

## ÉDITORIAL

# Renforcer les systèmes de données pour promouvoir la santé et les droits sexuels et reproductifs en Afrique subsaharienne

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Le développement de la santé et des droits sexuels et reproductifs (SDSR) en Afrique subsaharienne est fondamentalement entravé par la « pauvreté des données de santé »<sup>1</sup>. Si de nombreux pays à revenu élevé ont réalisé des progrès significatifs dans le renforcement de leurs systèmes de données de santé, l'Afrique subsaharienne continue de faire face à d'importantes lacunes<sup>1-3</sup>. Malgré le besoin crucial de pratiques fondées sur des données probantes, le paysage régional des données est caractérisé par une méconnaissance généralisée de la valeur intrinsèque de données exactes. De nombreux pays de la région ne disposent pas de recensements de population réguliers, de dossiers de santé fiables ni de systèmes fonctionnels d'état civil et de statistiques vitales.

L'exactitude des données est souvent compromise par une réticence profondément ancrée des populations à fournir des informations personnelles. Dans de nombreux contextes africains, les tabous culturels, les croyances religieuses et la méfiance envers les « étrangers » entraînent des taux de refus élevés lors des enquêtes menées auprès des ménages et dans les établissements de santé. Par exemple, une étude menée en Afrique du Sud a mis en évidence comment des femmes peuvent refuser de parler de santé reproductive en raison d'une opposition religieuse ou par crainte d'être jugées par les chercheurs<sup>4</sup>. Les données sont parfois sujettes à la falsification et au biais de désirabilité sociale. Les personnes interrogées « apprennent » souvent à répondre de manière à minimiser la longueur des questionnaires, par exemple en déclarant moins de partenaires sexuels pour éviter les questions complémentaires.<sup>5</sup>

Plus grave encore, la crainte de répercussions juridiques ou sociales conduit à la dissimulation active d'informations sensibles par les individus et les établissements de santé. Des personnes ont déclaré avoir menti sur leur statut sérologique ou sur les violences sexistes qu'elles ont subies par crainte d'une intervention policière ou de la stigmatisation sociale.<sup>4</sup>

Même lorsque des données sont disponibles, on observe une minimisation et une non-utilisation systématiques des informations factuelles pertinentes pour la prise de décision et la planification stratégique. L'institutionnalisation du suivi fondé sur les données demeure faible et les plans annuels sont souvent élaborés sans tenir compte des informations sanitaires courantes.<sup>6</sup> Dans de nombreux cas, la planification fondée sur des données probantes est supplantée par l'ingérence politique et le népotisme, où les intérêts politiques — plutôt que les données empiriques — déterminent quels programmes de santé sont mis en œuvre et qui est nommé pour les diriger.<sup>7</sup> Sans s'attaquer à ces barrières culturelles et structurelles, les systèmes de données continueront de produire des informations de mauvaise qualité qui ne permettront pas d'améliorer significativement les résultats en matière de santé sexuelle et reproductive dans la région.<sup>1,8</sup>

Depuis la Conférence internationale sur la population et le développement (CIPD) du Caire en 1994 et jusqu'aux Objectifs de développement durable (ODD) pour 2030, la santé sexuelle et reproductive est reconnue comme un droit humain fondamental.<sup>9-11</sup> Ce droit est désormais inscrit dans les politiques nationales de santé et les cadres juridiques de nombreux pays.

Le droit à la santé sexuelle et reproductive comprend l'accès à la contraception, aux soins de fertilité et d'infertilité, aux services de santé maternelle et périnatale, à la prévention et au traitement des infections sexuellement transmissibles, à la protection contre les violences sexuelles et sexistes, et à l'éducation à des relations saines et sans risque.<sup>12</sup> comprend également le droit à l'information et la capacité de faire des choix éclairés concernant sa vie reproductive.

Lorsque cet accès est retardé ou refusé, les conséquences peuvent être graves, notamment le décès, un handicap permanent et des difficultés socio-économiques. Pour que ces droits se concrétisent, les systèmes de santé ont besoin de systèmes de données robustes. Des données précises, actualisées et

## ORIGINAL RESEARCH ARTICLE

# Understanding the social, emotional and economic challenges of surrogate mothers in Ghana: A phenomenological study

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## Abstract

Surrogacy is an emerging assisted reproductive practice in Ghana that expands pathways to parenthood but presents significant challenges for surrogate mothers. This study examines the lived experiences of surrogate mothers in Accra, focusing on the physical, emotional, social, and economic difficulties they face. The study adopted a phenomenological qualitative approach. 21 surrogate mothers were purposively sampled from three agencies in the Greater Accra Region. Data were collected through semi-structured interviews and analysed thematically. The findings show that surrogates experience intense social stigma. Emotional distress, ranging from depression to symptoms of post-traumatic stress, often stems from abrupt separation from babies and limited psychological support. Physical challenges, including pregnancy complications and unwarranted caesarean sections, further shape their experiences. Economic exploitation emerged as a critical issue, with participants dissatisfied with inadequate compensation and minimal bargaining power. Surrogacy additionally strained personal relationships, with several women reporting partner conflict or separation. The study underscores the urgent need for regulatory frameworks that safeguard the rights and well-being of surrogate mothers. Clear legislation, mandatory counselling, fair compensation, and public education to reduce stigma are recommended. The study contributes to the limited literature on surrogacy in sub-Saharan Africa and offers insights for improving practice in Ghana. (*Afr J Reprod Health* 2026; 30 [12]:62-72).

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**Keywords:** Surrogacy, Ghana, Stigma, Commodification, Exploitation

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## Résumé

La gestation pour autrui (GPA) est une pratique de procréation médicalement assistée émergente au Ghana qui élargit les possibilités d'accéder à la parentalité, mais présente des défis importants pour les mères porteuses. Cette étude examine le vécu des mères porteuses à Accra, en se concentrant sur les difficultés physiques, émotionnelles, sociales et économiques auxquelles elles sont confrontées. L'étude a adopté une approche qualitative phénoménologique. Un échantillon ciblé de 21 mères porteuses a été constitué à partir de trois agences de la région du Grand Accra. Les données ont été recueillies au moyen d'entretiens semi-structurés et analysées thématiquement. Les résultats montrent que les mères porteuses subissent une forte stigmatisation sociale. La détresse émotionnelle, allant de la dépression aux symptômes de stress post-traumatique, découle souvent de la séparation brutale d'avec les bébés et du manque de soutien psychologique. Les difficultés physiques, notamment les complications de grossesse et les césariennes non justifiées, influencent également leur vécu. L'exploitation économique est apparue comme un problème majeur, les participantes se plaignant d'une compensation insuffisante et d'un faible pouvoir de négociation. La GPA a également mis à rude épreuve les relations personnelles, plusieurs femmes faisant état de conflits ou de séparations avec leur partenaire. Cette étude souligne l'urgence de mettre en place des cadres réglementaires garantissant les droits et le bien-être des mères porteuses. Elle recommande une législation claire, un accompagnement obligatoire, une juste rémunération et une sensibilisation du public afin de réduire la stigmatisation. L'étude contribue à la documentation, encore peu abondante, sur la gestation pour autrui en Afrique subsaharienne et propose des pistes d'amélioration des pratiques au Ghana. (*Afr J Reprod Health* 2026; 30 [12]: 62-72).

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**Mots-clés:** Gestation pour autrui, Ghana, stigmatisation, marchandisation, exploitation

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## Introduction

Surrogacy represents a transformative advancement in assisted reproductive technologies (ARTs), offering new pathways to parenthood for individuals and couples facing infertility or other

reproductive challenges. However, the practice is fraught with complex social, ethical, and medical implications, particularly for the women who undertake the role of surrogate mothers. While extensive research has explored the legal and ethical dimensions of surrogacy,<sup>1-3</sup> the lived

experiences of surrogate mothers remain underrepresented, especially in sub-Saharan Africa.

Taebi, Alavi, Ahmadi emphasize that surrogate mothers frequently report physical and emotional fatigue, exacerbated by a lack of comprehensive healthcare support.<sup>4</sup> These challenges are compounded by psychological stressors, including the potential for post-partum depression and the emotional complexities of relinquishing the child to the intended parents.<sup>5</sup>

Social stigma further complicates the experiences of surrogate mothers, particularly in cultures where traditional notions of motherhood are deeply entrenched. Yeshua-Katz and Khvorostianov highlight that surrogate mothers often resort to secrecy as a coping strategy to navigate societal judgment and accusations of immorality.<sup>6</sup> Similar findings are reported in studies from India, where surrogate mothers are stigmatized as “baby sellers” and ostracized by their communities.<sup>7</sup>

Exploitation is another critical issue in surrogacy arrangements, particularly in contexts where economic disparities influence participation. Studies from India and other low-income settings suggest that financial necessity often drives women to become surrogates, rendering them susceptible to exploitation by commissioning parents and intermediaries.<sup>8</sup> Carsley and Deonandan, Green, van Beinum caution that inadequate regulatory frameworks exacerbate these vulnerabilities, with surrogate mothers frequently receiving minimal compensation relative to the physical and emotional sacrifices involved.<sup>9,10</sup> The commodification of reproductive labour thus raises profound ethical concerns, challenging notions of autonomy, agency, and justice.

Despite these global insights, the experiences of surrogate mothers in Ghana remain largely undocumented. This lack of empirical evidence hinders the development of policies and practices that prioritize the health, rights, and well-being of surrogate mothers.

As surrogacy continues to gain traction in Ghana, it is imperative to examine how surrogate mothers navigate the physical demands, social stigma, and ethical dilemmas inherent in their roles. Such research is vital not only for protecting their interests but also for fostering a more equitable and

ethically sound approach to surrogacy in the Ghanaian context.

Building on global studies,<sup>11-13</sup> this article aims to contribute to the nascent body of literature on surrogacy in Ghana by exploring the lived experiences of surrogate mothers. It seeks to illuminate their challenges and coping strategies, situating these narratives within the broader socio-cultural and economic landscape. By doing so, this study underscores the urgent need for comprehensive frameworks that safeguard surrogate mothers and promote ethical practices in this evolving reproductive terrain.

## Methods

### *Research design and setting*

This study forms part of a larger research project that explores the lived experiences of surrogate mothers in Ghana. A phenomenological qualitative research design was adopted to align with the study's objectives. Twenty-one participants were recruited from three privately owned surrogate agencies in the Greater Accra Region of Ghana, specifically located in Tema, Osu, and Labone. The Greater Accra Region was chosen as it hosts 15 out of the 19 in-vitro fertilization (IVF) facilities in the country.

### *Sampling*

The three surrogate agencies were purposively selected through the Fertility Society of Ghana provided us with contact details of five agencies and three agreed to participate. These agencies, referred to as Agency L, Agency O, and Agency T for ethical reasons, offer various infertility management services, including gamete donation and surrogacy.

The participants were surrogate mothers recruited by these agencies from across Ghana. Participants were either currently pregnant as surrogate mothers (with a gestational age of 16 weeks or more) or had delivered within two years of providing surrogate services. These criteria ensured participants could accurately recall their experiences and motivations. Women with pregnancies of less than 16 weeks were excluded,

as they might lack sufficient experience regarding antenatal care.

### **Data collection**

Data were collected between 10<sup>th</sup> December 2020 and 27<sup>th</sup> June 2021 using a semi-structured interview guide. In interview guide was divided into three main sections. The first section contained questions on socio-demographic characteristics. The second section dealt with motivations for getting into surrogacy, and the last section had items on the challenges faced by surrogate mothers. All interviews were conducted on phone due to the sensitive nature of the topic and the desire of participants to remain anonymous. This approach was further necessitated by the constraints of the COVID-19 period. On the average, all interviews lasted between 45 to 60 minutes. A total of 21 surrogate mothers participated in the study (See Table 1). The sample size was determined based on data saturation. Interviews lasted between 40 minutes and an hour. 17 interviews were in Twi, three in English, and one in Ga. With participants' consent, all interviews were audio-recorded.

### **Data analysis**

Thematic analysis, guided by Braun and Clarke's (2006) approach, was employed. Interviews were transcribed verbatim by the third author and a trained research assistant. Transcriptions of interviews conducted in Ga and Twi were translated directly into English. To ensure accuracy, all authors independently compared the transcriptions with the audio recordings. Transcripts were then uploaded into NVivo (Version 10) for analysis.

The analysis began with repeated readings of the transcripts to ensure familiarity with the data. During this process, ideas for coding were noted. Subsequently, the data was coded using NVivo, with equal attention given to all data items. Multiple codes were created, which were organized into potential themes as parent nodes in NVivo. These themes were theory-driven and aligned with the research questions. The coding and development of themes were done by the first and second authors separately to ensure inter-coder reliability.

The final themes reflected recurring patterns of meaning within the data in relation to the

research aim, the challenges of surrogate mothers in Ghana. All extracts presented are verbatim reproductions from the data

### **Ethical considerations**

The Ethics Committee for the Humanities at the University of Ghana (ECH 039/20-21) approved the study. Participants were informed that participation was voluntary, and they could withdraw at any point without repercussions. Verbal informed consent was obtained since face-to-face meetings were not possible. Confidentiality and anonymity were assured, with pseudonyms used for both participants and facilities in reporting. The research followed the Helsinki Declaration on ethical principles of research involving human subjects.

## **Results**

### ***Social stigma and management of information***

Stigma is a discrediting attribute that leads others to view a person negatively and stereotypically.<sup>14,15</sup> The data show that some surrogates anticipated such stigma and prepared strategies to manage it. Many hid their involvement in surrogacy from family and friends. Two main approaches emerged: first, avoiding any intentional disclosure by keeping their surrogacy status secret; and second, not retaining copies of their surrogacy agreements to prevent accidental exposure. These strategies are discussed further below.

### ***Not retaining a copy of surrogacy agreement***

One strategy surrogate mothers employed to avoid enacted stigma and maintain their discreditable status was deliberately choosing not to keep a copy of the surrogacy agreement. This decision stemmed from their apprehension that other family members or close associates might inadvertently discover the document. Such a discovery could potentially shift their status from being discreditable to being discredited. By eliminating any material traces, surrogate mothers safeguarded their privacy and mitigated the risk of stigmatization in their immediate social environments. For instance, when

**Table 1:** Socio-demographic characteristics

Item Description	n
<b>Age:</b>	
20-25	3
26-30	10
31-35	5
36-40	3
<b>Ethnicity:</b>	
Akan	10
Ga Dangme	7
Ewe	3
Frafra	1
<b>Marital Status:</b>	
Married	6
Not married	15
<b>Level of Education:</b>	
Junior High School	7
Senior High School	12
Tertiary	2
<b>Occupation:</b>	
Trading	8
Hairdressing	5
Waitress	2
Cleaner	1
Unemployed	3
Student	2

it was inquired from Ophelia if she has a copy of her surrogacy agreement, she responded:

*“No please. I didn’t even ask for a copy because I don’t want it to be seen by anyone later. You don’t know what people will say about you when they hear of it.” (Ophelia, 26-yr-old waitress).*

Similarly, Ursula also narrated:

*“After signing the agreement, I handed it over to the nurse because I don’t want to take it home for anybody to see it and get to know that I have been a surrogate mother before.” (Ursula, 25-yr-old trader).*

### **Non-disclosure**

By *non-disclosure*, we refer to the deliberate and intentional choice by participants to withhold or refrain from revealing their surrogacy status to others. This strategy involves a conscious effort to avoid discussing or communicating any information that could expose their involvement in surrogacy. The practice of non-disclosure as a

means of avoiding stigmatization aligns closely with Erving Goffman's concept of *impression management*, which underscores how individuals actively control the image they present to others to maintain social acceptance.

In this context, participants rely on concealment and silence as their primary tools for managing impressions. By choosing not to disclose their surrogacy status, they aim to blend seamlessly into their social environments, thus "passing" as ordinary or "normal" individuals whose lives align with societal expectations.<sup>16</sup> For these participants, non-disclosure is thus not merely a passive act but a calculated strategy for self-preservation in a society where deviation from normative family and reproductive roles can attract significant negative attention. For instance, Botor remarked:

*“... it is between me and my God and I will not mention it to anyone because they will say all sorts of bad things about me. Apart from the one who brought me here I will not mention it to anyone. For her I know she will not tell anyone too”. (Botor, 38-yr-old cleaner).*

A similar response was also given by Delight:

*“I have not told anybody and I will not tell anybody. You know in our society people talk a lot; what they will say is that you have sold your child to someone, people will be pointing their fingers at you and at times your family may not agree with you.”. (Delight, 29-yr-old unemployed).*

Delight’s response also suggests that there is limited knowledge on the practice of surrogacy in Ghana. Many people do not fully understand this assisted reproduction method and for that matter, several meanings may be put on it which may lead to the surrogate mother being stigmatized. However, surrogate mothers’ desire to maintain secrecy as a way of avoiding stigma is not limited to the Ghanaian context. Similar findings have been reported in India where women who go for surrogacy insist on anonymity for fear of social stigma.<sup>17</sup>

These findings also resonate with those of other scholars who suggest that most women in developing countries frequently keep the fact that they are surrogates or they once have been surrogates private.<sup>18,19</sup>

### **Physical health challenges during surrogacy**

It is estimated globally that most pregnancies progress without complications or any incident; but approximately 8 percent of all pregnancies involve complications that if left untreated, may harm the mother or the baby.<sup>20</sup> Like any other pregnant woman, interactions with the participants revealed that some of them encountered some health challenges whilst providing the surrogate services. Below are some of the narrations regarding the health challenges experienced:

*“I was there one day when the pregnancy was about 6 months old and I started having severe headache I complained to the agency head who called the doctor and informed him. I was taken to the hospital and when they checked my blood pressure and other vital signs, they said my blood pressure was too high. I was given some medicines to take and asked to have enough rest. I continued with those medications till eight months of pregnancy and they operated me and took the baby out.” (Emily, 26-yr-old trader).*

Similar responses of health challenges came up during the interaction with the other surrogates. An agency head also confirmed that occasionally, they do have some of the surrogates' experience pregnancy and childbirth related complications. She narrated an instance she will never forget:

*I was called by one of my midwives that one surrogate was in labour and had to be sent to the hospital for delivery which was done, about two hours later, I received another call from the midwife that the lady (surrogate) has delivered but is in a critical condition and bleeding profusely...when I got there, surgery had been done, her uterus had been removed (total abdominal hysterectomy), and she had been started on blood transfusion; she had a total of 6 pints of blood transfused at the end of it all. She spent two weeks in the hospital before discharge. (Agency head).*

### **Lack of social support, stress of pregnancy and detachment from baby**

Pregnant women often face emotional and psychological challenges stemming from hormonal

changes, societal expectations, and individual circumstances. Hormonal fluctuations can lead to mood swings, heightened sensitivity, and increased vulnerability to anxiety and depression.<sup>21,22</sup> Some women also experience post-partum depression emanating from a combination of hormonal, psychological and social factors.<sup>23-25</sup> While it is sometimes expected of women to have special emotional needs during pregnancy, studies have shown that these needs are often more profound in surrogates.<sup>26</sup> The surrogates in our study expressed some emotional challenges during and even after their engagement as surrogates. Symptoms of depression and post-traumatic stress disorder were experienced by surrogates during pregnancy and after birth.

For instance, Caro narrated how she felt during the later stages of her pregnancy:

*When the pregnancy was around 7 months and I had stayed at the agency all that while, I became tired and fed up with the place. I insisted that they should remove their baby and let me go to my home because I was tired of carrying the pregnancy. Sometimes I cry all day without eating well, so when the pregnancy reached 8 months, they operated me and removed the baby. (Caro, 24-yr-old hairdresser).*

Some other sources of the emotional stress that surrogates faced is the fact that some felt cheated financially and their needs were not adequately met during the pregnancy. Their expectations in relation to how they would be taken care of financially while pregnant were not met. This is reflected in the responses of Harriet and Patience:

*I wasn't happy with anything over there; the meals were not as you want as a pregnant woman, you know during pregnancy, there are times you want to eat something at all cost but here you are in a confined agency where no one cares about such needs, it is very sad and then you even regret doing this, I wept several times but what could I have done, I only waited patiently till the delivery. I would say the agency only fulfilled their promise (financial reward) because apart from that I didn't enjoy my stay there. (Harriet, 31-yr-old trader).*

*Hmmm it is very sad that you help someone you don't even know and have to go through all these.*

*The food you are provided by the agency is what you have to eat even if you don't like it. The monthly upkeep money of 300 Ghana cedis is what you use for any other need. You cannot go anywhere to do any job to get extra income too because you might be seen by someone who knows you. The payment you receive at the end of the whole process is also not enough to set up any good business. (Patience, 36-yr-old trader).*

This situation also reflects the idea of commodification. Once an agreement has been reached between the surrogates and their agencies, these agencies feel no obligation to attend to any extra needs of the surrogates. As seen by the comments above, the situation of surrogates was compounded by stigma. Surrogates had to remain confined in the hostels provided by the agencies to avoid stigmatization. They lacked the needed emotional and social support all because their services have been bought and paid for.

It is also pertinent to note that the emotional challenges surrogates faced were not constrained to the pregnancy period but extended to the post-partum period. The emotional troubles that surrogates faced were largely due to the abrupt detachment from their babies. Symptoms of depression and post-traumatic stress disorder were reported by some of the surrogates in our study.

Gina expressed her post-delivery emotional challenge this way:

*After the operation when I heard the child crying, I also began to cry because I do not know where the child is going, they injected me to sleep and when I woke up the child is gone. I have been thinking about the child a lot. I feel so sad whenever I think about the child and this has made me regret the decision I made to be a surrogate. Madam, the thing keeps haunting me. What pains me most is I didn't see my child (Gina, 26yr-old hairdresser).*

Though the surrogates were aware they were carrying the pregnancy for other people, they developed emotional attachment to the babies and the abrupt separation thus adversely impacted their emotional well-being. However, due to the transactional nature of the services provided, no extra support was put in place to deal the emotional well-being of surrogates, post-separation.

### **Economic and bodily exploitation of surrogates**

Our study suggests that surrogates in Ghana often experience exploitation in their arrangements. A key finding is that surrogates are excluded from negotiating their compensation, as this is predetermined by agencies. These agencies provide fixed stipends for monthly upkeep and a final payment after the process, but surrogates remain unaware of the full costs charged to intended parents. Many expressed dissatisfactions with the compensation, feeling exploited. The quotes below reflect these sentiments:

*Before you start, they will tell you that you will be well taken care of but once you move in everything is different. The food served at the agency home is not always what you want as a pregnant woman but you have to eat it like that or use your upkeep money of 300 Cedis a month which is not enough to support your feeding. You are already there; what can you do? At the end of everything, I was given 15,000.00 Ghana Cedis compensation which I realized was not enough for the work I did as a surrogate though I didn't do it for the money. It is a pity. (Ophelia, 26-yr-old waitress).*

*This whole thing is cheating, because I was desperate to get money at the time, when they mentioned the 20,000.00 Ghana cedis, I thought it was big money. It was when I started the whole thing and thought through the engagement period of a whole 9 months before being paid the rest of the money that I regretted. It is not good at all; the compensation amount has to be increased (Patience, 36-yr-old trader).*

Furthermore, copies of the gestational surrogacy agreements provided to the researchers by the agencies indicated that surrogates shall be given extra compensation for delivering via caesarean section. However, 19 out of 21 surrogates interviewed underwent caesarean deliveries but no additional compensation was provided for these surgical deliveries.

With regards to what we refer to as bodily exploitation, we found that these caesarean sections were not always for medical reasons but to ensure the birth of a healthy child for the intended parents, who were prioritized.

*I was just there one day and the nurse called me that I should prepare myself for surgery the next day. So, I asked her why, because the pregnancy was just 8 months old and not yet due for delivery; but she says the commissioning parents want their baby (Delight, a 29-year-old unemployed)*

*At the beginning I asked them the mode of delivery and they told me it depends on my health and that of the baby but later I noticed I will be operated. They will not tell you that part at the beginning of the contract but later I got the information that I will be operated and they also stitched my cervix after the third month of the pregnancy. They did not give me any explanation as to why they even stitched the cervix... so one Saturday morning I was informed to prepare myself to the theatre so I decided to call the friend who sent me there but she did not pick my call. After the whole process that is when she called and I told her the reason why I was calling her but she said she wasn't around (Klorkor a 29-year-old hairdresser).*

The poor socioeconomic background of women recruited into surrogate motherhood and their eagerness to make money at the time of engagement makes this practice a breeding ground for exploitation. The poor financial dynamics thus enabled the surrogacy agents to make unfair offers to the surrogates. It was clear from the responses of the research participants that financial crisis led them to rush into the agreement without critically examining the benefits that come with it. Most of the surrogates expressed their regret for having engaged in the process and felt exploited as revealed in the excerpts above. This finding tallies with the assertion of some authors on the low remuneration of surrogates in Africa compared to other Western countries.<sup>27,28</sup>

This exploitation was partly confirmed by the agency head as she disclosed that GHS 30,000 was paid to a surrogate who had total abdominal hysterectomy as compensation. According to her, that was the highest compensation a surrogate can get in her agency.

### **Impact of surrogacy on spousal relationships**

Eighteen out of the 21 interviewees were married or in a romantic relationship when they entered into a surrogacy agreement. However, only three

remained with their partners after the surrogacy period, while the partners of the remaining 15 left during or after the process. The breakdown of these relationships was attributed to various factors, including prolonged absences from home, physical distance, lack of communication, stigma, and superstitions. The following direct quotes illustrate the experiences of the 15 interviewees whose partners abandoned them.

*... my husband has left me for another woman. When I returned from the surrogate home my husband has impregnated another woman. Now he has totally left me for that woman (Ophelia, 26-year-old waitress).*

An unmarried respondent but in an intimate relationship at the time she went into surrogacy narrated her experience this way:

*I lied to my boyfriend that I was going to take care of my sick uncle in Koforidua for a while. After a long absence, he called that I should give him direction to come and visit but I didn't respond. Later, I called to tell him I was sick in my abdomen and the doctors are saying they are going to do surgery. When I returned, he told me that someone has told him that I cannot give birth because of the surgery so we broke up. (Ursula-25-year-old trader).*

For the interviewees who had their relationships with their spouses intact after the surrogacy, their narratives revealed that one told her husband about entering a surrogacy agreement and both of them mutually agreed to the agreement while two others hid their surrogacy from their partners.

One respondent who sought the consent of her husband narrated that her husband remained with her after the surrogacy period and she stated that prior to agreeing to the surrogacy agreement, her husband followed her to the surrogacy agency:

*Hmmm when I even told my husband that this is what I have heard about, he was sad. I explained to him that it is not our baby that we are going to sell but I am only going to keep the child for the parents so he agreed and went to the agency with me because we needed the money to top up our savings and pay our rent. I even have to beg the agency head to give me part of the compensation before*

*completing the process so I can give it to my husband to top it up to what we have saved to enable us pay the landlord and secure our room. (Patience-36-year-old trader).*

Another participant claimed she kept being a surrogate a secret from her boyfriend, she did this by telling her partner that she went to take care of her sick mum.

*I told my boyfriend that my mum was not feeling well and that I was taking care of her; he wanted me to direct him to the place so he can come and see me but I told him my stepdad was strict so he shouldn't come. (Dora, 26-yr-old trader).*

The data thus suggest that for those who agreed with their husbands or partners prior to their involvement were more likely to continue with their partners after the surrogacy. For those who didn't, inability to conceal the information or provide tangible reasons for the prolonged absence and separation from their partners led to the breakdown of their relationships. This finding about the negative consequence of surrogacy on surrogates' marital life or relationships has also been found by other studies.<sup>26</sup> Subedi, however, notes that husbands of surrogates sometimes agree for their wives to be surrogates because it serves as a means to financial ends to them and in such cases, they usually continue to be married to their wives after the process.<sup>29</sup> This is similar to the narrative of 36-year-old Patience who sought the consent of her husband as their "rent has expired" and they "needed money to renew the rent".

## Discussion

The findings from this study underscore the multifaceted challenges faced by surrogate mothers in Accra, Ghana. These challenges, spanning social stigma, psychological distress, health complications, exploitation, and strained personal relationships reflect broader systemic issues tied to the socio-cultural, economic, and regulatory landscape of surrogacy in Ghana.

Social stigma emerged as a significant barrier for surrogate mothers, compelling them to conceal their surrogacy involvement. This aligns with Yeshua-Katz and Khvorostianov, who found that stigma and moral judgment force many

surrogate mothers to adopt secrecy as a primary coping strategy.<sup>6</sup> Participants in this study echoed similar strategies, such as avoiding disclosure to family and friends and refraining from keeping copies of surrogacy agreements to prevent inadvertent discovery.

The stigma surrounding surrogacy, rooted in traditional notions of motherhood and morality, is not unique to Ghana. Bhattacharyya notes similar societal attitudes in India, where surrogate mothers are often labelled as "baby sellers."<sup>27</sup> Public education initiatives, as suggested by Trowse and Cooper, could challenge these misconceptions, fostering broader acceptance of surrogacy as a legitimate reproductive option.<sup>30</sup>

Many participants reported symptoms akin to depression, post-traumatic stress, and emotional distress due to the abrupt detachment from their babies. These findings corroborate Jadva et al's longitudinal study, which revealed that surrogate mothers experience emotional challenges even years after the process, particularly in contexts where emotional support is lacking.<sup>12</sup> Khalaf and Elah, Tarahomi emphasize the importance of counselling services in mitigating the psychological burdens associated with surrogacy.<sup>5</sup> Integrating counselling as a mandatory component of surrogacy arrangements could help alleviate the emotional strain on surrogate mothers, as also advocated by Taebi, Alavi and Ahmadi.<sup>4</sup>

Participants in the current study also reported significant physical health challenges, including pregnancy-related complications and caesarean deliveries. These align with findings from Jain, who highlighted the increased health risks surrogate mothers face, often driven by the medicalization of pregnancy to meet commissioning parents' preferences.<sup>31</sup>

The prevalence of non-medically indicated caesarean sections among participants in our study underscores the commodification of reproductive labour, where the health of surrogate mothers is often secondary to the desires of intended parents. This finding resonates with Arvidsson, Vauqueline, Johnsdotter and Essén, who documented similar practices in India.<sup>32</sup>

Enhanced regulatory oversight is critical to ensure that medical decisions prioritize the health and well-being of surrogate mothers.

Economic exploitation was a recurring theme, with participants expressing dissatisfaction with their compensation and limited negotiation power. Carsley and Deonandan, Green, van Beinum argue that inadequate regulatory frameworks often exacerbate such exploitation, leaving surrogate mothers economically disadvantaged.<sup>9,10</sup>

The study's findings also align with Suryanarayanan's analysis of commercial surrogacy in India, which highlights the intersection of poverty and exploitation.<sup>8</sup> Many participants in the current study echoed these concerns, likening their surrogacy experiences to commodification. This finding also supports Deonandan's claim that most surrogates in low-income nations are economically powerless.<sup>10</sup> Deonandan aptly describes surrogacy practice in low-income countries as "exploitation of desperation." The desperation of the surrogates in our study to address their financial needs clouded their judgement to critically assess the compensations offered at the point of entry into the surrogacy agreement.

The current study also revealed significant disruptions in personal relationships, with many participants experiencing separation from their partners due to prolonged absences and societal misconceptions. Sloth-Nielsen notes similar patterns in South Africa, where stigma and secrecy around surrogacy strain familial bonds.<sup>13</sup>

### ***Strengths and limitations***

The qualitative nature of the research allowed us to capture the lived experiences of surrogate mothers in Ghana. This is particularly valuable for a sensitive and under-researched topic like surrogacy. The use of semi-structured in-depth interviews allowed us to probe sensitive issues such as stigma, exploitation and autonomy, thus helping to situate surrogacy experience within a socio-cultural context rather than treating it as purely bio-medical issue. The study also provided a voice to a marginalized group. Surrogate mothers are often invisible in public discourse in Ghana. Our study amplifies their perspectives, which can stimulate policy, advocacy, and ethical debates.

We also recognise that this study also has some limitations. As with most qualitative studies, our findings are not statistically generalizable to all surrogate mothers in Ghana. More so, surrogate

mothers are a hidden or hard-to-reach population and the reliance on Agency Heads and snowball sampling presents a potential bias. It is possible that those who were willing to speak make differ from those who refused. Moreover, because interviews were conducted over the phone, it is possible that several non-verbal cues were missed. The findings of the study should thus be interpreted with caution.

### ***Policy and practice implications***

The lack of comprehensive legal frameworks governing surrogacy in Ghana amplifies the vulnerabilities of surrogate mothers.<sup>33</sup> Trowse and Cooper argue that regulatory gaps not only enable exploitation but also hinder the development of ethical practices.<sup>30</sup>

The current study highlights the need for clear legislation should be enacted to regulate surrogacy to ensure the protection of surrogate mothers' rights and provide them with mandatory counselling services. Public awareness campaigns should be carried out to reduce stigma and promote informed decision-making. Finally, compensation structures should be streamlined to prevent economic exploitation.

### **Conclusion**

This study highlights the multifaceted challenges faced by surrogate mothers in Accra, Ghana, including social stigma, psychological distress, health complications, economic exploitation, and strained relationships. These findings reveal systemic gaps in the surrogacy framework, reflecting the intersection of cultural, economic, and regulatory factors. Surrogates often navigate their roles in a context marked by stigma and inadequate support, highlighting the pressing need for targeted interventions. To address these challenges, the implementation of comprehensive legal and policy frameworks is critical. Such frameworks should prioritize the rights and well-being of surrogate mothers through equitable compensation, mandatory counselling, and health safeguards. Public education campaigns are also essential to destigmatize surrogacy and foster broader societal understanding. By addressing these areas, Ghana can establish a more ethical and supportive environment for surrogacy.

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## Conflict of interest

The authors declare no conflict of interest

## Data availability

The data upon which this paper is based have been deposited at Mendeley Data Repository and is freely available for reasonable use. The data can be accessed via the link: <https://data.mendeley.com/drafts/dbnknwrvv6> Or DOI: 10.17632/dbnknwrvv6.1

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