

## ■ Original article

## Legal constraints of using surrogacy

Mitra Zandi<sup>1</sup>, Zohreh Vanaki<sup>2,\*</sup>, Marziyeh Shiva<sup>3,\*\*</sup>, Eesa Mohammadi<sup>2</sup>, Narges Bagheri Lankarani<sup>4</sup>, Morteza Karimi<sup>4</sup>

(Received: 16 Sep 2014; Accepted: 26 Oct 2014)

### Abstract

**Background and Purpose:** Surrogacy is a new assisted reproductive technology requiring to be perceived based on the real experiences of surrogacy patients regarding its legal issues so that legislators are able to enact appropriate laws for such patients' safety. This study pursues the goal to examine the experiences of commissioning mothers and surrogates confronting legal issues.

**Methods:** This paper is part of the findings of a larger study conducted over 20 months from October 2011 to June 2013 using the grounded theory approach to explain the process of becoming a mother in commissioning mothers. The experiences of mothers using gestational surrogacy have been analyzed through the conventional content analysis method and then reported in terms of the legal issues of surrogacy. Overall there have been 20 participants including 11 commissioning mothers and 4 surrogates. For incorporating the resources, 5 fertility clinic personnel have also been interviewed. Totally 25 unstructured in-depth interviews have eventually been performed. Data have been collected via purposive sampling method within Royan Institute, and then due to the inadequate number of samples, sampling continued in other surrogacy treatment centers.

**Results:** Commissioning mothers and surrogates suffer a great amount of stress at the time of childbirth, and lack of legal support imposes plenty of problems on them. Participants' experiences revealed a common theme of "legal constraints" with three dimensions as "inefficiency of current laws", "receiving inadequate educational support services" and "stress and frustration".

**Conclusion:** Results indicate disagreeable legal settings for surrogacy leading to a high level of stress imposed on the clients using these technologies. The treatment team should inform the families about the entire process ahead of them before they make their final decision so as to enable them to enter the process fully aware.

**Keywords:** Assisted reproductive technologies, Infertility, Surrogate mother, Legislation, jurisprudence, Commissioning mother

### Introduction

Infertility affects much of the world's childbearing population. Across the world, an estimated 40.2–120.6 million women aged 20–44 years and living in committed relationships fail to conceive after 12 months of trying. Of these, 12–90.4 million are likely to seek medical help (1).

The remarkable advances in the science of medicine lead to the development of new human, ethical, legal and social issues every day; sometimes, the emergence of these problems limits or puts an end to using these medical advances. The functional development of these technologies

\*Corresponding Author 1: Nursing Department, Faculty of Medical Sciences, Tarbiate Modarres University, Tehran, Iran. Email: vanaki\_z@modares.ac.ir

\*\*Corresponding Author 2: Department of Endocrinology and Female Infertility, Reproductive Biomedicine Research Center, Royan Institute for Reproductive Biomedicine, ACECR, Tehran, Iran. Email: shivamarzieh@yahoo.com

<sup>1</sup>Nursing Department, Faculty of Nursing and midwifery, Shahid Beheshti University of Medical Sciences, Tehran, Iran.

<sup>2</sup>Nursing Department, Faculty of Medical Sciences, Tarbiate Modarres University, Tehran, Iran.

<sup>3</sup>Department of Endocrinology and Female Infertility, Reproductive Biomedicine Research Center, Royan Institute for Reproductive Biomedicine, ACECR, Tehran, Iran.

<sup>4</sup>Department of Epidemiology and Reproductive Health at Reproductive Biomedicine Research Center, Royan Institute for Reproductive Biomedicine, ACECR, Tehran, Iran.

depends on the responses given to the questions and issues raised (2,3). Surrogacy is one of the scientific developments of the past few decades for treating infertility that has recently become the most controversial issue of assisted reproductive technologies due to its unique characteristics and aspects (4), and has so far had profound implications for religion, law, ethics and the society (5, 6). Surrogacy is an agreement with a woman who indicates a readiness to become impregnated or an infertile couple and to give up the baby to them after delivery. The woman carrying the baby is the surrogate mother and the commissioning couple is considered the child's genetic (biological) parents (7). Surrogacy helps couples have their own biological children. Surrogacy is classified into two general categories namely gestational (full, host) surrogacy in which the surrogate mother is not genetically related to the child, and partial (traditional, straight) surrogacy in which the surrogate mother becomes the child's genetic mother through donating her egg. Both procedures might be performed with commercial incentives, that is, the surrogate mother receives monetary compensation for carrying and delivering the baby, though sometimes surrogacy is performed with non-commercial (altruistic) incentives (1).

Surrogacy has attracted the interest of many infertile couples in Iran as well and many Shia jurists and legal scholars have permitted its use (8). In Iran, surrogacy was first introduced in 2001 in a number of fertility clinics (9). Commercial surrogacy is currently the more common type of surrogacy in Iran (10); however, there is no precise statistics on the actual number of surrogacies performed in the country.

Although surrogacy is conducted in many countries, few laws have been ratified regarding this procedure (6, 11). For instance, in certain countries such as India and Australia, only the first draft of surrogacy laws has been developed (6, 11, 12). The Iranian legal system lacks particular laws and the rule of precedent or legal precedent pertaining to

surrogacy (13), and the law of embryo donation to infertile couples enacted in 2003 as the only statutory law regarding new methods of pregnancy in our country, which is not helpful as it does not address issues related to surrogacy (14). The current rules and regulations enforced in Iran therefore put the medical team involved in these treatments in a predicament where finding a resolution seems very hard -if not quite impossible. According to Iranian laws, physicians are required to issue birth certificates under the name of the woman who has delivered the child. Issuing false birth certificates is a criminal liability for physicians and entails subsequent punishment. As laws have kept silent on the subject of applying surrogacy, including to issue birth certificates, physicians are unsure about their duties in such conditions (15). If the birth certificate is issued under the surrogate's name, however, the genetic parents face difficulties for having birth certificates issued and having their child's names inserted into their own birth certificates (16). As we know, no studies have been conducted inside or outside the country focusing on a dedicated purpose to describe the experiences of individuals involved in surrogacy in their confrontations with legal issues. In general, there are few empirical data available on surrogacy in Iran; therefore, its effects on the recipients and donors are ill-defined. Investigating the various aspects of using alternative assisted reproductive technologies in Iran, particularly in terms of religion and law, is a pre-requisite for introducing this technology (17). The prevalence of surrogacy has been growing and it is getting more likely for health care providers to be exposed to it in clinical settings (18). Collecting data is therefore a necessary step to informing the institutors of this technology and legislators about the existing issues and also to the development of appropriate rules ensuring the safety of the infertile couple, the surrogate mother and the child (19). Given the current lack of information about

the confrontation of commissioning mothers with legal issues, the present study has been conducted to understand and describe the experiences of commissioning mothers and surrogates about the legal issues of surrogacy and to also examine their manner of dealing with the situation.

## Materials and Methods

This paper is part of the findings of a larger study performed over 20 months from October 2011 to June 2013 employing the grounded theory approach to explain the process of becoming a mother in commissioning mothers. The experiences of couples using surrogacy have been analyzed through the conventional content analysis and then reported in terms of the legal issues of surrogacy. To achieve its objective, the study applied an inductive qualitative approach and also the content analysis method. The purpose behind the content analysis is to provide knowledge, access to new insights, represent events and present a useful action guide (20). The conventional content analysis and the inductive method are useful when there is a shortage of theories and studies on the studied phenomenon (20, 21). Royan Institute constituted the research setting of the present study; however, due to the shortage of samples, other participants admitted to physicians' offices, hospitals practicing surrogacy and fertility clinics across a number of different cities (Yazd, Qom, Rasht, etc.) have also been interviewed for a period of time in the study. Selecting the participants started out through the purposive sampling method and continued until data saturation.

**Data Collection Method:** The present study primary method for data collection was by unstructured in-depth interviews with open-end questions. The unstructured interviews have been done for flexibility and enabled the researcher to keep up with the interests and ideas of the participants (22). Interviews began with the open-

ended question posed as: "How did you spend the waiting period? Would you please describe your experiences and feelings about surrogacy"? To clarify the concept under study, probing questions were asked based on the information obtained from the participants. Based on the answers provided, in-depth questions were asked such as, "Can you clarify further on this subject?", "What do you mean to convey?" and "Can you provide an example?" Interviews have been performed individually and lasted between 30 to 180 minutes with a mean duration of 74 minutes. Data collection has been carried out over 10 months from November 2010 to July 2011.

**Data Analysis Method:** Data collection and analysis have been conducted simultaneously through the conventional content analysis method. This method has the potential to reveal the hidden patterns from the content of the data the participants provide (23). In conventional content analysis, data analysis starts with reading the data several times so that the researcher can achieve a proper understanding of them through long periods of immersion. The second stage is reading the data word by word to deduce their key concepts and ideas as codes. The initial codes are then listed and classified into subcategories; finally, based on the links between the subcategories, the researcher can organize and categorize them into fewer dimensions (21).

In the present study, interviews were recorded with the participants' consent and then promptly typed up word by word in Microsoft Word along with non-verbal gestures such as, crying, laughing and silence, and then imported into Max QDA 2007 software, which is an efficient tool for organizing textual data (23). They were then read and reviewed several times to finally be broken into semantic units. After each semantic unit was reviewed once again, appropriate codes were developed for each unit. The initial open codes were classified based on their conceptual and semantic similarity and then assigned to the main

general and comprehensive categories based on their semantic similarities. These categories were finally reduced to the common theme of “legal constraints”.

To increase data validity, the researchers resorted to holding long periods of immersion in the research subject (for over a year), obtaining both participants’ and observers’ review and triangulation data sources (mothers, surrogates and fertility clinic personnel). Some mothers were unable to vent their emotions and express their previous concerns since they wanted to conceal the truth from others; they therefore found the interviews to be a very comforting outlet for their inner pressures, which increased the study’s validity all the more. Using a sampling technique with maximum diversity helps the reliability and transferability of the findings. For confirmability, reliability, transferability and auditing of the study, the stages and processes have been recorded and reported every minute and step by step for others to be able to follow the study.

## Results

The analysis of the findings finally yielded a common theme of “legal constraints”. This theme indicated the predicaments of the participants in the absence of specific surrogacy laws, the non-applicability of general laws and the difficult legal processes requiring recommendation letters from fertility clinics. Most families learnt about these problems too late and therefore underwent a lot of stress. Under these conditions associated with the feelings of abandonment and stress, lack of support by the treatment centers due to their ill-defined legal duties only aggravates the difficulty of the situation. The theme known as “legal constraints” thus includes three dimensions, “inefficiency of current laws”, “receiving inadequate educational support services” and “stress and frustration” presented in Table 1.

**Table 1.** Summary of the categories formed through analysis

lack of specific surrogacy laws	<b>Inefficiency of current laws</b>	<b>Legal constraints</b>
Surrogate mother, the child’s legal mother		
The difficult legal processes of surrogacy		
Lack of knowledge about the legal issues	<b>Receiving inadequate educational support services</b>	
Receiving no support at the time of delivery		
Stress resulting from a state of anarchy	<b>Stress and frustration</b>	
Feeling abandoned		

1. Inefficiency of Current Laws: “Inefficiency of current laws” implies the absence of specific statutory laws pertaining to surrogacy and the general rules non-applicability and the difficult legal processes requiring recommendation letters from fertility clinics for presenting at the court, and encompasses the three aspects of “the absence of specific laws for surrogacy”, “surrogate mother, the child’s legal mother” and “difficult legal processes of surrogacy”.

1.1. Absence of Specific Laws for Surrogacy Although surrogacy has been practiced in Iran for more than a decade, no specific laws have been developed for surrogacy in the country; using surrogacy is not banned in Iran and applying this technology is growing increasingly. The personnel of one fertility clinic with years of experience consulting with these families said: “Well, right now we don’t have any specific rules for surrogacy. You know that hospital considers the woman delivering the child as the mother. Unfortunately, this is because the law is very insufficient” (Personnel 5).

A mother who underwent a lot of stress for choosing a hospital as the due date approached said: “They said it’s a legal procedure, but in the end they made it look illegal” (Mother 7).

This issue was also confirmed by the surrogates’ experiences. One of the surrogates facing a lot of difficulties at the time of delivery stated: “At the

time of delivery they say it's illegal. If it's illegal, why does the clinic perform it?" (Surrogate 2).

As there are no specific rules and regulations for using surrogacy, the only remaining solution at the present moment is to bind secure contracts between the parties; however, the existing surrogacy contracts are not supported by law and thus cannot be considered a form of legal support for the families. These contracts are not clear, either and do not consider how to deal with the potential common problems such as multiple pregnancy, premature birth and pregnancy difficulties such as, pregnancy-induced hypertension and diabetes. Consequently, the contracts are not taken into account by either the contract parties or the fertility clinic personnel to be used as a strong basis for support. One of the mothers says on this issue: "The contract we signed was too much of a formality. And the contract we signed in the clinic was not legally binding, either. I mean, if they didn't want to give us the baby, they easily could" (Mother 2).

The fertility clinic personnel also directly noted the ineffectiveness of the existing contracts: "The truth is that these contracts are of no help, and the whole thing is just a matter of conscience. The commitment is precisely moral and conscientious" (Personnel 4).

One of the main problems of the existing rules is that the Iranian civil law has refused to define the word 'mother' due to the clarity of its signification, and the current laws are written in such a manner that the woman giving birth to the child is recognized as his/her mother; as a result, the birth certificate is only issued under the name of the woman who has given birth to the child causing numerous problems for the genetic mothers solely commissioned a surrogate to have their own genetic child. One of the mothers narrated her experiences this way: "During the last month, I mean week 37, we came to the clinic and told them that we have heard in our town up-north that the surrogate's name is written in the birth certificate. They

confirmed what we'd heard and said that we might face some problems and so on" (Mother 11).

The fertility clinic personnel confirmed this finding: "The problem is that, according to the Iranian civil law, the woman who gives birth at the hospital is considered the child's mother. So if the hospital wants to issue a certificate, it will do so under the name of the woman who has given birth to the child-naturally, that's the surrogate" (Personnel 3).

"We can only record the name of the surrogate, and then her name will be inserted in the child's certificate, which isn't pleasant for many people" (Personne 11).

1.3. Difficult Legal Processes of Surrogacy: As previously mentioned, according to the Iranian law, the woman giving birth is considered the child's mother. One way to deal with the current situation is to go to the court with a recommendation letter from the fertility clinic or the physician and explain the situation and obtain permission from the court. But going through these stages legally in Iran requires a claim of parentage and evidence of parentage and the surrogate's presence at the court, which is very difficult and takes months; rules that are very difficult to be practiced are ultimately useless. The statements of fertility clinic personnel as the experts in surrogacy laws support this claim:

"Its legal process is very difficult and can be solved by the court, with a claim of parentage and evidence of parentage carried out through several court sessions, which usually calls for surrogates to be taken in and out of the court, while most surrogates don't want to be in touch after giving birth. They don't want anyone to know about their arrangement" (Personnel 3).

2. Receiving Inadequate Educational Support Services: "Receiving inadequate educational support services" signifies not receiving training in the field of surrogacy legal issues and laws before choosing this method and starting treatment and also not receiving legal support at the time of delivery from hospitals and treatment centers including fertility

clinics. This concept encompasses two aspects of “being unaware of the legal issues” and “receiving no support at the time of delivery”.

2.1. Being Unaware of Legal Issues: Families unawareness of the legal issues of surrogacy is a major problem with commissioning families and surrogates. The participants stated that they had not received clear training on the legal issues of this method prior to making their choice, and were also kept unaware of them during their waiting period; therefore, toward the end of the waiting period, exactly when the families are preparing themselves for choosing a hospital for childbirth, they suddenly learn about these legal issues. One of the mothers who had six-month old twins at the time of the interview and who had gone under a lot of stress said: “Toward the end, we asked the hospital and they told us that we should go get a letter from the court. They told us this at the very last minute! Well, they could have told it to us 9 months earlier so that we knew! We didn’t have any time left for going to the court and doing this stuff! And my kids were born prematurely, toward the end of the 8<sup>th</sup> month. They were incubated at the hospital. We didn’t have time for this” (Mother 7).

2.2. Receiving No Support at Delivery Time: Due to the existing legal issues and lack of support from the legal authorities, no organization, including the fertility clinics and hospitals took on the responsibility of delivering the surrogate child, so families faced a lot of problems, including the legal ones, on the day of delivery, which is a crucial day for everyone and the fear of losing the baby threatens the family's last hopes.

“We didn’t know what to do at all. There is no support system for us. I was shattered during those 9 months! Like, for the birth certificate, I called a lot of places, different hospitals -none of them took on the responsibility” (Mother 7).

The surrogates had also experienced this lack of support and confirmed the mothers' experiences. One of the surrogates said: “The delivery day was a tough day for us, being too uninformed! It was a

terrible day! We had expected something else. We had expected more cooperation on the part of the institute, but we didn’t get that. I’m very *discontent* with the institute. We thought that Ms. I-don't-remember-her-name would be with us. Since she was there for us from the beginning, we'd hoped that she would be there, but she wasn't, and it didn't seem like such an improper expectation to me” (Surrogate 2).

Also, as there are no rules and regulations about the use of surrogacy, hospitals and fertility clinics had to refuse taking responsibility for delivery, and could not support patients at the time of delivery because of potential problems that could arise. A fertility clinic staff explained the current conditions: “Hospitals don’t know what to do, because there is no legal support for this case. When they go to the hospital, what is the hospital going to do? The hospital has to admit the surrogate and record her name in the papers. So it's yet another problem when her name is recorded” (Personnel 5).

3. Stress & Frustration: In this state of anarchy, the contract parties, i.e. the commissioning couples and the surrogates, are the ones who suffer at the time of delivery. “Stress and frustration” resulting from the legal conundrums characterizes the emotions of both mothers and surrogates when running into the existing legal barriers, and include two aspects of “stress resulting from a state of anarchy” and “feeling abandoned”.

3.1. Stress Resulting from a State of Anarchy: Commissioning mothers go through very difficult and stressful processes towards the end of their waiting period and childbirth is one of the most stressful stages of becoming a mother for them due to concerns about the fetus and the surrogate's health. However, in addition to the concerns about the delivery and the health of the fetus and the surrogate, confronting legal issues fuel the delivery stage related stress and difficulty. One of the mothers narrates her experiences of the final days of her waiting period: “On the one hand, I was worried about his birth certificate, because, at that time, they

had told us that we might face some difficulties since my name wouldn't be inserted; well, I was very worried about. It could become very problematic for me later. I wondered what if they don't accept it. What am I to do?" (Mother 10).

A mother with a 16-month old child at the time of the interview says about her experiences at the hospital and during the surrogate's delivery: "We had to go through a lot at the hospital. At first, when we told them that the woman in labor was our surrogate, they said they should consult with the head of the hospital. Come on! And then we had to wait there for a long time, all worried! Consider how much they wasted our time!" (Mother 1).

Since the insertion of the mother's name in the child's birth certificate requires parental evidence at the court, which is a complex, time-consuming process, to prevent from the surrogate's name being inserted in the birth certificate, some families have to resort to illegal instruments, such as the surrogate's admission to the hospital under the mother's name, and these inefficient strategies are per se a source of additional concern for them. For example, in one case, the surrogate was admitted to the hospital under the mother's name and the mother had been too worried about the consequences of this illegal action:

"What I worried about was if at the time of delivery, this woman (the surrogate) was to die under anesthesia, my name is there on the forms! I was afraid that if something went wrong for her, we would have to correct the documents telling the court 'hey this is me, I'm alive, and this is what actually happened'. God forbid, if she died, the burial permit would be issued under my name. This made me sick with worry" (Mother 6).

Surrogates undergo a lot of stress for their resort to these illegal strategies as well. One of the surrogates admitted to the hospital under the mother's name stated about her experiences on the delivery day: "I introduced myself as [the mother's name]! On that day I had to handle the stress of keeping all that information in my head, who was I?

Where was my husband from? Then my husband would sit and wait, and I would go file a case with Mrs. [the mother's name]'s husband. The conditions weren't so suitable for delivery" (Surrogate 2).

3.2. Feeling Abandoned: The feeling of abandonment, frustration and disappointment emerge as the result of lack of legal support for the families by the government and consequently, by fertility clinics and hospitals. One of the mothers presenting herself to the fertility clinic to choose a hospital in the last days of her surrogate's pregnancy tells of her experiences: "One authority at the fertility clinic said: 'No Madam, this is illegal, do something yourself. See if you can find someone you know at some hospital. We got very disappointed. It was very disappointing for an authority of the clinic to tell us that our undertaking was illegal! It was very difficult for us. Suddenly we began to doubt what we were doing! We were lucky that when he said our undertaking was illegal, my husband wasn't in the room. If they said that in front of my husband, he'd say, 'Maybe this isn't our child? Maybe it works a different way that they now say it's illegal? There must be something wrong with it'. And that's too bad! Their whole work is undermined!" (Mother 11).

Another mother who had presented herself to the fertility clinic in order to select a hospital towards the end of her waiting period and had suddenly learnt about the legal issues with surrogacy asserted: "We were totally lost, we didn't know what to do or where to go. When we went to the clinic, we were told to talk to Ms. so and so and then she would tell us that she didn't want to get the hospital into trouble, and would then guide us to the office of so and so. But we had started the whole process here, now our work is almost done, approaching its end. Where do we go if we want to get done with everything? Who do we go to see? They all passed us back and forth to each other" (Mother 7).

Other surrogates' comments also confirm these experiences: "Then we went to the hospital, we

were very confused there, not knowing what to do” (Surrogate 2).

The fertility clinic personnel acknowledged their abandonment of the patients at the time of delivery and believed the main factor for their not being supportive was lack of support from the law for service providers and patients.

“These people (patients) suddenly feel detached, you know! Like, imagine they have been in constant touch with a social worker for 9 months, undergoing treatments, for ultrasound, follow-up, whatever problem, bleeding, and the like, and they have received all kinds of support from the clinic, and then comes the time of delivery, and they are completely abandoned, just because there are no laws on it” (Personnel 5).

## Discussion

The study aims to investigate the experiences of commissioning mothers and surrogates in confronting with legal issues. The participants' experiences suggested that surrogacy clients undergo a lot of stress due to lack of laws and regulations in particular on surrogacy and the silence on the part of legislators on this issue. To escape legal barriers and obtain a birth certificate under the genetic mother's name, patients resort to illegal actions, on their own that leads to additional financial, mental and psychological pressure for them. The participants' experiences revealed a common theme of “overcoming legal constraints”, including three aspects of “inefficiency of current laws”, “receiving inadequate educational support services” and “stress and frustration”. To better organize the discussion, we first proceed to investigate and compare the Iranian law and the other countries' laws and then move on to comparing the issues faced by surrogacy patients and how they deal with them in Iran and in other countries.

An overview of different countries' laws for surrogacy suggests a range of them. On the one side

of this range, there are laws that ban all forms of surrogacy agreements and consider their practice an offense, for instance, China, France, Germany, Sweden, Switzerland (1, 24), Finland, Denmark, Spain, some states of the U.S.A (24) and some states of Australia such as Queensland and Tasmania (12, 24) where surrogacy is prohibited in all forms; in the middle of this range is the legal ban on commercial surrogacy only, for instance, in Canada (since 2004) (1, 25, 26), U.K. (1, 27, 28) and Australia (1, 29). Commercial surrogacy is permitted in Israel, but familial surrogacy is forbidden on religious grounds (1). At the other end of the range are countries whose law has been silent on this topic, or in which both commercial and non-commercial surrogacy forms are exempt from prohibitions, for instance, in Thailand, India (since 2002) (30), Russia, Ukraine (6) and almost half of the states in the US (24). Iran is also among the countries where both commercial and non-commercial surrogacy forms are exempt from legal bans.

In countries where applying surrogacy is prohibited in all its forms, patients are clear about their liberties and will be convicted and investigated in case they perform surrogacy; however, given that having children is a natural right of human beings (24), general bans on using new assisted reproductive technologies such as surrogacy do not seem reasonable and have been problematic to some extent. According to the studies conducted (1, 30), trips from the patients' country of origin to other countries, particularly to developing countries such as India, for using assisted reproductive technologies is rapidly growing. Surrogacy birth rate doubled in India from 2003 to 2006; in 2011, approximately 2,000 children were born through this technique in India alone, and researchers estimated that over 1000 of them to have been British patients, in whose country commercial surrogacy is forbidden and has only had 100 births through surrogacy in 2011 (1). From late 2012, India has stopped issuing visas for gay, single and



de facto intended parents resulting in a decline in India-bound travels and instead an increase in trips to Thailand (29). Among Asian countries, India and Thailand have had the highest rate of providing assisted reproductive care to international patients, even though this trend is rising in Singapore, Malaysia and South Korea, particularly for the patients of that region. A fundamental reason for seeking fertility care in other countries is the legal restrictions applied to treatments in the people's country of origin; therefore, banning surrogacy altogether in some countries leads to the commercialization and exploitation of women, especially in developing countries where employing this method is an option (30).

Although surrogacy technology is performed in many countries, statutory laws particular to this issue are fairly limited (6, 11). In some countries such as India and Australia, specific surrogacy laws are nothing but the first draft (6, 11, 12). In Japan, there are no legislations for using this method leading to the emergence of social and ethical nuisances (24). Indian databases include a list of 600 IVF clinics and 400 made-up clinics that perform surrogacy with no regulations (1). In 1985, U.K. hastily passed laws that banned employing commercial surrogacy contracts only and also all advertisements related to it; however, no definition was provided for commercial and non-commercial contracts implying that using altruistic surrogacy is allowed. The law has not outlawed payments to the surrogate mother. Distinguishing between commercial and non-commercial surrogacy is thus problematic. The majority of the countries legally banning commercial surrogacy have not taken account of non-commercial (altruistic) surrogacy contracts (11). Surrogacy contracts do not have a legal status in many countries, including the U.K. (11) and Iran (31). Van den Acker (2007) writes that legal texts are still filled with laws with devastating effect on the surrogacy triad (the commissioning mother, the surrogate and the

offspring). Today, in the U.K. (unlike some states of the US), neither party of the surrogacy triad can be certain about the child's future and contracts are not legally applicable in the U.K. (28). In the US, there are no national legislations on surrogacy contracts and each state is free to enforce its own legal view on this issue. Some states strictly refuse to approve such contracts while some others have developed penetrating laws in this regard (11). Different U.S.A state laws can be classified into six general categories from the most desirable to the most restricted, with the larger part of the states being placed in the middle of the range (19).

As demonstrated by the present study results, the legal conditions of surrogacy contracts in many countries are largely similar to those of Iran; no particular surrogacy law has yet been approved in Iran (6). Under the present conditions, legal problems resulting from the existing laws have imposed many limitations on preparing, documenting and developing the contracts between the infertile couple and the surrogate and also on supervising the treatment centers when implementing the contract (31). Akhondi (2008) writes that, evidently, if the Islamic Consultative Assembly takes the first step in this regard, the problems of infertile couples applying to use surrogacy services will be largely overcome (31). It is interesting to know that in most U.S. states, the task of developing laws for surrogacy contracts, for instance developing applicable contracts, has been entrusted to the courts, even though courts are little prepared for setting rules on such complicated matters (19); What is important, however, is that legislators require detailed, comprehensive and holistic medical information to set rules on such complicated and multifaceted issues, which itself requires the treatment team to take the initiative. It is upon the physicians and fertility clinic personnel, who have the opportunity to closely observe handling such issues and consequences of these actions, to

inform legislators of the exact conditions and to help improve the interdisciplinary understanding of this phenomenon and try to resolve the issue together with the legislators. In addition, accrediting fertility clinics is another important issue that must be contemplated in Iran. In Australia, there are no extensive legislative organizations dealing with assisted reproductive technology services; however, all fertility clinics are annually visited by the Reproductive Technology Accreditation Committee to ensure their compliance with the minimum standards and to encourage them to improve the quality of care provided to their patients. Furthermore, through the National Health & Medical Research Council (NHMRC), the Federal Government of Australia has published ethical strategies for clinical use in assisted reproductive technology services and research (12). About confronting legal issues, as suggested by the participants' experiences, the current registration rules do not permit to issue birth certificates under the genetic parents' name; the physician is therefore obliged to issue the child's birth certificate under the surrogate's name, unless he seeks to commit an offense and issue the certificate under the genetic parents' name or unless the surrogate is inevitably forced to commit an offense and admit herself to the hospital under the genetic mother's name. These limitations have halted the use of this permissible method of treatment despite its being absolutely ethical and moral, and have imposed a lot of limitations on infertile couples (31). Issuing the birth certificate under the name of the woman giving birth to the child is not specific to Iran and most countries, including, Australia (12), the U.K. (11, 28, 32), the Netherlands (33) and some states of the U.S. such as Kentucky (11), also consider the woman who gives birth to the child as the legal mother; in Australia, in case the surrogate has husband, he is considered the child's legal father (12). In his review article, Dermis August (2010) states that, in the Netherlands, after the

child is born, his birth certificate is issued under the name of the surrogate and her husband, and one year after the child's birth, the commissioning couple can finally take actual custody of the child; he further asserts that the purpose of this one year of unnecessary stress dictated by the law is unclear, and recommends reforms to be made to the surrogacy laws of this country so that the child's custody is immediately given to the commissioning couple (33). In the U.K., the surrogate is the child's legal mother (even if the sperm and ovum belong to the commissioning parents); therefore, if the surrogate wants to keep the baby, the commissioning couple cannot put her under pressure (11, 28, 32). If the surrogate is willing to give up the child, the commissioning couple can adopt the child (11, 28). Illinois laws also stipulate that, based on the current rules, the woman who has given birth to the child is considered its mother, but a written confirmation and a confession letter emphasizes that the surrogate mother and her husband are not the embryo's parents so as to prevent post-birth relevant problems (6); in California, however, the court gives custody of the child to the woman who wants to have a child of her own first; it thus seems that California has the most agreeable laws for commissioning couples. In India, the surrogate is not considered the child's legal mother under any circumstances (11), which appears to be the main reason for which India had the highest rate of providing international reproductive care until 2012.

Although conditions are fairly similar to Iran in other countries, very few studies have examined the experiences of families running into these legal issues. In a study performed in 2014 by Everingham et al. on the experiences of commissioning couples with surrogacy, 75% of the participants mentioned their fear of the surrogate's decision to keep the child, which has been a main factor in pursuing the use of surrogacy outside of Australia for them (29). In a

study in the U.K., Acker (2000) stated that 8% of mothers were concerned during their waiting period (i.e. during the surrogate's pregnancy) about the possibility of legal problems and 23% were worried that it might prove emotionally difficult for the surrogate to give up the child (34); in another study (2007), he briefly refers to the fear of the surrogate not giving up the child and also to the existing legal problems (28). To develop secure laws can be considered a critical source of support for surrogacy commissioning couples. There were no studies addressing "the participants' experiences" receiving educational support services suggested to be considered for future research. In a study conducted in Iran by Shamaeian Razavi et al. (2014), even the medical personnel had very little knowledge on the ethical and legal bases of surrogacy (35). In his article, Hamaberg (2011) writes that, in Australia, counseling is mandatory for all parties involved in a surrogacy contract and one provision of such consultations is to ensure that adequate legal advice on surrogacy contracts is provided in all the states where surrogacy is performed (12). When a couple chooses surrogacy, it is the task of the physician to ensure that the couple is fully familiar with all the legal and ethical aspects and issues of surrogacy, its advantages and the alternative techniques available, in addition to all the medical aspects of the procedure and its risks. If the fertility specialist is not familiar with these issues, they should refer the couples to a good counselor (11). Kirk (1998) refers to the direct or indirect role of all professionals involved in assisted reproductive services, including, the nurses, midwives and social workers, in informing the society & supporting and informing the infertile couples seeking treatment about the potential problems existing ahead of them, and states that professionals should be aware of the problems people might go through this process and also emphasizes the importance of updating the knowledge base of the professionals employed

in such rapidly progressing fields (32). In his article, Akhoondi (2007) suggests that a major point requiring attention in laws is recording both parties' full written consent about their selection of either treatment method. This consent should clarify the surrogate's commitment to ignore all the rights and obligations of giving birth to a child and state very clearly that the infertile woman is the child's legal mother and the infertile couple's commissioning surrogacy is its legal parents. Consulting with an attorney well-informed in this field is essential to get information on the existing laws and the potential problems of this process. Any information that might make the couple change their decision for using these techniques should be provided in many consultation sessions held ahead of starting the treatment, and the use of these techniques should be bound to the time when the couple has accepted the treatment and given their consent to it fully knowledge. Using these techniques to treat infertile couples without performing the preliminary health assessments on the donor and the recipient and the failure to provide accurate information for the infertile couple on various jurisprudential, legal, psychological, social and moral aspects of the treatment can cause irreparable social damages for the couple and the offspring; therefore, fertility clinics should pay particular attention to this matter (17). Unfortunately, due to lack of legislative support for the treatment team, physicians, hospitals and fertility clinics, families are often not informed about the legal issues with surrogacy until getting into the waiting period and thus ending up going under a lot of stress.

## Conclusion

The participants' experiences in the present study indicate the disagreeable legal settings for surrogacy, leading to excessive stress imposed on the patients resorting to these new technologies. To prevent the additional psychological, mental and

financial stress imposed on the patients, it appears necessary to handle this issue more seriously and to develop clear rules pertaining to it. Moreover, treatment teams should comprehensively inform the families about the course of the treatment and enter them into the process fully knowledgeable. People to agree with them and promoting the public general knowledge about HIV/AIDS.

### Conflict of interest

The Authors declare that they have no competing interests.

### Author's contributions

M. Zandi collected and analyzed the data and prepared the draft article; Z. Vanaki and E. Mohammadi (the supervisor and the advisor) evaluated the entire process continually. Z. Vanaki, E. Mohammadi and M. Shiva conducted the critical evaluation of the draft article. N. Bagheri Lankarani and M. Karimi contributed with finding samples, coordinating the interviews, providing necessary facilities for interviews and translating the article.

### Acknowledgments

This study is part of a nursing PhD thesis and a joint research project with Tarbiate Modarres University and Royan Institute separately approved by the Ethics Committee of Tarbiate Modarres University and Royan Institute (2010, Project No. 3-431). Hereby, we would like to express our gratitude to all of the participants for their valuable experiences and also to the research deputy of Tarbiate Modarres University for their financial support and to Royan Institute for their sincere cooperation.

### References

1. Knoche, J.W. Health concerns and ethical considerations regarding international surrogacy. *Int J Gynaecol Obstet.* 2014; 126: 183-186.

2. MacCallum F, Lycett E, Murray C, Jadva V, Golombok S. Surrogacy: the experience of commissioning couples. *Hum Reprod.* 2003; 18(6): 1334-1342.
3. Jadva V, Murray C, Lycett E, MacCallum F, Golombok S. Surrogacy: the experiences of surrogate mothers. *Hum Reprod.* 2003; 18(10): 2196-2204.
4. Kian EM, Riazi H, Bashirian S. Surrogacy: viewpoints of Infertile Women. *Iran J Obstet Gynecol Infertil* 2013; 16(49-50): 23-32 (Persian).
5. Yousefi H, Ghahari S. Perspectives and challenges of surrogacy in Iran. *J Reprod Fertil.* 2008; 9(2): 138-143.
6. Asemani O, Emami M. Comparing the Iranian surrogacy law and the gestational surrogacy act of illinois. *J Reprod Infertil.* 2010; 11(4): 305-318.
7. Kisu I, Banno K, Mihara M, Iida T, Yoshimura Y. Current status of surrogacy in Japan and uterine transplantation research. *Eur J Obstet Gynecol Reprod Biol.* 2011. 158(2): 135-140.
8. Garmaroudi S. Gestational surrogacy in Iran. *J Reprod Fertil.* 2008; 9(1): 51-64.
9. Hamdolahi A, Roshan M. Comparative study of jurisprudence and legal contract of Surrogacy. First ed. 2009, Tehran: Majd. 312.
10. Aramesh K. Ethical assessment of monetary relationship in surrogacy. *J Reprod Fertil.* 2008; 9(1): 37-42.
11. Sharma B.R. Forensic considerations of surrogacy an overview. *J Clin Forensic Med.* 2006; 13(2): 80-85.
12. Hammarberg K, Johnson L, Petrillo T. Gamete and embryo donation and surrogacy in Australia: The Social Context and Regulatory Framework. *Int J Fertil Steril.* 2011; 4(4): 176-183.
13. Alizadeh M. ed. Effects of surrogacy arrangements. Razavi University of Islamic Sciences. 2009; 12: 167-187.
14. Avecina-Infertility-Center[editorial], Surrogacy. 2007, Tehran: SAMT.
15. Milanifar AR, Akhondi MM, Behjati Ardekani Z, Abdolazadeh A. Issuing birth certificates and ID cards for newborns following a surrogate birth and the legal and ethical relationships of the medical team. *J Reprod Fertil.* 2008; 9(1): 83-88.
16. Rahimi H. Civil responsibility in surrogacy. *J Reprod Infertil.* 2008; 9(2): 166-181.

17. Akhondi M.M, Behjatiardakani Z, Arefi SS, Sadri ardekani H, Arabi M, Zarnani AH, et al. A close look at natural and in vitro fertilization as well as the need for donated gametes in treatment of infertility Payesh. 2007; 6(4): 307-321.
18. Burrell C, Edozien C. Surrogacy in modern obstetric practice. *Semin Fetal Neonatal Med.* 2014; 19(5): 272-278.
19. Gugucheva M. *Surrogacy in America, 2010*, Council for Responsible Genetics: Cambridge.
20. Elo S ,Kyngas H. The qualitative content analysis process. *J Adv Nurs.* 2008; 62(1): 107-15.
21. Hsieh HF, Shannon SE. Three approaches to qualitative content analysis. *Qual Health Res.* 2005; 15(9): 1277-1288.
22. Abedi H.A, Ravanipoor M, Karim Elahi M, Yusefi H. *Qualitative research methods in nursing.* 2006, Tehran: Boshra.
23. Zhang Y, Wildemuth B.M. *Qualitative Analysis of Content.* 2007: 1-12.
24. Kisu I, Banno K, Mihara M, Iida T, Yoshimura Y. Current status of surrogacy in Japan and uterine transplantation research. *Eur J Obstet Gynecol Reprod Biol.* 2011; 158(2): 135-40.
25. R.Reilly D. Surrogate pregnancy: a guide for canadian prenatal health care providers. *CMAJ.* 2007; 176(4): 483-485.
26. Lozanski K. Transnational surrogacy: Canada's contradictions. *Soc Sci Med,* 2014: pii: S0277-9536(14)00649-2.
27. Schenker JG. Assisted reproduction practice in Europe: legal and ethical aspects. *Hum Reprod Update.* 1997; 3(2): 173–184.
28. van-den-Akker OB. Psychosocial aspects of surrogate motherhood. *Hum Reprod Update.* 2007; 13(1): 53-62.
29. Everingham SG, Stafford-Bell MA, Hammarberg K. Australians' use of surrogacy. *Med J Aust.* 2014; 201(5): 1-4.
30. Whittaker A. Cross-border assisted reproduction care in Asia: implications for access, equity and regulations. *Reprod Health Matters.* 2011; 19(37): 107–116.
31. Akhondi M.A, Behjati-Ardakani Z. Surrogacy and the necessity for its application in infertility treatment. *J Reprod Infertil.* 2008; 9(1): 8-13.
32. Kirk M. Relative concerns associated with genetics and surrogacy. *Br J Nurs.* 1998; 7(12): 717-721.
33. Dermout S, van de Wiel H, Heintz P, Jansen K, Ankum W. Non-commercial surrogacy: an account of patient management in the first Dutch Centre for IVF Surrogacy, from 1997 to 2004. *Hum Reprod.* 2010; 25(2): 443-449.
34. van-den-Akker O. The importance of genetic link in mothers commissioning a surrogate baby in UK. *Hum Reprod.* 2000; 15(8): 1849-1855.
35. ShamaeianRazavi N, Abbaspour S, Khademi H, Farhadifar A. Investigating Perspectives of doctors, nurses and midwives about Surrogacy treatment. *Journal of Torbat Heydariyeh University of Medical Sciences.* 2013; 1(2): 31-38 (Persian).

