Nigerian Medical Journal
NIGERIA MEDICAL ASSOCIATION
Print ISSN 0300-1652, E-ISSN 2229-774X

Case Report

The Growing Trend of Surrogacy in Nigeria: Implications for Quality Newborn Care: A Case Report

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Abstract

Surrogacy involves a woman (surrogate) who consents to carry a pregnancy on behalf of an individual or a couple who cannot conceive for medical reasons. Surrogacy is gaining popularity in Nigeria among infertile couples, partly because surrogacy provides an easier means to having children than adoption. Surrogacy can be either gestational or traditional. Though surrogacy gives hope to infertile individuals, it also comes with peculiar challenges that affect the newborn with medical, ethical, and legal dimensions that caregivers need to be aware of.

We present three sets of preterm triplets conceived by Invitro fertilization (IVF), carried by gestational surrogacy, and managed in our facility. This case report highlights challenges encountered while managing these neonates to create awareness and suggest solutions and guidance to neonatal practitioners.

Topmost challenges include the unsustainability of feeding with the mother's own milk, lack of kangaroo mother care, abandonment of care by commissioning parents, delay in getting consent for treatment/procedures, determining the legal status of the child vis-à-vis simple issues such as changing the name of the child from that of the surrogate to that of the commissioning parents. The hospital's legal and welfare departments were key resource units and were involved early in managing these neonates. One baby from each set of triplets was successfully discharged home to the commissioning parents.

In conclusion, surrogacy is becoming increasingly common as a means of becoming parents for infertile individuals. There is an urgent need for proper regulation and legal framework for surrogacy and assisted reproduction in Nigeria.

Keywords: Surrogacy; Commissioning Parents; Newborn; Law; Assisted Reproduction; Medicolegal.

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How to cite: Ezenwa BN, Ibrahim UO, Moronkola OA, Fajolu IB, Ndukwu L, Oleolo-Ayodeji KO, et al. The Growing Trend of Surrogacy in Nigeria: Implications for Quality Newborn Care: A Case Report. Niger Med J 2024;65(5):792-799.https://doi.org/10.60787/nmj-v65i3.515 .

Quick Response Code:

Introduction

With the increase in infertility rates all over the world, more and more couples are looking into surrogacy to enable them to become parents[1,2] Surrogacy is a type of third-party reproduction in which a woman undertakes to carry a pregnancy for the commissioning parent(s) who cannot carry a pregnancy due to medical or social reasons.[1] A surrogate mother (or surrogate) is a woman who becomes pregnant through artificial means, either by insemination or embryo transfer, and carries the pregnancy for another couple or party with the sole aim of transferring the baby to the commissioning parents after she delivers. Usually, the other couple or individual could not have children by themselves. The couple who goes into this type of contract with a surrogate is referred to as intended parents or commissioning parents. Surrogacy is an age-old phenomenon that has been documented even in biblical times. When successful, it provides an easier path to having children for infertile couples than adoption in Nigeria.[3]

Surrogacy can be classified as gestational or traditional. Gestational surrogacy involves a woman known as a gestational carrier (or host) who agrees to bear a genetically unrelated child with the help of assisted reproductive technologies for an individual or a couple who intend to be the legal and rearing parent(s), referred to as the intended parent(s)[1,4] In this type, also called host surrogacy, the surrogate mother does not contribute genetically to the conception of the child and is strictly the carrier of the pregnancy. Traditional surrogacy is one in which the surrogate mother is the egg donor in addition to carrying the pregnancy, which is conceived either by artificial or natural insemination of spermatozoa or by in-vitro Fertilization technique. Here, the surrogate mother contributes genetically to the conception and is both the biological and gestational mother of the child. The sperm donor may be the intending father or another donor.[4]

Surrogacy can also be altruistic or commercial, depending upon whether the surrogate receives a financial reward for her pregnancy. In the case of altruistic surrogacy, a surrogate does not receive any monetary compensation, and most of these agreements often involve close relatives of the intended parents.[4] Commercial surrogacy contracts involve stipulation of the amount of monetary reward to gain. Many countries frown upon commercial surrogacy and only permit altruistic surrogacy arrangements.

There are various drivers of surrogacy in Western countries, such as infertility, medical conditions, same-sex couples' parenting, and other social reasons.[5]
In Nigeria, surrogacy is fast gaining ground, and the driver is majorly medical reasons, of which infertility is uppermost. It is becoming increasingly popular as a source of reprieve for couples unable to conceive for medical reasons.

All types of surrogacies are seen in Nigeria.[1,3] However, gestational surrogacy is becoming the more popular option due to legal challenges such as the identity of the rightful mother that may arise in traditional surrogacy.[1] As surrogacy becomes more widespread, many countries have enacted legislation to regulate surrogacy.[2,4] Nigeria is not one of these countries. Although the country does not prohibit surrogacy, it has not laid down any legal framework to govern the surrogacy process. This leaves both the intending couple and the surrogate mother, and even healthcare workers that deal with the products of these relationships, in a legal vacuum, wherein the parties are exposed to legal risks. [6]
Nigeria has no legal framework governing the process of assisted reproduction and surrogacy.[1] This then gives room to challenges and ambiguities in the care of the affected families, which may affect the care of the newborn. Though surrogacy gives hope to infertile individuals, it also comes with peculiar challenges that affect the newborn with medical, ethical, and legal dimensions that caregivers need to be aware of.

We present a case series of gestational surrogacy with three sets of triplets managed in our facility, highlighting the challenges encountered in their management to create awareness, suggest solutions, and guide neonatal practitioners.

Case Report

We present three sets of preterm triplets carried by gestational surrogacy and managed in our facility. All the triplets were IVF conceptions and were delivered preterm. Table 1 shows the baseline characteristics of the sets of triplets, while Table 2 shows the clinical characteristics and outcomes of the different triplets. All the triplets suffered respiratory distress syndrome, which was radiologically confirmed. Seven had suspected neonatal sepsis, which was culture-confirmed in only one triplet. One triplet also had associated congenital anomalies. We discharged four of the triplets and lost five (5/9 = 56% mortality; only two were perinatal deaths). The greatest challenges encountered during their management are listed in Table 3.

Table 1. Baseline characteristics of the three sets of triplets

Patients	**GA at delivery (weeks)**	**Maternal age (years)**	**Maternal parity**	**Type of surrogacy**	**Mode of conception**	**Mode of delivery**	**Evidence of legal contract**
OW Triplets	33	27	P1+0	Gestational	In-vitro fertilization	Cesarean section	Yes
OL Triplets	27	31	P3	Gestational	In-vitro fertilization	Vaginal delivery	No
AK Triplets	29	28	P4+2	Gestational	In-vitro fertilization	Cesarean section	Yes

Table 2. Clinical features and outcomes of the triplets

Patient	**Sex**	**Need for delivery room resuscitation/ Respiratory support in the first 48h**	**Weight**	**APGAR**	**Diagnosis at admission**	Final diagnosis if different	**Length of hospital stay**	**Outcome**
Baby OW 1	F	No/Yes	1830g	6^1 8^5	Respiratory distress syndrome	Respiratory distress syndrome	18 hours	Dead
Baby OW 2	F	Yes/Yes	1620g	4^1 8^5	Perinatal asphyxia	Early-onset	8 days	Died

						neonatal sepsis		
Baby OW 3	M	No/Yes	1640g	$6^1 8^5$	Respiratory distress syndrome	MDR-Klebsiella pneumonia sepsis	20 days	Discharged
Baby OL 1	F	Yes/Yes	760g	$4^1 7^5$	Respiratory distress syndrome	Early-onset neonatal sepsis	98 days	Discharged
Baby OL 2	F	Yes/Yes	920g	$2^1 5^5 8^{10}$	Respiratory distress syndrome	Intraventricular Haemorrhage	18 hours	Died
Baby OL 3	M	Yes/Yes	940g	$2^1 5^5 8^{10}$	Respiratory distress syndrome	Early-onset neonatal sepsis	12 days	Died
Baby AK 1	F	No/Yes	1080g	$6^1 7^5$	Respiratory distress syndrome	Early-onset neonatal sepsis	38 days	On admission
Baby AK 2	F	No/Yes	1410g	$6^1 9^5$	Respiratory distress syndrome	Early-onset neonatal sepsis	38 days	Discharged
Baby AK 3	M	Yes/Yes	1210g	$5^1 8^5$	Respiratory distress syndrome In a child with multiple congenital anomalies	Early-onset neonatal sepsis in a child with Bilateral cleft lip and palate Congenital amniotic band syndrome	9 days	Died

Table 3. Identifiable Challenges that affected quality care of the neonates

PATIENTS	Challenges Affecting Quality Care
OW Triplets	Prematurity
	Low birthweight
	Unavailability of human milk (only available for the first 2 weeks of life)
	Multidrug-resistant Klebsiella pneumoniae sepsis
OL Triplets	Extreme prematurity
	Extremely low birthweight
	Unavailability of human milk (only available for the first week of life)
	Multidrug-resistant Klebsiella pneumoniae sepsis
	Intraventricular haemorrhage
	Retinopathy of prematurity (1st triplet)
	Financial constraint
	Abandonment of care by the commissioning parents at a point.
	The physical absence of commissioning parents from point of admission to discharge (Commissioning mother had no form of interaction with babies)
	Delay in getting consent for procedures as proxies must communicate over the phone to the commissioning parents and wait for decisions.
	Unavailability of Kangaroo mother care (proxies were only available occasionally)
AK Triplets	Prematurity
	Very low birthweight
	Unavailability of human milk (only available for the first 2 weeks of life)
	Sepsis
	Congenital anomalies (bilateral cleft lip and palate, and congenital constriction band of the arm in the third triplet)

Discussion

Surrogacy is regarded as an option to overcome childlessness by many devotees and is being utilized rapidly in Nigeria.[1,3,6] Though surrogacy is not prohibited in Nigeria, there is no law regulating its process. Most parents seeking fertility care in Nigeria choose the transfer of multiple embryos after in-vitro fertilization, which explains why the majority of surrogacy cases in Nigeria are multiple gestations. The implications for the newborn include the risk of preterm birth and prematurity and its various complications, increased risk of congenital malformations, and intrauterine growth restriction. Though cases of surrogacy involving multiple gestations may not present with medical problems for the babies if they are delivered at term or close to term, many cases still end up as preterm deliveries. The three sets of triplets in this case report were preterm, with one having congenital abnormalities. All the babies were of low birth weight (LBW). Studies have shown that babies born via surrogacy and assisted reproductive technologies are more at risk of being born with low birth weight.[7]

Due to the high rate of multiple embryo implantation, the risk of preterm birth increases with surrogacy in Nigeria. Also, the higher the order of multiples the more prone to prematurity and LBW the products will be compared to singleton pregnancies.[7] Although surrogacy is popular in Nigeria, it remains affordable only to those in the middle to upper socioeconomic class, most of whom live abroad and earn in foreign currencies. Because of the prohibitive cost involved, the desire to boost success is usually very high, leading to the transfer of multiple embryos with its multiple obstetric challenges.[8]

Top neonatal challenges include the immediate separation of the surrogate mother and baby, leading to the interruption of the natural maternal-infant bonding. This lack of bonding may have started in utero. All the surrogate mothers in this study were reluctant to initiate breastfeeding. One of the surrogate mothers left the hospital shortly after birth due to the end of her agreement with the intended parents. The consequences of feeding preterm infants with non-human milk are well known. Surrogacy makes it difficult and unsustainable to feed these vulnerable infants with their mother's own milk. The World Health Organization (WHO) has recommended skin-to-skin care as an important intervention for preterm infants.[9,10] Despite the well-documented benefits of skin-to-skin care or kangaroo mother care in the survival of preterm infants,[9,10] we were not able to sustain this intervention for these babies as the surrogates, intended parents, and proxies were unavailable for KMC.

Other challenges encountered include a lack of preparedness for financing the care of the extreme preterms as intended parents never expected such preterm delivery and various complications. They became reluctant and stopped contributing to the care of the babies for a long time due to a perception of future impairments if the babies survived. Abandonment of newborns with impairments in surrogacy has also been reported in China.[11] This abandonment may be because the commissioning parents had yet to develop any bonding or connection with the infants. In contrast, the surrogate mother has completed her contract.

Another challenge experienced in the care of the babies was the delay in getting consent for procedures such as treatment of retinopathy of prematurity as most of the intended parents were not available, and proxies also lived far away from the hospital. Delays have been found to narrow the therapeutic window of quality lifesaving treatments and interventions.[12] Determining the legal status of the child vis-à-vis simple issues such as changing the name of the child from that of the surrogate to that of the commissioning parents was also a subtle challenge to note. Newborn case files are usually opened in the birthing mother's name in our hospital. Changing it to that of the commissioning parents requires some legal procedures, too. The hospital's legal and welfare departments were key resource units involved early in managing these neonates. Their importance should not be underscored, especially in our country,

where there is no guideline or legal framework to fall back on. Their advice and guidance cannot be replaced.

Conclusion

Surrogacy is increasingly common as a means of becoming parents for infertile individuals or couples. Newborns of surrogacy face peculiar challenges, especially when born preterm. There is an urgent need for proper regulation and legal framework for surrogacy and assisted reproduction in Nigeria.

Recommendations

Laws should be made to regulate the practice of surrogacy in Nigeria, including a law limiting the maximum number of embryos to be transferred in assisted reproduction.

Legal experts who have experience in reproductive medicine and ethics should be involved at every point, including before starting assisted reproduction.

Counseling should be extensive, repeated as necessary, and should start even before the process of IVF is underway. This should include discouraging the implantation of multiple embryos, discussing the entire process, and describing the implications for the newborn.

There should be a written contract between the surrogate mother and the intended parents clearly spelling out the responsibilities of each party.

The concepts of breastmilk banking and engaging the services of wet nurses should be considered.

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