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Regulating surrogacy frequency and the age of surrogate mothers in South Africa: The imperative for legislative limits

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Chapter 19 of the Children's Act 38 of 2005 (the Act) establishes the legal framework for regulating surrogate motherhood in South Africa (SA). Section 295 prescribes specific requirements that must be satisfied for a High Court to confirm a surrogacy agreement. However, significant *lacunae* persist in practical application of the Act, partly ascribed to the absence of regulations regarding certain aspects of surrogacy. Two pertinent issues are the lack of clarity concerning the maximum number of times a woman may serve as a surrogate mother, and the age limitation of a proposed surrogate mother. These gaps necessitate legislative attention to ensure consistency, safety, and ethical integrity in SA's surrogacy framework.

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The South African Children's Act 38 of 2005 (the Act),[1] delineates the prerequisites for High Court confirmation of surrogacy agreements. Specifically, sections 295(a), 295(b) and (c) outline requirements for commissioning parents and surrogate mothers. Commissioning parents must be permanently unable to conceive or bear a child, competent to enter into an agreement, suitable to assume parenthood, and fully cognisant of the legal implications, rights, and obligations arising from the agreement. The surrogate mother must similarly be competent, suitable in all respects to act as a surrogate, understand the legal consequences, rights, and obligations under the Act, and surrogacy must not be pursued for financial gain but for altruistic motives. The surrogate must have a history of at least one successful pregnancy and viable delivery and have a living child of her own. The High Court is mandated to consider the personal circumstances and family situations of all parties, prioritising the best interests of the child to be born.

The judgment in *Ex parte JVDM and Others* (JVDM),[2] examines section 295 of the Act and raises a pivotal issue: whether a legal limit should be imposed on the number of times a woman may act as a surrogate mother, given the inherent risks of pregnancy and childbirth to both the surrogate and the fetus.

This article analyses the JVDM judgment, and evaluates the health risks associated with multiple pregnancies and caesarean sections. Furthermore, it evaluates the risks associated with advanced material age of a proposed surrogate and of fertility treatment, and advocates for regulatory reform to limit the frequency of surrogacy engagements, drawing on comparative legislative frameworks.

The judgment in *Ex parte JVDM and Others*

In *Ex parte JVDM and Others*,[2] the applicants sought High Court confirmation of a surrogacy agreement. The first and second applicants, married on 29 January 2022 after a decade-long relationship, had a three-year-old daughter. The first applicant suffered a ruptured uterus during her second pregnancy at 20 weeks, resulting in loss of the fetus and an emergency peripartum hysterectomy. She was unable to gestate further pregnancies as a result thereof (paragraphs 2, 4 and 5). The third applicant, the proposed surrogate, aged 33, had three children of her own, all delivered via caesarean section, and had previously acted as a surrogate twice, delivering twins in 2022 and a singleton in 2023, both via caesarean section. This application marked her third surrogacy and would require a sixth caesarean procedure (paragraphs 9 and 10).

Neukircher J addressed two critical questions: (i) whether the surrogate complied with section 295(c)(ii) of the Act (whether the surrogate was in all respects a suitable person to act as surrogate mother), given her history of five previous caesarean sections, and (ii) whether a legal limit should be imposed on the number of times a woman may act as a surrogate. A reproductive medicine specialist testified that prior caesarean sections do not preclude further pregnancies if the uterus remains healthy, emphasising the proposed surrogate's current clinical condition over the number of surgeries (paragraph 11). A gynaecologist-obstetrician similarly confirmed that no universal limit exists on caesarean sections, as risks would depend on the individual women's health profiles (paragraph 13). The Centre for Child Law, as *amicus curiae*, highlighted the absence

of South African (SA) regulations limiting surrogacy frequency and recommended legislative reform to address this gap (paragraphs 18 and 22). The court granted the application, finding compliance with the Act and no medical contraindications for the surrogate's sixth caesarean section. However, the court noted that jurisdictions such as India and Vietnam impose limits on the frequency that women may act as surrogates, but that SA lacks such restrictions (paragraph 25). The position in India and Vietnam is addressed further below.

Risks associated with pregnancies and childbirth

Pregnancy and childbirth entail significant risks for both the mother and fetus that escalate with multiple pregnancies. Hung,[3] notes that risks increase after three or four pregnancies, particularly among socioeconomically disadvantaged women. Pre-existing risk factors include maternal age, weight, prior pregnancy complications, and certain medical conditions.[4] Women aged 35 or older face elevated risks of pre-eclampsia, gestational diabetes, chromosomal abnormalities, stillbirth, and complications such as placental abruption (placenta separates prematurely from the uterine wall) or placenta praevia (placenta implants low in the uterus and partially or completely cover the cervix).[4] Five or more pregnancies increase the risk of very rapid labour and excessive bleeding after the delivery.[4] Maternal obesity increases the likelihood of macrosomia, birth defects, miscarriages, and caesarean delivery, while underweight women risk delivering low-birthweight infants.[4] Structural uterine or cervical abnormalities heighten risks of miscarriage, preterm labour, and caesarean necessity.[4]

Caesarean deliveries, compared with vaginal births, are associated with doubled risk of severe maternal morbidity, including postpartum haemorrhage, infection, and perineal lacerations.[5] Neonatal risks include respiratory distress syndrome and transient tachypnoea, attributed to the absence of labour-induced physiological changes.[6] High-risk pregnancies may also predispose children to behavioural issues, respiratory conditions, and developmental delays.[6]

Risks inherent to fertility treatment

Fertility treatments, such as *in vitro* fertilisation (IVF) used in surrogacy, introduce additional risks to both surrogate mothers and commissioned children. IVF stimulation protocols increase the incidence of thromboembolic events, such as deep vein thrombosis,[7] while pregnancy-related risks include ectopic gestation and multiple gestations,[8] although the latter can be mitigated by limiting embryo transfers. Assisted reproductive technologies (ART) carry a 30 - 40% higher risk of fetal congenital anomalies, and mothers may experience increased rates of labour induction and caesarean delivery.[9] Placenta praevia is also more prevalent in ART pregnancies.[4] The American Society for Reproductive Medicine aptly observes that although a child may not, strictly speaking, be "harmed" as a result of fertility procedures that made its birth possible, concerns about future harm to offspring may be validly taken into account when making ethical assessments about those treatments.[10]

Ethical concerns arise regarding how ART pregnancies may potentially affect children in the long term, as ART may contribute to developmental risks, underscoring the need to balance reproductive autonomy with child welfare.[11]

Risks inherent to advanced maternal age

Although JVDM[2] did not mention the issue of advanced maternal age (AMA) in surrogacy, this aspect merits discussion. AMA refers to women over the age of 35 years, and is associated both with the risks of female infertility and of advanced-age pregnancies for both the woman and the child(ren).[12] Importantly, ART cannot guarantee a live birth as the medical interventions themselves are risky.[13] It is a well-known fact that a woman's fertility begins to decline throughout her 30s, the decrease becoming more prominent by the age of 35 years and accelerating further after the age of 40.[14] If a surrogacy agreement is to be in the commissioned child's best interests, the risks involved should be considered should the proposed surrogate become pregnant as a result of IVF treatment. Although section 295 of the Children's Act[1] does not impose a fixed age limit for the proposed surrogate, we propose that an age limit be introduced to safeguard the commissioned child(ren) and surrogate mothers' health and wellbeing. The surrogate's maternal age limit should be distinguished from the age limit of the oocyte donor. An oocyte donor's age limit is set according to an ART procedure's success rate, which begins to decline when a woman reaches the age of 40 and older.[14] Medical complications are more common for advanced-aged pregnant women, and may include cardiac disease, hypertension, diabetes, placental abruption and caesarean delivery.[4] For the fetus, the risks include chromosome abnormalities, decreased birthweight and death.[14] We submit that setting an age limit as one of the requirements for becoming a surrogate mother constitutes a justifiable and reasonable limitation under the Constitution of the Republic of South Africa, 1996[15] of a woman's rights to equality (section 36) and to reproductive health care (section 27(1)(a)) in the context of assisted reproduction.

An age limit for surrogate mothers aligns with the legal comparative overview below, which explores the frequency of surrogacies per surrogate mother and a fixed age limit for surrogate mothers.

Comparative analysis of surrogacy laws: Restrictions on frequency and rationale

Surrogacy laws vary significantly across jurisdictions, reflecting diverse cultural, ethical, and medical considerations. There are currently key differences in restrictions on the number of times a woman may act as a surrogate. As will be discussed below, India restricts women to acting as surrogates no more than three times,[16] while Vietnam limits surrogacy to once per woman.[17] In contrast, jurisdictions such as SA, the Netherlands, the United Kingdom, Greece, and Russia impose no explicit limits on surrogacy frequency. The next section briefly examines some of the provisions in these jurisdictions as well as in Australia, Canada and Ukraine.

India

The Indian Surrogacy (Regulation) Act, 2021[18] explicitly caps surrogacy at three instances per woman to mitigate health risks associated with repeated pregnancies, such as uterine scarring and psychological strain. This restriction applies to both altruistic and commercial surrogacy arrangements, although section 3(ii) of the Act bans commercial surrogacy. The cap reflects a precautionary approach, prioritising the surrogate's health amid concerns about exploitation in India's previously unregulated surrogacy industry.[19]

Section 2 of the Surrogacy (Regulation) Act,[18] fixes the legal age limit of a proposed surrogate in India to between 35 and 45 years.

Vietnam

Vietnam's Law on Marriage and Family permits surrogacy only once per woman and solely for altruistic purposes, typically for close relatives.[20] This limit aims to prevent commercialisation and protect women from the physical and emotional toll of multiple surrogacy cycles. The law emphasises ethical considerations, ensuring surrogacy serves familial rather than financial motives.[20] Article 95 of the Law on Marriage and Family does not provide an age restriction for the proposed surrogate mother.[20]

South Africa

In SA, the Regulations Relating to the Artificial Fertilisation of Persons (2012) limit gamete donors to six conceptions but do not address surrogacy frequency.[21] The Children's Act, which governs surrogacy requires court approval for surrogacy agreements but does not impose caps on how often a woman may act as a surrogate (section 295).[1] This lack of restriction may indicate focus on individual autonomy and less concern about health risks, although it raises questions about potential gaps in protecting surrogates from exploitation. The Children's Act[1] does not impose an age restriction for the proposed surrogate, nor do any regulations promulgated under the Act.

Netherlands, United Kingdom, Greece, and Russia

No statutory limits are imposed on surrogacy frequency in these jurisdictions. The Netherlands,[22] and the United Kingdom,[23] permit altruistic surrogacy and regulations focus on consent and legal parentage rather than frequency caps. No age restriction is set in the UK Surrogacy Arrangements Act, 1985.[23]

Greece allows altruistic surrogacy with judicial oversight but does not regulate the number of surrogacy cycles.[24] Article 1458 of the Greek Civil Code determines the permissible age limit for a surrogate to between 25 and 45 years.[25]

Russia, known for its permissive stance on commercial surrogacy, similarly lacks restrictions, prioritising access to surrogacy services over health-based limits.[26] The absence of frequency caps in these countries may reflect confidence in medical oversight or differing cultural attitudes toward reproductive autonomy.[27] The Russian Federal Law sets the age limit for surrogate mothers at between 20 and 35 years.[26]

Australia

Surrogacy laws vary by state in Australia, but altruistic surrogacy is the norm and commercial surrogacy is prohibited. For example, the state of Victoria's Assisted Reproductive Treatment Act, 2008[28] does not impose a specific limit on the number of times a woman may act as a surrogate, although clinics often follow ethical guidelines recommending against excessive surrogacy cycles to protect health. Queensland and New South Wales similarly lack statutory caps but emphasise rigorous counselling and medical screening to mitigate risks.[29] We submit that this approach balances autonomy with medical caution, relying on professional discretion rather than legislative limits. The Australian Law Reform Commission (ALRC) is currently reviewing surrogacy laws to propose a more uniform national framework, and a final report is expected by July 2026. The Commission has been asked to deliver its final report to the Attorney-General by 29 July 2026, though the deadline has been extended to 11 September 2026, with the latest possible public release by 18 November 2026. Although the Australian states follow different policies, a surrogate mother's minimum age limit is fixed at 25 years.[30]

Canada

Canada's Assisted Human Reproduction Act, 2004[31] permits only altruistic surrogacy and does not set a federal limit on surrogacy frequency.[31] However, guidelines and fertility clinics often recommend limits based on medical risks, typically advising no more than three to five pregnancies (including surrogacy and natural births) to minimise complications such as placental abnormalities.[32] Provinces such as Ontario and British Columbia[33] rely on contractual agreements and medical oversight rather than statutory caps, reflecting a flexible but health-conscious approach.[34] The Assisted Human Reproduction, 2004 sets the minimum age for a surrogate mother at 21 years (section 6(4)), but does not impose an upper age limit.[31]

Ukraine

Ukraine, a hub for commercial surrogacy, imposes no legal restrictions on the number of times a woman may act as a surrogate.[35] The Family Code of Ukraine, 2002,[35] regulates surrogacy but focuses on legal parentage and contractual obligations rather than health-based limits. This permissive stance has drawn criticism for potentially exposing surrogates to health risks, particularly in a country where economic incentives drive participation in surrogacy programmes.[36] Medical clinics in Ukraine often set internal guidelines, but these are not legally binding. Ukrainian legislation sets the age for surrogate mothers at between 20 and 35 years.[35]

Comparative insights

The variation in surrogacy frequency restrictions reflects differing priorities. India and Vietnam adopt precautionary approaches, prioritising surrogate health and ethical concerns via strict caps on surrogacy frequency. In contrast, SA, the Netherlands, the United Kingdom, Greece, Russia, Australia, Canada, and Ukraine rely on medical oversight, ethical guidelines, or individual autonomy rather than legislative limits. These differences highlight tension between protecting surrogates and preserving access to reproductive technologies. Jurisdictions without caps may assume that medical professionals and surrogates can make informed decisions, although the lack of caps risks overlooking cumulative health implications, as evidenced by studies linking repeated pregnancies to increased risks of hypertension and uterine complications. Regarding fixed age ranges or restrictions for surrogate mothers, India, Greece, Russia and Ukraine have established specific age limits for proposed surrogate mothers. These restrictions aim to protect both the surrogate mother and the commissioned child.

Conclusion

The JVDM[2] judgment underscores a critical gap in SA surrogacy law: the absence of regulations limiting the number of times a woman may act as a surrogate. While the court upheld the surrogacy

agreement based on medical assurances and compliance with the Children's Act,[1] the risks associated with multiple pregnancies, caesarean sections, and fertility treatments demand legislative attention. Comparative jurisdictions such as India and Vietnam demonstrate that restricting surrogacy frequency is a feasible and prudent measure to safeguard maternal and fetal health.

The brief overview of the surrogacy regulation global landscape reveals a spectrum of approaches, from tightly controlled systems in India and Vietnam to more permissive frameworks in SA, Australia, Canada, and Ukraine. Expanding regulations in SA to include evidence-based limits on surrogacy frequency, as in India, would enhance surrogate protections without unduly restricting reproductive freedoms. Similarly, imposing an age range for surrogate mothers in SA would further protect the interests of all parties to the surrogate agreement. For example, Indian constitutional jurisprudence, considered to be an instructive and comparable example for the SA Bill of Rights (Chapter 2 of the SA Constitution),[15] is often referenced when rights in the SA Constitution are interpreted.[37] We opine that the Indian surrogacy limitations provide a valuable guideline for the SA regulatory framework, in which the omission to impose the limits discussed in this article indirectly prioritises reproductive autonomy over the commissioned child's and the surrogate's best interests and wellbeing.

To align with prudent and justifiable best practices discussed in this article, including emphasising health and ethical considerations, the SA legislator should amend the Children's Act [1] to establish a maximum number of surrogacy engagements, potentially capping them at three, as in India, and should consider introducing an age range limit of between 20 and 35 years for surrogate mothers to protect individual health risks. The argument that examples of women far beyond 40 years carrying pregnancies successfully to term exist, is not convincing and adequate to justify exclusion of a maternal age restriction. These few cases are rather the exception than the norm in accordance with existing medical evidence. Similarly, a proposed age range limit of between 20 and 35 for surrogate mothers provides a useful yardstick for courts. Nothing stops applicants in the surrogate agreement confirmation application from presenting medical evidence to convince a court that deviation from this age range is justified in specific cases.

We submit that the proposals for the limitations discussed in this article present a satisfactory compromise between all relevant parties' rights, including those of the commissioning parents, surrogates, and the prospective children, ultimately fostering a more equitable and safer surrogacy framework. However, changes in clinical evidence over time should be factored into the framework so that it can be revised to record medical developments in maternal health and fertility.

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