

## **Gay men's experiences of surrogacy clinics in India**

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**Abstract:** While growing numbers of Australian gay men are entering into 'offshore' surrogacy arrangements in order to become parents, little empirical research has been conducted with this population. This paper reports on a qualitative analysis of interviews with 12 gay men who had entered into surrogacy arrangements in India. The findings outline both positive and negative experiences in terms of support pre-conception, during the birth and post-birth. Changes to legislation in India mean that gay men can no longer access surrogacy services there, but it is important to understand the experiences of men who had previously accessed those services. The paper concludes by highlighting aspects of the data that demonstrate the particular experiences of gay men who undertake offshore surrogacy arrangements, especially with regard to their need for support and involvement in all aspects of the process. A more thoroughly developed network of care may help to facilitate such support and this may further increase the positive outcomes reported by gay men who form families through surrogacy arrangements.

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## **Introduction**

A small but growing body of research has documented that a rapidly increasing number of gay men are becoming parents via surrogacy arrangements.[1] Such arrangements can be either altruistic (without payment, other than direct expenses, to the woman who acts as a surrogate) or commercial (with a fee paid to the woman who acts as a surrogate), and can involve the use of either the surrogate's own ovum or the implantation of an embryo derived from a donor egg (gestational or IVF surrogacy).[2, 3]

This paper reports on interviews with 12 Australian gay men who had become parents through an 'offshore' surrogacy arrangement in India. Australian laws concerning surrogacy are complex and vary between the state and territory jurisdictions, with commercial onshore surrogacy essentially illegal.[4,5] Given the challenges in negotiating an altruistic surrogacy arrangement, most Australian gay men who decide upon surrogacy as their route to become parents enter into offshore commercial surrogacy arrangements, almost always involving gestational surrogacy.[6]

The advocacy group *Surrogacy Australia* estimates that 269 children were born to Australian citizens through offshore surrogacy arrangements in 2011,[7] compared to over 300,000 children born in Australia that year. [8] Of the 269 children, only 14 were born as a result of altruistic surrogacy arrangements.[9] There are currently no reliable statistics on the numbers of gay men from Australia entering into offshore commercial surrogacy arrangements, and their experiences of negotiating such arrangements and receiving a child as a result have been under-researched. Whilst legislative change in India in 2013 now prevents gay men from utilising commercial surrogacy services, it is important to understand the experiences of this population of men given they will likely continue to engage commercial clinical services in other countries that may adopt practices similar to those found in India.

## **Previous Research on Gay Men and Surrogacy**

Given the fact that no empirical research was identified focusing specifically on gay men undertaking surrogacy in India, it seemed most appropriate to contextualize the

present paper in terms of existing literature on outcomes for families formed by gay men via surrogacy arrangements, in order to orientate readers to this specific family form and the experiences that arise from it.

One of the earliest empirical studies concerning gay men who had children through surrogacy was undertaken by Bergman et al,[2] who interviewed 40 fathers in a committed gay relationship in the United States (US). The research found that gay fathers faced issues both similar and different to heterosexual parents in forming families through surrogacy arrangements. In terms of differences, the research found that becoming parents led gay men to change their goals, with increased focus on their family rather than career. Bergman et al noted that this differs from the findings of many studies concerning heterosexual fathers, who often work the same or more hours after having children. Most of the men in the study also reported being closer to their extended families after having children, and that this was an important source of support. This finding is supported by Tuazon-McCheyne's research with seven Australian couples who had children through offshore surrogacy in the US,[10] which reported that a strong family support network was critical to ensuring positive outcomes for families formed through surrogacy.

Kruczkowski's study of 52 US gay men examined a number of factors arising from the experiences of coupled gay men who had children through surrogacy arrangements, including relationship satisfaction and overall wellbeing.[11] Participants reported a relatively equal division of household labour within the couple, and that the most significant factors predictive of relationship quality were the amount of paid work hours and satisfaction with division of labour. Those who worked more or who felt less satisfied with the division of household labour rated their relationship quality lower. Notably, no differences in relationship satisfaction were found between participants in terms of which partner's sperm was used in the conception of the child(ren).

In terms of decisions concerning which partner donates sperm, the work of Greenfield and Seli[12] highlights the importance of counselling prior to entering into a surrogacy arrangement. They interviewed 15 coupled gay men who were in the process of entering into onshore surrogacy arrangements in the US. They found that

the men had put considerable time into thinking about becoming a parent, but that decisions about whose sperm was used were nonetheless complex. Six of the participants reported selecting the elder man in the couple, two made the decision based on whether one of the partners already had children, two on the fact that one partner had a greater desire to be a genetically-related parent, while the remaining three chose to implant multiple embryos. Australian research by both Dempsey and Murphy found that genetic relatedness is a salient topic amongst gay couples who become parents through a surrogacy arrangement.[6, 13] Both of these studies suggest that ongoing family identity management is undertaken by gay couples either to ensure that information about genetic relatedness is kept secret, or that it does not affect the equal treatment of both men as fathers. It is perhaps the latter desire that shaped the reason why no differences were found in Kruczkowski's study in terms of the influence of genetic relatedness upon relationship quality.[11]

## **Method**

Following ethics approval from the first author's institution, a message was circulated to members of *Surrogacy Australia* via the group's administrator. It stated that the first author was looking to interview people who had had children through surrogacy arrangements in regard to their experiences and support needs. A total of 21 people responded. Of these, five represented a heterosexual couple, fifteen represented a gay male couple, and one represented a single gay man. Five had undertaken surrogacy in the US and the remaining 16 had undertaken surrogacy in India.

Telephone interviews were then arranged. Participants were given full information about the project, and were asked to return a signed copy of a consent form electronically. Questions in the interview schedule included "How did you decide upon surrogacy as a mode of family formation?", "Was it difficult negotiating a surrogacy arrangement?", and the question of interest to this paper "Do you feel that you were adequately supported by your clinic?" Interviews were audio recorded and transcribed verbatim.

As indicated in the introduction, what is lacking is empirical knowledge about the experiences of gay men who have undertaken surrogacy arrangements in India,

specifically with regard to experiences of support from clinics. The analysis below therefore focuses solely on the gay men who undertook surrogacy arrangements in India as previous empirical research on offshore surrogacy in India had focused on heterosexual couples, and such research on gay men has focused on those seeking offshore surrogacy in the US.

## **Results**

Through repeated analysis of responses to the interview question related to experiences with clinics, it was apparent that responses fell into one of two overall categories: either positive or negative experiences of support from clinics. In order to present the findings more clearly, these were then broken down into further categories: the journey through surrogacy, including experiences pre-conception; experiences with the birth; and experiences of support post-birth. The analysis presented below thus explores both negative and positive experiences of engaging with clinics in these various stages by providing indicative extracts from the interviews.

### ***Positive experiences of support***

In terms of positive experiences, overall these tended to be characterized by participants reporting that they had received what they had paid for - a child. With few exceptions, what constituted a positive experience was professional service, the delivery of a child, and adequate information provided about the entire process. Experiences that went beyond these to encompass a more holistic network of care for all parties were thus the exception to the rule of a generally adequate standard of care.

#### ***Support pre-conception***

When speaking about their experiences prior to conception (in terms of initial contact with clinics, receiving information about the process, and being counselled to consider their options), participants who spoke positively about clinics emphasized professionalism and responsiveness as key to positive experiences:

"The clinic's been extremely professional. Any questions or hesitations I've had they've dealt with. They have a legal team, they've got highly qualified and trained professionals and when we visited the clinic the lead doctor really put my mind at ease."

As information is key to decision making for any person entering into a surrogacy arrangement, it might be suggested that what is regarded here as 'positive' is simply the meeting of a minimum standard of care for intending parents. Of note, however, none of the interviewees mentioned discussions with clinics that might have helped intending parents decide if surrogacy really was the most appropriate route to parenting for them.

### *Support during birth*

In comparison to positive comments about experiences prior to conception, there were far fewer positive comments across the sample about experiences with the birth of the child. As the negative comments presented in the following section indicate, this may be due to the fact that in most Indian clinics it is standard practice for intending parents not to be present at the birth. Whilst prior to conception most might have accepted this as fair, some were disappointed about not being present. One of the few exceptions was:

"We had a conversation before conception about what would happen if a caesarean was necessary, and we were informed that it was pretty standard for us not to be there, so we were pretty relaxed when that happened. I mean she knows what's going on, it's her body, she's doing us an amazing favour, so we could accept not being there."

While we have classified this as a positive experience in regard to the birth of the child, we would again note that what was positive about this experience was that a procedure was agreed upon prior to conception, so the participants knew what to expect if a caesarean was necessary. What we cannot know, however, is if this was something that they were happy with, or if instead it was agreed to because there was no other choice.

### *Support post-birth*

Regarding experiences of support post-birth, positive responses were mixed. Some participants felt that they received an adequate standard of care, whilst one participant felt that their clinic had exceeded the basic standards of care:

"The support from the clinic was very genuine, but we were one of many, many clients they had and I wouldn't say they went super out of their way to support us, but they were certainly there emotionally and to this day we are still friends with people at the clinic."

"The support we received was fantastic. We still keep in contact with our doctor. Whilst we probably only hear from her every few months, it is very caring: she sends birthday presents for the kids on their birthday and she's always keen to see photos of them."

These extracts are interesting for the suggestion of what would constitute going 'out of the way' to support intended parents. Ordinarily, when health care is considered, best practice typically relates to addressing the patient's ill health in whatever form it takes. Increasingly, however, research indicates that what patients want goes beyond attention to their physical needs, and encompasses their emotional needs as well.[14, 15] Research concerning onshore surrogacy arrangements similarly indicates that patients expect clinics to offer a level of emotional support or counselling.[16] Given the considerable desires that accompany any person's journey to becoming a parent, it is logical that intending parents would seek more from clinics than simply the provision of a child. These extracts suggest that what is wanted by intending parents is a connection with the clinic staff: that the child is not simply part of a transaction, but rather is part of a network of care.

### *Negative experiences of support*

Negative experiences ranged from what could be seen as failure to provide a minimum standard of care, to experiences that appeared to be the product of a sole

focus upon surrogacy as a transaction and lack of accompanying focus on the emotions attached to the surrogacy journey for intending parents.

### *Support pre-conception*

With regard to negative experiences of support prior to conception, we note that many of the participants who reported such experiences were cognisant of the inadequacy of the support or information they received during initial conversations with the clinic, yet continued with the surrogacy arrangement regardless. We would suggest that this is not a sign of complacency on the part of the participants, but rather of the intense desire to have children, even at emotional cost to themselves.

"No, we didn't feel supported. We didn't get to choose the surrogate, which at first I was a bit funny about. But I told myself it's just one of those things in India and you have to accept that."

"I felt that they told me what they thought I wanted to hear, rather than actually getting down to the nitty gritty. I felt that I was a pawn in their goal of increasing success rates, rather than as someone on a journey to becoming a parent."

"In terms of multiple implantations, we definitely didn't receive adequate counselling about the consequences – that there might be selective reduction. It certainly wouldn't be your definition of counselling, but you are told. You are told that this is what's gonna happen and it's in the contract."

These extracts indicate a clear ambivalence about clinics prior to conception, yet all the participants found a way to reconcile themselves to what they perceived to be inadequate support, or potential outcomes that were not what they desired. This highlights the vulnerability of intending parents to agreeing to terms not of their making if their desire for a child is overriding.

### *Birth*

Two key issues arose in the interviews in terms of negative experiences with support around the birth of a child. One related to decisions being made by clinics about the birth without consultation with the intending parents, and the other related to a lack of sensitivity in regard to pregnancy loss. Clearly the latter occurrence is likely to be experienced negatively regardless of the support received, but one of the extracts below highlights how this was exacerbated by a lack of support from a clinic.

"We planned to go over early and then travel domestically in India to see some sights but the clinic did not tell us that they were going to induce labour and just induced the baby. Once we got in the country, we went and met with the clinic that day, checked into our hotel, and then they just rang us and said come to the hospital as the baby was born."

"When it came to a late term pregnancy loss, the clinic straight away started talking about finding us another surrogate who had a high success rate. The grief we went through at the time was rarely acknowledged; they didn't really help us running around, there were lots of things we had to organise in terms of bringing ashes home and organising the funeral and that kind of thing and we didn't have help with any of that. I think they wanted the whole problem to go away in a sense, 'cos it was one of their worst nightmares."

Whilst clinics may need to make decisions about a birth in order to ensure the best outcomes for the child and the surrogate, it was also the case that some participants felt that decisions were made on the basis of the current prevalence of caesarean births in many countries.[17] For intending parents who were given no choice in regard to an otherwise unnecessary caesarean section, the sense of being disconnected from the process of their child being born was heightened.

In the case of pregnancy loss, the academic literature contains numerous examples of both doctors and the general public failing to recognize the significance of pregnancy loss for many parents.[18, 19] With surrogacy, the pregnancy loss appeared to be exacerbated for some participants by their perception of concern on the part of the

clinic that the loss would affect their success rate. This type of response contributed to the loss already experienced by participants, in that they felt they were simply a number, and not people trying to fulfil their desire for a child.

### *Support post-birth*

In terms of support post-birth, those who reported negative experiences spoke of feeling that the clinic was less interested in them once the birth had occurred - and the final payment for the service had been made. This reinforced the feeling for some participants that clinics were mercenary in their approach. Other participants acknowledged that their clinic made some effort, but nonetheless felt that support post-birth was lacking.

"The only emails that I've received from them were asking for a written testimonial for their website. Not any "how are you going?" not any follow up."

"Once the children were born I found the clinic to be not as involved. I think they could have picked up a bit on that, especially when you're in a foreign country, because you're actually quite isolated there. They were fairly good in a lot of respects but I think the follow on was lacking. It would have been nice if you'd seen the doctor you've dealt with a bit more."

Whilst it could be argued that in providing a healthy baby the clinic has fulfilled its role, we would suggest that caring for a newborn baby, especially in a foreign country, would be likely to be a considerable challenge for most people, and that post-birth support is as important as any other aspect of the surrogacy journey.

### **Discussion**

The findings presented here indicate a number of trends. First, there were more instances of negative experiences of support from clinics than there were positive. The second trend to emerge from the data was the perception from many participants

that clinics were either mercenary or solely clinical in their approach. The final trend to emerge was that even what is termed here as ‘positive support’ might otherwise be seen as a basic standard of care that any patient should expect.

In terms of specific advice to practitioners working in the field, the findings clearly suggest that what is needed is an approach to supporting gay intending parents that acknowledges that surrogacy arrangements represent more than just the getting of a child. Such arrangements represent the fulfilment of hopes and dreams that for many may be long-held, and are often accompanied by a complex and challenging journey to becoming a parent. Both offshore clinics and onshore services that may facilitate support and decision-making for intending parents would be wise to acknowledge such hopes, dreams, and journeys as a constant factor shaping how services are perceived and experienced. The implementation of a ‘network of care’, mentioned throughout the findings as desired by intending parents, would greatly increase the likelihood that they would feel more adequately supported and that they would view the service they receive as more than simply an exchange of goods. Such a network could be developed by offshore clinics and linked in with support services available in the intending parents' home country

Regarding gay men specifically, the assumption that not bearing a child personally places an intending gay parent as emotionally removed from a surrogacy arrangement is clearly flawed and marginalizing. Particularly with regard to pregnancy loss, clinic services, both offshore and onshore, will better serve gay clients if they are understood as sharing similar hopes, dreams and journeys with regard to parenthood as heterosexual parents.[20] This is not to discount the specificity of gay men’s experiences, but rather to acknowledge that the loss of a child is significant for all parties involved, regardless of their involvement in the genetic and reproductive conception of a child. Whilst no intended parent can be truly prepared for pregnancy loss, clinics will better serve their gay clients if greater attention is paid to this as a possible outcome of surrogacy arrangements, and that adequate support and counselling is provided, rather than immediately encouraging another surrogacy arrangement.

## **Conclusion**

This paper has focused on offshore commercial surrogacy arrangements, but the implications are applicable to clinics who offer onshore commercial services, in addition to services that aim to help intending parents in terms of decision making prior to conception and to offer support following the birth. While the findings may also be broadly applicable to heterosexual intending parents, for gay intending parents specifically, gendered assumptions about gay men *as men* may potentially shape the amount of emotional support offered by clinics, and indeed whether or not clinics view men's involvement and consultation in the pregnancy and birth process as necessary at all. All clinics and services that work with gay men to achieve the birth of a child through a surrogacy arrangement may thus improve their practice by considering the findings documented in this paper in terms of the emotional needs of gay intending parents, and to acknowledge especially that gay intending parents will benefit from ongoing support that extends beyond payment for the birth of a child. Given the positive findings from previous literature summarized earlier in the paper, in which the successes of gay men having children through surrogacy are highlighted, it is important to acknowledge that outcomes for both fathers and children may be even more positive if a more sustained network of care is available.

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### **Competing Interests**

None declared.

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