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Ana Rita Rodrigues Igreja
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Assinatura conforme cartão de identificação:

Ana Rita Rodrigues Igreja

NOME

Ana Rita Rodrigues Igreja

NÚMERO DE ESTUDANTE

E-MAIL

201203353

anaritaigreja@hotmail.com

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Bioética e Deontologia Médica

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Surrogacy: challenges and ambiguities

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Assinatura conforme cartão de identificação:

Ana Rita Rodrigues Igreja

Surrogacy: challenges and ambiguities

Ana Rita Igreja¹, Miguel Ricou²

¹ Master Degree in Medicine, Faculty of Medicine of the University of Porto

² Assistant Professor of Bioethics in Faculty of Medicine of the University of Porto

Abstract

Surrogacy, an increasingly frequent form of family building, allows individuals to become parents despite an infertility diagnosis or a biological impossibility. Regardless of the inherent medical, psychological, ethical and legal complexities, altruistic gestational surrogacy became legal in Portugal in 2016. This paper's main goal is to analyse the existing scientific knowledge on the subject and try to understand it in light of the current Portuguese Law. To achieve this goal, PubMed, Scopus, and Web of Science databases were used to search original studies published in English, that included the key-words 'assisted reproduction, commissioning couples, cross-border surrogacy, ethics, gay father, gestational carriers, gestational surrogacy, surrogacy, surrogacy families, surrogate mothers', from 2011 to 2017. Positive outcomes for both the surrogacy child and the surrogate mother have been reported, including in cases of same-sex male couples and single persons, who still have their access to surrogacy restricted in Portugal. Even though payment is forbidden in Portugal, an on-going debate still exists because remuneration does not necessary involve undue inducement of the surrogate or transformation of the child into a commodity. The growing cross-border surrogacy business raises discussion on the women exploitation's risks and the lack of security for all parties involved. Additionally, the alarming hazard of surrogacy children becoming stateless creates an urgent need for international regulations. The right to regret and the doctors' autonomy before the committee are two issues neglected by the Portuguese Law that should be investigated. Nevertheless, literature on surrogacy is scarce, and most of the existing studies have important methodological limitations, so further investigation is much needed.

Keywords: assisted reproductive technology (ART), cross-border surrogacy, Portugal, same-sex couples, surrogacy, surrogacy children, surrogate mother

Resumo

Gestação de substituição é uma opção de construção de família cada vez mais frequente, que permite a indivíduos tornarem-se pais, independentemente do diagnóstico de infertilidade ou da impossibilidade biológica. Apesar dos riscos médicos, psicológicos, éticos e legais que lhe são inerentes, a gestação de substituição altruísta tornou-se legal em Portugal em 2016. O objetivo principal desta tese é analisar o conhecimento científico existente, e tentar compreendê-lo à luz da Lei Portuguesa. Para alcançar este objetivo, as bases de dados Pubmed, Scopus e Web of Science foram utilizadas para pesquisar estudos publicados em língua inglesa, que incluíam as seguintes palavras-chave ‘assisted reproductive technology (ART), cross-border surrogacy, Portugal, same-sex couples, surrogacy, surrogacy children, surrogate mother’, de 2011 a 2017. A maioria das referências encontradas apontam para resultados positivos nos processos de gestação de substituição, nomeadamente no que diz respeito à criança e à gestante de substituição, incluindo nos casos de casais homossexuais masculinos e pais solteiros, os quais ainda são discriminados em Portugal no que diz respeito ao acesso à gestação de substituição. Apesar do pagamento ser proibido em Portugal, um debate contínuo sobre o tema ainda existe, uma vez que existe quem defenda que a remuneração poderá não implicar um incentivo inapropriado à gestante ou a transformação da criança numa comodidade. Ainda assim, o crescente negócio da gestação de substituição além-fronteiras parece levantar questões quanto aos riscos de exploração de gestantes e à falta de segurança existente para todas as partes envolvidas. Adicionalmente, o perigo de a criança ficar sem nacionalidade cria uma urgente necessidade de regulações internacionais. O risco de arrependimento e a autonomia do médico perante a comissão são outros dois assuntos ignorados pela Lei Portuguesa que deveriam ser examinados. Não obstante o que foi anteriormente dito, a literatura sobre gestação de substituição é ainda escassa, e a maioria dos estudos apresentam limitações metodológicas, como tal investigação futura é necessária.

Palavras-chave: casais homossexuais masculinos; crianças; gestação de substituição; gestação de substituição além-fronteiras; gestante de substituição; Portugal; procriação medicamente assistida (PMA)

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List of Abbreviations

ACOG – American College of Obstetricians and Gynecologists

ART – assisted reproductive technology

ASRM – American Society for Reproductive Medicine

CBRC – cross-border reproductive care

CBS – cross-border surrogacy

CNPMA – Conselho Nacional de Procriação Medicamente Assistida

ESHRE – European Society for Reproductive Medicine

FIGO – International Federation of Gynecology & Obstetrics

IVF – in vitro fertilization

1. Introduction

‘Surrogacy’ consists in an arrangement in which a woman (surrogate or gestational carrier) is willing to carry a pregnancy on behalf of others (intended or commissioning parents) and to deliver the child (surrogacy child) after the birth, relinquishing her maternal duties and rights (Decreto de Lei n. ° 32/2006; Shenfield et al., 2005; Zegers-Hochschild et al., 2009).

While some nations have substantial reservations about the practice of surrogacy, declaring it illegal, others support it with specific legislation (FIGO, Committee for Ethical Aspects of Human Reproduction and Women’s Health, 2008). The legalization of surrogacy is an ongoing debate. On one hand, some argue that it should be legalized because all parties can benefit from it, and its prohibition constitutes a limitation to both the infertile couples’ right to found a family, stipulated in the Universal Declaration of Human Rights, and to the women who desire to help them through surrogacy. On the other hand, others allege that the risks outweigh the benefits and that is not feasible for a woman to give a fully informed consent about relinquishing a child until after the birth (Söderström-Anttila V et al, 2016). They fear harms to the new-born, the surrogate mother, her own existing children and to society as a whole, due to the inherent risk of trivialization of transactions regarding women’s reproductive capacities. Since children are considerably more vulnerable than adults and have no voice in the matter, ethically, harms to them are more serious. Based on these concerns, the consequences of surrogacy should be studied in order to understand if they are likely to be avoided by means of proper counselling, forward planning or supervision (ACOG, 2008).

Surrogacy is an extremely complex issue, involving both medical and social dilemmas, related to laws and ethics (FIGO, 2008). This paper will focus on the Portuguese reality of surrogacy, only recently legalized in 2016, by the third modification to Law n. ° 32/2006, from 26 July, on assisted reproductive technology (ART), altered by the Laws n. ° 59/2007, from 4 September, 17/2016, from 20 June, 25/2016, from 22 August, and 58/2017, from 25 July (Decreto de Lei n. ° 32/06, 26 Julho). The outcomes for the surrogacy child, the complexities attached to being a surrogate, the payment controversy, the subsequent cross-border surrogacy (CBS), the access’s restriction on same-sex male couples and single individuals, the neglected right to regret, and the doctors’ autonomy before the National Committee on ARTs, are pertinent points that will be further explored on this paper.

1.1. Surrogacy Divisions

Two types of surrogacy agreements exist, traditional and gestational. In traditional surrogacy (also called genetic or partial) the surrogate is artificially inseminated with the intended father’s or donor’s sperm, making her genetically related to the offspring. The origins of this type of surrogacy are found in the Old Testament of the Holy Bible, where an infertile wife requested a maid to carry her husband’s child. A more recent alternative is gestational surrogacy (also called host, full or IVF surrogacy) where the embryo stems from in vitro fertilization (IVF) of gametes from the intended parents, donors or both, and is afterwards transferred to the surrogate’s uterus. Under these circumstances there is no genetic connection between the surrogate and the surrogacy child (Norton W et al., 2013; Söderström-Anttila V et al, 2016). This arrangement was successfully performed for the first time in 1983 (Utian et al., 1985) and has become increasingly more frequent over the past years (ACOG, 2016). Since only gestational surrogacy is legally allowed in Portugal,

and this paper focuses on the Portuguese reality, only this type of surrogacy agreements will be addressed.

Surrogacy can also be split in commercial or altruistic, contingent on if the surrogate financially benefits from her pregnancy. In commercial surrogacy, the surrogate's recruitment is generally made through an agency, her medical expenses are reimbursed and her gestational services are paid. Alternatively, in altruistic surrogacy, the surrogate is usually found through family, friends, acquaintances or advertisement, and is only repaid for her medical expenses strictly associated with the pregnancy and for the income's loss consequential to the pregnancy (FIGO, 2008; Söderström-Anttila V et al, 2016).

2. The Portuguese Present Reality

According to the International Federation of Gynecology & Obstetrics (FIGO)'s committee for the ethical aspects of human reproduction and women's health, gestational surrogacy is the preferable option, considering the added complexity of traditional surrogacy, and it should not be commercial (FIGO, 2008). These recommendations are followed by the Portuguese Law. As a matter of fact, according to Article 8 (3) of Law n. ° 32/2006, surrogacy in Portugal is only possible if at least one of the intended parents' gametes is used, and the surrogate cannot donate any of her own oocytes to the procedure in which she will take part. This means that only gestational surrogacy is legal, excluding the surrogate from any parental rights, since the offspring born through surrogacy, pursuant to Article 8 (7), is considered to be the child of the commissioning couple. This is enforceable even if the contract is not valid, since no exception to this rule nor a restriction to valid contracts is included in the law (Raposo VL, 2017). Besides, according Article 8 (2) all surrogacy agreements must have an altruistic nature. Therefore, only altruistic gestational surrogacy agreements are legal in Portugal. The execution or promotion of contracts outside the conditions foreseen on the Law are considered a criminal offence (Decreto de Lei n. ° 32/06, 26 Julho). According to the Implementing Decree n. ° 6/2017, the relationship between the surrogate and the surrogacy child must be limited to the minimum indispensable, due to potential psychological and affective risks (Decreto Regulamentar n. ° 6/2017, 31 Julho).

2.1. Access Restrictions

The International Covenant on Economic, Social and Cultural Rights, on Article 15 (1b), states that everyone has 'the right to enjoy the benefits of scientific progress and its applications'. However, Article 4 (2) of Law n. ° 32/2006 establishes that surrogacy, like the others ARTs, is a subsidiary method of reproduction, not an alternative one, therefore it is exclusive to medical indications, on account of the ethical, legal and psychological complexities and potential medical risks (ACOG, 2016; FIGO, 2008). Thus, it should never be available to those who are capable but unwilling to carry a child wishing to escape the inconveniences of being pregnant and giving birth (Brandel A, 1995). Furthermore, according to Article 6 (2), its access is also not available for those under 18 years old, or with a psychiatry interdiction or inability (Decreto de Lei n. ° 32/06, 26 Julho). In order to apply for a surrogacy contract, the ages of the parties involved should be within the limits defined by the National Council of Assisted Reproductive Technology (CNPMA, Conselho Nacional de Procriação Medicamente Assistida). In regard to the contracting parents, the men can be up to 60 years old and the women up to

50 years old. For the surrogate mother, the limit is 45 years old, unless she is the mother or sister of one of the members of the commissioning couple, in which case she can be up to 50 years old (Comunicado CNPMA, 2017).

Article 6 (1) on the beneficiaries, stipulates who is allowed to undergo ARTs, which are heterosexual couples or same-sex female couples, married or living in similar conditions, and all women regardless of their marital status and sexual orientation; a measure which restricts single men and same-sex male couples. Single women who fit the criteria of Article 8 (2) are also excluded from using surrogacy, because the CNPMA argues that the law states that surrogacy is not an ART, but instead a treatment who requires the use of an ART, so the concept of ‘beneficiaries’ in surrogacy can justifiably not be the same as in article 6 (1). In Article 8 (3), the existence of a ‘beneficiary couple’ is implicit, therefore, only the first part of the Article 6 (1) should be considered when talking about surrogacy (heterosexual couples or same-sex female couples) (Deliberação n. ° 20-II/2017, 20 Outubro). In Portugal, Article 8 (2) stipulates that surrogacy contracts are only allowed in exceptional situations: in cases of absence of uterus, lesion or pathology of this organ that absolutely and definitively prevents a pregnancy, or other clinical conditions that justify it. This last part of the Article is ambiguous, leaving an open clause up for people’s interpretation.

All the contracts require approval by the CNPMA the entity in charge of the ethical, social and legal questions related to the use of reproductive techniques in Portugal, and who supervises the entire process of surrogacy. They should perform complete and independent evaluations on the intended parents and the surrogate (Art. 2 (9)) (Decreto Regulamentar n. ° 6/2017, 31 Julho) and request the Medical Association’s opinion on the case, prior to rendering their decision (Art. 8 (4) and 30 (1)) (Decreto de Lei n. ° 32/06, 26 Julho). When submitting the request to undergo surrogacy, the CNPMA requires the intended parents to present a medical certificate, from the clinic where the ARTs will be performed, stating that the woman/women from the couple meet the requirements present in Article 8 (2, 3). This medical certificate is latter sent to the Medical Association’s for them to deliver an opinion on the issue. So, we can conclude that ultimately the interpretation of ‘clinical conditions that justify it’ is performed by the CNPMA after hearing the Medical Association’s (Raposo VL, 2017).

2.2. Management of Interests

Surrogacy is a particularly complex subject since the interests of the intended parents, the surrogate and the future child may differ (Shenfield et al., 2005). In accordance with the UN Convention on the Rights of the Child, even though the interests of the children are the ‘primary consideration’ (Art. 3 (1)), the rights and duties of the other parties should also be taken into account (Trimming K & Beaumont P, 2011). It is the CNPMA’s responsibility to ensure that all surrogacy contracts prioritize the interests of the child, over those of the other parties, and that the surrogate’s interests are taken into account (Decreto Regulamentar n. ° 6/2017, 31 Julho). In recent years a growth in this practice has been observed, with the vast majority of cases being successful, due to a strict program, transparent practices and an effective cooperation between medical, social and legal professionals (Dar S et al., 2015). The media coverage on the topic has also increased, after celebrities like Nicole Kidman, Elton John and Cristiano Ronaldo resort to surrogacy to build their families. However, the same thing cannot be said about studies examining the outcomes of surrogacy for all the parties involved, since these are still

scarce and with plenty of methodological limitations (Burrell C, 2014; Jadvá V et al., 2012).

2.3. Health-Care Conduct

Obstetricians-gynecologists are highly likely to be faced with the challenges of surrogacy, as they might have to counsel potential gestational carriers, care for them while pregnant, and advise and refer infertile couples contemplating this treatment. Therefore, they should stay informed on the medical, psychosocial and ethical complexities of surrogacy. Physicians should discuss medical risks, benefits, and alternatives, recommend proper medical and psychosocial counselling, and perform a complete medical evaluation on all parties involved. Separate and independent professionals should work with the intended parents and the surrogate in all stages of the process, in order to avoid conflicts of interests and optimize patient advocacy (ACOG, 2016; FIGO, 2008; Reilly DR, 2007; Shenfield et al., 2005).

Psychosocial education and counselling by qualified mental health professionals to all parties involved, including the partners of all potential surrogates, is strongly advised. This is crucial to ensure that everyone is aware of their responsibilities, as well as their rights in the contract. Article 2 (d) of the Implementing Decree n. ° 6/2017 requires both the intended parents and the surrogate to have a psychiatrist or psychologist certificate in favor of their participation in a surrogacy contract (Decreto Regulamentar n. ° 6/2017, 31 Julho). This assessment should feature a clinical interview and, if needed, psychological testing; it should be factual, respectful of the person's view and noncoercive. Some of the topics that should be explored are the potential psychological issues and risks, the relationship between the intended parents and the surrogate, the disclosure to the child, future contact, and the impact of the pregnancy on both families' and community's dynamics (FIGO, 2008; Practice Committee of the ASRM, 2017). In order to reduce potential conflicts during pregnancy, the American College of Obstetricians and Gynecologists (ACOG) encourages discussion between the intended parents and the surrogate of all possibly predictable decision-making scenarios in the pregnancy and recommends formal documentation of the plans for addressing these situations in the surrogacy contract (ACOG, 2016). Expert groups from the American Society for Reproductive Medicine (ASRM) and European Society for Human Reproduction and Embryology (ESHRE) summarized general requirements for the screening and testing, and recommendations related to psychosocial consultations, which might be the solution to avoid major predictable and avoidable conflicts that can arise in the future (Practice Committee of the ASRM, 2017; Shenfield et al., 2005). Post-birth counselling should also be offered to all parties to address any psychosocial problems that may emerge during and after the post-natal period (Dar S et al., 2015). The Portuguese Law, on Article 12 (3c), grants all beneficiaries the right to be informed of the potential medical, social and legal implications (Decreto de Lei n. ° 32/06, 26 Julho), and Article 3 of the Implementing Decree n. ° 6/2017, grants the surrogate the right to receive psychological counselling before and after the delivery (Decreto Regulamentar n. ° 6/2017, 31 Julho). Neither the other parties involved in the contract, the surrogate's husband nor her own children have this right granted by the Law.

Genetic parents must undergo the same screening as gamete donors. They should be subjected to a complete medical evaluation, including a meticulous history and physical examination, and an appropriate genetic evaluation to safeguard that they are sufficiently healthy to carry on with the practices involved in assisted reproductive technology.

Qualified health professionals should also perform a complete medical evaluation on potential surrogates, paying close attention to their personal and sexual history, in order to identify those with a high risk for STIs or other acquired infections possibly transferable to the fetus. ASRM recommends all surrogates and their partners to be tested in the 30 days prior to the embryo transfer so that all the parties involved have their health and interests protected. Even though no method fully assures the prevention of infectious agents' transmission to the gestational carrier or the foetus, laboratory testing of all parties to exclude individuals at high risk for HIV and other STIs should be performed, because these tests in combination with a proper medical history should significantly reduce these risks. Testing the blood type and Rhesus (Rh) factor is also recommended due to the potential for Rh incompatibility (Dar S et al., 2015).

Confidentiality and protection of medical information should be guaranteed to all individuals involved (Practice Committee of the ASRM, 2017). Nevertheless, it is fundamental to obtain consent to share pertinent information between the gestational carrier and the intended parent(s) that might make one of the parties reconsider their decision on entering a surrogacy agreement (Dar S et al., 2015). Clause 3 (e) of the surrogacy contract available in CNPMA's website, only foresees the duty of the surrogate to inform the commissioning parents of any situation that can prevent or modify her following the contract, such as any health-related problem that may compromise the pregnancy (Contrato de gestação de substituição).

3. Outcomes for the Surrogacy Child

The inherent dignity of all children is established on the UN Convention on the Rights of the Child, therefore it should be protected at all times. Additionally, 'in all actions concerning children the best interests of the child shall be a primary consideration', making it imperative to study the possible consequences that surrogacy might have on the surrogacy child.

The media has highlighted examples where problems have emerged, such as the cases of Baby M and Baby Gammy, contributing and reinforcing society's prejudice towards surrogacy. Baby M was born through a traditional surrogacy agreement in 1986, and the surrogate decided to keep the child after the birth. The case went to court where it was granted legal custody to the genetic father and visiting rights to the surrogate mother (Peterson, 1987). In Baby Gammy's case, his diagnosis of Down Syndrome led to his abandonment by his intended parents. In the cross-border surrogacy chapter of this paper, this case will be further explored.

There are fears of the new-borns being abandoned by the commissioning parents and/or surrogate if unexpected complications or congenital malformations occur (FIGO, 2008). However, in Western countries, the risk of intended parents abandoning their child must be estimated as low, since those who go through this complicated and time-consuming treatment are generally highly motivated to become parents (Söderström-Anttila V et al, 2016). Nevertheless, proper counselling might help anticipate and solve unplanned outcomes (ACOG, 2016).

3.1. Health and Psychological Concerns

Health wise, perinatal outcome and risk of fetal anomalies for the children conceived through surrogacy were comparable to standard IVF and oocyte donation, and no

evidence of harm was found (Dar S et al., 2015; Söderström-Anttila V et al, 2016). In an UK longitudinal study that collected information at six different time-points (ages 1, 2, 3, 7, 10 and 14), no difference was found on the psychological wellbeing and the quality of family relationships between adolescents unaware of their biological origins, those aware of the circumstances of their birth (at any age), or those naturally conceived. However, since it would not be ethical to interview children that were not aware of their biological origins, mothers were the only data source for these comparisons. Therefore, this absence of differences might not truly represent reality. In the group of those aware of their biological origins, the disclosure age was examined, and researchers found that an early disclosure (before age 7) was related with adolescents' more positive perception of family relationships and higher levels of well-being. This might be due to kids being more accepting of this information until age 7, before they acquire a deeper understanding on the significance of lack of a genetic and/or gestational connection to their mother. Even though these findings are coherent with the children's socio-cognitive development at that age, it cannot be ruled out that the differences found are due to a more positive relationship between the family, rather than an earlier disclosure age, because families with good relationships with the child may find it easier to open up about this topic. Nevertheless, no difference was found in the development of psychological problems according to the age of disclosure (Ilioi E et al, 2017). Additionally, the presence or absence of a genetic connection between the mother and the child was shown to have a lower impact on the children's psychological well-being than the quality of family relationships (Golombok S et al, 2011).

The parents' decision to tell a child about their conception remains one of the most controversial and difficult one's to make (Ilioi E et al, 2017). Readings et al. compared the parents' secrecy of children conceived by donor insemination, egg donation and surrogacy, and it was found that surrogacy parents were much more willing to tell their children about their conception than the other two types (Readings et al., 2011). A 10 years longitudinal study performed by Jadva et al., comparing surrogacy families to gamete donation families, found that more than 90% of surrogacy families had explained to their child the use of a surrogate, reinforcing that families who use surrogacy are more open with their child about their use of ART. Different reasons might justify this, one being the arrival of a baby in the absence of a pregnancy, making it nearly impossible for parents to not disclose it to family and friends, existing therefore a higher chance of the child finding out from someone else. Furthermore, the explanation parents need to give their child about surrogacy is simpler to understand and it does not require any understanding on human reproduction and the role of gametes, unlike the explanation of the other gamete-donation parents. The increasing tendency to disclose may also be due, in part, to a reduction on society's stigma attached to the technique, as a consequence of the growing prevalence of ARTs (Jadva V et al., 2012; MacCallum et al., 2003; Readings et al., 2011). Therefore, as previous studies suggested, a progressive disclosure suitable to the child's level of understanding might be the most beneficial method, making disclosure a 'non-event' for the child.

3.2. The Truth Behind the Disclosure

While many of the intended parents' reason to opened up was the child's right to know, approximately as many did it to prevent eventual negative outcomes of accidental disclosure. Some even mentioned future hypothetical scenarios, like organ matching, in

which the best interest for the child would be dependent on previous disclosure (Readings et al., 2011).

Even though some parents may see secrecy as a way to protect their children, when the latter find out intentionally or by accident, they might hold it against their parents and regard it as intentional concealment. In fact, many of the mothers that are still unsure about disclosure, when the child is a baby, will remain unsure as the child grows older. With the importance of disclosure having an increased emphasis, providing trustworthy information to parents can be the key to solving these issues (Readings et al., 2011).

Most children who are conscious of their surrogacy feel either indifferent or positive towards it. In fact, their narratives about it are likely influenced by how the parents explained surrogacy to them, and only when they are older they will have their own views about their conception and the use of a surrogate. Of those in contact with their surrogate by the age of 10, the majority reported liking them and feeling positive about their surrogacy birth. They praised the surrogate's altruistic motivations for helping their parents, raising the question on how they would feel if the surrogate was obtaining financial benefits from the surrogacy (Jadva V et al., 2012). Considering the above-mentioned findings, it is fair to say that the majority of scientific research on this topic does not support the Implementing Decree n. ° 6/2017 statement, that demands the relationship between the surrogate and offspring to be limited to the minimum indispensable, due to the potential psychologic and affective risks (Decreto Regulamentar n. ° 6/2017, 31 Julho).

Nevertheless, all conclusions up to now should be carefully interpreted, and further studies are needed to understand surrogacy's impact on the children as they grow older and to determine whether they desire to meet their surrogate (Jadva V et al., 2012; Jadva V et al., 2015). The Portuguese Law n. ° 32/2006 has this in consideration, and states, in Article 13 (2), that beneficiaries should provide all information related to the child's health and development, in order to allow scientific investigation on health and psychosocial outcomes of children born through ARTs. According to Article 30, it is the CNPMA's job to collect this information, perform the scientific investigation, and recommend pertinent legal alterations, needed to adapt to the scientific, technological, cultural and social progress (Decreto de Lei n. ° 32/06, 26 Julho).

4. Complexities of the Surrogate Mother

Considerable criticism of surrogacy has been made over the past years, and some of the main objections are the exposure of the surrogate to unexpected health risks related to the pregnancy and delivery, and the possibility of post-partum psychological problems due to the distress of relinquishing the child. Some thought that a bond between her and the offspring may develop, making it particularly difficult to relinquish the new-born. Contrarily, it has also been proposed that surrogates believing this child is not theirs, might detach themselves from the unborn baby, leading them to more easily put their and the unborn child's health at risk. Furthermore, for those women who do hand over the child, additional strain might be added to their psychological health due to feelings of anger or guilt and the risk of post-partum depression (FIGO, 2008; Jadva et al., 2003; Ragoné H, 1994; Söderström-Anttila V et al, 2016).

4.1. Acceptance Requirements

In order to have a legitimate surrogacy arrangement, it is fundamental that all potential gestational carriers are perfectly informed of the potential benefits, risks, and complications of pregnancy and delivery (ACOG, 2016). Just like any other pregnant woman, there are always possible maternal risks for the carrier even in the absence of obstetrics risk factors, such as common pregnancy complications, miscarriage or ectopic pregnancy. However, following the shown below acceptance recommendations of ESHRE, ASRM and FIGO, can minimize these risks.

Only one embryo at a time should, and is allowed to, according to Clause 1 (3) of CNPMA's surrogacy contract (Contrato de gestação de substituição), be transferred to the surrogate in order to prevent multiple pregnancies, which are associated with an increased risk of almost all maternal complications, such as, hypertensive disorders, hemorrhage, preterm labor, and operative delivery. Also, only one act of surrogacy is recommended per woman, unless the agreement is with the same commissioning couple (FIGO, 2008; Practice Committee of the ASRM, 2017; Shenfield et al., 2005).

The carrier should be within the, previously mentioned, age limits defined by the CNPMA (Comunicado CNPMA, 2017). Besides, ideally, she should have had at least one, term, uncomplicated pregnancy, should not have had more than five previous deliveries in total or three via caesarean section, and she should have a stable and supporting family environment to help her cope with the added stress of pregnancy (Practice Committee of the ASRM, 2017; Shenfield et al., 2005). Obstetric history is essential when evaluating the risks because it might more successfully predict future obstetric complications than the surrogate's age. Therefore, women with prior obstetric complications should not be accepted as carrier candidates (Dar S et al., 2015; Duffy et al., 2005). There are also theories exist who claim that this selection of healthy carriers with normal reproductive backgrounds may make up for possible abnormal immunological responses caused by a foreign embryo, and that their uterine environment, when compared to infertile oocyte recipients, might be more hospitable (Gibbons et al., 2011). No studies regarding this matter were found comparing surrogates who are unrelated to the commissioning couple with those who are family members. The Portuguese law is silent to all the previously mentioned restrictions.

4.2. Autonomy's Importance

Surrogate's body integrity and autonomy are paramount, and should be respected at all stages, even if that conflicts with the commissioning couple's interests (FIGO, 2008). The decision to undergo the pregnancy must be free and deliberate; therefore, the surrogate should behave as a conscious pregnant woman, following antenatal care recommendations and avoiding risky practices that can endanger the fetus (Shenfield et al., 2005). Nevertheless, when vulnerable women are exploited to carry children in exchange for economic benefits, this autonomy can be vitiated (Burrell C, 2014).

Article 8 (11) of Law n. ° 32/2006 forbids any restrictions to the surrogate's behavior, or rules that undermine her rights, freedom and dignity, creating ambiguity over which clauses can be included in the surrogacy contract, since several contractual laws end up restricting the surrogate's rights (Decreto de Lei n. ° 32/06, 26 Julho; Raposo VL, 2017). Questions raise on whether it is allowed to forbid the surrogate from having unprotected sex with her partner, in order to avoid gestation of a child biologically related to the two of them; or forbid her from adopting behaviors that can put the child at risk, such as smoking, consuming drugs or alcohol, having a poor diet, not taking the appropriate

vitamins, not attending medical appointments, or practicing risky sports. If none of these restrictions are allowed on contract, then no breach of contract can be alleged in court when these situations happen. If every single clause eventually becomes forbidden, the surrogacy contract's goals, including its main one, which is the creation of a child, will be jeopardized, since the child's well-being can be threatened (Raposo VL, 2017). However, we must also realize that inevitably all clauses will limit the surrogate's autonomy.

Even though it is morally wrong to end a healthy pregnancy against the wish of the intended parents, in light of the principle of respect for autonomy, the surrogate has the legal right to do it, being impossible to prevent or force her to terminate the pregnancy. According to Article 8 (10) of Law n. ° 32/2006, all the parties involved need to sign a written contract, that should necessarily state the provisions to be respected in case of fetal malformations or disease, and of an eventual voluntary termination of pregnancy. However, as above stated, Article 8 (11) prevents the existence of any restrictions to the surrogate's behavior (Decreto de Lei n. ° 32/06, 26 Julho). The CNPMA defends that a prior agreement on these matters cannot be stated on the contract, since the rights of the surrogate cannot be limited according to Article 8 (11), which includes her right to voluntary terminate pregnancy until 10 weeks or to terminate it until 24 weeks, in case of congenital malformations or severe diseases. When there are major reasons to believe the offspring will suffer from an incurable serious disease or from a congenital malformation, the decision on whether to terminate the pregnancy should involve all parties. The primacy of the surrogate's autonomy also means that she can decide what information she wants to receive and share about the details of her pregnancy. When medical decisions need to be made during pregnancy, labor or delivery, the obstetrician should not look for the intended parents input, and in life threatening situations, the surrogate's health should be prioritized over the well-being of the fetus (ACOG, 2016).

The intended parents should be aware of these risks before stepping into the agreement and pre-conception counselling should help prepare all parties for these foreseeable hazards. Even though, legal enforcement of the surrogate's behavior is not possible before the delivery, she should be clearly informed of the specific financial and/or legal consequences that may come in case of a contract breach (ACOG, 2016; Shenfield et al., 2005). These consequences in Portugal are further explored in the 'Right to regret' chapter.

4.3. Future Contact

Berend analyzed the forum of the largest US surrogacy website (<http://www.surromomsonline.com>) and noticed a change over the years. Initially, in the early 2000s, the surrogates usually expressed expectations of an ongoing friendship with the commissioning parents and were extremely disappointed when this did not happen. Nowadays, the surrogates' thoughts shifted. Even though they still get disappointed when there is no contact, they try to understand the parents point of view, support each other and refocus on the satisfaction of 'creating life'. To some extent, the existence of contact depends on the commissioning parents' decision to disclose the surrogacy arrangement to their child. Surrogacy is regularly seen as hybrid of a contractual and a gift relationship, and the latter does not end after the last payment, unlike the former. Therefore, surrogates see contact as the best way of showing appreciation and friendship, and as proof that the relationship wasn't just a business (Berend Z, 2014; MacCallum et al., 2003).

Surrogacy arrangements are successfully implemented most of the times, the surrogates are well-motivated and have little difficulties handing over the new-born, since they don't see the child as theirs (Jadva et al., 2003; Söderström-Anttila V et al, 2016). This comes in line with Ragoné's findings that surrogates tend to distance themselves from the child (Ragoné H, 1994). The majority of surrogates kept in contact with the families, reported positive relationships regardless of the frequency of the contact and did not regret their decision to take part in a surrogacy arrangement (Imrie and Jadva, 2014; Jadva et al., 2003; Jadva V et al., 2015). Contact with mothers was more frequent than with either children or fathers, supporting previous findings that suggest that a relationship between the surrogate and the intended mother is key to the surrogacy experience (MacCallum et al., 2003; Ragoné H, 1994). Nevertheless, surrogates also maintained positive relationships with the majority of fathers and children. The level of contact between them was negotiated and kept at a level where the surrogates were comfortable and happy (Imrie and Jadva, 2014). Face-to-face contact exists in most cases, even though the frequency of the contact varied a lot. In a number of arrangements there was no ongoing contact with the child or the parent(s), hence emphasizing the multiple ways in which the contact can be negotiated (Jadva V et al., 2012). The amount of the contact does not seem to correlate with how the involved individuals feel about each other or about the surrogacy process (Jadva V et al., 2015). The above-mentioned results come from research performed in the UK, and the inexistence of commercial agencies in the UK promotes direct contact between the surrogate and the intended parents, allowing a strong trusting relationship to develop. This might be the reason why most of these arrangements were viewed by the surrogate as positive experiences (Jadva V et al., 2012). Nevertheless, most surrogacy arrangements in the UK that were examined involved a non-profit surrogacy organization, and it is possible that this involvement could also have had a role helping building and maintaining these good relationships.

Previous research suggested that maintaining contact with the child might be too difficult for the surrogate, however Imrie and Jadva findings prove the opposite. Most surrogates maintained contact with the child, appreciated the relationship they had, and did not perceive the child as their own (Imrie and Jadva, 2014). In a prospective 10 years study, the majority maintained a good relationship, allaying the worries that the relationship would become difficult as the child grew older. The frequency of contact decreased over time, however the contact between surrogates and intended parents that previously knew each other kept stable, being the most frequent one. This might be due to living in close proximity and to the establishment of the relationship previously to the surrogacy contract (Jadva V et al., 2012). On another study, even though the frequency of contact with the parents did not changed significantly, it had lessened considerably with the child. Nevertheless, most surrogates would be happy to be contacted by offspring in the future if the latter wished so (Jadva V et al., 2015).

An important field for future investigation is the identification of the factors that enable a good relationship to be maintained over time (Imrie and Jadva, 2014). It is important to mention that all previous conclusions refer to countries with regulated surrogacy. In cross-border surrogacy, no studies exist on the relationships between the intended parents and the surrogate mother, who eventually might be unknown to the commissioning couple or speak a different language. The risk of conflicts is likely to increase with the continuous growth of this 'reproductive tourism' and the scarcity of regulations in countries where commercial surrogacy is practiced (Söderström-Anttila V et al, 2016; Surrogacy Arrangement Act UK, 1985).

There was no difference regarding the quality of the relationship with the commissioning couple between known and unknown surrogates, dispelling the concerns that such alliances between strangers will unavoidably create problems. To some extent, all parties involved are relying on trust between strangers; however, the time wait before starting the treatment allows all parties to carefully consider their decision before rushing into it whilst still unsure (Jadva et al., 2003; MacCallum et al., 2003).

In concerns to the previously known surrogates, there is the risk of coercion, pressuring the woman to become a surrogate, and of surrogacy damaging the relationships within a family. However, little evidence of coercion was found, considering that in over three-quarters of cases, the woman herself suggested becoming a surrogate. Nevertheless, professionals should be aware since familial coercion can be subtle. In other forms of ARTs involving a third party, such as gamete donators, this risk does not exist since their identity generally remains anonymous. However, this is not possible in surrogacy, since a bond between the surrogate and the commissioning couple must be established (Burrell C, 2014; FIGO, 2008; MacCallum et al., 2003).

4.4. Reasons Behind the Choice

Women who choose to undergo surrogacy generally have a completed family of their own and have the desire to help a couple whose ability to have genetically related children is restricted to this technique; therefore, they primarily participate in surrogacy arrangements for altruistic reasons. This was found both in the UK, where only altruistic surrogacy is legal (ACOG, 2016; Jadva et al., 2003), and in the US where commercial surrogacy is practised (Golombok et al., 2016; Jadva V et al., 2015; Ragoné H, 1994). This does not support to the common belief that surrogates will have psychological problems. Actually, a feeling of self-worth is often reported (Jadva et al., 2003). It is also possible that altruistic arrangements create further long term positive outcomes for all individuals involved (Jadva V et al., 2015).

Surrogates undertaking multiples surrogacy arrangements reported as their primarily motivation the desire to help give a sibling to a couple's existing child, in part to 'complete a family', and in part due to the trusting relationship that already exists with the couple (Ragoné H, 1994). A previous positive surrogacy experience also motivated the surrogate to repeat the experience, as well as the wish to help a childless couple (Imrie and Jadva, 2014). Surrogates who carried out more than one surrogacy arrangement reported that now it is easier than it was 10 years before, due to the practice being more commonly accepted and the existence of additional support to surrogates (Jadva V et al., 2015).

4.5. Psychological Risks

Psychological health problems associated with surrogacy were rare; however, the likelihood of surrogacy originating psychological problems deserves further research to expose the specific aspects that may contribute to this. Samples used cannot be considered representative of the UK surrogacy reality, neither is it possible to generalise the findings. Future studies with representative samples are much needed, however this might prove to be a challenge because of the difficulty in monitoring the number of surrogacy arrangements taking place (Imrie and Jadva, 2014). Some surrogates experienced some psychological problems after the handover, however these were not severe, they tended to be temporary, disappearing over time. None of them at 1 year following the birth were suffering from post-partum depression (Jadva et al., 2003). No psychological problems

were experienced by the majority of surrogates in the decade following the birth of the offspring, demonstrating the good well-being of the former (Jadva V et al., 2015).

4.6. Surrogate's Family

In general surrogates were open with their friends and family about the surrogacy agreement; plus, the majority of their partners were supportive and their own children reacted positively (Jadva et al., 2003). The interests of the surrogate mothers' children must also be taken into account during the counselling process (Shenfield et al., 2005). In fact, in the UK it is mandatory for clinics to consider the wellbeing of any 'children who may be affected' by the birth of a child through a fertility treatment, which includes the surrogate's children (Human Fertilization and Embryology Act, 1990). It is therefore surprising that this matter has received such little interest over time. The great majority of surrogate's children viewed surrogacy as a positive experience and were proud of their mothers for helping another family. They were able to maintain a positive relationship with the intended parents and the surrogacy child. However, even when this contact did not exist, most of the children were also happy; therefore, showing that different agreements work for different families, as long as all parties are happy. This study focused on the target age of 9 years old, which means these findings can be considered the long-term impact of surrogacy (Jadva et al., 2003; Jadva V & Imrie S, 2014).

5. Payment

ESHRE and FIGO agree that surrogacy arrangements should not be commercial and are best performed by non-profit agencies. Nevertheless, reimbursement of reasonable expenses and compensation for loss of actual income should happen (FIGO, 2008; Shenfield et al., 2005). These reasonable expenses should not be limited to medical expenses during pregnancy or pregnancy-related complications; in fact, they should also include living costs and losses consequent to employment issues, albeit these are difficult to estimate (Dodson WC, 2016). In Portugal, all types of payments or donation of any commodity are forbidden, and the surrogate can only receive remuneration to cover pregnancy health related expenses, including the transportations, as stipulated on Article 8 (5) of Law n. ° 32/2006. So, the surrogate will not be compensated for loss of income due to missing days at work, or possible loss of employment opportunities consequent to the pregnancy. Additionally, since no health or life insurance is required, any disability or health condition caused by the pregnancy to the surrogate is her own financial responsibility (Raposo VL, 2017). Furthermore, Article 8 (6) there cannot be any relation of subordination between the involved parties. (Decreto de Lei n. ° 32/06, 26 Julho).

5.1. Fair Compensation

Proper compensation is one of the main factors that requires regulation, and it is also the major cause of many legal disputes surrounding surrogacy (Dodson WC, 2016). Accepting remuneration does not mean that the surrogates view children or pregnancies as commodities to be bought and sold (Berend Z, 2014). In reality it is understandable that women might be hesitant to undertake the responsibilities and risks of pregnancy on behalf of strangers, without some sort of compensation for their time, effort, and risk (ACOG, 2008). A socioeconomic division between surrogates and intended parents has often been created. Even though this does not necessarily translate into undue inducement, it is important to realize that disproportionate payment can lead to

commercial exploitation. Nevertheless, we should also realize that a certain amount of compensation that might be appropriate in some social, economic and geographic situations, might be completely coercive in others (ACOG, 2016; FIGO, 2008). Besides, if the payment is too low, commissioning parents can be accused of exploiting the surrogate by not giving her a fair compensation, and if the payment is too high they can also be accused of exploiting her by making the offer irresistible and coercive. If payment is allowed, the intended parents' high costs to undergo a surrogacy arrangement may restrict this reproductive technique only to wealthy people, even though the same problem exists for most services related to infertility (ACOG, 2008; Schover, 2014). ESHRE recommends a partial reimbursement for treatment to assure impartial access for all citizens (Pennings G et al., 2008).

5.2. Commercialization of Surrogacy

From a legal point of view, Article 3 of the EU Charter of Fundamental Rights and Article 21 of the Council of Europe Convention on Human Rights and Biomedicine forbid making the human body and its parts a source of financial gain. Plus, Article 2 (a) of the Optional Protocol to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography defines 'sale of children' as 'any act or transaction whereby a child is transferred by any person or group of persons to another for remuneration or any other consideration'. Additionally, Article 35 and 36 of the UN Convention on the Rights of the Child guarantees the right to dignity of the child, and states that all state parties should take 'all appropriate measures to prevent the abduction, sale, traffic' and 'all other forms of exploitation' in children. Therefore, it can be argued that commercial surrogacy involves the use of the human body for economic profit and the 'sale of children', breaking several international laws. However, it could be possible for the surrogate to be reimbursed beyond reasonable expenses and not be selling the child. In order for this to happen, payment should never be contingent on the delivery of an 'acceptable product', a live and healthy child. Instead, payment would be for her labor rather than for the child (ACOG, 2008; McLeod C & Botterell A, 2014).

From an ethical standpoint, the commercialization of surrogacy transforms the woman's reproductive capacities into a service that can be bought, objectifying the human body, making the surrogate just an 'incubator'. This reproductive trivialization might not just harm surrogates, but also women's status as a whole. Independent legal representation and mental health counselling are mandatory, otherwise the potential for exploitation of vulnerable women and inappropriate coercion are tremendous (ACOG, 2008; Dodson WC, 2016; Shenfield et al., 2005). The need or eager for economic profit might attract unprivileged women from poor socio-economic backgrounds, leading them to undergo surrogacy agreements with citizens of resource-rich countries. As it was predictable, this led to the development of an international surrogacy business (cross-border surrogacy), and the creation of 'surrogacy villages', where the offspring is considered a product (Dodson WC, 2016; FIGO, 2008; Söderström-Anttila V et al, 2016).

6. Cross-Border Surrogacy

Cross-border reproductive care (CBRC) is a rapidly growing worldwide phenomenon that generates a burgeoning multibillion dollar international industry and affects both the departure and destination countries of the intended parents. The most popular destination regions are North America, Eastern Europe and Asia. It was estimated in 2012 that more

than 25 000 children were born to surrogates in India, 50% of which are from the West (Shetty P, 2012); however, an accurate accounting of global ART travel remains a goal rather than a reality, due to the lack of a proper international reporting system. International surrogacy agreements are made by a surrogate mother that has a different nationality from that of the commissioning parents in a state other than the one where the commissioning parents are nationals or reside (Crockin SL, 2013; Ethics Committee of the ASRM, 2016; Ghráinne BN & McMahon A, 2018; Pennings G et al., 2008).

6.1. Motivations to Travel Abroad

Hamper access to surrogacy in a country, can lead its residents to resort to these international agreements. Restrictions might exist as legal prohibitions of specific treatments, or be based on the person's demographics, such as age, marital status and sexual orientation. Hence, for the interested individuals, international surrogacy might be their only option to fulfil their reproductive needs. Those with the money and resources to travel abroad for reproductive care are mainly looking for a broader array of high-quality treatment options, more affordable treatments, circumvention of legal restrictions and/or of a long wait list in their countries, and privacy protection (Ethics Committee of the ASRM, 2016; Schover, 2014). A question that arises when talking about CBRC is whether citizens living in a democracy have the right to receive abroad treatments that are illegal in their own country. Even though 'there is a *prima facie* obligation of citizens to obey national law', reproductive autonomy has been attributed a bigger value. This principle legitimizes transgression in some scenarios provided that safety, efficacy and wellbeing of the patient and the future child are assured (Pennings G et al., 2008). The majority of intended parents using CBS choose gestational surrogacy contracts. These are undeniably more expensive, as it requires IVF as opposed to artificial insemination as in traditional surrogacy but prevent any genetic connection between the child and the gestational surrogate. This reduces the risk of the surrogate being recognized the legal mother in countries who recognize motherhood based on genetics (Crockin SL, 2013).

6.2. Additional Challenges

Compared with domestic gestational surrogacy, cross-border surrogacy faces even greater ethical and legal challenges, with obstacles to ensure proper medical safety, prevent coercion of gestational carriers, and establish parentage and nationality of the offspring (Ethics Committee of the ASRM, 2016; FIGO, 2008; Ghráinne BN & McMahon A, 2018). Health wise, the transmission risk of infectious diseases or genetic disorders to the offspring can be higher due to the absence of international policies and norms imposing quality control measures. This contrasts with the Portuguese reality, where only establishments approved by the Health Ministry are allowed to perform ARTs (Art. 5(1)), and maximum medical safety should be assured (Decreto Regulamentar n.º 6/2017, 31 Julho). Additional harms include the possibility of law changing in destination jurisdictions, that might unable the removal of the new-born from the country. Plus, in societies where the women's status is already problematic, the creation of 'surrogacy markets' can fuel the view that a woman's value is restricted to her physical characteristics and child-bearing capacity. The surrogate's autonomy can easily be jeopardized as they might be pressured to live constrained by certain conditions while being paid. Malfeasance by surrogacy agencies can also exploit both the gestational carriers and the intended parents, due to typical lower individuals' protection. For example, it was reported that in India, during the pregnancy, surrogates are often isolated from their

families in dormitories, receiving daily visits from counsellors who remind them that the child is not theirs to keep (Schover, 2014; Söderström-Anttila V et al, 2016).

In rare but devastating cases, failure or refusal by the intended parents to claim parentage over the offspring can leave the gestational carrier with a child, that is not hers, to care and no legal recourse against the foreign commissioning parents (Ethics Committee of the ASRM, 2016). Moreover, the intended parents' divorce prior to the child's birth or the birth of a child with genetic anomalies unacceptable to the intended parents are possible reasons for these breaches of contract (Crockin SL, 2013). Baby Gammy's case, who made international news, illustrates this problematic. An Australian couple used a broker in Thailand to find a surrogate who eventually became pregnant with twins. When at 4 months it was found that the male twin had Down's Syndrome, the intended father asked the surrogate to abort, however, she refused, alleging her Buddhist beliefs; besides, abortion under the justification of fetal malformations is illegal in Thailand. After the surrogate delivered the twins, the intended parents took the healthy sister back to Australia and left the seriously ill baby Gammy with the surrogate mother (BBC News Asia, 2014; Schover, 2014). Nowadays, some of the most pursued countries, like Thailand and India, are introducing bans on these international agreements; however, instead of halting the practice this might drive it to the black-market or simply to other more liberal countries (Ghráinne BN & McMahon A, 2018).

The country's healthcare system may also be affected. Since it is likely that providing basic health care for their own citizens is already a struggle, the resources that are being used on foreigners could be used more efficiently for their own people. Besides this, with the consequent increase in the market demand, prices of these services will probably increase, making them inaccessible for the local patients (Pennings G et al., 2008).

6.3. Health Dilemmas

Physicians from both countries are faced with dilemmas when treating these patients. The Ethics Committee of the ASRM believe that physicians in the departure countries have no independent duty to inform their patients about cross-border surrogacy options, but they must not misinform them when answering questions about these options abroad (Ethics Committee of the ASRM, 2016). ESHRE Task Force on Ethics and Law states that when the country's law prohibits surrogacy, referral to a center abroad is morally allowed, taking into consideration the reproductive autonomy of the patients. This referral does not abolish all responsibility from the doctor, as he should collect data to ensure the safety, efficiency and the welfare of the offspring, and counsel his patients to inform them on what will happen. Fee-splitting is a practice in which a doctor refers patients to another doctor, in exchange for money from this latter. This practice is unacceptable because it may generate conflicts of interests, leading to decisions who don't prioritize the best interests of the patients (Pennings G et al., 2008). Regarding destination country physicians', they should deliver the same quality of care given to all domestic patients, but they have no duty to act as a patient's legal advisor, informing or warning patients about the potential legal or practical hazards that may occur. Patients considering cross-border surrogacy should search for advice from qualified legal experts both in the departure and destination countries (Ethics Committee of the ASRM, 2016).

6.4. Stateless Children

The establishment of the child's nationality is one of the challenges that international surrogacy agreements present to the affected states. This matter depends on who the states

involved recognize as legal parents and can be even more intricate when donors are used in states that tie nationality to biological links, because the intended parents would not necessarily be genetically related to the new-born. Besides, if international surrogacy agreements are illegal in the intended parents' state, that state might be hesitant to recognize the legal effects of surrogacy. Since states owe to their nationals many rights and responsibilities, that have an inherent economic burden, oftentimes they are reluctant to recognize international surrogate children as their nationals, leaving them stateless.

Broadly speaking, nationality can be determined by two principles, *jus soli*, or 'the right of the soil', meaning nationality of the territory in which the person is born; and *jus sanguinis*, or 'right of the blood', defining nationality according to the state from which the parents or ancestors are nationals. If the state where the surrogacy arrangement took place operates under an absolute *jus soli* law, this state will grant the child its nationality. However, problems arise when the state where the child is born operates under a *jus sanguinis* law, and the state of the intended parents operates a *jus soli* framework, because none of the states will recognize the offspring as their national. Additional problems might exist when the state where the child is born operates a conditional *jus soli* approach, including requirements of residency periods, that a new-born would never satisfy. Additionally, if the child is abandoned by the intended parents, it is possible that no recognizable state will intervene to defend the child's rights, because what is at discussion is the nationality itself (Ghráinne BN & McMahon A, 2018). In Portugal, according to Article 1 of Nationality Law n.º 37/81, the *jus sanguinis* principle is applied, giving Portuguese nationality to children of Portuguese nationals born abroad (Art. 1 (1c)). So, the children of Portuguese nationals who travel abroad to undergo a surrogacy agreement, have their Portuguese nationality protected. Nevertheless, Portugal also grants its nationality to those who are born in Portuguese territory, from a Portuguese mother or father (Art. 1 (1a)); or from foreigner parents, if one of them was born in Portugal and has its residence there when the child is born (Art. 1 (1e)), or if one of them has lived in Portugal for at least 5 years (Art. 1 (1f)). Trimmings and Beaumont defend that the 'country of origin' of the surrogate should be the one taken into consideration, instead of the country where the birth happened, in order to prevent the movement of women to a 'surrogacy-friendly' jurisdiction, solely to serve as a surrogate there. This migration has inherent risks of human rights abuse, since the move might be involuntary and contribute to women trafficking (Trimmings K & Beaumont P, 2011).

The limitation of international law is the fact that each country has a sovereign right to determine who its nationals are under its own law. Article 15 of the Universal Declaration of Human Rights states that 'everyone has the right to a nationality' and that 'no one shall be arbitrarily deprived of his nationality', however nothing is said about which state must grant nationality. The UN Convention on the Rights of the Child, which is the most widely ratified international treaty, stipulates in Article 3 that 'in all actions concerning children the best interests of the child shall be a primary consideration'; in Article 7 that all children have 'the right to acquire a nationality' and 'to know and be cared for by his or her parents' and that 'States Parties shall ensure the implementation of these rights in accordance with their national law and their obligations under the relevant international instruments in this field, in particular where the child would otherwise be stateless'. Even though this does not specifically establish that the state where the child is born is the one who should grant nationality, it says that when statelessness is at risk, that is what should happen. Additionally, Article 9 establishes that 'a child shall not be separated from his or her parents against their will', and Article 10 that 'applications by a child or his or her

parents to enter or leave a State Party for the purpose of family reunification shall be dealt with by States Parties in a positive, humane and expeditious manner'. The Article 1 (1g) of the Portuguese Law on Nationality n. ° 37/81, provides Portuguese nationality to those, born in Portuguese territory, who would otherwise be stateless. This protects the children's rights and interests, and prevents any child born through surrogacy in Portugal to be stateless.

6.5. Same-Sex Couples' Obstacles

An additional problem may exist for same-sex couples from states that prohibit same-sex marriage. Their return home with a new-born resulting from CBS might pose many problems, since the state might refuse to recognize both members of the couples as legal parents. This is not the case of Portugal, since, as previously mentioned, the *jus sanguinis* principle protects all children from Portuguese parents (Decreto de Lei n. ° 37/81, 03 Outubro). Legal recognition by the country where the child was born does not guarantee parentage status in their home country. Therefore, once again, obtaining experienced and sound legal advice on these issues prior to undergoing CBS is critical (Crockin SL, 2013).

6.6. International Conventions

While infertility and the desire to have children may be universal, no overarching international treaties or formal laws on surrogacy are in place. Instead, legal regulations are enforced on a country-by-country basis (Ethics Committee of the ASRM, 2016). This reflects the deep religious, ethical, political and policy differences surrounding family building in the world (Crockin SL, 2013). Most of the literature on international surrogacy acknowledges the need for a new international convention on surrogacy and agrees that the Surrogacy Convention proposed by the Hague Conference on Private International Law might be a solution. However, its negotiation and enforcement could take years, with no guarantee that it would ever be completed, and there would inevitably be cases that would not be covered by the convention. Besides, it would unlikely be ratified by the states that legally forbid surrogacy (Ghráinne BN & McMahon A, 2018). Demanding that both states involved agree with the surrogacy contract before its implementation, and that the receiving state allows the child to cross their borders and recognizes the intended parents as the legal parents, would enable a feasible convention, with a neutral stance in respect to surrogacy (McLeod C & Botterell A, 2014). Besides, the best interests of the child would be protected if states ensured the intended parents suitability prior to the arrangement, and the preservation of information about identity of the surrogate (and gamete donors if involved) (Trimmings K & Beaumont P, 2011).

The legalization of surrogacy can avoid the potential harms to the health and well-being of those taking part in unregulated cross-border surrogacy contracts (Söderström-Anttila V et al, 2016). For the states who refuse this option, maintaining surrogacy itself illegal but regulating its legal implications, such as legal parenthood, is another way of reducing the legal uncertainties (Trimmings K & Beaumont P, 2011). The current framework surrounding this issue does not completely safeguard children against statelessness, therefore Public International Law conventions, like the UN Convention on the Rights of the Child, should be ratified and implemented in domestic law, to offer a solution in the short term for children who would otherwise be stateless. National public policy concerns looking forward to ban or restrict surrogacy must not prevail or be prioritized over children's human rights (Ghráinne BN & McMahon A, 2018). An evident cross-border crisis in Europe has been created due to the conflicts of laws, contributing to the fast-

growing unregulated surrogacy market, that pose distinct concerns related to human rights (Watson C, 2016). Even though it can be argued that the countries who allow surrogacy are the ones to blame for these international surrogacy problems, the main focus should be on finding the best way to ensure all citizens their human rights.

ESHRE recommends the adoption of less restrictive legislation, to prevent large groups of people from feeling forced to travel abroad, and the installation of systems of control and verification to guarantee patients a safe and effective treatment wherever they go. This includes both the medical and psychological assessment. The interests of infertile couples should be promoted by national and international societies and patient organizations, in order to safeguard ethical pluralism and the respect for different opinions, and so that the media, the public and the law makers are informed of the negative outcomes of restrictive laws, the benefits of ARTs for infertile couples, the possible dangers of CBRC, and the doctor's referral responsibility (Pennings G et al., 2008).

6.7. Spain Turning to Portugal

With the Portuguese legalization of altruistic surrogacy and the access to it being independent of the intended parents' nationality (Contrato de gestação de substituição), Spanish couples are turning to Portugal to fulfil their reproductive wishes, since the neighbor country Spain forbids both altruistic and commercial surrogacy. In recent news, it was reported that out of the 99 surrogacy requests presented to the CNPMA, 41 were from foreigners, and out of those 39 were from Spanish couples (Malhado AR, 2017). This emphasizes the global impact that different countries' surrogacy laws can have. Even though surrogacy's legalization is recent in Portugal, a lot of interested individuals are already trying to fulfil their reproductive desires there.

7. Restrictions of Single Persons and Same-Sex Male Couples

Worldwide, ART is mostly offered to heterosexual couples, however, a burgeoning number of single persons and same-sex couples (non-standard applicants) are applying for it, raising several ethical and medical questions (Dar S et al., 2015; De Wert et al., 2014). The traditional definition of family, composed of a man married to a woman and their children, has considerably changed over the years, due to the increasing number of divorces and out-of-wedlock births, adoption, advances in ART, the acknowledgement of women's rights, the gay rights movement and the legalization of their marriages in some countries (Ethics Committee of the ASRM, 2013; Greenfeld DA & Seli E, 2011). Single men and same-sex male couples become fathers mainly in their early- to mid-40s (Carone N et al., 2017a; Carone N et al., 2017b; Grover SA et al., 2013; Norton W et al., 2013), unlike single mothers who tend to be in their mid- to late- 30s (Jadva V et al. 2009). This delay is due to the influence of societal sexism, regardless of sexual orientation; however, gay men struggle additionally with issues related to coming out and internalized homophobia (Baiocco R & Laghi F, 2013; Carone N et al., 2017b).

7.1. The Portuguese Restrictive Law

Even though, the state of sexuality of commissioning couples is not part of the ESHRE definition of surrogacy (Shenfield et al., 2005), Article 6 (1) of the Portuguese Law n. ° 32/2006 only allows heterosexual and same-sex female couples to use surrogacy, therefore banning its access to single persons and gay male couples. The restriction on

single women who suffer from the conditions establish by Article 8 (2) is an assumption made by the CNPMA based on their interpretation of the Law and the concept of ‘beneficiaries’, as previously stated on ‘Access Restrictions’ subtopic. Therefore, the Law should clarify if the clause on Article 6 (1) which allows all women regardless of their marital status and sexual orientation to use ARTs also applies to surrogacy (Decreto de Lei n. ° 32/06, 26 Julho).

The true nature of this Law is not a discriminatory one, otherwise same-sex female couples would also not be allowed to enter these agreements. The reason behind this restriction is surrogacy’s subsidiary nature imposed by Article 4 (2), therefore requiring that all intended parents are individuals who would be able to reproduce if the uterine pathology or clinical conditions that are present did not exist. This excludes same-sex male couples and single men since these would be able to reproduce in the first place. However, the law should not restrict single women who fit the criteria on Article 8 (2) and should acknowledge surrogacy as subsidiary mean of reproduction for these women, like it is for same-sex female couples. If the Portuguese Law grants single women access to ARTs, it should not discriminate those with uterine problems or clinical conditions that are not capable of carrying the pregnancy (Decreto de Lei n. ° 32/06, 26 Julho).

7.2. Gay Male Couples’ Struggles

Once the decision on using surrogacy is made by gay couples, they need to agree on which father will have a genetic connection to the offspring. It is possible, for the couples who have equal desires of genetic parenthood, to either mix their sperm, or fertilize the donor’s eggs with sperm of both of fathers, creating multiple embryos that will later be transferred to the surrogate, originating half genetic twin siblings. This latter was the most chosen method in a Canadian cohort of same-sex male couples and single men. Another option for them is taking genetic parenthood in turns, meaning one father provides sperm for the first child, and the other father for the subsequent children. Parental age, the existence and/or heritability of health conditions, personal preferences, and previous children from heterosexual relationships, may take part in the parenthood decision process (Blake et al., 2017; Greenfield DA & Seli E, 2011; Grover SA et al., 2013).

A US study on the surrogacy decision’s influencing factors found that the most popular one was the feeling that adoption was less desirable and/or accessible. Others reported that, at that time, adoption for them was either not allowed or only possible as open-adoption. Genetic connection with the offspring was the reason for choosing surrogacy in approximately half of the fathers, either as an individual or a couple. All the, past and present, social and legal constraints on gay couples’ reproductive autonomy understandably affect their decision to undergo surrogacy and their beliefs on the significance of genetic relatedness for family relationships. Most gay fathers analyzed had supportive families and friends; however, since often homosexuals face family dissolution and social stigmatization, potential parents’ social support should be assessed. Gay male couples require more education and counselling on the female reproductive system than heterosexual couples, as it is essential for the former to have a clear understanding of the demands involved in surrogacy (Blake et al., 2017; Greenfield DA & Seli E, 2011).

The majority of gay fathers were happy with their decision on surrogacy and their choice regarding genetic connection; however, since the individuals studied were volunteers, it cannot be excluded that these were the ones with the most positive experiences.

Understanding the motivations behind these couples' decision to resort to surrogacy as their reproductive method, may help clinicians and counsellors work with this population. Most fathers are satisfied with the close and ongoing relationship they have with the gestational carrier, with those who are discontent wishing further contact. They appreciated the surrogate, defending her and valuing her female presence. The quality of the relationship was generally positive, and most surrogates had already met the child and other family members (Blake L et al, 2016; Blake et al., 2017; Golombok et al., 2016; Greenfeld DA & Seli E, 2011). These findings are similar to those reported from heterosexual couples (13, Jadva et al., 2003; Jadva V et al., 2012; Jadva V et al., 2015; MacCallum et al., 2003).

Gay fathers need to explain to their children their biological origins, due to the absence of a female partner in the relationship. This disclosure may be easier when there is a relationship with the surrogate, since she might be available to clarify potential doubts and questions the offspring poses over the years (Carone N et al., 2017a). Besides explaining the role of the surrogate, they can also reveal which father has a genetic connection to the child. Most fathers in an US study, with children between the ages of 3 and 9, had already started the explanation process, with an increasing level of detail's disclosure and children understanding according to the age. The majority of children seemed to have a neutral or distant relationship with the surrogate, proving that previous concerns about possible negative outcomes of disclosure were unfounded (Blake L et al, 2016). Nevertheless, further research is necessary to explore the development of these relationships over time, and the children's perspective regarding their surrogates. It would also be interesting to assess the differences experienced by gay fathers who went through surrogacy, comparing the legal and socio-cultural contexts existent in different countries, and the social-demographic characteristics of the fathers, such as age, ethnicity, social class and relationship status (Norton W et al., 2013).

7.3. Single Men's Complexity

Access policies to ART for single men also differ considerably between countries; some prohibit it, like Portugal, and others leave the decision to the physicians, like the US. Only recently fertility clinics in some countries have started accepting, as candidates for surrogacy, single men, either heterosexual or gay, despite the previous ethical calls, by both European and American societies (De Wert et al., 2014; Ethics Committee of the ASRM, 2013), to end discrimination based on marital status and sexual orientation. The decision to parent alone and create a family through surrogacy and egg donation is complex and carefully considered. Often times previous conversations with family, friends, other single fathers and health practitioners influence it. Making the decision required professional and financial security, social network encouragement, and overcoming their concerns regarding single parents' responsibilities and the child's risk of hypothetical teasing and negative reactions due to growing up in the absence of a mother.

The main reasons for undergoing single parenthood were: 'not want to wait for the 'right' relationship', desire to 'pass on their genes', and 'fear of getting older'. Furthermore, some embarked on surrogacy alone because they want to prevent their child from experiencing parental separation, or they fear losing custody of the child in the case of divorce. The majority of single fathers were happy with their decision to parent alone. However, these findings should be carefully interpreted since half of them would prefer to be a parent in the context of a relationship. Nevertheless, consistency exists between

these findings and the existing literature on gay fathers (Blake et al., 2017) and single mothers (Carone N et al., 2017b).

7.4. On-Going Debate

In the existing ethical debate on whether these individuals should be granted fertility assistance, several factors should be taken into account, such as their autonomy rights and reproductive interests, the welfare of the future child, and the physicians' autonomy to denial treatment based on an individual's demographic characteristics. Reproduction is a significant element of a person's autonomy; thus, moral objections to single parenthood or homosexuality do not justify limiting child rearing or reproduction. The acknowledgement of reproductive interests, along with the concept of equal rights, has raised the support for identical treatment of all people. Furthermore, considering the principle of formal justice, identical cases should be dealt with in a similarly. Different treatments should only be allowed if morally relevant differences between the cases exist. Nevertheless, objections are still present, and can be divided into deontological, who claim these practices are 'unnatural' and unreconcilable with medicine's goals; and consequentialist, who focus on the alleged harms to the future children, society and surrogates (De Wert et al., 2014; Ethics Committee of the ASRM, 2013)

From a human rights viewpoint, the burden of proof lays with those who criticize and deny the equal right to reproduce. The 'unnatural' argument requires an interpretation on what is considered 'natural', and the existence of a convincing interpretation is doubtful. It is often argued that treatments should only be performed if there is a medical indication, which, in this case, would mean infertility or genetic risks. However, this raises questions on why ART in non-standard cases should also not be seen, in the wider sense, as an improvement on reproductive health of those involved. Considerable objections come from those who argue that the best setting for raising a child is a 'two-person, married, heterosexual family', and believe the child will experience social isolation and problems related to gender-identity or sexual-orientation. Single man and gay male couples are even a bigger target for this discrimination, due to preconceptions that they are less caring than women, that children need a mother, and that their children face a greater risk for sexual abuse, pedophilia, or other mistreatments. Researches on this topic analyzed by the ASRM suggest that children of homosexual persons do not differ significantly from those of heterosexual couples, in regards to development, adjustment and well-being (De Wert et al., 2014; Ethics Committee of the ASRM, 2013). After comparing gay fathers to lesbian mothers, similar findings were observed; children of both groups had high levels of psychological adjustment and positive relationships with their parents. Nevertheless, higher levels of externalization problems in children were found to be associated with stigmatization of the family and negative parenting, regardless of the family group. These findings add further support to the belief that the quality of family relationships is more predictive of child adjustment than parental sexual orientation, and that men are as competent at parenting as women (De Wert et al., 2014; Golombok et al., 2016). Professionals should not use double standards, namely they should establish which potential parents and families have a 'high risk of serious harm' to the future child, instead of worrying on whether one type of parent or family type is better than the others (ESHRE, 2007).

In many countries homosexuality is still socially condemned; therefore, despite the low welfare risks for the child, there are harmful social risks, such as stigma, exclusion and bullying. However, this should not be used as an argument to reinforce reproduction

discrimination of these individuals. Instead, the solution lays within a change in societies' respect and recognition of parenthood competence to homosexuals. Professional societies and policymakers have an important co-responsibility on this public re-education (De Wert et al., 2014). Given the importance of reproduction and the absence of harm to the child, ASRM believes that there is no reasonable justification for preventing single people and/or gays and lesbians from parenting (Ethics Committee of the ASRM, 2013).

7.5. Physicians' Denial Autonomy

There are two dimensions to professional autonomy, conscientious objections and civil disobedience. Respect for physicians' conscience is essential in medicine; however, in this case, the refusal to assist or facilitate any ART in non-standard applicants leads to discrimination and prejudice. Nevertheless, these professionals have an obligation to refer these patients to another professional (De Wert et al., 2014). Fertility specialists should bear in mind the country's regulations when dealing with these particular groups of persons, because laws might prohibit ART on the basis of marital status or sexual orientation or forbid the denial of ART to patients on the same basis. In the US, for example, state law prohibits discrimination based on sexual orientation in public accommodations, which include medical offices. Therefore, physicians' refusal to treat these individuals based on religious or personal moral views are not allowed. If the doctor wishes to conscientiously object surrogacy, then he should object all its practices and not only the ones involving same-sex couples or single persons.

Taking into account the human rights perspective and the ethical duty to treat individuals with equal respect, the ASRM Ethics Committee and the ESHRE Task Force on Ethics and Law defend that single persons and same-sex couples should be provided with the same treatment as heterosexual married couples. The ACOG shares the same opinion, adding that allowing this discrimination reinforces the scientifically unfounded belief that sexual orientation defines the aptitude to being a parent, supporting oppression of same-sex couples. Therefore, concerns on the well-fare of the children or the promotion of marriage do not legitimize denying reproductive treatments to these, often marginalized, people (ACOG, 2007; De Wert et al., 2014; Ethics Committee of the ASRM, 2013).

The first child born through a surrogacy arrangement to gay parents happened in 1996 (Carone N et al., 2017a), and despite the increase in the number of same-sex male couples and single men using surrogacy, research on the topic is still very scarce and further longitudinal studies are required (Blake et al., 2017; Grover SA et al., 2013; Greenfeld DA & Seli E, 2011). Therefore, a moral responsibility should exist on the doctors who treat these people in order for them to invest in follow-up studies for data collection (De Wert et al., 2014).

7.6. The Future Transsexual Applicants

Applications by transsexual people are currently rare but likely to increase. Surrogacy is an option for transsexual women (male-to-female transsexuals) in relationships with men. However, fertility preservation may be the solution to allow these individuals to have genetically related children in the future (De Wert et al., 2014). Information on these individuals is even scarcer, but their particularities and discrimination deserve further study. This shows how deep the complexity that surrounds surrogacy is.

8. Right to Regret

One of the most difficult questions in surrogacy is whether the right to regret should be granted to both the intended parents and the surrogate. According to Article 14 (4,5) of Law n. ° 32/2006, the consent given by all parties, when signing the written surrogacy contract, is freely revocable until the beginning of the ART procedures, therefore, it is crucial to define what is accepted as the ‘beginning of ART’. Regardless of the ambiguity present in the law, CNPMA, after being contacted via email, clarified that the definition is contingent on the specificities of the case and the individuals involved, due to its dependence on the several steps that are taken, such as male and/ or female gametes collection, the possible existence of cryopreserved embryos, and the uterine preparation for embryo transfer. For example, regarding the intended parents, for the woman it can be ovulation induction, and for the man semen collection; for the surrogate, it would be the uterine preparation for embryo transfer (Decreto de Lei n. ° 32/06, 26 Julho).

After the ‘beginning of the ART’, there are three situations in which the carrier is legally allowed, according to Article 142 (1) of the Portuguese Penal Code, to revoke her consent and terminate pregnancy. Firstly, until the first 10 weeks of pregnancy, where all pregnant women can voluntarily terminate the pregnancy. However, as stated in Clause 8 (2) of the CNPMA Surrogacy Contract, in such cases, the surrogate must reimburse the intended parents all the money they spent on surrogacy-related treatments, and the money she received for her previous expenses. Secondly, a surrogate’s unpenalized revocation of contract is legal at all times if the termination of pregnancy is the ‘only way to remove a risk of death or serious and irreversible lesions to the surrogate’s body or her physical and mental health’. In this situation, in accordance with Clause 11 of the CNPMA Surrogacy Contract, no compensations should be made to the intended parents. Thirdly, ‘if there are strong reasons to predict that the new-born will suffer from an incurable severe disease or congenital malformation’, termination of pregnancy until 24 weeks is legal to all pregnant women. Additionally, in cases of nonviable fetus, the termination of pregnancy is allowed at all times. Nevertheless, as previously mentioned, in this third case, the decision to terminate pregnancy should involve all parties. If the surrogate terminates the pregnancy against the will of the intended parents alleging this third reason, in line with Clause 10 of the CNPMA Surrogacy Contract, she is forced to compensate the parents for patrimonial and non-patrimonial damages. Other than in the three circumstances above-mentioned, none of the parties involved are legally allowed the ‘right to regret’ in any other time (Contrato de gestação de substituição). Nevertheless, the carrier is the only one, allowed by Penal Code, to make decisions regarding abortion. So, ultimately, the decision will always belong to her, however she has to deal with the consequences of her actions that unlawfully breach the contract (Raposo VL, 2017). It is important to notice that all these enforcement measures are only stated in the CNPMA’s Surrogacy Contract available on their website for the interested parties to sign. Law n. ° 32/2006, which is the one who indeed regulates ARTs in Portugal, is completely silent on this matter. Therefore, future alterations to the current law should have specify what the consequences are to the surrogates who choose to legally terminate their pregnancy (Decreto de Lei n. ° 32/06, 26 Julho).

8.1. Surrogate’s Perspective

Pregnant surrogates can change their minds about relinquishing the child they gestate, which is the case in the majority of situations, or about continuing the contract pregnancy. There are those who claim that their consent should not be revocable at any stage since

the child they carry is not theirs in the first place. However, this topic opens debate on who is considered the ‘mother’ of the child. Nevertheless, this restriction would clearly go against the respect for the women’s bodily autonomy. If, in the future, any form of the right to regret is allowed in Portugal, it is essential to define the time-frame in which it can be done. The period should not be too long, since the surrogate might become more attached to the new-born, nor too short, otherwise she will not have enough time to make a decision. Since gestational surrogacy is the only type of surrogacy allowed in Portugal, a separation between gestational and genetic contributions is guaranteed, reducing the physical and emotional connection between the surrogate and the child. Considering that the surrogate has no genetic connection to the child, and that she gave a free and informed consent, then her right to regret should not be recognized since she is just a carrier (McLeod C & Botterell A, 2014; Raposo VL, 2017).

8.2. Commissioning Parents’ Perspective

Commissioning parents may also regret their decision to have a child, which results in the abortion of the offspring, the surrogate being left with an unwanted child, or the child being given to adoption, if the surrogate refuses to keep it, either for personal or economic reasons. If this change of mind occurs after the embryo transfer, the intended parents cannot impose their new desires on the surrogate. Since it is not possible to impose a child on anyone, the parents’ right to regret is not legally deniable. Nevertheless, several penalties can be enforced. Additionally, the law does not foresee rejection of the new-born due to the presence of serious medical condition transmitted by the surrogate, or due to her behavior while being pregnant. Once again, the only thing that can be done is request compensation in court, though in some cases the causal connection might be hard to establish. If all the possible risks mentioned and its legal consequences were anticipated in the contract, the need for court’s interventions to settle disputes would decrease (Raposo VL, 2017).

8.3. Contract’s Enforceability

Despite the fact that contract law regulates every aspect of a surrogacy contract, the judicial enforcement of this contract is usually not feasible, since no women can be forced to continue or terminate a pregnancy, and no parents can be forced to receive a child they do not want. Nevertheless, the delivery of the child to the intended parents is enforceable, even against the surrogate’s will, because Article 8 (7) of Law n. ° 32/2006 recognizes the offspring to be the child of the commissioning couple. This is why a ‘cooling off period’, prior to signing the contract, is recommended, so that all parties can carefully consider their decisions, possibly avoiding these troubling problems (Decreto de Lei n. ° 32/06, 26 Julho; Raposo VL, 2017; Shenfield et al., 2005).

9. Doctors’ Autonomy Before the Committee

Physicians’ evaluation of potential commissioning parents faces a possible conflict between two ethical principles, autonomy and non-maleficence. Autonomy is a fundamental principle of medical ethics that gives all individuals the power to make free decisions about their lives, including their reproduction, as long as their decisions do not negatively impact the lives of others. According to the non-maleficence principle, doctors should deny interventions that run the risk of harming others. Therefore, he should also consider the well-being of the future child and assess if the conditions for this human

being to safely grow older exist (De Wert et al., 2014; Ethics Committee of the ASRM, 2016).

9.1. Parental Vetting

The parents' autonomy right is not absolute, as it is indeed conditioned by the principles that rule clinical practice. One of these principles is the doctors' responsibility towards their patients, especially when these are vulnerable, which is the case of children. Doctors should consider both the rights of the intended parents and the rights of future children. Therefore, if the doctor believes the couple is not able to provide an appropriate environment for the future child, the doctor should have the legal right to withhold the couple's access to surrogacy (Serejo R & Ricou M). This practice is known to as 'parental vetting' (McLeod C & Botterell A, 2014), and it is not foreseen in the Portuguese process to undergo surrogacy. Therefore, physicians in Portugal have no saying in this process. Only a psychiatrist or psychologist certificate in favor of the parties' participation in the surrogacy contract is requested (Decreto Regulamentar n. ° 6/2017, 31 Julho). This translate into psychiatrists and psychologist having a stronger decision power than the doctor who already previously knew the individuals involved. What we propose as a solution is the creation of a multidisciplinary team that would know the intended parents and work with them, evaluating if they have the proper conditions to care for a child. This would be a more trustworthy opinion than the current one given by psychiatrists or psychologist who write the certificate, and by the CNPMA, which for sure does not know the individuals.

On one hand, it can be argued that ARTs are simply aimed to give people the possibility to reproduce, just like others with no reproduction obstacles, and that doctors should not deprive them from this right (Serejo R & Ricou M). Nevertheless, following this line of thought, single persons and male homosexual couples should also have that same reproductive opportunities, which is not at the moment allowed under the Portuguese law, as previously mentioned (De Wert et al., 2014). On the other hand, others claim that if prospective adoptive parents have to undergo this, prospective commissioning parents should have to as well (McLeod C & Botterell A, 2014). The recommended counselling for intended parents can undeniably allow easier understanding of the couple's dynamics, assessing if they have the means to provide a safe environment for the child, and ensure the best interests of the latter (Trimmings K & Beaumont P, 2011). The intended parents' motivations should be analyzed since they might be an important predictive factor of future negative outcomes (1). The conclusions reported by the counsellor should be taken into account by the CNPMA. If the couple has issues that prevent them from undergoing a surrogacy agreement, help should be provided to overcome them, allowing them to enjoy their autonomy and reproductive right (Serejo R & Ricou M).

9.2. Physicians' Personal Beliefs

In medicine, respect for doctors' conscience is essential, however, they have an ethical obligation to put their religious or personal moral beliefs aside when evaluating intended parents. It is their obligation to perform an honest assessment, keep this information until when requested, and to obtain only usual compensation for these medical services (ACOG, 2016; De Wert et al., 2014; Ethics Committee of the ASRM, 2013). A 2017 Swedish survey found out that the majority of healthcare professionals believed surrogacy creates less healthy children, and one in five feared they had a higher risk of mental health and social stigmatization. Even though these beliefs do not represent the majority of the

current scientific knowledge on surrogacy, they highlight the need for educational interventions and development of proper guidelines for health professionals. One possible explanation for these findings is that fact that in Sweden all types of surrogacy are prohibited, reinforcing pre-conceptions regarding the harms of surrogacy and increasing stigmatization (Armund G et al., 2018). Nevertheless, Article 11 (2) of Law n. ° 32/2066, states that doctors have no moral nor legal obligation to be part of nonemergent medical care connected to domestic or cross-border surrogacy arrangements (Decreto de Lei n.° 32/06, 26 Julho; Shenfield et al., 2005) However, those who decide to participate should grant the same level of medical care as they would to any other patient, regardless of their personal beliefs or the complexity of surrogacy (Shenfield et al., 2005).

10. Conclusion

Since surrogacy was only legalized in Portugal in 2016, its reality in the country is extremely recent, with the first case being approved by the CNPMA in December 2017. The Portuguese Law is still far from being ideal or clarifying all situations, however there is potential for future improvement in order to solve all the unanswered problems and safeguard the rights of those involved.

In light of the existing scientific research, surrogacy is a reproductive option detached of negative outcomes in most cases. Since the majority of its contracts are successful, the media should enlighten the population by focusing their attention on the several success cases, instead of highlighting the worst situations and contributing to societies prejudice.

The lack of psychological problems in surrogacy children further supports the view of surrogacy as a safe technique. In fact, the presence or absence of a genetic connection between the mother and the child was shown to have a lower impact on the children's psychological well-being than the quality of family relationships. All parents should be informed of the importance of disclosure since children in the future might see secrecy as intentional concealment. The disclosure process should start at a young age and be gradual and adequate to the child's understanding. The majority of the children aware of their surrogacy conception feel either indifferent or positive towards it, therefore the Implementing Decree n. ° 6/2017 should not demand for the relationship between the offspring and the surrogate to be limited to the minimum indispensable, due to it claims of potential psychological and affective risks being unsubstantiated. Since only altruistic surrogacy is allowed in Portugal, a relationship between the surrogate and the intended parents is likely to develop during the entire process. The decision regarding future contact should be made by the intended and the surrogate in a way in which all parties feel comfortable. The children who are informed about the circumstances of their conception should also take part in this decision process once they grow older.

The majority of surrogates found their experience positive and had no significant psychological complications reported. These findings together with those of the surrogacy children allay the claims that surrogacy has negative consequences on the groups who are mostly exposed to the risk, the surrogate and the offspring. A good relationship with the intended parents and the offspring is maintained in the larger part of cases. However, this only refer to countries with regulated surrogacy, so further studies are necessary to understand how this relationship is in cross-border surrogacy, since individuals might not know each other and speak different languages. Surrogate's autonomy is a fundamental value that must be safeguarded in all arrangements. Doctors

should make sure that all decisions regarding the pregnancy are made by the surrogate, and they should be aware of situations where autonomy is compromised, such as familial coercion, even though its prevalence was low when studied (MacCallum et al., 2003). In cross-border surrogacy it is extremely difficult to safeguard this autonomy, especially when women from low socio-economic backgrounds are involved. In Portugal restrictions to the surrogate's autonomy are forbidden; however, it is demanded that the contract contains the provisions to be respected in cases of fetal malformations or voluntary termination of pregnancy. These two clauses are contradictory since the provisions would be limiting the future surrogate's behavior. The Law needs to be more explicit and clarify what restrictions can be included in the surrogacy contract, in order for the child's well-being not to be threatened and the surrogacy contract not get jeopardized.

Counselling is essential and can be the key to avoid the majority of future problems. If all the parties involved are correctly informed about the potential medical, social and legal implications, their decision to undergo surrogacy is a carefully thought one, with lower regretting risks. Besides, psychological competence to undergo this long and complex process should also be evaluated before the financial and emotional investment associated with surrogacy. Currently, article 2 (d) of the Implementing Decree n. ° 6/2017 requires both the intended parents and the surrogate to have a psychiatrist or psychologist certificate in favor of their participation in a surrogacy contract. Physicians who know the Law n. ° 32/2006 grants counselling to all parties before surrogacy, however post-delivery psychological support is only offered to surrogates in Implementing Decree n. ° 6/2017. Therefore, the intended parents should also be granted by law the before and after delivery counselling.

Regretting the decision to undergo surrogacy is allowed to all parties until the beginning of the ART. However, despite CNPMA's clarification on this issue, the Law still lacks a description on what is consider the beginning of the ART. If someone wants to breach the contract in between the process, they must be aware and accept the consequences set out in the surrogacy contract itself. Regardless of the clauses present in the contract, no surrogate can be forced to continue or terminate her pregnancy, and no parent can be forced to accept a child they no longer desire. The only thing that can be done is improve counselling in future cases of surrogacy in order to prevent these troubling situations.

In Portugal, as recommended by FIGO's committee, only gestational surrogacy is allowed. This measure safeguards all parties involved because the lack of a genetic connection between the surrogate and the offspring reduces the risk of future custody battles and reinforces that the intended parents are the legal parents of the child. This last provision further protects the new-born due to its enforceability in all situations with no exception, even if the contract is not valid.

The mandatory altruistic nature of all Portuguese surrogacy contracts complies with ESHRE and FIGO's recommendations, however these organizations also advocate that reasonable expenses should be reimbursed to the surrogate, and that loss of actual income should be compensated. Under the current Portuguese Law, this cannot take place since it is only legal to reimburse the surrogates for health-related expenses. A wider view on the subject should be adopted and law makers should realize that pregnancy's inherent costs are not limited to health expenses. Instead, they also included the added living costs, and the loss of income due to missing days at work or even refusal of job opportunities. Besides, there are possible disabilities and health conditions that may be consequential to

the pregnancy, to which the surrogate has no protection for, since no health or life insurance is required. Therefore, all these additional expenses are currently the surrogate's responsibility to pay. Even though these expenses are difficult to estimate, at least payments of the ones possibly estimated should be made, as well as a health insurance for possible complications that might arise from the pregnancy and/ or delivery. This does not necessarily translate into commercializing surrogacy and attracting unprivileged women, since the ultimate goal is not to provide a source of financial profit. Instead, the surrogate would be reimbursed so that no any financial loss on her part would happen.

Nevertheless, payment beyond reasonable expenses should also happen in our opinion, because women deserve to be compensated for their time, efforts and risks. This does not transform pregnancies and children into commodities to be bought and sold; instead it creates an assurance that a fair compensation is being made. This payment would be for the labor rather than the child, and it could never be contingent on the delivery of a live and healthy new-born. Even though the possibility for exploitation of vulnerable women can never be completely excluded, it can be reduced to a minimum if proper independent counselling is performed, and if only non-profit organizations are allowed to perform these contracts. Therefore, the argument that payment unavoidably creates a commercialization of the human body and of children, and an exploitation of women is not valid. Even though we believe payment beyond reasonable expenses should happen to compensate surrogates, this is more an idealist concept than a practical one, since even with counselling it would be extremely difficult assure that women are not tempted to undergo surrogacy for the economic profit.

Increasingly, intended parents from all over the globe are crossing national borders to seek ART treatments abroad, including surrogacy (Ethics Committee of the ASRM, 2016). This movement is an inevitable consequent of the restrictive and discriminatory laws, and the long wait lists and high-costs of treatments that exist in several countries. In fact, less restrictive legislation is advisable by the ESHRE in order to reduce the large number of individuals who turn to CBS. The different existing policies in different states create multiple challenges mainly for the intended parents and the surrogates, but also for international law makers since they have to create a convention that will be ratified by the majority of countries. Banning international surrogacy is not the solution to solve the problems created by its existence, since it might just drive the arrangements to the black market or more liberal countries. Instead, additional legislation is needed to assure the surrogate and the intended parents' rights and safety, support them in cases of adversities, protect the best interest of the offspring and guide healthcare professionals (Burrell C, 2014). In order to ensure all children their right to have a nationality, established by the Universal Declaration of Human Rights and the UN Convention on the Rights of the Child, all states should adopt Portugal's position, giving its nationality to all the children born in their territory that would otherwise be stateless. Even though this is not the final answer to solve statelessness, it can protect all children while the much-needed international convention on surrogacy is not yet drafted. A countries agreement to accept the child as their national and recognize the intended parents as legal parents prior to the negotiation is an alternative option to avoid the possible problems that can arise from CBS. For states who refuse the legalization of surrogacy, they should at least regulate the legal implications of surrogacy.

As the views of society change regarding parenting by same-sex male couples and single persons, the number of these individuals that want to embark on the journey to parenthood through surrogacy is increasing (Grover SA et al., 2013). Low welfare risks for the offspring were described by the existing studies and the ASRM, ESHRE and ACOG issued opinions on the inexistence of reasons to prevent access to the same treatments as heterosexual couples. Despite all of this, Portugal stills restricts these individuals, denying them they reproductive human right and not enforcing the principle of formal justice. This is a consequence of the subsidiary nature of surrogacy and the additional complexities that this ART presents when compared to other ARTs.

Women who fit the criteria in Article 8 (2) of Law n. ° 32/2006 have their access to surrogacy denied. Article 6 (1) of the same Law allows the use of ARTs to all women regardless of their marital status and sexual orientation, recognizing in all women their ability and right to procreate. In cases of single women without uterine problems that prevent pregnancy, these can use other ARTs other than surrogacy to reproduce. However, the single women included in Article 8 (2), according to the CNPMA's declaration on who the beneficiaries of surrogacy can be, are excluded from these, since they are not part of a heterosexual couple or a same-sex female couple. It is not coherent that the Portuguese Law on surrogacy acknowledges the women's right to procreate, but that the CNPMA restrict its access based on the Law's lack of clear clarification. The CNPMA's decision to restrict access to the previous mentioned individuals is based on their allegation that surrogacy is not indeed an ART, but instead a treatment who requires the use of an ART, therefore justifying different access norms between surrogacy and all other ARTs. This claim by the CNPMA goes against the opinion of the International Committee for Monitoring Assisted Reproductive Technology (ICMART) and the World Health Organization (WHO) who in fact consider surrogacy an ART (Zegers-Hochschild et al., 2009). To ensure that the Law is not restrictive, the Portuguese Law should extend surrogacy's access to same-sex male couples and single individuals.

Currently, doctors cannot interfere in surrogacy's acceptance process if there are reasons to believe the intended parents are not able to provide the appropriate environment for the future offspring, even if they know the individuals applying for surrogacy. The parent's autonomy right to reproduce prevails over the doctors' responsibility towards their patients, which includes the child. If the argument used is that ARTs are simply meant to enable reproduction, just like in other individuals without reproduction obstacles, then society is accepting and contributing to children being born in unacceptable environments. It is society's responsibility to protect all human beings, even if they are not born yet. Therefore, parental vetting should be allowed in Portugal in all ARTs, providing rejected parents the necessary help to develop the competences necessary to undergo surrogacy in the future (Serejo R & Ricou M).

Even though surrogacy arrangements have been performed in some countries since the late 1980s, there is still very limited research on the outcomes for the all parties involved. The majority of studies have serious methodological limitations, such as small sample size and lack of controls. Low response rate, particularly in studies on psychological follow-up, introduces a risk of selection bias since people with negative experiences are less likely to participate in these studies. The risk of socially desirable responding should also be taken into account due to surrogacy being particularly stigmatized, therefore interviews should be designed in a way to minimize this (Golombok S et al., 2006). Other possible reasons to explain the literature's scarcity are the difficulty to secure financial

support for research on such a controversial topic, the struggle to track the number of children born through surrogacy, and the intended parents' unwillingness to sacrifice their privacy to participate in these studies, due to the social stigma that surrounds surrogacy. In Portugal, Article 13 (2) states that the information related to the child's health and development should be provided in order for to allow further scientific research. Large-scale longitudinal studies in different cultural contexts are much needed in order to strengthen the existing scientific knowledge on the matter and prevent the biases inherent to retrospective studies (Blake et al., 2017; Carone N et al., 2017b; Dar S et al., 2015; Imrie and Jadvā, 2014; Jadvā et al., 2003; Shenfield et al., 2005; Söderström-Anttila V et al, 2016). Furthermore, all findings on this subject can also contribute to a more adequate counselling and guidance of the interested individuals (De Wert et al., 2014).

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ANNEX

Publication Norms from the Journal:

JBRA Assisted Reproduction

Instructions for Authors

GENERAL INFORMATION

JBRA Assisted Reproduction (JBRA Assist Reprod) is the official publication by both the Brazilian Society of Assisted Reproduction (SBRA – www.sbra.com.br), the Latin America Network of Assisted Reproduction (www.redlara.com) and Pronúcleo - Brazilian Association of Embryologists destined to scientific-based and quarterly issued papers. It is designated to specialists and researchers in the health area, in particular to gynecologists, andrologists, biologists, urologists and embryologists. Basic and clinical studies in the areas of assisted reproduction, infertility, reproductive genetics, reproductive immunology, andrology, reproductive microbiology, laboratory in assisted reproduction and gynecological endocrinology will be accepted for evaluation in the form of original articles, reviews, update articles and case reports (as detailed below). Articles must be submitted in English.

Papers submitted to JBRA Assisted Reproduction must be original, that is, they cannot have been either published or submitted for analysis by other journals, partially or in the whole. In cases where the illustrations have been published previously, an authorization must be granted and the source cited.

The Instructions for Authors by JBRA Assisted Reproduction is comprised of the recommendations given by the Uniform Requirements for Manuscripts Submitted to Biomedical Journals. The complete version of the text is available at www.icmje.org. Manuscripts not in accordance with the instructions presented herein will be returned for modifications to be made before the Editorial Board has evaluated them.

Authors should state that the study was approved by the Research Ethics Committee /REC from the institution where it was carried out (or from another that has a constituted and been appropriately designed), also mentioning the approval or exemption of the free informed consent by the same committee. If needed, the journal reserves the right to require the authors its sending.

When studies in humans are being reported, authors should indicate if the study processes are in accordance with the ethics standards defined by the committee in charge for studies in humans (institutional or national, if applicable) and in accordance with the 1975 Helsinki declaration, which was reviewed in 2013. If studies are performed in animals, authors must indicate if the institutional/national guidelines for care and use of animals were followed. In any research, be it clinical or experimental.

Every article published in JBRA Assisted Reproduction undergoes a review process by specialists (peer review). Submitted articles are primarily sent to editors for an initial evaluation as to the scope of the work and the editorial demands of the journal. In case of a positive evaluation, the article is then sent to two reviewers specialized in the appropriate area. Every process is anonymous, that is, reviewers are not aware of author's identity and place of origin and vice versa. After the articles are evaluated by reviewers, they can be accepted without alterations, refused or returned to authors along with

suggestions for modifications. Each article may return to its author several times for clarification and alteration, without necessarily meaning a future acceptance of the article.

The co-authorship concept connotes substantial contribution in the creation and planning of the paper, analysis and interpretation of data not to mention the writing and critical revision of the text. Significant contributions given to the study which do not fit these criteria must be cited in the acknowledgements section.

Clinical trials articles should be registered in the Clinical Trials Registry validated by the criteria established by the World Health Organization and by the International Committee of Medical Journal Editors (for instance, www.actr.org.au, www.clinicaltrials.gov, www.ISRCTN.org, <http://www.umin.ac.jp/ctr/index.htm> and www.trialregister.nl). The study identification number shall be presented at the end of the abstract.

For texts accepted for publication, a statement signed by all authors shall be sent to the journal, including the following information: a) the manuscript is original; b) the manuscript has not been previously published nor submitted to any other journal, and will not be published in case it is accepted by JBRA Assisted Reproduction; c) all authors have actively taken part in the preparation of the study and have approved of the final version of the text; d) situations on potential conflict of interests (either financial or of any other nature) are being informed; e) an approval of the study by the Ethics Committee of the institution to which the paper is linked was obtained (for articles reporting experimental research data); f) an informed consent by the patients included in the study was obtained (when applicable). All information on the approval of the study by the Ethics Committee and the possession of an informed consent should also be mentioned in the Methods section of the article.

Before the publication of accepted articles, the corresponding authors will receive the published article via e-mail attachment in a PDF archive for approval. At this point, corrections should be limited to typographic mistakes, without altering the content of the study. Authors should return approved papers by e-mail or fax 48 hours after receiving the message.

TYPES OF PUBLISHED ARTICLES

Original articles. Pieces of work resulting from scientific research presenting original data about experimental or observational aspects of medical, biological, biochemical and psychosocial character and including descriptive statistical analysis and/or inferences of own data. These articles have priority for publication. They must be composed of: title page, abstract and keywords, text (divided in Introduction, Material and Methods, Results, Discussion or equivalent, Conclusion), acknowledgments (if applicable), references, tables (if available), figure legends (if available) and figures (if available).

Reviews. Papers whose aim is to summarize, analyze, evaluate or synthesize investigative papers already published in scientific journals. They must include a synthesis and critical analysis of the researched literature and cannot be confused with update articles. They must be composed of: title page, abstract and keywords, text, references, tables (if available), figure legends (if available) and figures (if available).

Update or opinion articles. Papers reporting usually current information on themes of interest to certain specialties (such as a new technique or method). They have different characteristics from reviews, since they do not display critical analysis of the literature. They must be composed of: title page, abstract and keywords, text, references, tables (if available), figure legends (if available) and figures (if available).

Case reports. Articles representing descriptive data of one or more cases, exploiting a method or problem through example(s). The selected cases should be of great interest, with unusual disease or evolution or submitted to unexpected or alternative treatments. They must involve humans or animals and should present the studied individual's characteristics (gender, age, etc.). They must be composed of: title page, abstract and keywords, text (divided in: Introduction, Case Description and Discussion or equivalent), references, figure legends (if available) and figures (if available).

Letters to the reader. Letters to the editor commenting, discussing or criticizing articles published in JBRA Assisted Reproduction will be welcome and published as long as they are accepted by the Editorial Board. They must be composed of: title, name of author, identification of the publication being commented on and references (if available). It is recommended to include 500 words at the most, references inclusive. Whenever possible, a reply by the authors will be published alongside with the letter.

COVER LETTER

You have to prepared a cover letter for your submission, explaining why we should publish your manuscript and elaborating on any issues relating to our editorial policies detailed in the instructions for authors, and declaring any potential competing interests. This should be provided using the 'cover letter' section of the submission process.

The cover letter have to carry the following information:

Title

Authors' names

Authors' institutional affiliation, showing department/unit, institution and geographic region

Name of the institution where the work was carried

Name, mailing address, telephone and fax numbers, and e-mail address of the corresponding author

PREPARATION OF ORIGINAL PAPERS

Preferably use Microsoft Word® processor. Papers should be typed in Times New Roman font sized 12, single-spaced and aligned to the left. Every section should be started on a new page in the following order: title page, abstract and keywords, text, acknowledgements, references, tables, figure legends and figures. All of the pages should be numbered consecutively.

Abbreviations should be spelled out in the first mention in the text; and after the first appearance, only the abbreviation should be used. In the abstract, the use of abbreviations should be avoided.

Chemicals should be presented by their generic name. If relevant, commercial name of the substance and the manufacturer's name must be informed in parentheses.

The presentation of units of measurements should follow the International System (IS).

Genes of animals should be presented in italics with capital letter initials (example: Sox2); genes of human beings should also be presented in italics; however, with all capital letters (example: SOX2). Proteins should follow the same pattern: capital/small, without italics, though.

Title Page

The title page should carry the following information:

Concise and comprehensive title, representing the content of the article

Short running head (no more than 40 characters including letters and spaces)

Information about support given in the form of loan, equipment or drugs

Congresses where the study was presented

Abstract

The content of the texts should not exceed 250 words.

For original articles, the abstract should be structured as follows: Objective, Methods, Results and Conclusion. For case reports, reviews and update articles, the abstract should not be structured. The use of abbreviations should be avoided in the abstract, and references should not be cited. Right after the abstract, three to six keywords should be presented.

Acknowledgements

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References

In the text, the citations will be identified by the author's last name in parentheses followed by the publication year.

Examples: one author (Step toe, 1978), two authors (Edwards & Step toe, 1980), and more than two authors (Van Steirteghem et al., 1988).

The references should be presented in alphabetical order (each author's surname followed by his/her first two initials), and should not be numbered. Papers by the same author should be chronologically organized; papers by the same author in the same year should be identified with letters after each year (2000a, 2000b, etc.). The presentation of references will follow the format proposed in the Uniform Requirements for Manuscripts Submitted to Biomedical Journals (see examples below). All references cited in the list should be mentioned in the text and vice-versa.

Journal Article

Edwards RG, Step toe PC, Purdy JM. Establishing full-term human pregnancies using cleaving embryos grown in vitro. *Br J Obstet Gynaecol*. 1980;87:737-56.

Book

Wolf DP, Quigley MM, eds. *Human in vitro fertilization and embryo transfer*. New York: Plenum Press; 1984.

Book Chapter

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Tables And Figures

Tables and figures (graphs, photographs, etc.) should be numbered in Arabic numerals according to the order in which they appear in the text and should have individual legends, presented at the end of the paper.

In the tables, use horizontal lines only, and each piece of information should be in an independent cell. Explanations about items in the tables should be presented in footnotes identified by the following symbols, in this sequence: *, †, ‡, §, ||, ¶, **, ††, ‡‡.

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