Part 2

Research on Surrogate Mothers, Commissioning Parents, Parenting and the Surrogate Offspring

Explaining behaviours associated with surrogate mothers involves explaining factors associated with commissioning parents and surrogate babies and vice versa. This part therefore provides a detailed account of research specifically on surrogate mothers in Chap. 4 and on commissioning parents in Chap. 5, separation and parenting and surrogate offspring in Chaps. 6 and 7 respectively. Surrogate motherhood occurs within triads and therefore discussing one without touching upon the other is neither sensible nor always possible or desirable, hence their placement within this second part of this monograph. Research on surrogate mothers is not as prolific as might be expected. Surrogate mothers carry a huge responsibility to themselves, the unborn baby and the commissioning parent(s). They also put themselves at a substantial physical, social and psychological risk and may be exploited and stigmatised (van den Akker 2015; and see Chap. 4). The journey through a surrogate motherhood arrangement for commissioning parents too is riddled with uncertainty, risks and potential stigma due to their infertility and their non-traditional route to parenthood. These issues are discussed in detail in Chap. 5. Chapter 6 covers research and theory on separation and parenting, because surrogate mothers need to adjust to the loss of the baby they conceived, carried and nurtured successfully to term and commissioning parents need to adjust and adapt to parenting a non-gestational and possibly non-genetic baby. The research shows that parenthood and
particularly motherhood are concepts that were relatively certain over the centuries. Increased use of third-party-assisted conception and alternative types of parenthood has led to uncertainty in genetic and gestational parenthood. This uncertainty has resulted in a very slow shift in traditional attitudes and has led to questioning the morality of surrogate mothers and the parenting motivations and abilities of commissioning parents. Importantly the uncertainty in parenthood has focused upon the welfare of the resultant child, and these issues relevant to offspring brought about via surrogate motherhood arrangements are covered in Chap. 7.

Surrogate motherhood or surrogate ‘kinships’ represent a far cry from traditional kinship ideology as represented in much of the Western world. Assisted conception using third-party gametes or embryos in IVF treatment or in surrogates is increasingly common and fulfils a population need of massive proportions, way beyond the needs of the medically infertile. This is because many more diverse families now also seek assisted conception services for social infertility, including single or older women and men and same-sex couples, contributing to the move away from what was known as traditional family structures. These social or lifestyle uses of assisted reproduction for involuntary childlessness represent an increasing proportion of treatments, shifting what was once a heterosexual two-parent family norm. Despite this shift in non-normative family building, national statistics which help to predict future expenditure do not always accurately reflect the consequences of behavioural and lifestyle changes of individuals within populations including accurate birth registrations. Furthermore, the decreasing fertility prospects as a result of lifestyle choices such as delayed childbearing, solo or same-sex parenting mean that many of those not in a medical or social position to conceive without a third party will be requiring assistance to build their families. In the United Kingdom, health care resources may fund these needs for some who request it, but not as frequently for same-sex or single individuals (HFEA 2014). Records show the NHS funds around 40% of IVF treatment cycles, with the remaining 60% privately funded (HFEA 2012). Similarly, for treatments using gamete donation the NHS funds even less. Women in same-sex partnerships and without a partner are much less likely to receive NHS funding for their treatment (HFEA 2014, p. 20). In areas where funding is not provided, health inequalities
determine who has and who does not have treatment to overcome involuntary childlessness for social and lifestyle or medical reasons. With the increasing national uptake and international commercialisation of gamete, embryo and surrogate services, further amplification of inequalities of family building possibilities develops and surrogate mothers are party to this developing trend.

References

