Global Consensus Statement on Minimal Standards for Surrogacy

Abstract

Introduction: Some countries have legislation allowing surrogate arrangements to proceed within the country; others have a ban on surrogacy. In some countries, relevant legislation is absent. Poorly managed surrogate arrangements have resulted in exploitation of women, human trafficking of children and young girls/women and other bad outcomes. These issues have attracted attention from the mass media and the United Nations Special Rapporteur on Violence Against Women and Girls (5), who has called for an international ban on surrogacy.

Aims: To bring together global professional organizations which guide the practice of assisted reproduction, to produce a consensus statement on minimum standards for surrogacy.

Methods: Two regional societies (the Asia Pacific Initiative in Reproduction, the European Society of Human Reproduction), a federation of fertility societies (the International Federation of Fertility Societies) and a large national society (the American Society for Reproductive Medicine) each nominated three (3) representatives from diverse backgrounds (legal, ethical, clinical and scientific) with expertise in surrogacy. The representatives met monthly over fourteen (14) months to generate a series of statements for review by all members of the parent bodies and the International Federation of Gynecology and Obstetrics. Twenty-one (21) statements and narrative reviews were generated and circulated for feedback to members of all the parent bodies and the reviewers and editors of their respective journals. The writing group collated, reviewed and assimilated the feedback into either the statements or the narrative review.

Results:

Conclusions

DRAFT

Background

Gestational surrogacy (also called gestational carriage), according to the most recent international glossary (1), is defined as an assisted reproductive technology (ART) procedure in which an embryo originating from the gametes of the intended parent(s) and/or a third party (or parties) is transferred into the uterus of another woman with an agreement that she will give the offspring to the intended parent(s). This group prefers to use the term “surrogacy” and to define it as a situation in which a woman carries a pregnancy with the intention that following the birth of the baby, parental responsibilities and rights will be undertaken by the intended parent(s). Some countries have legislation allowing surrogate arrangements to proceed within the country; others prohibit surrogacy. In some countries, relevant legislation is absent (2).

As a result of differing national legislative and regulatory arrangements regarding assisted reproduction worldwide and various other “push” factors, intended parents (IP) may cross borders to access infertility care and surrogate arrangements. Cross border surrogate arrangements have been associated with exploitation, trafficking and lack of access to information (3). Some authorities have called for a ban on all surrogate arrangements, especially cross border arrangements (4, 5) such a ban has not been implemented at the present time..

In the absence of a global ban, there is a need to generate normative tools, interdisciplinary consensus and ethical protocols that guarantee respect for human rights, individual autonomy and transparency in the provision of reproductive care. These recommendations seek to define a minimum standard of care applicable in all settings though in some settings the standards may be higher. It is recommended that all countries establish legislation on, or regulation of, surrogacy (6). Where legislation exists that differs from these recommendations, the legislation applies and takes precedence over these recommendations. If legislation is absent or there are statutory gaps, it is recommended that these standards, at a minimum, should apply to all those involved in surrogacy arrangements. This document seeks to establish consensus between a large national society (the American Society for Reproductive Medicine (ASRM) and three global societies involved in assisted reproduction and surrogacy (the Asia Pacific Initiative in Reproduction, the European Society of Human Reproduction and Embryology, and the International Federation of Fertility Societies).

Definitions and terminology

Terms and abbreviations used throughout this document are generally consistent with the International Glossary (1) though some may vary, and are defined as follows:

- **Surrogacy**, a term which is preferred to gestational carriage, is embedded in some legislative instruments and will be used throughout this document. It is defined as the situation in which a woman carries a pregnancy with the intention that following birth of the baby, parental responsibilities and rights will be undertaken by the intended parent(s). Gametes can originate from the intended parent(s) and/or a third party (or parties).

- **Surrogate** refers to an adult woman who undertakes the responsibility of gestating a pregnancy to term and live birth, and who has an agreement that following the birth of the

baby, parental responsibilities and rights will be undertaken by the intended parent(s). Gametes can originate from the intended parent(s), a third party (or parties) or the surrogate herself. Surrogate therefore encompasses both gestational surrogates and traditional (or genetic) surrogates.

- **Gestational surrogate** refers to an adult woman who undertakes the responsibility to allow the transfer of an embryo into her uterus with the purpose of gestating the pregnancy to term and live birth, and who has an agreement that following the birth of the baby, parental responsibilities and rights will be undertaken by the intended parent(s). Gametes can originate from the intended parent(s), a third party (or parties) but not the surrogate herself. However, the term gestational carrier is used by the ASRM and may be used by some lawyers.

- **Intended parent(s)** (IP) refers to the person or persons who seek to have a child with the assistance of a surrogate and who undertake the social and legal responsibilities and rights to parent the child born from the surrogacy arrangement.

- **Traditional (or genetic) surrogacy** (TS) is a surrogate arrangement where the surrogate is also the oocyte donor for the IP.

- **Paid (remunerated, commercial) surrogacy** (PS) is a surrogacy arrangement where the surrogate receives monetary payments at an agreed frequency, often in advance and pre-birth for living expenses, out of pocket costs, time, effort, pain, and other considerations.

- **Altruistic surrogacy** (AS) or unpaid surrogacy is a surrogacy arrangement where the surrogate does not receive monetary pre-birth support payments. However, AS may include payment of direct expenses or reimbursement of actual lost income due to the pregnancy and delivery with the goal of ensuring financial neutrality for the surrogate.

- **Cross-border reproductive care** (CBRC) is traveling from one jurisdiction (country or state or county) to another to access reproductive health care.

- **Intermediaries** are brokers, often called agencies, who match potential surrogates and IPs and assist in the negotiation of the arrangements. Some countries have regulations which apply to intermediaries. Intermediaries may include fertility clinics. In countries with legislation pertaining to surrogacy, intermediaries often have a legal background in surrogate arrangements.

- **Assisted Reproductive Technology (ART) lawyers** (or attorneys) are legally qualified personnel with particular expertise in family law and surrogacy arrangements.

- **Trafficking in persons** means the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation.

- **Proportionality** is a term which reflects purchasing power parity in different resource settings where CBRC is planned. It seeks to avoid excess payments, which in a lower resource setting could be coercive. Under the principle of proportionality, measures must be suitable and necessary to achieve the desired end and must not impose a burden on the individual that is excessive in relation to the objective sought to be achieved

Methods

Members of the group were nominated by the societies and the federation as individuals with backgrounds in surrogate arrangements and expertise in legal, ethical, scientific and/or clinical frameworks. Some members had children through surrogate arrangements, while others had concerns about reported adverse events associated with surrogate arrangements.

The members of the committee met on 25 February 2025 and 31 March 2025 to determine the scope of the consensus statement, during which the following issues were identified.

1. Avoidance of human trafficking
2. Ensuring appropriate care of surrogates
    a. Reduction of medical risks (e.g. twins or higher order multiple gestation)
    b. Freedom from constraints of movement and coercion
    c. Independent legal representation
    d. Informed consent by an independent physician as well as by the fertility clinic physician, in the individual's own language. For individuals with low literacy, with independent advisor who speaks the same language should be involved. A cooling off period and a termination clause should also be included in the surrogacy contract
    e. Provision of a joint psychosocial consultation involving the surrogate, her representative and her family, together with the IP, to discuss and agree on pathways for managing disputes and adverse outcomes.
3. Ensuring that the well-being of the future child is considered in the assessment of the IP
    a. Medical health of IP
    b. Psychosocial health of IP
    c. Provision for future care of child in the event of demise of the IP
    d. Agreement on how to manage prenatal diagnosis or unexpected findings during pregnancy, including expectations of the IP
    e. Access to information about identity of surrogate and any gamete donors
4. Clearly defined pathways of access to medical and psychological care for the surrogate and her family.
5. Transparent financial arrangements for all circumstances.
6. Clearly defined responsibilities of intermediaries
    a. Disclosure of incentives.
    b. Provision of information in advance regarding parentage orders.

Thereafter, the group met approximately monthly until June 2026. The available literature and resources were reviewed by nominated members of the committee. For each issue, statements were developed and agreed upon by consensus.

The finalized statements were circulated to the Boards of the Asia Pacific Initiative in Reproduction (ASPIRE), the American Society for Reproduction (ASRM), the European Society of Human Reproduction and Embryology (ESHRE) and the International Federation of Fertility Societies (IFFS) for circulation to their members. Feedback was collected over a three (3) week period via a portal set up by ASPIRE. The Editors of the journals of the respective societies were also invited to review and provide comments.

Results/Statements

Statement 1: Avoidance of human trafficking

1. All people involved in surrogate arrangements must actively avoid human trafficking or exploitation of vulnerable women. Important considerations are ensuring awareness of risk factors for human trafficking, ensuring a potential surrogate's ability to provide informed consent, by supporting her personal autonomy, and preserving her freedom of movement. Building connections between the potential surrogate and intended parent(s) is an important part of ensuring that human trafficking is avoided.

Human trafficking does not necessarily involve transfer across borders, and vigilant awareness is required by all those involved in surrogate arrangements to prevent human trafficking. Prevention requires the identification of poverty and inequality, recognition and rejection of discriminatory attitudes, and the reduction of corruption and complicity, along with other contributing factors. (7) Reducing the demand for surrogacy, particularly across borders, may also be an important part of preventing human trafficking. (7).

Statement 2: Best interests of the child to be born

2. The best interests and well-being of the child to be born must have been carefully considered in the assessment of the IP and the surrogate and her family and all other matters (for example, access to information about biological and gestational heritage, and the suitability of granting a parentage order).

The welfare of the child needs to be carefully considered by all parties involved in a surrogate arrangement. (8)

Statement 3: Indications for surrogacy

3. The IP must be unable to conceive and/or carry a pregnancy safely to term on medical and/or biological grounds.
Indications for surrogacy include:

- Congenital or acquired absence of the uterus;
- Significant uterine anomalies, such as extensive intrauterine scarring associated with Asherman syndrome or a congenital uterine malformation which results in the inability to conceive a pregnancy and/or in recurrent pregnancy loss;
- Absolute psychological or medical contraindication to pregnancy;
- Serious psychiatric or medical condition that could be exacerbated by pregnancy or pose significant risk to the IP or fetus;
- Familial structures in which gestation by an intended parent is biologically infeasible including male same-sex couples, single men and transgender women.

The potential IP must sign a document allowing the fertility clinic to access all past medical records.

The indications for surrogacy have been published (9). In particular, it is noted that surrogacy is unacceptable and contraindicated if at least one of the IPs is able to gestate a pregnancy herself without significant risks or negative impacts on her own medical or psychological health. (10)

Statement 4: Preliminary assessment of surrogate

4. The surrogate must be at least 21 years of age or the age of majority, whichever is higher, and must have given birth without complication to a healthy child of her own whom she has parented or is parenting without restriction. She must have no detectable infectious diseases which are potentially transmissible to the fetus she may carry.

A potential surrogate must have had at least one child of her own and be informed of the infectious disease screening she needs to undertake. (8) Defining an upper age limit at which a woman should no longer be a surrogate is difficult. After 40 years of age, the medical risks associated with pregnancy increase and surrogacy should be discouraged after the age of 45. Regardless of age, obstetrical risks also increase if a woman has had five (5) or more vaginal deliveries (11), four (4) lower uterine segment caesarean section deliveries or one (1) classical caesarean section delivery (12). These should be considered contraindications to being a surrogate. This will limit the number of pregnancies a woman can have and, consequently, the number of times she can be a surrogate.

Statement 5: Autonomy of the surrogate and informed consent

5. The potential surrogate must have the capacity, information, and understanding required to give informed consent free from undue pressure, duress and/or coercion. The potential surrogate should also have full autonomy over her health and welfare decisions regarding the pregnancy. Consent requires full information (including risks and adverse outcomes) which is provided in a way that is understandable to the potential surrogate and there should be sufficient time for reflection on the information, the opportunity to ask questions and have them adequately answered (with or without a support person). Consent also needs to be actively given.

According to the International Federation of Gynecology and Obstetrics (FIGO), informed consent means that the surrogate adequately understands the medical, psychological, and social implications of the surrogacy arrangement. This includes potential health risks, emotional impacts, financial considerations, and the legal ramifications of relinquishing parental rights (13). The key elements of informed consent are information, capacity and voluntariness (14).

Statement 6: Requirement for independent support person for the surrogate

6.An independent support person or persons of the surrogate's choice must be available at all times (preconception, antenatally, at the time of delivery, and postpartum). Information in appropriate language should be given.

Statement 7: Assessment of the surrogate must be independent of intermediaries and/or clinics

7. All prospective surrogates must undergo independent assessment of their physical, mental, and psychosocial health, to ensure their suitability and capacity. Ideally, the mental health and social work professionals involved in the assessment of the surrogate should work independently of the intermediaries or clinics who will conduct the treatment cycle so that they are able to report honestly and without fear of reprisal or conflict of interest. Assessment should take into account the social context in which the potential surrogate lives, to ensure decisions are made freely (without coercion and undue pressure).

Statement 8: Assessment of physical health of the surrogate

8. Assessment of the physical health of the potential surrogate should include a full physical and gynaecology history and examination and screen for sexually transmissible and other infectious diseases which could potentially have a negative impact on the pregnancy or fetus. Some of these diseases may be more relevant in different geographic populations (e.g. malaria, HTLV.) It is particularly important to ensure the risk to the surrogate's health of undertaking a pregnancy is acceptably low.

Appropriate assessment of physical health is essential to ensure maternal safety, fetal well-being, and ethical integrity in surrogacy arrangements. The potential surrogate should undergo a comprehensive medical and obstetric evaluation to confirm her suitability for pregnancy.

Statement 9: Assessment of the mental health of the surrogate

9. The potential surrogate must sign a document allowing access of the fertility clinic to all past medical records.

Contraindications to being a surrogate are psychiatric or psychologic history, including but not limited to the following:

- Perinatal mood and anxiety disorders;
- Major depression;
- Significant anxiety disorder requiring on-going medication and/or psychotherapy
- Bipolar disorder;
- Psychosis;
- Eating disorder;
- Prior hospitalizations, suicide attempts, psychotropic medication(s), and on-going psychiatric or psychological counseling

There is little information available regarding the long-term health of women who have been surrogates with the most recent report at twenty (20) years being selected from altruistic surrogates and had a high dropout rate (15).

Statement 10: Psychosocial assessment of the surrogate

10. A criminal history check in the country/countries of residence should also be obtained.

Psychosocial contraindications to being a surrogate are:
- Past history of a conviction relating to harm of a human being or an animal
- History of abuse or violence
- Drug or alcohol abuse or addiction

Statement 11: Assessment of the physical health of the intended parents

11. The IP must sign a document allowing access of the fertility clinic to all past medical records to confirm appropriate indication(s) for surrogacy and to confirm adequate physical health for parenting.

When the IP is single special attention needs to be taken to the physical health of the IP to ensure the best outcome for the child.

Contraindications to being an IP
- Life-threatening disease (e.g. cancer, severe heart disease) which is likely to significantly shorten life expectancy to an extent that would compromise the intended parent's ability to parent the child to adulthood
- Absence of provision of a guardian and administrator for the child in cases where the age or health status of either IP raises reasonable concern regarding their ability to parent the child to adulthood.
- Carrying an infectious disease which is transmissible to the surrogate via the embryo and which cannot be reduced by effective treatment
- Not having a legitimate indication for surrogacy

This statement particularly aligns with Statement 2 on the welfare of the child born as a result of a surrogate agreement.

Persons providing gametes to be used in a surrogate arrangement must undergo screening for infectious disease to minimize preventable risks to the surrogate as well as the fetus. Genetic screening of those providing gametes should be performed according to the wishes of the IP. The wishes of the surrogate should also be taken into account.

If the infectious disease status of the gamete sources cannot be confirmed at the time of embryo creation, embryos may be quarantined for an appropriate period of time, until testing confirms that the gamete sources are negative for infectious disease, to minimise the risk of disease transmission to the surrogate.

Statement 12: Assessment of the mental health of the IP

12. Each IP must sign a document allowing access of the fertility clinic to all past medical records to allow assessment of the mental health of the IP.

Contraindications to being an IP are psychiatric or psychologic history, including but not limited to the following:
- Major depression, on-going and uncontrolled with medication, excluding perinatal mood and anxiety disorders;

- Significant anxiety disorder, on-going and uncontrolled with medication and/or psychotherapy;
- Bipolar disorder, on-going and uncontrolled with medication;
- Psychosis;
- Eating disorder;
- Prior psychiatric hospitalizations or suicide attempts

This statement particularly aligns with Statement 2 on the welfare of the child born as a result of a surrogate agreement.

Statement 13: Psychosocial assessment of the IP

13. A criminal history check in the country/countries of residence should also be obtained.

The following are psychosocial contraindications to being an IP

- History of conviction relating to harm of a human being or an animal
- Past or current protection order from the IP for a child to which the IP had access
- History of abuse or violence
- Drug or alcohol abuse or addiction
- Inability to establish a relationship with the potential surrogate (as assessed by the health professionals and the surrogate and her family)

This statement particularly aligns with Statement 2 on the welfare of the child born as a result of a surrogate agreement.

Statement 14: Written agreement of all parties prior to embryo transfer

14. Prior to embryo transfer all parties should have discussed and agreed in writing with respect to the approach to screening of the pregnancy for (and the management of) fetal abnormalities. However, the bodily autonomy of the surrogate should be considered paramount, rendering such an agreement necessarily non-binding. A surrogacy agreement should be drafted by an ART lawyer detailing all the terms of the arrangement, including what will happen if IPs separate during the pregnancy or the child is born with a disability. The care of the surrogate pre- and post-natally should also be agreed in writing.

Statement 15: Written agreement on transfer of parentage prior to embryo transfer

15. Before the embryo transfer, clear pathways (which are legally possible) should be discussed and agreed to by all parties, which cover actions after the birth of the child which allow for the safe transfer of the born child to the custody of the IP. This is particularly important when CBRC is planned. The IP and surrogate require separate legal counselling to clarify and document contractually what happens if the surrogate were to change her mind following birth of the baby. This is especially important in a traditional surrogacy arrangement.

The law of the place of birth often takes precedence over any prior contractual arrangement, and this should be planned well in advance of the embryo transfer (16). Birth registration, adoption and legal responsibility may be unclear in donor relationships and polyamorous

relationships across different jurisdictions. There has considerable work internationally to create frameworks for legal parentage orders across borders(17) but multilateral work is currently not advancing and will not be revisited within two (2) years(18).

Statement 16: Mandate for single embryo transfer only

16. Embryo transfer to a potential surrogate should always be a single embryo (regardless of the stage of development of the embryo) to minimize the risk of multiple pregnancy and its associated risks to the surrogate. Monozygotic twinning is widely considered to be an unavoidable potential consequence of single embryo transfer and needs to be discussed prior to transfer.

All transfers to surrogates should be single embryo transfers (9).

Statement 17: Type of embryo transfer treatment cycle

17. Current evidence suggests that a natural cycle frozen embryo transfer is preferable to an artificial cycle (exogenous oestrogen and progesterone to prepare the uterus) unless the surrogate is deemed very low risk for pre-eclampsia (10), or there are no other options If natural cycle frozen embryo transfer is planned, appropriate precautions must be taken to ensure that the pregnancy results from the embryo transfer and does not result from the surrogate's own oocyte and the sperm of her sexual partner.

Statement 18: Obstetric care of the surrogate

18. The surrogate must have access to good quality obstetric care. In regions, where maternal mortality is high and or Sustainable Development Goals for obstetric care have not yet been met, provision should made for antenatal care, delivery and postnatal care to be provided in a highly performing hospital or facility that meets national guidelines or recognized benchmarks for maternal outcomes.

The Sustainable Development Goals (SDG) target for maternal deaths is a global maternal mortality rate (MMR) of less than 70 maternal deaths per 100,000 live births by 2030. The global MMR in 2020 was estimated at 223 maternal deaths per 100,000 live births down from 227 in 2015 and 330 in 2000. During the Millennium Development Goal period (2000-2015) the global annual reduction rate was 2.7% but this fell to negligible levels during the first five years of the SDG era (2016-2020)(19). Some countries have not met SDG target for MMR(20) but women may have access to high quality obstetric care in private or centralized facilities in some of these countries.

Statement 19: Traditional surrogacy

19. Traditional surrogacy should be avoided, if possible, due to the potential risk of regret. It may be judiciously and carefully considered only if no alternative exists. If unavoidable, traditional surrogacy requires extra psychosocial and legal counselling to minimise psychosocial harm to the surrogate arising from relational complexities and regret.

Statement 20: Intermediaries

20. Intermediaries involved in surrogacy arrangements, including agencies, brokers, coordinators, legal facilitators, and other third-party organisations, should operate according to principles of transparency, accountability, and respect for the rights, welfare, and autonomy of all participants. Their primary role should be to facilitate informed, ethical, and legally compliant arrangements rather than to maximise financial gain.

Regulation of intermediaries and the establishment of minimal standards has been proposed in Australia where unpaid surrogacy is allowed but CBRC for commercial surrogacy is banned (21). The United Kingdom has regulation of intermediaries in place (22).

Statement 21: Paid surrogacy

21. The contractual terms are different for altruistic surrogacy and paid surrogacy. Where paid surrogacy is allowed and regulated, there should be guidance on allowable reimbursements and reasonable, non-coercive compensation ranges indexed to local income distributions, to ensure proportionality and to protect surrogates from exploitation.

Paid surrogacy is controversial with some arguing that it should be paid and appropriately remunerated, like any other work, and others describing it as an infringement of human dignity, the exploitation of vulnerable women, the instrumentalization of the female body, or the commodification of reproduction. These latter considerations are of special concern when the surrogate is in a low-income country, and the IP are from a high income country, with little oversight of the well-being of the surrogate. (10) The effects on the children born following a PS are mixed with some becoming advocates for surrogacy and others calling for a ban on surrogacy (23).

Recommendations for the future

1. Each country should have legislation addressing surrogacy. Where surrogacy is allowed, there should be clear regulation governing all parties involved, including intermediaries, health professionals and lawyers.
2. In the absence of adequate legislative provisions, countries should develop a roadmap for legal reform.
3. It is recommended that there be global collaboration to establish a registry of surrogate arrangements and birth outcomes to clinics facilitating surrogate arrangements should require their patients to consent to the reporting of de-identified information and outcomes.
4. Countries with legislation are encouraged to issue licenses to compliant organizations, with requirements for adverse event reporting, audit and inspection. National fertility organizations can develop recommendations based on this document if no regulations exist in their countries.

Acknowledgement: The contribution of Sonia Allan, a nominee of the IFFS is gratefully acknowledged and respected. She spent many years researching adverse outcomes associated with surrogate arrangements and contributed to the development of this document. She encouraged the writing group to be mindful of the pitfalls of surrogacy in many parts of the world. She passed away before the final version of the document was prepared and therefore did not have the opportunity to review or endorse it.

References

1. Ziegers-Hochschild F, Dyer S, Admamson D et al. The International Glossary on Infertility and Fertility Care 2025. Fertility and Sterility and Human Reproduction (in press). 2025.
2. Ory S. International Federation of Fertility Societies' (IFFS) Triennial Report 2025: Global Trends in Reproductive Policy and Practice, 10th edition. Global Reproductive Health. 2025.
3. Assembly UNG. *Report of the Special Rapporteur on the sale and sexual exploitation of children, including child prostitution, child pornography and other child sexual abuse material*. 2018.
4. Assembly UNG. *Violence against women and girls, its causes and consequences*. 2025.
5. Klein RZ. Surrogacy A Human Rights Violation. 1st ed: Spinifex; 2017.
6. Writing Group on behalf of the EEC, Shenfield F, Tarlatzis B, Baccino G, Bounartzi T, Frith L, et al. Ethical considerations on surrogacy. Hum Reprod. 2025;40(3):420-5.
7. Human Rights and Human Trafficking. In: Nations U, editor.: United Nations; 2014.
8. Ethics Committee of the American Society for Reproductive Medicine. Electronic address aao. Consideration of the gestational carrier: an Ethics Committee opinion. Fertil Steril. 2023;119(4):583-8.
9. Practice Committee of the American Society for Reproductive M, Practice Committee of the Society for Assisted Reproductive Technology. Electronic address aao. Recommendations for practices using gestational carriers: a committee opinion. Fertil Steril. 2022;118(1):65-74.
10. Writing Group on behalf of the EEC, Shenfield F, Tarlatzis B, Baccino G, Bounartzi T, Frith L, et al. Ethical considerations on surrogacydagger. Hum Reprod. 2025;40(3):420-5.
11. Peled T, Weiss A, Hochler H, Sela HY, Lipschuetz M, Karavani G, et al. Perinatal outcomes in grand multiparous women stratified by parity- A large multicenter study. Eur J Obstet Gynecol Reprod Biol. 2024;300:164-70.
12. Thompson BB, Reddy UM, Burn M, Abdel-Razeq S, Xu X. Maternal Outcomes in Subsequent Pregnancies After Classical Cesarean Delivery. Obstet Gynecol. 2022;140(2):212-9.
13. Zadykowicz R, Watson K, Antsaklis A, Reproduction FCoEAoH, Women's H. FIGO position statement on surrogacy: Ethical considerations. Int J Gynaecol Obstet. 2025;171(2):588-92.
14. United Nations Educational SaCO. Universal Declaration on Bioethics and Human Rights. Paris: United Nations Educational, Scientific and Cultural Organization; 2006. Contract No.: SHS/EST/BIO/06/1.
15. adva V, Shaw K, Hall P, Ross S, Imrie S. Surrogates 20 years on: long-term psychological health, contact with surrogacy families, and thoughts and feelings about post-birth contact. Hum Reprod. 2026;41(2):239-45.
16. Shenfield F, Pennings G, De Mouzon J, Ferraretti AP, Goossens V, Care ETFCBR. ESHRE's good practice guide for cross-border reproductive care for centers and practitioners. Hum Reprod. 2011;26(7):1625-7.
17. Hague Conference on Private International Law. 2025 [Available from: https://www.hcch.net/en/projects/legislative-projects/parentage-surrogacy.
18. Hague Conference on Private International Law. 2026 [Available from: https://www.hcch.net/en/projects/legislative-projects/parentage-surrogacy.
19. World Health Organization. Trends in maternal mortality2000 to 2023: estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division 2025 [14 March 2026]. Available from: https://www.who.int/publications/i/item/9789240108462.

20. World Health Organization. https://www.who.int/news-room/fact-sheets/detail/maternal-mortality 2025 [
21. Millbank J. The Role of professional facilitators in cross-border assisted reproduction. Reprod Biomed Soc Online. 2018;6:60-71.
22. Surrogacy Arrangements Act 1985 s.2, (1985).
23. Allan S. 2025.

DRAFT