

### **Conclusions and Implications**

This study aimed to explore experiences of surrogate mothers in Gujarat, India with a special interest to inform surrogacy policy and practice. The review indicated the need to understand experiences of women in the context of family and situate their experiences in the conception of the ‘Indian self’ and the ‘psychological agency of women in India.’ The conceptual framework of this study was developed using the cultural psychology perspective as a base and explored the women’s journey through surrogacy treating women in the context of family as intentional agents. This chapter reports the conclusions and recommendations that evolve from this study.

In response to the research question one exploring the experiences of surrogate mothers, the study revealed that systemic failures in the form of the macro-context of poverty, poor educational attainments and limited livelihood opportunities promoted participation of women in surrogacy. Women’s motivations revolved around needs of their family, especially children. They viewed surrogacy as the only means to break the cycle of poverty and ensure a good future for their children. Women believed that fulfilling the duties towards their children and family will ensure for them respect in the family and society and reciprocal care in the old age. Throughout surrogacy, surrogate mothers were systematically objectified and their rights were compromised. The practices followed at the ART clinic reduced surrogate mothers to mere means to an end. The study indicated lack of preparedness of women when they embarked on the surrogacy journey. Miscarriages left women with barely any financial gains as 85 percent of the money was paid after successfully handing away the baby. Fear of financial loss compelled women to obsessively adhere to the restrictions imposed during gestation. The primary barriers women experienced included alternative childcare arrangements for own children during institutionalisation, conflicts with

spouse and family over the decision to participate in surrogacy, social stigma, alienation during institutionalisation, medical regimen and extensive care work, health challenges, limiting experiences with commissioning parents, and fear of loss of pregnancy. Inadequate or excessive contact with commissioning parents during gestation, linguistic barriers, and unsatisfactory closure of the surrogacy were primary challenges reported with the commissioning parents. Though, women's positive experiences with the commissioning parents outnumbered negative experiences, a few women reported coercion for participation in surrogacy or to share the income earned through surrogacy with the extended family members. It appeared that the micro-context of women, especially stability of their marital relationship was crucial for the positive surrogacy outcome. Need for professional counselling and guidance was glaringly evident.

The second research question focused on understanding the development of maternal identity in the course of surrogacy. It was found that the concept of '*Dava Goli Nu Baalak*' (a child born through medication) juxtaposed non-maternal and maternal identity of the surrogate mothers pushing them to idealise the surrogate role. An ideal surrogate mother confirmed to the rules, avoided demands for extra benefits, avoided claims over the child, demonstrated self-control, and maintained positive relationships throughout surrogacy. Majority of the surrogate mothers (85%) asserted their maternal identity as 'one of the mothers' of the surrogate child if not the primary mother and almost half of the surrogate mothers referred to the commissioning mother as an adoptive mother of the child born through surrogacy. Surrogate mothers selectively used both indigenous and scientific perspectives of procreation to obliterate maternal identity of the commissioning mother; albeit with the recognition that the financial contract would eventually lead to the relinquishment of the baby.

The third research question explored psychological agency of women in the context of surrogacy in India and revealed its complexities. Most women (85%) appeared to have some control over the decision to participate in surrogacy though experienced considerable resistance from their spouse. Different individuals assumed a lead role at unique junctures during decision-making while women negotiated their participation with the family members. The predominant agency practices women used in the context of surrogacy included, 'ascertaining facts', 'selective disclosure', 'assertion', 'negotiation', 'request', and 'persuasion'. Women formed alliances in the familial setting to utilise collective power in pursuit of their own goals either to seek approval of the male family members or to override decisions taken by men. They used collective agency in the clinical setting to negotiate their goals with commissioning parents and medical professionals. Most women exercised agency more frequently in the context of family in comparison to the clinical setting. The authoritative power position held by medical practitioners in the Indian society possibly restricted expression of women's agency in the clinical setting. Women's agency practices appeared to be associated with traditional patriarchal mentalities, gender roles, and a familial self that valued duties, hierarchy, and context sensitivity.

Finally, the fourth research question sought to study the influence of surrogacy on the lives of women and revealed that participation in surrogacy helped majority of women alleviate poverty to some extent. Most of the women stated that they invested at least part of their surrogacy income in some form of savings which gave them a sense of security. Other than material gains, women reported improvements in their personal lives in the form of increased say in the family matters, respect in the family or in rare cases in society, and sustained contact with the commissioning parents and

the fellow surrogate mothers who became friends. These new relationships added to a sense of personal fulfilment.

Overall it appeared that monetary compensation was not the primary factor leading to exploitation of women in the context of surrogacy. The routine practices followed in the surrogacy programme, lack of preparedness of women for surrogacy, and preference given to the needs of the commissioning parents as a paying party over the needs of the surrogate mothers lead to subtle forms of exploitation. Ban on commercial surrogacy proposed under the Surrogacy (Regulation) Bill, 2016 therefore is inadequate to protect the well-being of the surrogate mothers in India. The policy instead needs to focus on standardising surrogacy programmes across the nation and mandate inclusion of a rigorous counselling component to promote informed decision making and ensure physical and mental well-being of the women entering surrogacy. The remainder of this chapter reviews the Surrogacy (Regulation) Bill, 2016 in light of the findings of this study and the literature review conducted for this study, and proposes amendments to it. The chapter also proposes structured counselling guidelines to ensure well-being of Indian women entering surrogacy arrangements.

### **Implication for Policy**

The Surrogacy (Regulation) Bill, 2016 introduced by the Government of India to regulate unbridled growth of surrogacy and to ensure the well-being of the surrogate mothers, commissioning parents and the children born through surrogacy is a welcome step. The Bill is comprehensive in its coverage as it,

- directs to constitute national and state Surrogacy Boards to govern its practice
- establishes clear terms for the registration and regulation of surrogacy clinics with detailed eligibility criteria for the clinics and all the professionals/service providers

- determines eligibility requirements for the commissioning parents as well as surrogate mothers
- mandates measures for the well-being of the surrogate mothers including insurance coverage and informed consent for the treatment as well as any abortion required
- establishes a violation of prescribed terms as a punishable offence

The Bill also changed the definition of infertility from ‘the inability to conceive after at least one year of unprotected coitus’ to ‘inability to conceive after five years of unprotected coitus.’ It is a commendable move without which the burgeoning profit-driven ART industry may otherwise push couples to seek ART services too early. A careful analysis of the provisions of the act indicates the need for further strengthening some areas and a need to reconsider some restrictions imposed. The identified lacunae in the Bill are as follows,

Clause 2 (b) defines ‘altruistic surrogacy’ as, *“the surrogacy in which no charges, expenses, fees, remuneration or monetary incentive of whatever nature, except the medical expenses incurred on surrogate mother and the insurance coverage for the surrogate mother, are given to the surrogate mother or her dependents or her representative.”* The Bill, however, does not specify under any of its sections, the precise conditions under which dependents or her representatives receive the medical expenses incurred on the surrogate mother and the insurance coverage for her. It is important to set out clearly these conditions in the Bill.

Clause 2 (q) defines ‘insurance’ as, *“an arrangement by which a company, individual or intending couple undertake to provide a guarantee of compensation for specified loss, damage, illness or death of a surrogate mother during the process of surrogacy.”* The Bill does not specify under any of its sections what amounts to

‘loss’, who determines whether the loss is worthy of compensation, who determines the amount suitable for such compensation, and what would be the base criteria for determining the amount of such compensation. It would be useful to specify minimum amount and cap maximum amount payable as compensation under various circumstances. Further, whether the commissioning parents provide government sponsored health and life insurance schemes to the surrogate mother and shift the burden of any health complications or death of the surrogate mothers on the public insurance system is not specified.

Clause 3 (vii) states that,

*“No surrogacy clinic, registered medical practitioner, gynaecologist, paediatrician, human embryologist, intending couple or any other person shall store a human embryo or gamete for the purpose of surrogacy: Provided that nothing contained in this clause shall affect such storage for other legal purposes like sperm banks, IVF and medical research for such period and in such manner as may be prescribed”.*

The objective for restricting storage of embryos and gametes for use in surrogacy is not clear especially when the Bill permits it for research and other purposes. Ability to store embryos and gametes can help commissioning parents and donors to prevent undergoing the painful and risky procedures of egg extraction repeatedly and may reduce repetitive procedural costs. The Act should reconsider restrictions imposed on the storage of human gametes and embryos for the purpose of surrogacy.

Clause 3 (b) (II) stipulates, *“No person, other than a close relative of the intending couple, shall act as a surrogate mother and be permitted to undergo surrogacy procedures as per the provisions of this Act.”* This clause is especially

problematic for two reasons. Firstly, the Bill does not specify the definition of a ‘close relative’ anywhere (Kala & Rao, 2016). Secondly, in the strong patriarchal, hierarchical and duty based familial set-up, women are likely to be forced to enter surrogacy arrangements against their will to help infertile family members. Empirical evidence on surrogacy and egg donations in India has already highlighted that in majority of the cases surrogate mothers and egg donors were from within the family. In addition, evidence from this study indicated that when commissioning parents were directly involved in recruiting surrogate mothers, they may exert greater control over the surrogate, can divulge the facts for own advantage and severely curtail the freedom of surrogate mothers. The Clause 3 (b) (II) accentuates the possibility of subjugation of women to forcefully enter surrogacy arrangements, reinforces traditional gender roles of women and disregards the notion of choice in motherhood and must therefore be reconsidered.

Clause 3 (c) (III) imposes eligibility criteria for commissioning parents to avail surrogacy stating,

*“The intending couple have not had any surviving child biologically or through adoption or through surrogacy earlier. Provided that nothing contained in this item shall affect the intending couple who have a child and who is mentally or physically challenged or suffers from life threatening disorder or fatal illness with no permanent cure and approved by the appropriate authority with due medical certificate from a District Medical Board.”*

Evidence indicates that of the Indian population suffering from infertility, 98 percent experience secondary infertility due to poor care during delivery and post-partum and inadequate nutrition. The clause limiting surrogacy provisions for people

who already have one child restricts right to procreate for many Indian couples suffering from secondary infertility. Further, the clause equates disability with reduced human worth by establishing a previous child with a disability as a permissive condition for people to seek surrogacy.

Clause 4 (ii) (e) prescribes an eligibility criterion for commissioning parents, *“any other condition or disease as may be specified by regulations made by the Board.”* Clause 4 (iii) (c) (IV) further determines eligibility of commissioning parents as, *“such other conditions as may be specified by the regulations”* and Clause 48 (a) states, *“The National Surrogacy Board with the prior approval of the central government may make regulations to provide for the fulfilment of any other condition under which the eligibility certificate for intending couples may be issued by the appropriate authority.”* Kala and Rao (2016) argue that the Bill should clearly state all the qualifying conditions and should not delegate it to the respective boards for regulation.

Clause 6 (i) sets regulatory limit over practice of surrogacy prohibiting its conduct unless, *“explained all known side effects and after effects of such procedures to the surrogate mother concerned.”* It will be beneficial if the Bill standardises exact contents for discussion with the surrogate mothers for various medical procedures involved. Empirical evidence suggests that ART practitioners often trivialise the risks associated with surrogacy. A Dutch surrogacy programmes demonstrated the power of pre-educating surrogate mothers stating after detailed counselling, many women who had initially expressed interest in becoming a surrogate for altruistic reasons withdrew (Dermout, van de Wiel, Heintz, Jansen, & Ankum, 2010). Strengthening the counselling component in surrogacy is of utmost importance to protect the well-being of surrogate mothers.



Clause 6 (ii) mandates informed consent of the surrogate mother as a prerequisite condition for the practice of surrogacy stating, *“Obtained in the prescribed form, the written informed consent of the surrogate mother to undergo such procedures in the language she understands.”* The clause could further specify that when the woman concerned is not literate, the brief provided to her and her consent should be audio/video recorded to protect her best interest and avoid any malpractices. The data from this study also revealed that in absence of trained counsellors, medical practitioners were involved in ‘counselling’ women prior to seeking their consent. However, the ethos of the session was authoritative and women hesitated to clarify their doubts with the medical practitioners. It is therefore recommended that specifically trained counsellors should be involved in the educational counselling of women and seeking a fully informed consent from them for participation in surrogacy.

Clause 8 restricts number of oocytes or embryos that can be implanted stating, *“The number of oocytes or embryos to be implanted in the surrogate mother for the purpose of surrogacy shall be such as may be prescribed”*. The clause should set a clear upper limit on the maximum number of embryos that practitioners can implant in the womb of surrogate mother. Implantation of more than one embryo often results in multiple gestations and exposes women to the additional ‘foetal reduction’ or ‘selective reduction’ procedures thereby increasing gestational risks to her. In addition, multiple gestations often result in caesarean section deliveries and compromise health of the surrogate mother involved. The bill should encourage practice of implanting single embryo to protect best interests of the surrogate mothers.

Apart from these lacunae in the specific clauses, the Bill restricts provision of surrogacy only for the heterosexual couples married for at least five years and

proposes a blanket ban on commercial surrogacy and all the transnational surrogacy services. The bill therefore fails to recognise alternative forms of families and restrains right to procreate for the unmarried adult cohabiting couples, for single men and women, and same sex couples. Promotion of altruistic surrogacy also propagates long held gender biases which demand women to be selfless nurturers. Such a ban coupled with a mandatory requirement that the surrogate mothers and egg donors must be close relatives of the commissioning parents further accentuates the possibility of coercion of women in the patriarchal familial set-up to help their infertile relatives. A mere ban on commercial surrogacy may not necessarily protect women against exploitation. Instead, a robust regulatory framework along with clear specification of standardised compensation payable to the surrogate mothers would be a worthwhile option to consider. The decision regarding whether to opt for altruistic or commercial surrogacy must be left to the prospective surrogate mothers and commissioning parents.

Compensation for surrogacy, if any, should be equally distributed across the gestational period. The current payment structure wherein over 80 percent of the compensation is paid to the surrogate mothers upon successfully relinquishing the child born through surrogacy is problematic because of lower success rates of surrogacy and high prevalence of miscarriages. Despite undergoing arduous medical treatment, in the event of late term miscarriages women did not gain much in the current payment structure.

The contents of the informed consent form for the surrogate mothers should be standardised and must clearly enlist rights of the surrogate mothers during surrogacy. Similarly, the contents of the surrogacy agreement or surrogacy contract between the surrogate mother and the commissioning parents should be standardised. The

standardised contract must clearly enlist rights of the surrogate mothers during surrogacy. The standardised contract should be drafted such that it does not infringe upon the human rights of the surrogate mothers. In addition, a separate clause should be included in the Bill prohibiting conduct of embryo transfer in the womb of the surrogate mother before the standardised surrogacy contract is duly signed by the surrogate mother and the commissioning couple in presence of each other and appropriate authorities.

The maximum number of embryo transfer cycles a prospective surrogate mother can undergo in the life time and ideal time interval between repetitive embryo transfer attempts must be specified by introducing an additional clause in the Bill. The data gathered in this study indicated a possibility that with increasing number of failed embryo transfer attempts, chances of attaining a surrogate pregnancy may diminish. Systematic collection of data for embryo transfers and associated outcomes along with variables like age and parity that have been previously linked with its success rate will help to generate conclusive evidence to set the upper limit for the maximum number of trials any woman can undergo to attain a surrogate pregnancy. A central national registry should maintain records of the women entering surrogacy and the number of embryo transfer cycles that they undergo to prevent women from undergoing repetitive embryo transfer cycles at multiple ART clinics. The Bill should explicitly prohibit the current practice of simultaneously transferring embryos of the same commissioning parents in two or more women, be it the commissioning mother and her surrogate mother or the multiple surrogate mothers for the same commissioning couple.

Difficult issues like surrogate mothers choice in institutionalisation for surrogacy, surrogate mother's right to abortion, her right to self determination for

critical medical decisions that have significant implications for her physical and mental health are not covered in the Surrogacy Regulation Bill, 2016. At present, commissioning parents are treated as patients who take crucial decisions pertaining to surrogacy while the body of the surrogate mother remains the site for medical intervention with significant threats to her health. A debate involving all the primary stakeholders including but not limited to surrogate mothers, clients seeking surrogacy services, medical and legal practitioners, and social scientists is essential for a progressive legislation that does not compromise rights and well-being of the Indian nationals, women in particular, irrespective of their marital status and sexual orientation.

Experiences of the women indicated that surrogacy was no less than a roller coaster ride with highs and lows and had significant mental health implications for the surrogate mothers. A robust surrogacy counselling component that promotes informed decision making and supports all the parties involved prior to, during and post surrogacy must be standardised under the Surrogacy (Regulation) Bill, 2016. Additionally, third party counselling should be encouraged to eliminate biased perspectives of medical practitioners and surrogacy agents encouraging women into surrogacy for own profits. Detailed counselling guidelines to ensure a smooth surrogacy experience for women in the Indian setting are proposed next.

### **Implications for Practice: Guidelines for a Counselling Component**

Narratives of women and observations in the field revealed the vulnerability of women across different stages of surrogacy. Women were deprived of the significant familial support system as they stayed away from their families for the period of surrogacy. Data indicated that novelty of surrogacy experience, alienation, and inferior social position of women made surrogacy journey challenging for the women.

In all the phases of surrogacy (before, during and post participation) women experienced specific challenges and emotional upheavals stemming from prolonged separation from family, novelty and uncertainty of surrogacy process, unfulfilled expectations, and lack of sensitivity amongst commissioning parents and medical professionals towards their needs.

The psychological issues that the surrogate mothers faced before, during and after their participation in surrogacy are potentially significant. Educational counselling prior to beginning the treatment can help women and their spouses gauge the pros and cons of surrogacy and facilitate informed decision making to participate in surrogacy. Regular counselling during surrogacy is required to explore feelings and expectations of women, encourage free expression, understand challenges and difficulties experienced by women and resolve them. Post surrogacy counselling is critical to ensure a smooth closure of surrogacy where surrogate mothers and commissioning parents are able to empathise with and appreciate each other and are satisfied with the overall surrogacy experience. In addition to provision of counselling support to the surrogate mothers and the commissioning parents, counsellors or psychologists should work with medical professionals and staff at the ART clinic to sensitise them towards the needs of surrogate mothers. Data from this study indicates that the provision of client or (patient) centred counselling is an indispensable part of the preparation of those accessing surrogacy. It should be provided by qualified and trained counsellors, and should be integrated into the ART clinic protocol for surrogacy treatment. It is highly recommended that counselling provided by the counsellor(s)/ psychologist of the ART clinic involve typically a number of sessions pre-treatment and over the course of surrogacy process as well as follow up counselling sessions following the birth of the surrogate child. Based on the

experiences narrated by surrogate mothers, the study has identified three phases for surrogacy counselling as depicted in the Figure 44:



**Figure 44. Proposed phases of counselling in surrogacy.**

This three phase counselling model is further detailed out in the form of specific counselling guidelines for the practicing counsellors or psychologists at the ART clinic. The guidelines clearly specify prominent challenges and vulnerability issues experienced by the Indian surrogate mothers during each of the surrogacy phases which must be addressed through a series of counselling sessions and a broad counselling objective for each phase. Each counselling phase is further broken down

into number of mandatory counselling sessions. Guidelines indicate session goal, type of counselling, counselling client/s, role of the counsellor, and essential documentation for each of the session.

**Pre-surrogacy treatment counselling.** Awareness and education about the ethical, legal, medical and psychological understanding of the surrogacy process is the primary objective of pre-surrogacy counselling aimed at helping prospective participants take an informed decision.

***Problems and vulnerability issues.***

- A desperate state of mind obsessed with transformative potential of surrogacy to alleviate poverty resulting in misappropriation of risks involved in surrogacy and associated treatment outcomes
- Use of jargon by medical practitioners limiting comprehension of surrogacy treatment process by prospective surrogate mothers and their spouses
- Limited knowledge of surrogacy treatment procedures, short term and long term consequences for health and family life, and terms and conditions of surrogacy agreement among surrogate mothers
- Unrealistic expectations about economic potential of surrogacy and the desire for extra payment and lifelong patronage from the commissioning parents beyond the contractual terms of the surrogacy agreement
- Coercion by family members for participation in surrogacy
- Limited or no time gap between primary educational counselling and signing of the surrogacy agreement
- Lack of access to child-care resources for own children during institutionalisation for surrogacy

***Counselling goal.*** Promote realistic understanding of the surrogacy treatment process and facilitate an informed decision for participation in surrogacy free of coercion among potential surrogate mother and her spouse

***Counselling session 1.***

***Session goal.*** Orient prospective surrogate mothers and their spouses to surrogacy programme and facilitate realistic understanding of the surrogacy process

***Counselling type.*** Group counselling.

***Counselling client/s.*** Group of prospective surrogate mothers along with their spouses. Significant family members that women may choose to involve for the session may be included on request.

***Counsellor role.***

- Provide adequate knowledge about the science of conception, surrogacy and medical procedures involved in surrogacy preferably through audio-visual media in a language known to the participants
- Share scientific evidence regarding short-term and long-term health consequences of surrogacy in a jargon free language with anecdotal evidence. Ensure that the information is shared in a manner that facilitates comprehension irrespective of educational attainments of the participants.
- Explain various steps in the surrogacy programme along with time-lines, programme requirements, and the legal requirements
- Check fulfillment of the eligibility criteria for each of the prospective surrogate mothers using standardised checklist format
- Introduce former surrogate mothers volunteering to share both positive and negative experiences during surrogacy with the participants



- Encourage participants to ask questions, discuss their concerns, and resolve any queries raised by the participants

*Essential documentation.* Eligibility checklist formats completed for all the prospective surrogate mothers, session note with a summary.

### ***Counselling session 2.***

*Session goal.* Assess motivation and agency of the woman for participation in surrogacy and any possibility of coercion. Facilitate realistic understanding of the surrogacy process covering ethical, emotional, legal, and medical implications to promote an informed decision.

*Counselling type.* Family counselling and screening

*Counselling client/s.* Prospective surrogate mother and her spouse

*Counsellor role.*

- Review socio-economic and familial background of the prospective surrogate mother and her motivation for participation in surrogacy
- Conduct a comprehensive biopsychological assessment to determine personality, quality of life, relational well-being, issues of trust, control and involvement of commissioning parents during surrogate pregnancy, and reproductive history of the prospective surrogate mother
- Determine availability of familial/ social support, expectations of surrogacy, and discuss disclosure to family members and others in the context of stigma
- Discuss implications of surrogacy for the prospective surrogate mother, her family, and child care arrangements during surrogate pregnancy
- Discuss critical issues including but not limited to implantation of multiple embryos and its consequences, possibility of repeated failures of embryo

transfers, likelihood of spontaneous abortions, Prenatal Genetic Diagnosis (PGD) and selective reduction of embryos, chances of caesarian section delivery and possibility of medical emergency situations to understand perspectives of prospective surrogate mothers and her spouse on these.

- Assess commitment and motivation to complete surrogacy and understanding of its unique demands and discuss potential benefits and costs to the surrogate mother and her family.
- Share a sample surrogacy agreement/contract format and facilitate its full understanding by the prospective surrogate mother and her spouse
- Orient the prospective surrogate mother and her spouse for medical screening and facilitate medical screening processes

*Essential documentation.* Case history and assessment reports, a report on views regarding critical issues during surrogacy and any identified challenges that must be resolved for a smooth surrogacy experience, reports of the medical screening, and a session note with summary.

### ***Counselling session 3.***

*Session goal.* Ensure that the consent of the prospective surrogate mother and her spouse is fully informed and free of coercion.

*Counselling type.* Individual counselling

*Counselling client/s.* Prospective surrogate mother and spouse individually

*Counsellor role.*

- Provide a realistic overview of participation in surrogacy programme summarising key aspects from previous sessions

- Confirm willingness of the prospective surrogate mother to participate in surrogacy in full privacy and ensure that her decision is fully informed and free from coercion.
- Confirm willingness of the spouse and his desire to support the prospective surrogate mother throughout surrogacy in full privacy and ensure that his decision is fully informed
- Brief the surrogate mother and her spouse about their right to legal redressal of grievances if any and the system/mode to access this right.
- Explain informed consent form in detail and ensure a minimum gap of one week between explanation and signing of the consent
- Enrol the woman on the list of prospective surrogate mothers for the programme if her and her spousal consent is satisfactory.

*Essential documentation.* Informed consent formats signed by the prospective surrogate mother and her spouse and a session note with summary.

**Surrogacy treatment counselling.** The prime objective of the counselling during surrogacy treatment is to help surrogate mothers and commissioning parents cope with this novel experience, deal with fluid parental roles and ensure open communication for a smooth surrogacy experience.

***Problems and vulnerability issues.***

- Anxiety about treatment procedures amongst surrogate mothers resulting from lack of awareness of exact details of various medical procedures
- Faulty beliefs about surrogacy process, nutrition during pregnancy, and foetal growth and development
- Excessive anxiety over possibility of miscarriage, feelings of homesickness and saturation and need for support

- Surrogate mother's unfamiliarity with the commissioning parents, limited or no opportunity for interaction with the commissioning parents and language barriers for communication with them
- Power imbalance between commissioning parents, surrogate mothers, and medical practitioners where interests of the commissioning parents prevail as a 'paying' party
- Excessive demands from the commissioning parents to control treatment aspects and the life style of surrogate mothers stemming from lack of trust and fear of pregnancy loss
- Unfulfilled expectations of the surrogate mother and feeling of resentment towards commissioning parents
- Lack of sensitivity in communicating pregnancy failure and/or handling incidences of miscarriage
- Threats from extended family members for monetary gains

***Counselling goal.*** Facilitate a smooth surrogacy experience especially for the surrogate mothers and for the commissioning parents by encouraging clear and open communication amongst all the stakeholders and provision of support and safety net to surrogate mothers where required.

***Counselling session 4.***

***Session goal.*** Establish a relationship of mutual trust and respect for each other amongst commissioning parents and the surrogate mother and encourage open discussions to identify and resolve differences of opinion

***Counselling type.*** Group counselling

***Counselling client/s.*** Surrogate mother, commissioning parent/s, spouse of surrogate mother. In case of trans-national surrogacy (if permitted in future), and

commissioning parents not being present in India, video conferencing should be used for this session. The group counselling session must be mandatory and cannot be passed over.

*Counsellor Role.*

- Facilitate introductory meeting between commissioning parents and surrogate mother and her spouse and promote development of trust by helping commissioning parents and surrogate mother to empathise with each other and build trust
- Encourage open discussions about expectations from each other and desired levels of contact during surrogacy.
- Discuss and resolve attitudinal differences on the issues including but not limited to institutionalisation during surrogacy, implantation of multiple embryos (if permitted by law), foetal reduction, medical termination of pregnancy in case of foetal anomalies, surrogate's right to make decisions regarding foetal health and health of self during surrogacy, course of action in the situation of conflict of interests, nutritional and lifestyle restriction during surrogacy and any other concerns.
- Discuss and resolve attitudinal differences regarding handing away baby, breast feeding of the child post-delivery, disclosure of surrogacy to the child born, and continued contact with the commissioning parents and the child born post surrogacy.
- Clearly demarcate rights and responsibilities of the surrogate mother and her commissioning parents throughout the surrogacy process and after completion of surrogacy.

- Ensure both the parties fully understand contents of the surrogacy agreement and maintain transparency in signing of the agreement, informed consent, insurance coverage, and financial and/or other incentives (if any permitted by law).

*Essential documentation.* A session note with summary.

***Subsequent monthly counselling sessions.***

*Session goal.* Provide continued psychological support to surrogate mothers and commissioning parents to facilitate a smooth surrogacy experience and safeguard surrogate mothers against exploitation.

*Counselling type.* Individual counselling, family counselling, group counselling with commissioning parents as required

*Counselling client/s.* Surrogate mother, spouse and/or extended family members of the surrogate mother and/or commissioning parents as required

*Counsellor role.*

- Brief women prior to any medical intervention or physical examination, including but not limited to embryo transfer and foetal reduction to reduce anxiety experienced by the surrogate mothers
- Communicate pregnancy test reports in person and provide mental support to overcome feelings of loss and despair on failure to conceive. Facilitate informed decision for discontinuation of treatment cycles after repeated failures.
- Orient expectant surrogate mothers towards next course of action as per the surrogacy programme. Clarify misconceptions and correct faulty beliefs of surrogate mothers regarding health care and nutrition during surrogacy.

- Ensure realistic expectations amongst stakeholders identify inter-personal challenges and provide support to resolve them, and balance power equations in various interpersonal relationships.
- Facilitate emotional expression, prevent burnt-out, and promote optimal mental health of surrogate mothers during surrogacy
- Acknowledge the maternal contributions of surrogate mother during surrogacy and help commissioning parents appreciate her contributions
- Acknowledge threats anticipated or experienced by surrogate mothers and protect them from exploitation from family members

*Essential documentation.* A session note with summary

**Post-surrogacy counselling.** Follow up counselling after treatment is highly recommended and should be available to all the stakeholders. Such counselling should primarily focus on post-partum physical and psychological wellbeing of the surrogate mother. Commissioning parents should be counselled separately about child care issues, legal issues, and a smooth closure with the surrogate mother.

*Problems and vulnerability issues.*

- Insensitive treatment of surrogate mothers by commissioning parents
- Unrealistic expectations of surrogate mothers from surrogacy arrangement, desire for extra payments, gifts, and continued patronage from the commissioning parents
- Possibility of monetary exploitation of surrogate mothers by extended family members
- Limited livelihood options post surrogacy
- Inadequate gap between two surrogacies (if second surrogacy is permitted by law)

*Session goal.* Ensure a smooth experience of closure for the surrogate mother and commissioning parents and provide continued support for reintegration of surrogate mother in her routine family life.

*Counselling type.* Individual counselling, group counselling, and family counselling as required

*Counselling client/s.* Surrogate mother, commissioning parents, and spouse of the surrogate mother where required

*Counsellor role.*

- Facilitate a positive experience of relinquishment for the surrogate mother by ensuring proactive involvement of commissioning parents during post-partum recovery of the surrogate mother
- Help commissioning parents to overcome insecurities if any, to empathise with the surrogate mother and acknowledge her maternal contributions to the child through labour of gestation. Ensure humanly and sensitive treatment of surrogate mother by the commissioning parents.
- Ensure unequivocal understanding among all stakeholders in matters including but not limited to breastfeeding infant, prolonged care of infant, desire of surrogate mother for extra benefits either monetary or in kind apart from the surrogacy agreement, and desire of surrogate mother for prolonged contact with commissioning parents and child born through surrogacy.
- Help surrogate mother to overcome post-partum sense of loss if any, support her against coercion if any exerted by the commissioning parents, spouse or extended family members.



- Assist surrogate mother in planning post-surrogacy life, utilization of money earned through surrogacy and discuss alternative avenues for employment
- Explain procedures for follow-up treatment to the surrogate mother for healthy post-partum recovery
- Support commissioning parents towards fulfilling legal requirements and fulfill terms and conditions of the surrogacy contract

*Essential documentation.* A session note with summary

**Conclusion.** There are different types of counselling roles related to surrogacy treatment thus counsellor must ascertain the specific requirements of practice in their particular context to ensure that the protocol fits the surrogacy programme requirements and clients' needs. The pre-treatment counselling needs to be respectful of the needs of all involved in the surrogacy, including the commissioning parent/s, the surrogate mother and her spouse. The pre surrogacy treatment counselling process must give time, space and intensity for a thorough consideration of the implications of the proposed treatment and the space for a change of mind, minimising possible rupture of personal relationships which may be longstanding. Factual information and case studies of women who experienced health complications during surrogacy should form an important element of pre-surrogacy counselling to prevent women from trivialising the risks involved in the surrogacy. Medical practitioners should be sensitised to the subtle differences in power experienced by the surrogate mothers, which may inadvertently led to coercion/exploitation. This comprehensive pre-surrogacy counselling should be an integral part of a full informed consent process.

The counselling during surrogacy treatment process should include multiple counselling sessions to address any psychological, emotional, physical or legal

issues. The post-delivery counselling is also very crucial phase for counselling.

During this phase both surrogate mother as well as commissioning parents should be counselled separately. Post –partum issues of surrogate mother and family re-integration issues need to be addressed. Counselling commissioning parents should include discussions regarding implications for any existing children and risks (any loss issues and how parents intend to deal with them) and any legal issues.

Counsellors should have a file for each case and maintain session wise summary notes.

Surrogacy is a rapidly increasing phenomenon in the contemporary Indian society with culture specific implications for the individual and family. Robust evidenced based policy and practice can facilitate its progressive yet responsible integration in the society.