International Coalition
for the Abolition of Surrogate Motherhood

It is a physical, psychological, and economic violence

ICAMS's 50 member organizations operate in 16 countries: Austria, Australia, Belgium, Canada, Colombia, France, Italy, Ireland, Japan, Romania, South Korea, Spain, Sweden, Ukraine, the United Kingdom, and the United States.

abolition-ms.org

Defining surrogacy: a social practice, not a medical technique

To better understand surrogacy, it's important to distinguish it as a social practice and not a medical technique. Surrogacy is the practice of recruiting, with or without payment, a woman to carry one or more children, whether or not conceived with her own eggs, with the aim of giving them to one or more persons who wish to be designated as the parents of these children.

Historically, surrogacy in the 1980s was primarily based on artificial insemination, but since the 2010s, in vitro fertilization (IVF) has become the norm. Surrogacy typically involves seven stages:

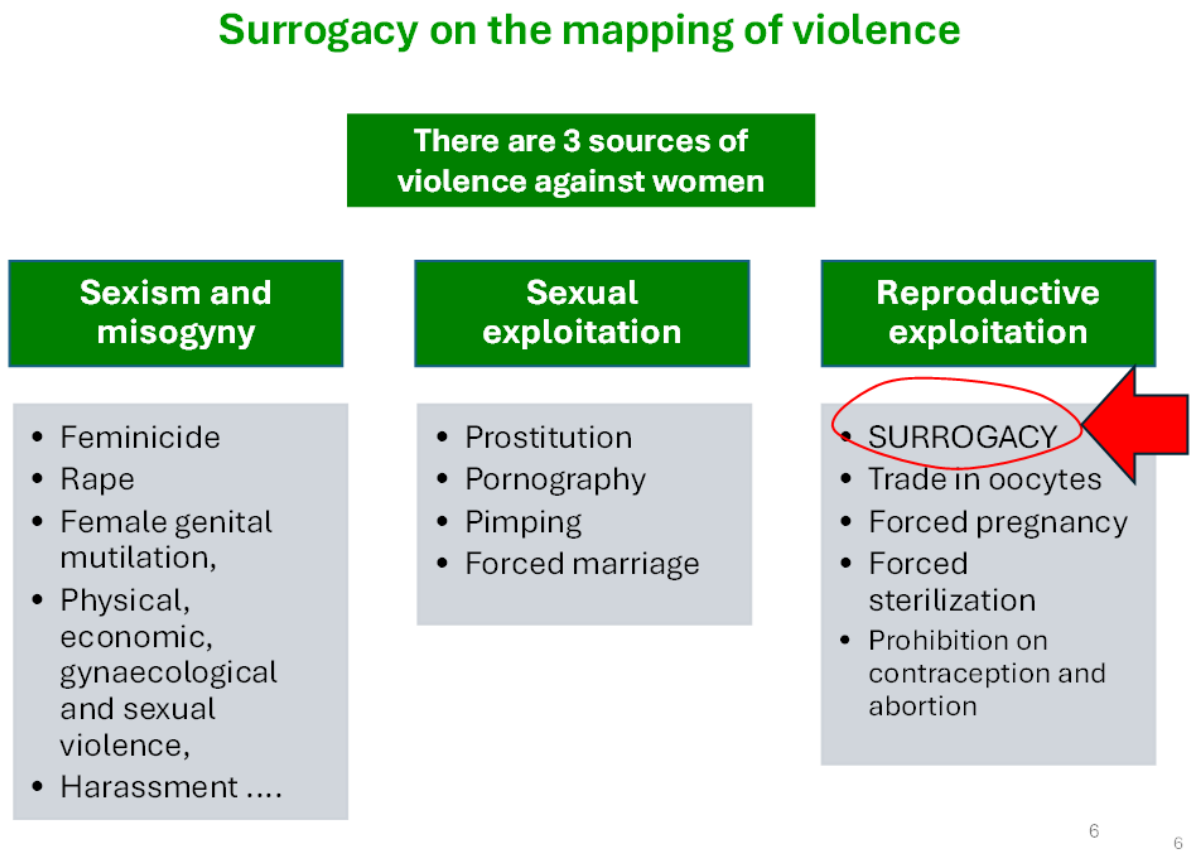
1. **Selection of the Surrogate Mother**: Identifying and choosing a surrogate, followed by the signing of legal contract.
2. **Embryo production and preimplantation genetic diagnosis**
    - Selection of Oocytes and Sperm: The oocytes (eggs) are often selected from a "catalogue" of women, and sperm is chosen either from a donor or the male client.
    - IVF is performed to fertilize the eggs, and embryos are screened for genetic health and other factors. In some cases, sex selection may also occur.
3. **Embryo transfer**
    - Preparing the surrogate's body for embryo implantation, which includes hormonal treatments and multiple screenings.
    - Embryo(s) are implanted into the surrogate's womb.
4. **Pregnancy confirmation**. Verifying that the surrogate is pregnant through medical testing.
5. **Pregnancy monitoring.** regular check-ups to ensure the pregnancy is progressing well and keep the commissioning people closely informed.
6. **Delivery and handover**: The surrogate gives birth, and the child is handed over to the commissioning people.
7. **Transfer of parentage.** Parentage is officially transferred from the surrogate to the commissioning people.

While only one stage of surrogacy directly involves medically assisted reproduction, the entire practice is incorrectly classified as a medical technology. Surrogacy is a social

practice that does not treat any individual, neither the surrogate mother (who is typically selected for her health) nor the commissioning parents.

Surrogacy and reproductive violence

It's crucial to recognize that surrogacy can be situated within a broader context of reproductive violence, alongside practices such as the trade of oocytes, forced pregnancies, sterilization, and ban to contraception and abortion. These practices are intertwined with the commodification of women's bodies, raising significant ethical and human rights concerns.



Surrogacy: a triad of violence against women - medical, psychological, and economic

Surrogacy inherently subjects women to a trifecta of violence: medical, psychological, and economic. We advocate for international recognition of surrogacy as a form of violence against women to end this exploitative practice.

Medical violence in surrogacy at all stages of the surrogate pregnancy

The health risks women face in surrogacy are underreported and rarely explored from a feminist perspective. Despite the critical health implications, official records on surrogate clinics, the health outcomes for surrogates, or the fate of children born through surrogacy remain sparse (even on children being left over by commissioning people). Evidence shows that the health risks in both "altruistic" and "commercial" surrogacy fall solely on women. Research indicates that in-vitro fertilization (IVF) pregnancies are high-risk, associated with adverse outcomes[1]. Studies on surrogate mothers confirm additional health threats, which occur throughout the pregnancy stages[2].

Hormonal treatments

To prepare the uterus, oestrogen and progesterone are administered so that the endometrial develops in the uterus and thickens up to 7 mm to receive the embryo. Drugs like Lupron (leuprolide), originally for prostate cancer, are repurposed to prevent ovulation, with documented severe side effects such as increased intracranial pressure.

Overmedicalization

Clinics prioritize successful embryo implantation over the surrogate's well-being, using unnecessary medications like Medrol[3], an immune suppressant, to reduce embryo rejection. Antibiotics[4] are also used preventively, with health protocols driven more by profit than medical necessity. Birth control pills and Lupron are used to prevent premature ovulation by the surrogate, which could interfere with the implanted embryo. Lupron, a common brand of Leuprolide, was initially developed to treat prostate cancer but is also used as a puberty blocker. Known side effects of Leuprolide include increased intracranial pressure[5].

Frequent screenings

To reassure commissioning parents, agencies may demand excessive screenings, from ultrasounds to invasive tests like amniocentesis (linked to miscarriage[6]), pushing surrogate mothers to endure high-risk procedures at any stage of pregnancy. Indeed, surrogate mothers are required to comply not only with the stipulations outlined in the contract but also with supplementary conditions mandated by agencies and any discretionary requirements specified by the commissioning parents."

Specific health risks:

Studies show that babies from IVF and surrogacy have higher rates of preterm birth and low birth weight, and surrogate mothers face increased risks of complications such as gestational diabetes, preeclampsia, hypertension, and placenta previa, compared to babies conceived naturally and carried by the same woman[7]. Carrying genetically unrelated embryos raises the likelihood of preeclampsia, a condition that can lead to life-threatening complications for the mother and foetus[8] [9].Pre-eclampsia is a significant

complication contributing to nearly 75% of maternal deaths worldwide[10].This phenomenon describes how a woman's prior exposure to a man's sperm can reduce her risk of preeclampsia in subsequent pregnancies with his child. Conversely, the risk is thought to be higher when carrying an unrelated embryo, particularly after approximately 20 weeks of gestation.

Without timely treatment, it can lead to severe consequences such as:

- **Eclampsia:** Convulsion
- **HELLP syndrome:** A life-threatening condition characterized by haemolysis, elevated liver enzymes, and low platelet count.
- **Premature birth:** The foetus may be born early due to insufficient oxygen and nutrient supply.
- **Emergency C-section:** Urgent surgical delivery may be necessary to protect the health of both the mother and the foetus.

Premature babies born to mothers with preeclampsia or gestational hypertension have a higher risk of stroke later in life. This may be due to impaired brain development in utero or vascular issues. Additionally, mothers with preeclampsia are more likely to develop cardiovascular disease later in life[11].

Multiple embryos transfer

In surrogacy arrangements, clinics frequently transfer multiple embryos to increase the chances of a successful pregnancy. However, this practice brings significant risks, including higher rates of preterm birth, stillbirth, and neonatal mortality. Despite medical guidelines advising against such practices, multiple embryo transfers continue, often coupled with "selective reduction" (in fact selective abortion) to manage the number of foetuses, further jeopardizing the health of surrogate mothers.

Growing demand for twins in surrogacy

In the surrogacy industry, there is a rising demand for twins due to cost savings compared to commissioning two separate surrogacies. It is common for intended parents to pay an additional fee, ranging from $5,000 to $7,000, for a second foetus. In some cases, such as among male same-sex couples, twins are requested so each child can be genetically linked to one of the partners[12].

The American Society for Reproductive Medicine[13] has issued guidelines limiting the number of embryos transferred during IVF cycles to encourage singleton pregnancies, reduce twin pregnancies, and prevent high-order multiples. The European Perinatal Health Report (2015-2019)[14] highlights the increased risks associated with multiple pregnancies compared to singleton pregnancies. Complications for mothers include a greater likelihood of preeclampsia, gestational diabetes, and caesarean delivery. Preterm birth rates are over 50% for multiples, compared to 6-7% for singletons, with heightened

risks of adverse outcomes like stillbirth, neonatal mortality, low birth weight, congenital conditions, and cerebral palsy.

Abortion: the hijacking of women's right to self-determination

In many surrogacy arrangements, contracts often stipulate who will decide on "termination or selective termination," a carefully constructed phrase for abortion. In such cases, this decision is frequently assigned to the commissioning parties, justified on the grounds that, as the paying clients, they have the authority to decide[15]. This approach fundamentally undermines the surrogate's autonomy, constituting a clear violation of her rights, and amounts to "forced abortion," a significant form of violence against women.

Delivery: unnecessary C-sections

The risks associated with surrogacy extend beyond pregnancy to include the delivery itself, particularly regarding an increased prevalence of caesarean sections (C-sections) in surrogate births. Surrogates are frequently subjected to C-sections not due to medical necessity, but at the request of the commissioning parents. This allows them to schedule and attend the birth, while also reflecting a belief that a surgical delivery reduces the surrogate's emotional connection to the child.

Studies show a striking disparity in C-section rates between surrogate and non-surrogate pregnancies: women in surrogacy arrangements are three times more likely to undergo C-sections than to deliver vaginally[16]. It is crucial to recognize that a C-section is a major surgical intervention, intended primarily for cases involving serious maternal or fatal life-threatening health risks[17]. For women who have undergone three or more C-sections—whether for surrogacy or previous pregnancies—future fertility risks, such as uterine rupture, are substantially elevated.

The risk of uterine rupture is influenced by both the number of prior C-sections and the specific incision used in previous surgeries. Approximately 1% of women with a single prior C-section experience uterine rupture in subsequent pregnancies, while the risk jumps to 3.9% for women who have had multiple C-sections[18]

Exploiting surrogatesmothers through lactation requirements

In some surrogacy contracts, the surrogate mother may be asked to provide breast milk for the child after birth. This arrangement often involves the surrogate pumping and shipping breast milk to the intended parents, typically for a fee of $200 to $300 per week[19]. Alternatively, surrogates may be encouraged to donate the milk to a bank or to undergo procedures to suppress lactation. Such practices raise ethical questions, as they extend the surrogate's physical commitment beyond childbirth, often for minimal compensation.

The hidden toll of surrogacy: deaths

The mortality rates for surrogate mothers are shrouded in secrecy. Few reliable statistics are available, likely due to confidentiality clauses imposed by surrogacy agencies and a general lack of transparency. This opacity makes it difficult to assess the full scope of risks surrogate mothers face, leaving many unaware of the serious health complications they may encounter.

While mainstream discussions often overlook these risks, tragic cases have surfaced on crowdfunding sites like GoFundMe, shedding light on the potential dangers associated with surrogacy. Stories like those of Brooke Lee Brown[20]and Michelle Reaves[21]reveal a darker side to the industry that is rarely acknowledged in promotional materials. In response, a coalition of surrogate mothers, egg donors, and feminist activists in the United States has begun to expose the exploitation within surrogacy and to advocate against its legalization, notably in states like New York[22].

In India, studies by researchers like Sheela Saravanan have documented the constant threats surrogate mothers endure. Saravanan's research uncovered cases where surrogate mothers, ovum donors and surrogate babies died, yet these incidents were not publicly disclosed by the clinics involve[23]. The study points to pervasive human rights violations, noting that economic desperation drives many women into surrogacy, with foreign couples and non-Indian residents making up the majority of commissioning clients.

The exploitation of risk: profit over well-being

Surrogacy agencies often exploit these health risks in their pricing strategies, meticulously detailing potential costs based on varying health scenarios for the surrogate. This business model prioritizes profit over women's health, capitalizing on the physical risks to women's bodies. For instance, commissioning parents are presented with cost estimates for catastrophic outcomes, such as the surrogate losing a reproductive organ or requiring a full hysterectomy, underscoring how surrogacy practices frequently place women's bodies in harm's way[24].

Dropped Cycle Fee (may pay more than once)	$500.00
Miscarriage Fee (more likely with multiples)	$1,000.00
Fetal Reduction (only applicable with multiples)	$2,500.00
Termination	$2,500.00
C-Section (more likely with multiples)	$2,500.00
Invasive Procedure	$1,500.00
Loss of reproductive organ	$3,500.00
Full Hysterectomy	$5,000.00
Weekly incidentals for bed rest (more likely with multiples)	varies
Lost Wages for bed rest (more likely with multiples)	varies
SURROGATE - FIXED TOTAL	**$58,650 - $82,650 (plus lost wages)**

MHB's Surrogacy Budgeting Guide
Inquiries? Members@MenHavingBabies.org

Psychological violence and surrogate pregnancies

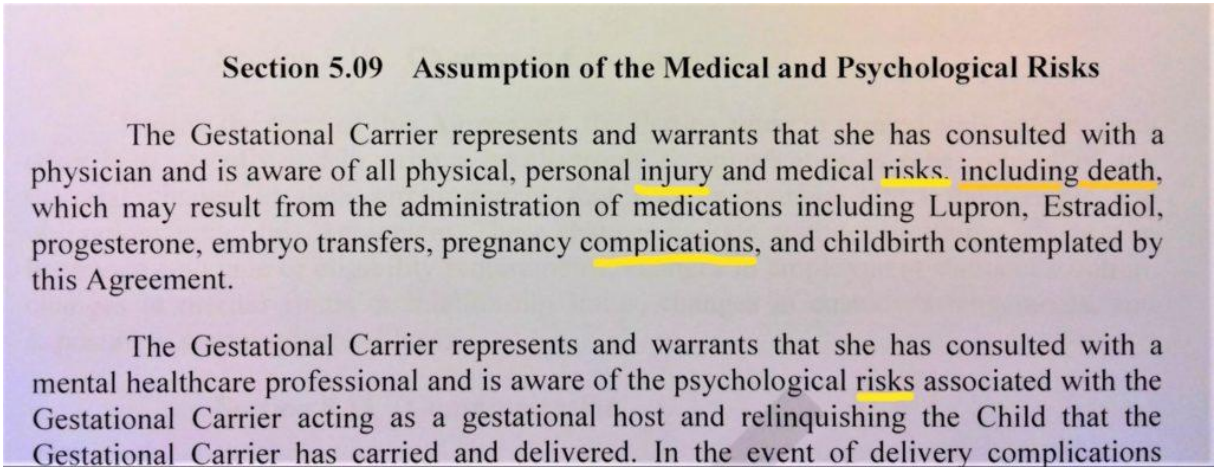
Our understanding of the physical impacts of surrogacy on women remains limited, and knowledge about the psychological effects is even more scarce. This gap highlights a form of often-overlooked violence in the surrogacy process.

Surrogate pregnancy should be recognized not only as a high-risk medical procedure but also as a high-risk emotional experience, as many surrogates report difficult and distressing experiences throughout the process[25]. Research indicates that surrogate mothers often develop a sense of emotional detachment—either positive or negative—toward the pregnancy. This detachment is a coping mechanism, helping surrogates dissociate from the child they will ultimately relinquish, thereby reducing feelings of loss and grief associated with separation[26].

Further studies reveal that surrogate mothers frequently begin their pregnancies with an acute sense of "risk" and experience significant scrutiny throughout. As pregnancy progresses, they endure substantial emotional turmoil, torn between maintaining a necessary detachment from the foetus and developing a sufficient attachment to ensure its healthy development[27]. This internal conflict is compounded by the knowledge that

they are nurturing and giving birth to a child they will not raise themselves, but for others who have commissioned the surrogacy.

The violent psychological strain in surrogacy cannot be ignored. Some contracts prepared by surrogacy agencies and legal advisors address this by including clauses that require surrogate mothers to accept the emotional, psychological distress inherent to the process.

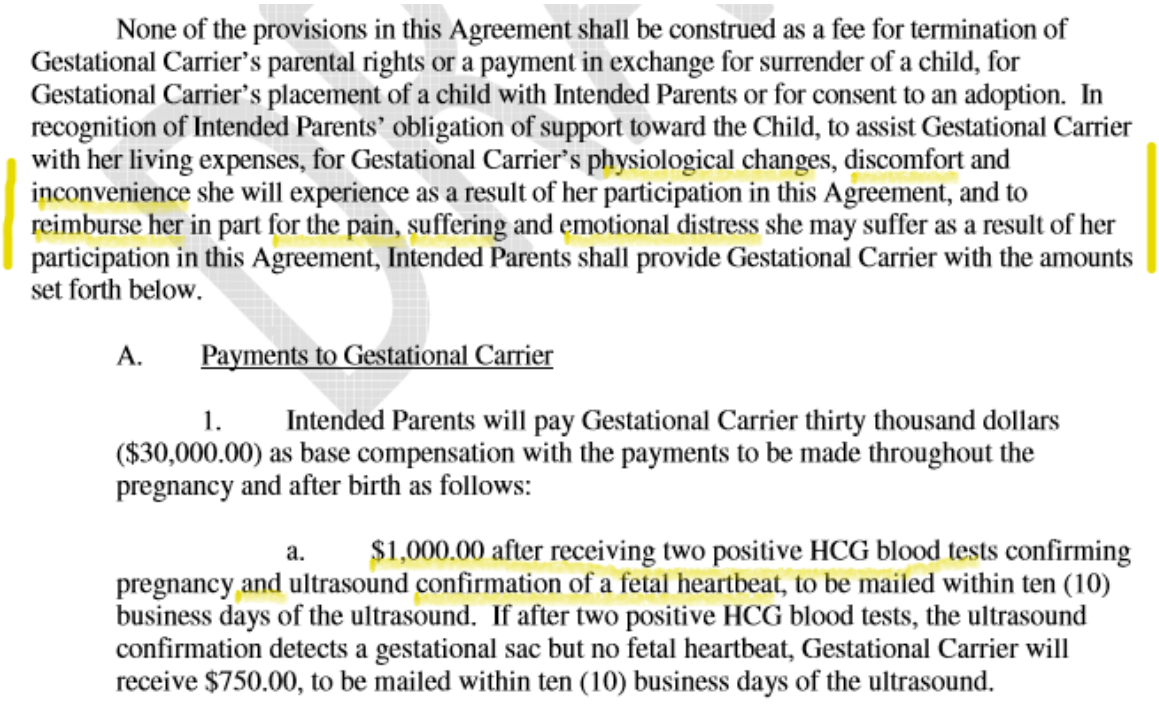


Section 5.09 Assumption of the Medical and Psychological Risks

The Gestational Carrier represents and warrants that she has consulted with a physician and is aware of all physical, personal injury and medical risks, including death, which may result from the administration of medications including Lupron, Estradiol, progesterone, embryo transfers, pregnancy complications, and childbirth contemplated by this Agreement.

The Gestational Carrier represents and warrants that she has consulted with a mental healthcare professional and is aware of the psychological risks associated with the Gestational Carrier acting as a gestational host and relinquishing the Child that the Gestational Carrier has carried and delivered. In the event of delivery complications

Figure 1: Section 5.09 "Assumption of the Medical and Psychological Risks"



None of the provisions in this Agreement shall be construed as a fee for termination of Gestational Carrier's parental rights or a payment in exchange for surrender of a child, for Gestational Carrier's placement of a child with Intended Parents or for consent to an adoption. In recognition of Intended Parents' obligation of support toward the Child, to assist Gestational Carrier with her living expenses, for Gestational Carrier's physiological changes, discomfort and inconvenience she will experience as a result of her participation in this Agreement, and to reimburse her in part for the pain, suffering and emotional distress she may suffer as a result of her participation in this Agreement, Intended Parents shall provide Gestational Carrier with the amounts set forth below.

A. Payments to Gestational Carrier

1. Intended Parents will pay Gestational Carrier thirty thousand dollars ($30,000.00) as base compensation with the payments to be made throughout the pregnancy and after birth as follows:

a. $1,000.00 after receiving two positive HCG blood tests confirming pregnancy and ultrasound confirmation of a fetal heartbeat, to be mailed within ten (10) business days of the ultrasound. If after two positive HCG blood tests, the ultrasound confirmation detects a gestational sac but no fetal heartbeat, Gestational Carrier will receive $750.00, to be mailed within ten (10) business days of the ultrasound.

Figure 2. "Payments to Gestational Carrier

1.a $1,000,00 after receiving two positive HCG blood tests confirming pregnancy and ultrasound confirmation of a foetal heartbeat, to be mailed within ten (10) business days of the ultrasound."

Economic violence and surrogate pregnancies

Surrogate motherhood is predominantly motivated by financial need rather than so-called "pure altruism"[28]. In countries with altruistic surrogacy frameworks, such as Australia, studies have found significant socioeconomic disparities between surrogate mothers and the commissioning people[29]. Surrogate mothers generally have lower levels of educational attainment and occupational status than the parents commissioning the surrogacy. Additionally, surrogate mothers and their families are more likely to live in less affluent areas, highlighting the structural inequalities that permeate these relationships.

These disparities are often overlooked, creating an environment where the structural inequities affecting surrogate mothers, their partners, and commissioning couples are both prevalent and troubling. Public decision-makers are more likely to empathize with commissioning parents, whose socioeconomic backgrounds often mirror their own. This implicit prejudice risks shutting out the voices of surrogate mothers and making their situation invisible.

These inequalities are further exacerbated by practices that target economically vulnerable populations. For instance, American surrogacy clinics have been criticized for recruiting military spouses, who face unique economic challenges. Military spouses often have limited job opportunities due to frequent relocations tied to their partners' deployments. This population also has a higher unemployment rate—three times that of civilian spouses—and many are already balancing significant caregiving responsibilities. Surrogacy agencies exploit these vulnerabilities, viewing military spouses as a dependable source of potential surrogate mothers[30].

Conclusion, the need for transparency and research

Public discourse and media coverage should prioritize these risks rather than glossing over them. Only with comprehensive, independent studies can society fully understand the range of challenges and forms of violence surrogate mothers face. The lack of governmental oversight and third-party monitoring exacerbates these issues, as surrogates often lack adequate legal protections and support systems.

The abolition of surrogacy is the ultimate goal to end up with this violence.

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INTERNATIONAL COALITION FOR THE ABOLITION OF SURROGATE MOTHERHOOD

ICASM is an international feminist umbrella organisation, working to eradicate surrogacy on national and international levels.

We oppose surrogacy as it exploits women's bodies and reproductive capacities, treats children as commodities, and ultimately undermines the rights of both women and children.

Through a global network of organisations and activists, we strive to end this harmful practice.

WHY OPPOSE SURROGACY?

- It turns women's bodies into profit-making machines, reducing children to mere objects of exchange.
- By exploiting vulnerable women as breeders for the wealthy, it perpetuates a cruel system that strips women of their agency and dignity.

ICASM' GOALS

- Promote equality between women and men.
- Advocate for the recognition of surrogacy as a form of violence against women and human trafficking.
- Support laws and policies protecting women's and children's rights.
- Ban all forms of surrogacy globally.

TAKE ACTION

- **Volunteer your skills:** Lend your expertise to our campaigns.
- **Spread the word:** Raise awareness about the dangers of surrogacy.
- **Share our message:** Promote our stance and arguments.
- **Donate:** Support our fight against exploitation.

Join ICASM for a world without reproductive surrogacy and child commodification.

Contact ICASM

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