at assisting IPs to find surrogates who are protected from unscrupulous service providers, and help them to make well considered, informed choices about their participation in surrogacy.

Australia can establish nationally consistent policy and legislation which ensures sufficient domestically based women are prepared to act as surrogates and at the same time uphold its international responsibilities to protect vulnerable women overseas who may become involved in exploitative arrangements.

Implications for models of domestic surrogacy

Having investigated a range of models for surrogacy provision (both domestic and international), I have yet to see a “perfect” model in action. However, Australia is in a position to implement a surrogacy practice model that selects the most ideal aspects of care and protection for all involved. We have an opportunity to learn from other legislators, and introduce sufficient protection and support to IPs, surrogates, and most importantly, the children born through surrogacy.

Provision of surrogacy in Australia is currently governed by a jigsaw of clinical guidelines and state-by state legislation. It is critical that consistency of regulation be introduced across Australia to simplify interstate arrangements. The complexity of surrogacy in the USA with enormous variation between states clearly demonstrates the risks of absent consistent regulation. Reliance on professional organisation guidelines and ethical codes is insufficient to guarantee standards of practice, as enforcement capacity is limited. It is evident in international models that certain providers of surrogacy services (most specifically the surrogacy agencies) often fall outside the scope of these guidelines, and only clear limits, based in legislation, can provide enforceable protections for surrogacy service users. All providers of surrogacy services must have regulatory frameworks around their practice.

The altruistic aspect of a surrogacy arrangement is imperative. Even generously compensated commercial arrangements also require a desire to help another person in order for surrogacy to operate smoothly. However, evidence from Australia and overseas has consistently indicated that there is generally insufficient motivation for women to engage in uncompensated surrogacy unless the surrogate has a pre-existing relationship with her IP. It would be reasonable for Australia to consider introducing limited compensation
for surrogates, as recognition for the time, effort and physical and social impact of undertaking a pregnancy for another person. This would predictably increase the availability of women prepared to undertake surrogacy, particularly for women with whom they have no pre-existing relationship.

Another primary reason for utilising CBS cited by IPs is the perceived cost of surrogacy in Australia. Costs are incurred for legal and counselling fees and surrogate expenses, but a significant cost results from the IVF treatment itself, as Medicare rebates currently specifically exclude ART in the context of third party reproduction. It would be appropriate for Medicare to treat all third party reproduction (including donor cycles and surrogacy) undertaken domestically with comparable rebate to any other fertility treatment. This would substantially reduce the cost for consumers of undertaking domestic surrogacy arrangements.

It can be incredibly difficult to identify qualified and experienced surrogacy providers who are genuinely capable of providing ethical quality services. Legal, medical and counselling practitioners working in the surrogacy industry should undertake specialised accreditation which acknowledges this specialised knowledge and experience, thereby assisting service users to identify and select appropriate service providers. All practitioners must comply with ongoing CPD requirements to maintain and update their skills and knowledge of surrogacy treatment and legislation.

Surrogacy agencies can provide a valuable function in selecting and matching suitable surrogates to potential IPs. They can provide a supportive function to both IPs and surrogates, and assist with management of advertising, screening and matching processes. Agencies could be designed to function within regulatory guidelines, as a means to avoid exploitative, unethical or substandard service delivery. Agencies could be required to involve representatives from all aspects of surrogacy (ie medical, counselling, nursing, legal and consumer), to provide oversight and compliance with legislative frameworks and ensure practice is managed in a manner which is ethical and non-exploitative.

The implementation of pre-birth orders for domestic surrogacy arrangements would simplify policies and practices regarding children born within Australia through surrogacy, and assist to clarify and streamline processes regarding birth registration and child support payments etc.

The establishment of trust accounts (similar in structure to escrow accounts, as used in the USA), could assist to ensure transparent financial management of surrogacy arrangements. This can be useful if third parties are involved in managing the arrangements (such as surrogacy agencies), but also for independently managed surrogacy arrangements. Trust accounts of this nature may help prevent issues occurring during the arrangement associated with poor communication around financial expectations, or mismanagement of funds.

Implications of CBS for Australians

It is evident that the current Australian prohibitive framework for overseas surrogacy has failed to prevent Australians undertaking commercial CBS arrangements. Australia has an international obligation to ensure that its citizens manage their personal affairs in a manner which is ethical, legal and does not risk exploitation of citizens of other countries. The current prohibitive legislation results in covert surrogacy practices overseas and limits Australia’s capacity to have oversight of its citizens’ behaviour.

Current regulation regarding CBS purports to prevent the exploitation of vulnerable women. Unfortunately, it seems that in some locations, particularly
less developed countries where income is extremely low, commercial surrogates are indeed exploited and at times given care/treatment which is arguably not in their best interest, or even with their real informed consent. Some treatment is also arguably not in the best interest of the developing baby.

By facilitating greater availability of domestic surrogacy, and ensuring that ensuring that all Australian IPs (whether they are contemplating domestic or CBS) are provided with informed and unbiased support/counselling we can support ethical, legal and non-exploitative decisions around fertility treatment. The issues that emerge in cross-border surrogacy arrangements could be managed by permitting surrogacy overseas in countries with compatible legislative frameworks to Australia. It is clear that even countries with historically questionable ethical standards for surrogacy (such as India) are moving towards implementation of regulations which are protective of all parties impacted by surrogacy, with a particular emphasis on reducing risk of exploitation. By facilitating surrogacy pathways with countries which have implemented protective regulations for surrogacy, Australia can motivate legislative change elsewhere and assist its own citizens to make safe ethical decisions about treatment. This would also reduce the risk of Australian children being born in hazy or unsafe regulatory frameworks and facilitate legal and accessible issuance of citizenship, passports and other documentation for surrogate born children. Australia should be working proactively to establish agreements with countries which have legalised surrogacy, and ensure services can be provided in a manner consistent with the Australian framework.

A critical concern regarding cross border third party reproduction is the international trend to maintain anonymity of egg / sperm / embryo donors and limit relationships with surrogates. Research has indicated there are adverse impacts for children born through third party repression if they later wish to identify their donor or surrogate and are unable to. Any IP accessing donor/surrogate treatment overseas should work with surrogacy services that operate consistently will current Australian guidelines for ART and third party reproduction. Australia could establish a national register for egg/sperm/embryo donors and surrogate (third party reproduction) and cross border donors and surrogates could consent to inclusion. This process could assist donor conceived and surrogate born children to identify and contact those persons involved in their conception and pregnancy, once they reach adulthood, and should they wish to make this contact.

Counselling processes for surrogacy

Parties involved in surrogacy do not always receive sufficient accurate and unbiased information available. This happens in both domestic arrangements, partly as a result of the limitations on advertising and facilitation of surrogacy arrangements particularly in the instance of CBS arrangements, which are frequently arranged covertly and away from informed Australian sources such as qualified medical staff, counsellor or lawyers. As a result, both surrogates and IPs are reliant on peer-advocacy groups with clearly vested interests / biases about surrogacy, or upon peer-based information sources such as social media and online forums where the accuracy of information is unverifiable.

All parties involved in surrogacy arrangements can benefit from support from properly trained and qualified medical and psychosocial counselling staff prior to, during, and after the surrogacy arrangement, even if the arrangements are being undertaken between parties with pre-existing relationships. Surrogates and IPs would benefit from access to independent advocates throughout the process who can provide them with unbiased assistance, support and information as required and assist them to make sound decisions regarding their surrogacy role. IPs must also have access to support regarding not just
the surrogacy and pregnancy, but also their eventual role as parents. For many IPs, years of infertility and ART has left them insufficiently prepared for the burden of providing care for an infant and coping with the complex transition to parenthood.

Counselling support can be provided at regular and scheduled intervals to both IPs and surrogates throughout the surrogacy process and even into the postpartum, to ensure all parties are coping well, and two assist with any “early intervention” necessary to maintain/buffer the surrogacy relationship. Contact from a counsellor at least monthly would be recommended to help each party gain “the other’s” perspective and negate the medical processing to assist in negotiating a healthy relationship between all parties (with the goal of ensuring a healthy baby).

At the appropriate developmental stage, surrogate born children would benefit from access to independent advocates assisting them to seek to access information about their surrogate, and (if relevant) their gamete donor (should they wish to access this information).

**Screening for surrogates**

Australia is a country with a relatively small population, and the number of IPs who wish to access gestational surrogacy is not huge (a few hundred families per annum). In the USA there are sufficient surrogates available to meet demand from both domestic and overseas IPs, and access to a suitable gestational carrier is guaranteed, at least within a few months. USA agencies report that many women apply to become commercial surrogates, but only 2-5% of these will actually pass the screening stage and proceed to a surrogacy arrangement, and this is still sufficient to meet the demand of IPs.

Screening must include an examination of medical suitability but also psychosocial assessment. This process can provide psycho-education regarding the surrogacy process, and provide an opportunity for surrogates to ask questions about expectations or possible outcomes/risks of the arrangement. A broad range of issues should be examined during psychosocial assessment, including capacity to provide informed consent, risk of exploitation, rights and protections for all parties involved.

**Implications for IPs**

For IPs considering surrogacy, there is a responsibility to choose a service location with a legislative structure that properly regulates the surrogacy arrangement. When regulation artificially imposes treatment standards, ethical practice inevitably improves. It is also sometimes the responsibility of IPs to choose treatments which are better than what is permitted by local guidelines or regulations. As an example, even if multiple embryo transfer is permitted in a local regulation framework, rather than transferring multiple embryos, pregnancy chance could be increased through PGD selection. It is accepted that it is in a surrogate’s best interest to have only a singleton pregnancy, and the risks to the baby can be reliably decreased as a singleton, then the decision to only transfer a single embryo is appropriate, unless there is additional medical information that suggests otherwise. A surrogate may agree to having more embryos transferred, as she may be paid extra if she does, and may receive a bonus payment for a multiple birth. However, IPs have a responsibility to make decisions which protect their surrogate and their own child, and deliberately increasing the chance of a multiple pregnancy, is NOT making a decision which is protective.

It is also critical that IPs consent to good treatment decisions for their own safety. There have been multiple instances reported where IPs discover they
are “DNA negative” with their children. These errors are known to have occurred in clinics around the world, but quality assurance systems are generally better in western countries and the rate of errors has been consistently reported to be higher in countries such as India, Thailand and Mexico.

It is a responsibility of IPs to be sufficiently prepared for their role as parents after the baby has been born. This can also be a problem in domestic surrogacy arrangements, but it appears that remotely managed surrogacy (such as in cross-border arrangements) can amplify the “unreality” of becoming a parent through surrogacy. For many IPs undertaking cross-border surrogacy, there is great secrecy surrounding the upcoming birth and therefore a lack of engagement with services that would usually help to prepare for the transition to parenthood. Once the baby has been delivered, IPs in CBS arrangements are left trying to adapt to being a parent in a hotel in a foreign country. In some instances, they will be attempting to negotiate this transition to parenthood with not one, but two, or even three babies. This situation is further complicated if the neonate is ill or premature, and potentially limited services and social supports nearby.

My own experience of becoming unwell during the Fellowship made me consider the risk of an IP becoming ill during the process of a surrogacy. This is also a risk in a domestic surrogacy arrangement, but may be particularly complex in a foreign health system. The standard of care received during my own hospitalisation was significantly less than what I would have expected in an Australian hospital. Communication with treating staff was often extremely difficult, and although many of the Medical Consultants had excellent English, the nursing staff and junior doctors generally could not communicate with me. My medical costs were covered by the medical insurance company, and once I was medically cleared to fly, and I eventually negotiated to fly home prematurely, but I cannot understate how difficult it was to organise this. I felt very fortunate to have had support at home to relentlessly advocate with the insurance company on my behalf, while I was too ill to do this for myself. The thought of being in a situation such as this while also trying to care for a newborn is genuinely frightening, and must be considered as a risk in cross-border surrogacy.

**Recommendations for national legislative reform of surrogacy arrangements involving Australians**

It is generally acknowledged that there are three separate but intertwined parties in any surrogacy arrangement whom surrogacy laws should aim to protect:

1. Surrogacy laws must uphold the best interests of any child who may eventually be born as a result of surrogacy. This as yet unborn child has no potential to advocate for services or actions undertaken in his or her best interest, so the State must enact legislation which is protective on that child’s behalf. This includes ethical engagement of surrogacy practices but also medical decision making such as aiming for singleton pregnancy.

2. Surrogacy legislation should protect IPs from unscrupulous behaviour by surrogates, or service providers (clinics, agencies, surrogacy professionals), and prevent IPs from knowingly, or unknowingly acting in ways which are illegal, unethical or exploitative.

3. Surrogacy laws should protect the women who are vulnerable to exploitation as surrogates. That is, women who could potentially consent to arrangements that they feel coerced to comply with, or don’t
properly understand the risks of. Legislation should also be designed in such a way that prevents a surrogate who may be so inclined, from acting in a manner which is unethical or illegal or unsafe to the child or the IP during the course of the surrogacy.

Australian legislators must facilitate realistic access to surrogacy. The current domestic environment is overly logistically complex for those accessing third party reproductive services (including surrogacy). This complexity, combined with the incongruent legislative structures that currently exist between individual states, has resulted in many Australians seeking surrogacy and donor treatments overseas, and thereby engaging in behaviour which (in some jurisdictions) amounts to a criminal offence. In order to create their families, these IPs currently require Australian the immigration system to turn a blind eye to the illicit / covert nature of their overseas surrogacy arrangements.

It has become widely accepted that in the interests of protecting the integrity of the newly created family unit, surrogacy legislation which attempts to restrict overseas surrogacy acts as little more than a toothless tiger. The establishment of strict regulations preventing Australians from travelling overseas to engage a surrogate has done little to stop its occurrence, or to protect the parties involved. Legislators must choose whether to maintain the current almost unenforceable legislative structures, or, create change which will make domestic third party reproduction (including surrogacy) more accessible, with improved structures and protections. We must create legislation and processes which increase the likelihood that families will engage in domestic arrangements but also give families the opportunity to explore cross border options which would provide them with increased safety for themselves and their children, and reduce the likelihood of exploitation of women in the countries which they are visiting.

The current landscape of surrogacy in Australia is terrifyingly complex for those attempting to negotiate family creation in this manner. For many families who are considering surrogacy, there is great difficulty accessing clear, accurate and unbiased information about surrogacy treatment options, and there is an excessive reliance on communications modes such as web forums and social media. Many families dismiss options of domestic surrogacy, based on these opinions and seek overseas arrangements as their first preference.

The current Australian legislation is insufficiently protective of IPs, surrogates or potential children. Any user of ART is vulnerable to mishaps or inappropriate actions by the necessary presence of third parties in the reproductive equation. Conduct outside the standard of care by any ART service can produce physical, emotional, psychological, financial, and reputational harms29. It is necessary that reforms be made to surrogacy legislation, and that consistent legislation be introduced throughout Australian jurisdictions.

It is critical that consistent regulation for surrogacy be established across all states and territories. Surrogates and IPs are often based in different jurisdictions, and the additional complexity of negotiating multiple legislative frameworks only adds stress, difficulty and cost to surrogacy arrangements. There are insufficient lawyers with expertise in the area of surrogacy to properly

29 The Ethics Committee of the American Society for Reproductive Medicine (2014). Misconduct in third-party assisted reproduction: a committee opinion; Fertility and Sterility.101:38–42
assist families to understand and negotiate the legal complexities currently created by state to state, or cross-border laws.

All jurisdictions must establish consistent regulation in regards:

- **Eligibility for surrogacy services for IPs** (i.e. marital status, age, sexuality, fertility diagnosis, genetic relationship to child for at least one parent). The current state by state legislative framework is highly variable, and effectively discriminates against certain persons in some jurisdictions. Specific conditions which exclude eligibility as an IP should be mandated, and not left to the discretion of an agency or individual surrogacy practitioner.

- **Eligibility for surrogates** (i.e. age, obstetric history, health conditions, social situation, psychological wellbeing, legal/financial circumstances). Specific conditions which exclude eligibility as a surrogate should be mandated, and not left to the discretion of an agency or individual surrogacy practitioner.

- **Advertising / procurement of surrogacy arrangement.** The current limits on advertising for surrogates significantly limits access to domestic surrogacy, and drives potential IPs into “covert” advertising strategies such as online forums and social media. This results in extremely limited capacity to screen appropriateness of a potential surrogate prior to expenditure of both financial and emotional resources by IPs.

- **Compensation / reimbursement limits.** There is no doubt that lack of compensation for undertaking surrogacy is a limiting factor for women considering surrogacy. It is arguable that the current limitations on what can be reimbursed results in some surrogates being financially disadvantaged by their decision to provide altruistic surrogacy. Evidence from overseas jurisdictions has demonstrated that moderately (and this could be limited by regulation) compensated surrogacy increases the motivation for women to undertake surrogacy arrangements, and it is arguable that limited compensation would increase the number of women prepared to undertake surrogacy in Australia.

- **Counselling and psychosocial assessment.** It is essential that all parties (IPs, surrogates and donors) receive proper screening and implications counselling prior to commencement of a surrogacy arrangement. Counsellors should be properly trained and qualified in providing surrogacy counselling services, consistent with RTAC guidelines and Australian legislation. Ongoing CPD should be required by counsellors working in the sector to maintain skill and knowledge could be mandated. The function of these consultations should not be evaluation for fitness-to-parent. Rather, recipients the purpose should be to facilitate discussion of issues including:
  - common emotional responses to third-party reproduction
  - the biological inequality between recipient parents
  - limits to anonymity
  - consanguinity
  - data on family outcomes after disclosure of the use of surrogacy and donor gametes and provision of age-
appropriate resources to aid in disclosure conversations.\(^{30}\)

- **Legal advice.** It is essential that all parties receive legal advice prior to commencement of a surrogacy arrangement, and surrogacy agreements be formalised. Lawyers should be properly trained and qualified in providing legal advice in regards surrogacy arrangements. Ongoing CPD to maintain skill and knowledge could be mandated.

- **Surrogacy agency models.** The introduction of surrogacy agencies that operate within clear legislative boundaries would assist both IPs and surrogates to manage the legislative framework of a surrogacy, and to access properly qualified practitioners to support the surrogacy (i.e. counselling, legal, medical etc.). A clear structure of how an agency can operate and what services can be offered should be mandated by any legislation, to prevent problems that have emerged in surrogacy agencies overseas. There must be autonomy of counselling, medical and legal practitioners from the underlying agency structure, to ensure that independent provision of services occurs and consumers are protected from exploitation by unethical agencies.

- **Parental rights.** There must be consistency across Australia regarding allocation of parenting rights, for both domestic and international surrogacy arrangements. The incredible confusion created in the USA where there are significant state by state variations on parentage allocation must be avoided. Simplification of parentage rights could be achieved by pre-birth arrangements which ensure IPs are fully recognised as the child’s parents at the time of birth, and at issue of the original birth certificate.

- **Implications for CBS.** It is inevitable that some Australians will choose to travel overseas for surrogacy, and imperative that in these instances IPs are assisted to choose localities which have implemented legislative / regulatory structures which are consistent with those in Australia. Aspects of current legislation which (in some states) criminalise overseas surrogacy must be repealed. IPs should have access to unbiased information and counselling which permits them to make informed decisions about where they will access surrogacy.

- **Traditional / gestational surrogacy.** Consistent regulation should require formal fertility treatment to facilitate conception, in order to protect the health of IPs and surrogates. If a surrogate also has a genetic relationship to the child (i.e. traditional surrogacy), this must be specifically addressed in counselling.

- **Management of fees.** A consistent system which facilitates payments of fees to all parties (including reimbursement /

compensation to surrogates) should be implemented with a reliance upon independent trust accounts. Clear lessons can be learnt from the USA surrogacy system which, following previous mishaps, now requires the use of escrow accounts. Medicare should be applicable to donor cycles and surrogates arrangements as a means to reduce the cost of domestic surrogacy.

Personal Implications of the Churchill Fellowship and future directions

Since returning from the Fellowship I have delivered a submission to the House of Representatives Standing Committee on Social Policy and Legal Affairs Inquiry into Surrogacy. Submissions for the Inquiry closed on 11 February 2016, and I made one of the 91 submissions received by the Standing Committee. My experience in the Fellowship afforded me a unique perspective for comparing models of CBS. The Inquiry is ongoing and it is anticipated that a report will be made to the Australian parliament in mid-2016.

As I progressed through the Fellowship, I maintained a publicly accessible “blog” of my learnings, and this remains available in the public domain at narelledickinson.com.au. I have established professional relationships with Australian and international fertility and surrogacy service providers and patient advocates, and information regarding the blog and its content has been made available to each of these services. At time of writing, website statistics indicate that since establishing the blog, I have had over 2200 views from almost 900 viewers, originating from ISPs in Australia, New Zealand, USA, UK, Indonesia, India, Thailand, Canada, New Zealand, Cambodia, Germany, Russia, France, Vietnam, Macedonia, Japan, Nepal, Israel, Hong Kong, Ireland, Austria, Portugal, Qatar, Norway, South Africa, Sweden, Turkey, Senegal, Taiwan, Spain, Isle of Man, Lithuania, Argentina, Gibraltar, China, the Philippines and Singapore. Conference and workshop presentations about the findings of Fellowship are scheduled for fertility consumers and professionals (Families Thru Surrogacy Conference, Brisbane 2016), fertility counsellors (mid-year ANZICA workshop, Brisbane 2016) and fertility nurses (FNA nurses workshop, Brisbane July 2016).

I intend to continue distributing learnings gained during the Fellowship, and maintaining the collaborations and professional associations that were developed during my trip. I am hopeful that there will be legislative change in Australia in the near future which will result in a consistent and workable legislative model for surrogacy being implemented at a Federal level in order to increase the physical, legal; and emotional safety for families engaging in surrogacy arrangements. In the interim I hope that the information I am able to share directly with families, and indirectly with other service providers working in the surrogacy industry will help potential IPs to make better informed decisions about their surrogacy treatment and provide them with increased potential to safely create their families through surrogacy.
Appendix A:

International Third Party Reproduction
<table>
<thead>
<tr>
<th>Country</th>
<th>Surrogacy</th>
<th>Oocyte donation</th>
<th>Sperm donation</th>
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</thead>
<tbody>
<tr>
<td>Asia and Oceania</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australia</td>
<td>Altruistic surrogacy only available. No donor or surrogate matching available. Advertising for surrogates not legal All donors must be identified Ethics committee approval often required Foreigners cannot access surrogacy in Australia IVF per cycle $15,000, Surrogacy costs approximately: $22,000 Transfer of legal parentage available 4-6 months post birth if uncompensated domestic surrogacy</td>
<td>Altruistic only max 10 families, except NSW and WA max 5 families No anonymous donation</td>
<td>Altruistic only max 10 families, except NSW and WA max 5 families No anonymous donation</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>Regulatory framework unclear but surrogacy occurring</td>
<td>Commercial available</td>
<td>Commercial available</td>
</tr>
<tr>
<td>Cambodia</td>
<td>Absence of laws pertaining to surrogacy but COMMERCIAL surrogacy has been OCCURRING since late 2014 No laws protecting the rights of surrogates or intended parents approximately 16 IVF clinics, but only 4-5 providing surrogacy. Few IVF physicians. Limited capacity Surrogates can only be recruited by word-of-mouth Surrogacy cost approximately $45,000</td>
<td>Commercial available</td>
<td>Commercial available</td>
</tr>
<tr>
<td>China</td>
<td>Prohibited but commercial surrogacy occurring. Estimates of over 10,000 surrogacy babies born annually</td>
<td>Commercial available</td>
<td>Commercial available</td>
</tr>
<tr>
<td>Hong Kong</td>
<td>Altruistic surrogacy only, available only to married couples</td>
<td>Altruistic available max 3 families No anonymous donation</td>
<td>Altruistic available max 3 families No anonymous donation</td>
</tr>
<tr>
<td>India</td>
<td>No longer open to Foreign patients but commercial legal for Indian citizens Prior to November 2015: Only heterosexual couples married for &gt;2 years. IPs cannot be present for delivery Parents names on the BC as mother and father Indian surrogates cannot be named as the mother IVF: $2,000 + Surrogacy: $22,500 + Indian egg donor: add $4,000 Fly-in donor: add $14,000+</td>
<td>Commercial available Anonymous donation photos may be avail and some details</td>
<td>Commercial available Anonymous donation photos may be avail and some details</td>
</tr>
<tr>
<td>North Korea</td>
<td>No regulatory framework but surrogacy occurring</td>
<td>Commercial available</td>
<td>Commercial available</td>
</tr>
<tr>
<td>Japan</td>
<td>No regulation</td>
<td>Commercial available</td>
<td>Commercial available</td>
</tr>
<tr>
<td>Laos</td>
<td>No regulation framework, but surrogacy known to be occurring</td>
<td>Commercial available</td>
<td>Commercial available</td>
</tr>
<tr>
<td>Country</td>
<td>Surrogacy</td>
<td>Oocyte donation</td>
<td>Sperm donation</td>
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<tr>
<td>Malaysia</td>
<td>No regulation, but commercial surrogacy is known to be occurring</td>
<td>Commercial available</td>
<td>Commercial available</td>
</tr>
<tr>
<td>Nepal</td>
<td>Surrogacy contracts not recognised</td>
<td>Commercial available</td>
<td>Commercial available</td>
</tr>
<tr>
<td>Nepal</td>
<td>Prior to 2015: No legislative framework but surrogacy occurring using non-Nepalese surrogates (operated by &gt; 8 offshore agencies working with 3-4 locally-based embryologists and IVF specialists.) Parents names on the BC as mother and father indian surrogates cannot be named as the mother Surrogacy cost approximately $35,000 - $45,000</td>
<td>Commercial available</td>
<td>Commercial available</td>
</tr>
<tr>
<td>New Zealand</td>
<td>Altruistic only - travel expenses can be reimbursed</td>
<td>Altruistic only</td>
<td>Altruistic only</td>
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<tr>
<td>Pakistan</td>
<td>Prohibited</td>
<td>Available</td>
<td>Available</td>
</tr>
<tr>
<td>Philippines</td>
<td>No regulation</td>
<td>Commercial available</td>
<td>Commercial available</td>
</tr>
<tr>
<td>Singapore</td>
<td>Prohibited</td>
<td>Commercial available</td>
<td>Commercial available</td>
</tr>
<tr>
<td>Singapore</td>
<td>Non-medical gender selection prohibited in ART</td>
<td>Anonymous donation</td>
<td>Anonymous donation</td>
</tr>
<tr>
<td>South Korea</td>
<td>No regulation</td>
<td>Altruistic only</td>
<td>Altruistic only</td>
</tr>
<tr>
<td>South Korea</td>
<td></td>
<td>Max 1 donation</td>
<td>Max 1 donation</td>
</tr>
<tr>
<td>Taiwan</td>
<td>Prohibited but surrogacy occurring</td>
<td>Commercial available</td>
<td>Commercial available</td>
</tr>
<tr>
<td>Thailand</td>
<td>Commercial surrogacy prohibited for foreigners, but still occurring through legal loopholes</td>
<td>Commercial available</td>
<td>Commercial available</td>
</tr>
<tr>
<td>Vietnam</td>
<td>Prohibited</td>
<td>Commercial available</td>
<td>Commercial available</td>
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<tr>
<td>North America</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canada</td>
<td>Altruistic surrogacy only available, Foreigners can access surrogacy prohibited in Quebec $90,000 Non-medical sex selection prohibited</td>
<td>Compensation Permitted</td>
<td>Compensation permitted</td>
</tr>
<tr>
<td>USA</td>
<td>Foreigners can access surrogacy here see surrogacy laws by US state</td>
<td>Commercial available</td>
<td>Commercial permitted</td>
</tr>
<tr>
<td>Country</td>
<td>Surrogacy</td>
<td>Oocyte donation</td>
<td>Sperm donation</td>
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<td>South America</td>
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<tr>
<td>Argentina</td>
<td>Altruistic only</td>
<td>Commercial available</td>
<td>Commercial available</td>
</tr>
<tr>
<td>Brazil</td>
<td>Altruistic only</td>
<td>Commercial permitted</td>
<td>Commercial available</td>
</tr>
<tr>
<td>Guatemala</td>
<td>Unregulated but occurring commercially</td>
<td>Commercial available</td>
<td>Commercial available</td>
</tr>
<tr>
<td>Mexico</td>
<td>No longer legal for foreigners but continuing to occur in some states. Now legal for married heterosexual Mexican IPs with demonstrated medical need for surrogacy. Until December 2015: IVF treatment in Cancun and Mexico city with Surrogate birth only legal in Tabasco state (Villahermosa) Surrogacy approximately $39,000 (incl US egg donor)</td>
<td>Commercial available</td>
<td>Commercial available</td>
</tr>
<tr>
<td>Panama</td>
<td>Unregulated but commercial surrogacy occurring. Collaboration with US IVF clinics as USA “budget” option IPs may be heterosexual or same sex PGD available</td>
<td>Commercial available</td>
<td>Commercial available</td>
</tr>
</tbody>
</table>

N.B. Commercial egg and sperm donation also permitted in Belize, Barbados, Bolivia, Chile, Costa Rica, Dominican Republic, Paraguay, Peru, Puerto Rico, Trinidad and Venezuela, but no regulation in these countries for surrogacy.

<table>
<thead>
<tr>
<th>Middle East and Africa</th>
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<td>Prohibited</td>
<td>Prohibited</td>
<td>Prohibited</td>
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<tr>
<td>Israel</td>
<td>Altruistic only Traditional surrogacy prohibited, heterosexual IPs only</td>
<td>Commercial available Anonymous donation</td>
<td>Commercial available Anonymous donation</td>
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<td>Lebanon</td>
<td>Prohibited</td>
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<td>Libya</td>
<td>Prohibited</td>
<td>Prohibited</td>
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<tr>
<td>Kenya</td>
<td>Commercial available. Regulatory framework unclear</td>
<td>Commercial available</td>
<td>Commercial available</td>
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<tr>
<td>Morocco</td>
<td>Prohibited</td>
<td>Prohibited</td>
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<tr>
<td>Country</td>
<td>Surrogacy</td>
<td>Oocyte donation</td>
<td>Sperm donation</td>
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<td>Oman</td>
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<td>Palestine</td>
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<td>Qatar</td>
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<td>Saudi Arabia</td>
<td>Prohibited</td>
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<td>South Africa</td>
<td>Altruistic only</td>
<td>Commercial available Anonymous donation</td>
<td>Commercial available Anonymous donation</td>
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<td>Syria</td>
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<td>Tunisia</td>
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<td>Yemen</td>
<td>Prohibited</td>
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<tr>
<td>Uae</td>
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</tbody>
</table>

N.B. Commercial egg and sperm donation also permitted in Ghana, Jordan, Kenya, Kuwait, Iran, Nigeria, and Uganda but no regulation in these countries for surrogacy.

Europe

<table>
<thead>
<tr>
<th>Country</th>
<th>Surrogacy</th>
<th>Oocyte donation</th>
<th>Sperm donation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Azerbaijan</td>
<td>Commercial permitted</td>
<td>Commercial available</td>
<td>Commercial available</td>
</tr>
<tr>
<td>Armenia</td>
<td>Commercial surrogacy regulated for both heterosexual and same sex IPs</td>
<td>Commercial available</td>
<td>Commercial available</td>
</tr>
<tr>
<td>Austria</td>
<td>Prohibited</td>
<td>Commercial available No anonymous</td>
<td>Commercial available No anonymous</td>
</tr>
<tr>
<td>Belarus</td>
<td>Commercial permitted</td>
<td>Commercial available</td>
<td>Commercial available</td>
</tr>
<tr>
<td>Belgium</td>
<td>Altruistic only</td>
<td>Commercial available max 6 children Anonymous donation</td>
<td>Commercial available max 6 families Anonymous donation</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>Commercial surrogacy regulated as “substitute mother” treatment, maximum of 2 surrogacy pregnancies per surrogate</td>
<td>Commercial available</td>
<td>Commercial available</td>
</tr>
<tr>
<td>Croatia</td>
<td>Prohibited</td>
<td>Commercial available</td>
<td>Commercial available</td>
</tr>
<tr>
<td>Country</td>
<td>Surrogacy</td>
<td>Oocyte donation</td>
<td>Sperm donation</td>
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</tr>
<tr>
<td>Cyprus</td>
<td>Commercial available: Clinics are not legally able to provide surrogates. Instead IP must work with a third party who provides surrogates. For Gay couples and singles, legal protection of parentage is only available using a US or EU surrogate (Fly US surrogate to Cyprus for Embryo transfer, gestation &amp; birth in USA. IVF costs significantly reduced). IVF: $3,050+; Surrogacy: $32,500 (EU surrogate: add $21,700+)(US surrogate: add $62,000) IVF + Egg Donor: $6,100 (Fly-In Donor: add $5,430) Surrogate &amp; biological father listed on birth certificate</td>
<td>Commercial available</td>
<td>Commercial available</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>Unregulated but surrogacy known to be occurring. No laws which protect the surrogate of IPs. No treatment to single women or same sex couples.</td>
<td>Commercial available max age for IP: 49 years Anonymous donation</td>
<td>Anonymous donation</td>
</tr>
<tr>
<td>Denmark</td>
<td>Altruistic only</td>
<td>Commercial available, Anonymous donation. Cannot ALSO use sperm donor</td>
<td>Commercial available max 12 children, donor paid AUD$40-100</td>
</tr>
<tr>
<td>Estonia</td>
<td>Prohibited</td>
<td>Commercial available</td>
<td>Commercial available</td>
</tr>
<tr>
<td>Finland</td>
<td>Prohibited</td>
<td>Commercial available No anonymous</td>
<td>No anonymous</td>
</tr>
<tr>
<td>France</td>
<td>Prohibited Prohibited Non-medical sex selection prohibited in ART</td>
<td>Altruistic only, Anonymous donation</td>
<td>Commercial available max 5 families, Anonymous donation, no single or lesbian recipients</td>
</tr>
<tr>
<td>Germany</td>
<td>Prohibited Prohibited PGD and Sex selection prohibited in ART Legislation prohibits gamete donation</td>
<td>Prohibited</td>
<td>Commercial available Max 15 children, No anonymous Only married heterosexual IPs.</td>
</tr>
<tr>
<td>Georgia</td>
<td>Legal, Commercial available, only heterosexual married couples IVF: $8,500, Surrogacy: $26,000 +, Local egg donor add $5,000 + Intended Parents named on birth certificate to meet the criteria of countries such as the UK, single surrogates are available and DNA testing is available</td>
<td>Commercial available Anonymous donation</td>
<td>Commercial available Anonymous donation</td>
</tr>
<tr>
<td>Greece</td>
<td>Surrogate cannot be compensated beyond out-of-pocket expenses IVF: $5,100, Surrogacy: $34,000 + (EU surrogate: add $28,500+) Local egg donor: $1,360 + (Fly-in donor: add $12,200+) Recently opened up to foreigners Surrogate &amp; biological father listed on birth certificate</td>
<td>Commercial available Anonymous donation</td>
<td>Commercial available Anonymous donation</td>
</tr>
<tr>
<td>Country</td>
<td>Surrogacy</td>
<td>Oocyte donation</td>
<td>Sperm donation</td>
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<tr>
<td>Hungary</td>
<td>Prohibited</td>
<td>Commercial available Anonymous donation</td>
<td>Commercial available Anonymous donation Married recipients only</td>
</tr>
<tr>
<td>Iceland</td>
<td>Unregulated, although draft legislation. Some altruistic surrogacy</td>
<td>Commercial available</td>
<td>Commercial available</td>
</tr>
<tr>
<td>Ireland</td>
<td>Altruistic only</td>
<td>Commercial available</td>
<td>Commercial available</td>
</tr>
<tr>
<td>Italy</td>
<td>Prohibited Embryo cryopreservation prohibited for ART \</td>
<td>Prohibited</td>
<td>Prohibited</td>
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<tr>
<td></td>
<td>PHD and sex selection generally prohibited in ART</td>
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<tr>
<td>Kazakhstan</td>
<td>Commercial permitted</td>
<td>Commercial available</td>
<td>Commercial available</td>
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<tr>
<td>Latvia</td>
<td>Prohibited but commercial surrogacy occurring</td>
<td>Commercial available, Anonymous donation</td>
<td>Commercial available</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>Unregulated but draft legislation</td>
<td>Commercial available</td>
<td>Commercial available</td>
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<td>Malta</td>
<td>Prohibited</td>
<td>Prohibited</td>
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<tr>
<td>Moldova</td>
<td>Prohibited</td>
<td>Commercial available</td>
<td>Commercial available</td>
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<tr>
<td>Netherlands</td>
<td>Altruistic only, commercial or professionally arranged surrogacy prohibited</td>
<td>Altrustic only</td>
<td>Altruistic max 25 children No anonymous donation</td>
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<tr>
<td></td>
<td>Advertising or surrogacy prohibited, even by social media</td>
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<tr>
<td></td>
<td>Non-medical sex selection prohibited</td>
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<tr>
<td></td>
<td>Limited PGD permitted</td>
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<tr>
<td>Norway</td>
<td>Prohibited</td>
<td>Prohibited</td>
<td>permitted max 8 children No anonymous donation</td>
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<tr>
<td>Poland</td>
<td>Unregulated but surrogacy occurring</td>
<td>Commercial available</td>
<td>Commercial available</td>
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<tr>
<td></td>
<td>IVF: $10,850, Surrogacy: $35,800 + Known egg donor add $8,200 + Surrogate &amp; biological father listed on birth certificate</td>
<td></td>
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<tr>
<td>Portugal</td>
<td>Prohibited but surrogacy known to be occurring</td>
<td>Commercial available</td>
<td>Commercial available</td>
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<tr>
<td>Romania</td>
<td>Unregulated but surrogacy occurring commercially</td>
<td>Commercial available</td>
<td>Commercial available</td>
</tr>
<tr>
<td>Russia</td>
<td>Commercial permitted</td>
<td>Commercial permitted Anonymous donation max 5-6 families</td>
<td>Commercial available Anonymous donation no enforced maximum</td>
</tr>
<tr>
<td></td>
<td>Total cost estimated around AUD $90,000</td>
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<td>Slovenia</td>
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<td>Altruistic only</td>
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<tr>
<td>Country</td>
<td>Surrogacy</td>
<td>Oocyte donation</td>
<td>Sperm donation</td>
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<tr>
<td>Slovakia</td>
<td>Prohibited</td>
<td>Commercial available</td>
<td>Commercial available</td>
</tr>
<tr>
<td>Spain</td>
<td>Prohibited (surrogacy not legally recognised)</td>
<td>Commercial available max 6 recipients Anonymous donation</td>
<td>Commercial available max 6 children, Anonymous donation</td>
</tr>
<tr>
<td>Sweden</td>
<td>Currently prohibited, but legislative reform underway limited use of PGD in ART</td>
<td>Compensated only No anonymous Cannot ALSO use donated sperm</td>
<td>Compensated only Max 12 children to 6 families recipients only married heterosexual IPs No anonymous donation</td>
</tr>
<tr>
<td>Switzerland</td>
<td>Prohibited No PGD in ART No non-medical sex selection</td>
<td>Prohibited</td>
<td>Compensation only max 8 children No anonymous donation Only married heterosexual IPs</td>
</tr>
<tr>
<td>Turkey</td>
<td>Prohibited</td>
<td>Prohibited</td>
<td>Prohibited</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>Altruistic surrogacy only available. Advertising for surrogates not legal foreigners cannot access surrogacy in UK Transfer of legal parentage available No non-medical sex selection</td>
<td>Compensation only No anonymous</td>
<td>Permitted max 10 families “worldwide”, compensation only No anonymous donation</td>
</tr>
<tr>
<td>Ukraine</td>
<td>Legal, commercial, Only heterosexual married IPs IVF: $8,500, Surrogacy: $26,000+, Local egg donor add $5,000 + IPs named on birth certificate DNA testing available</td>
<td>Commercial available Anonymous donation</td>
<td>Commercial available, Anonymous donation</td>
</tr>
</tbody>
</table>
References:

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http://www.tapatimes.com/News/taiwan/archives/2013/07/20/2003567762
http://www.globalivf.com/directory/laws/vietnam/
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