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**Position statement of Our Bodies Ourselves**
**on the Child-Parent Security Act (S.17A)**
New York State Legislature
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A new and far-reaching era in human reproduction presents unprecedented opportunities for family formation for people with infertility, LGBTQ individuals and couples, as well as unmarried and single individuals. At the same time, for women who provide their services in contractual third-party reproduction, it can pose significant risks and create new inequities within an inadequately regulated industry. For almost 50 years Our Bodies Ourselves (OBOS) has provided evidence-based information to the public on pregnancy, birth, and infertility, advocated for LGBTQ rights and, for almost 20 years, been actively engaged in emerging issues in assisted reproduction, genetics, and public health. We have paid particular attention to potential risks to women's health arising with these new technologies and contractual arrangements, as well as their impact on future generations of children.

Contractual commercial surrogacy is a case in point. Surrogacy can be a financial, and sometimes altruistic, opportunity for gestational mothers (also referred to as "surrogates"- see note below [1]). However, many contracts favor the agencies/clinics' clients – the intended parents – and may not be sufficiently transparent to allow for real informed consent on the part of gestational mothers. Therefore, many women are unable to question or consent to conditions of their participation. As a result, they endure health risks associated with, for example, high doses of hormones for embryo transfer, medically unnecessary cesarean sections, and birthing multiples; limitations on their options to terminate or carry pregnancies at will; sometimes, limitation on movement or excessive monitoring, and restricted access to independent legal and medical counsel.

As New York State considers its bill on contractual surrogacy – the Child-Parent Security Act (S.17A) – it has an historic opportunity to correct unsound practices in an insufficiently regulated field, put in place protections for the health and rights of *all* participants to these arrangements, and develop a national (and perhaps global) model in still uncharted legal waters. Our Bodies Ourselves calls on New York legislators to ensure expanded options for family formation for everyone, protect the rights of intended parents pursuing these options, and *simultaneously*, to safeguard the health and rights of the women who make family formation through surrogacy possible – gestational mothers and egg providers. Further, it goes without saying that the health and well-being of future children born of these arrangements is a primary concern for all involved. Only by

[1] While many prefer to use the terms "surrogate," "gestational surrogate," or "gestational carrier," OBOS has opted for the term "gestational mothers" so as not to minimize – and rather to emphasize – the contribution made by these participants in a surrogacy arrangement. "Surrogate" connotes a "substitute" and someone who carries a pregnancy for nine months and gives birth is anything but a "substitute." "Gestational carrier" – common in marketing literature – has the effect of reducing the gestational mother to a "vehicle" or "vessel" and diminishing the dignity due to her. Further, it is important to recognize that children born of gestational surrogacy often have, biologically speaking, two "mothers" (the genetic and the gestational), while at the same time they have biological and/or non-biological intended parents who have initiated, as well as invested emotionally and financially in the surrogacy process and who, most importantly, will be their lifelong parents. In its position statement, OBOS attempts to recognize the contributions and roles of all participants, as well as the complicated nature of surrogacy arrangements. In doing so, the intent is not to take something away from the rights and central role of intended parents; but instead to propose an expansive and inclusive step that might serve to build a stronger foundation for new opportunities in forming families.

recognizing the necessary protections for *all* participants will assisted reproduction, and the new forms of family formation it makes possible, be made stronger and more equitable.

Safeguards for the rights of intended parents are already included in S.17A. A revised bill, however, will need to correct areas where these rights countermand the rights and health of others; specifically, go further by including provisions for gestational mothers, egg providers, and future children. Although these provisions – outlined below – will better safeguard the health of gestational mothers and egg providers, they will also increase the likelihood of a healthy baby, an obvious priority for intended parents and for all involved.

**For Gestational Mothers**

The bill should require the intended parents to pay for health insurance and/or medical costs for the gestational mother while she is participating in the surrogacy arrangement.[2] Coverage should begin with the process of becoming pregnant and extend through at least eight weeks of the post-partum period, especially because postpartum complications are often neglected unless proper postpartum care is provided. Equally important, the bill needs to safeguard the health and rights of the gestational mother in the ways outlined below.

**Adhere to best practice in medicine by contractually requiring:**

- **Single embryo transfer**. Gestational mothers often carry more than one embryo to increase the chance of a successful pregnancy. They frequently do so unaware of the risks and recommended cap by most experts in the field, and thus are unable to give or withhold informed consent to a practice with documented safety concerns. Many professional health and perinatal organizations such as the American Society for Reproductive Medicine (ASRM) and the Society for Assisted Reproductive Technology (SART) strongly urge capping transfers to one embryo for each IVF treatment cycle (for pregnancies using assisted reproductive technologies). This is due to the risks associated with multi-fetal pregnancies. Each additional fetus increases the likelihood of maternal conditions such as preeclampsia, diabetes, and placental abruption (separation of a placenta from the uterine wall). For children, multi-fetal pregnancies can result in premature birth (before 37 weeks), low birth weight, and immature organs, leading to problems of the digestive tract and heart, as well as to conditions such as spina bifida, and requiring neonatal intensive and long-term care. This contractual requirement for single embryo transfer would not only protect the health of the gestational mother, but also of future offspring, which is clearly of primary concern to intended parents and all involved. [3]
- **Only medically necessary cesarean sections.** Frequently, gestational mothers undergo mandated, medically unnecessary cesarean sections as a condition of their contract. Although cesarean sections can save lives, this surgical procedure also presents significant risks and is commonly overused, which is why the American College of Obstetricians and Gynecologists (ACOG) has worked to reduce cesarean rates through its practice guidelines*, Safe Prevention of Primary Cesarean Section.*[4] Risks from cesarean birth can include accidental cuts to adjacent organs, severe and ongoing pain at the incision site, infections, internal scar tissue, and in subsequent pregnancies, placenta accreta (a placenta that attaches too deeply to the uterus and can lead to uncontrollable bleeding). For children, short-term risks include accidental cuts, reduced blood flow from the placenta, breathing difficulty, and low Apgar scores; long-term children's risks include childhood-onset diabetes, asthma, and Crohn's disease. Because of these risks, ACOG has promoted safe vaginal birth options, including vaginal birth after cesarean (VBAC), and clinicians have

[2] There are insurance companies that specifically provide this kind of coverage.

[3] We recognize that this safeguard on behalf of the gestational mother and future offspring may create a greater burden for the older intended mother who may be providing her own eggs. The legislation could have an exception in this situation, allowing for up to two embryo transfers.

[4] Safe prevention of the primary cesarean delivery. Obstetric Care Consensus No. 1. American College of Obstetricians and Gynecologists. Obstet Gynecol 2014;123:693–711. These guidelines were reaffirmed in 2019, as noted here:https://www.acog.org/Clinical-Guidance-and-Publications/Obstetric-Care-Consensus-Series/Safe-Prevention-of-the-Primary-Cesarean-Delivery?IsMobileSet=false

spent more time educating parents about the advantages of avoiding unnecessary cesarean sections. Like prospective mothers in general, gestational mothers should be able to benefit from these best practices, and because many are not aware of them, including this provision is especially important.

- **Postpartum care for at least eight weeks after birth, if desired by the gestational mother.** Postpartum support is critical for many birthing mothers. In the case of gestational mothers, who are not likely to parent the children they birth, most will return to their own families, and all need to heal physically from birth, recover from hormone-driven processes, and cope with any emotional complications arising from trauma and loss. As mentioned above, these are often neglected unless proper postpartum care is provided.

**Adopt equitable health and legal protections by requiring:**

- **Agency in decision-making regarding medical interventions – including termination (or continuation) of a pregnancy – freedom of movement, and daily activities.** Staying physically active, emotionally/socially engaged, and individually empowered are the hallmarks of a healthy pregnancy. Often, and for many reasons, gestational mothers have been bound by contractual provisions that contradict common sense and practice, such as limited control over health care decisions involving tests, treatments, or whether to terminate (or continue) a pregnancy; and, sometimes, excessive control over daily activities and/or movement (e.g., diet, exercise, and travel). The physical and emotional toll of these requirements is impossible to quantify, but not hard to imagine given their impact on perinatal wellness. It is why many in the perinatal community work hard to ensure all birthing parents' right to self-determination on every aspect of pregnancy, birth, and postpartum. Gestational mothers deserve the same, and this bill needs to ensure their agency in these decisions.

**In addition to the above health and legal provisions, parentage should be assigned at birth to the gestational mother – *as one of the legal parents* – and remain in place for 72 hours, when parental rights would be relinquished by her.** A pre-birth judgment of parentage, is unworkable, as there is legally no child until birth. Granting the intended parents rights to a fetus (i.e., supporting fetal personhood) puts S.17A on a collision course with the right to abortion in Roe vs. Wade and makes all the safeguards for the gestational mother outlined above more difficult to implement. Finally, while changing one's mind about keeping the child is rare, gestational mothers should have 72 hours to do so. At the same time, an expedited process of adoption for one or both of the intended parents should ensure the transfer of the child after this period.

**<u>Egg Providers</u>**

Often overlooked in legislation pertaining to gestational surrogacy, egg providers are key participants in these arrangements. Given the known and unknown risks in the process of egg retrieval,[5] these healthy young women deserve to know what they are signing up for and to give informed consent – to the extent it is possible. **Surrogacy arrangements should adhere to best medical practice by requiring:**

- **Accurate medical information** be given to the egg provider about short- and long-term risks of the egg retrieval process, including the fact that there is, at present, scarce research data on long-term impact

[5]While there has been very little systematic study of the long-term risks associated with the drugs used in egg retrieval – despite repeated calls for such research – a number of concerning side effects have been reported. These include skin rashes and non-inflammatory joint pain, hypertension, and liver function abnormality. Short-term risks associated with egg retrieval include infection, bleeding, and anesthesia complications. Ovarian Hyperstimulation Syndrome (OHSS) is another risk, which causes the ovaries to become swollen and painful. The effects of OHSS depend on whether it's a mild, moderate or severe case, and may include rapid weight gain, abdominal pain, vomiting, shortness of breath and, in rare cases, death. A large number of serious long-term health problems have been reported to the US Food and Drug Administration by individuals who believe the adverse effects are associated with Lupron. Although Lupron has been replaced by other drugs in most ART procedures, insufficient research has been conducted to determine whether these drugs are associated with future infertility, or certain cancers such as uterine, colon, breast, ovarian, or endometrial cancers.

- **Controlling the levels of hormonal stimulation** to avoid the risk of OHSS (see footnote above). This might include a cap on the dosage of gonadotropins administered.
- **Coverage of health insurance and/or medical costs for egg providers by the intended parents,** including costs for any necessary hospitalizations during the period of hyperstimulation and up to four weeks post egg retrieval.
- **Exclusion of egg providers with a previous diagnosis of OHSS** or those who have already undergone more than six cycles of hormone stimulation (this limit of six is recommended by the American Society for Reproductive Medicine, although there are no data that would point to this as an ideal cut-off point).
- **Establishment of a mandatory registry** to collect safety data and allow for long term follow-up of egg providers. If resources are unavailable to design and establish an independent New York registry de novo, the Infertility Family Research Registry is a model for this sort of registry, and its Project Principal Investigator, Judy Stern, PhD., also Professor, Obstetrics and Gynecology and Pathology, Geisel School of Medicine at Dartmouth, has indicated she may be contacted regarding the establishment of a registry in New York.

**Children born through Gestational Surrogacy**

Conditions that are the hallmarks of a healthy pregnancy, and which promote the wellness of gestational mothers, will also be essential in ensuring the health of future children born through gestational surrogacy – as outlined above. Additionally, provisions in the bill to protect the rights of future children should include:

- **Access at legal age to information on genetic and gestational parentage.** Although little is known about the impact of contractual surrogacy on children regarding their origins and identity, lessons from other fields may help forge a path forward. Advocates of adoption reform, for example, have addressed the importance of access to medical information, birth records and birth stories. The Donor Sibling Registry, founded in 2000 to support donor-conceived children, now includes more than 62,000 members. The organization assists individuals born as a result of sperm, egg, or embryo donation who are seeking to make mutually desired contact with others with whom they share genetic ties.

- **Proscription of nuclear genome transfer and CRISPR (gene editing) technologies in gametes and embryos (the human germline).** These emerging and very controversial technologies will impact all subsequent generations, as well as the human genome itself. Allowing their use to come in through the back door by way of a surrogacy bill would be unacceptable and irresponsible public policy, as they do not have widespread endorsement by the public or medical researchers. Further, coming to a societal consensus on whether to proceed with experimental or clinical use of these technologies would require robust public discourse, which has not yet been initiated.