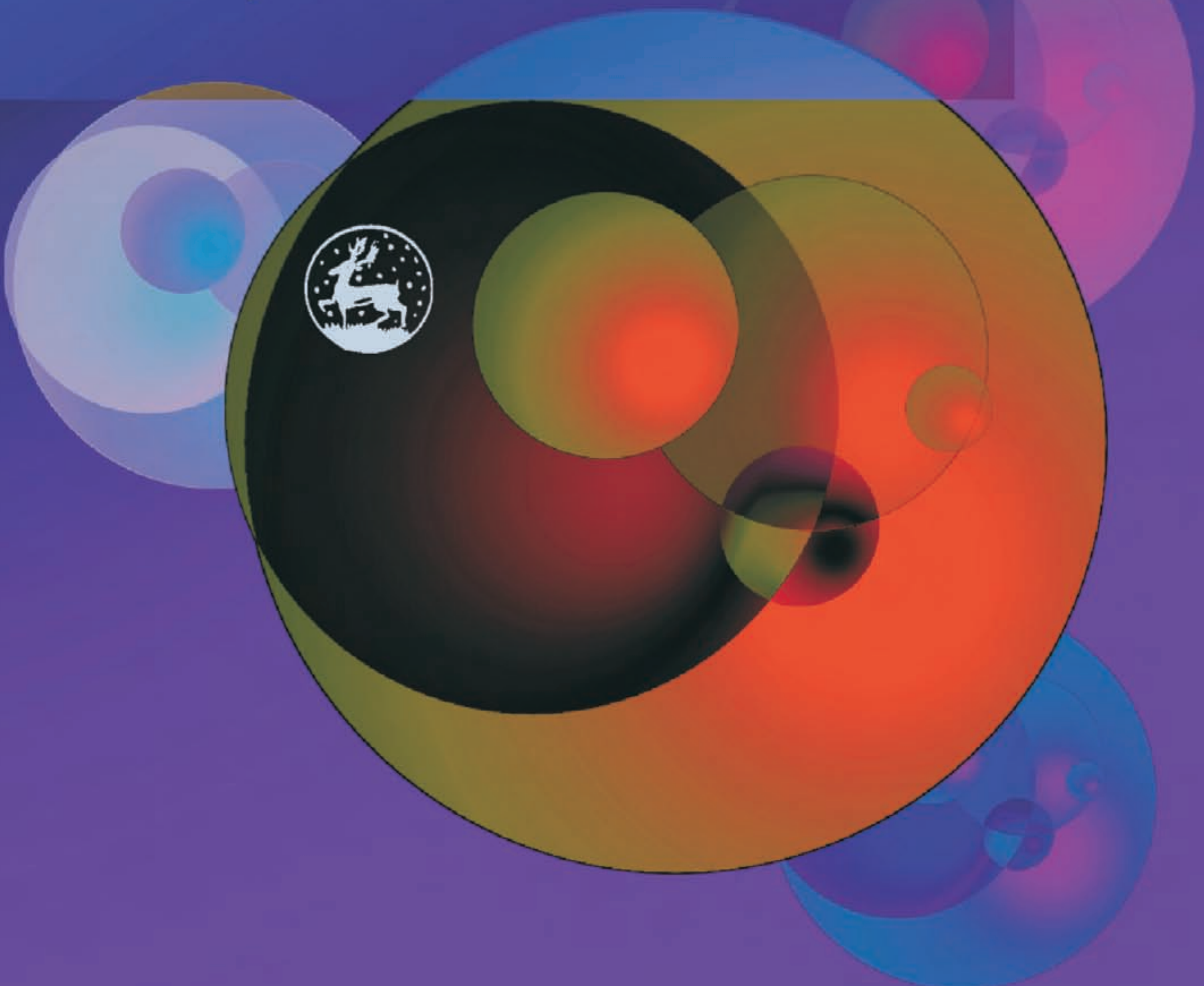
Third Party Assisted Conception Across Cultures

Social, Legal and Ethical Perspectives

Edited by
Eric Blyth and Ruth Landau



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Introduction

Eric Blyth and Ruth Landau

Throughout history involuntary childlessness has been an unwelcome burden. The biblical account of Rachel's plea to Jacob: 'Give me children, or I shall die' (Genesis 30:1) is reflected in Fiske's more recent description of women's experiences of infertility: 'You think you are absolutely desperate to have a child and you think you could put yourself through absolutely anything' (Fiske 2001, p.80).

Early accounts of third party interventions to achieve conception had their origins in animal husbandry. Artificial insemination of horses is reported to have occurred when Arabian tribesmen 'impregnated the well-bred mares of their enemies with semen from inferior stallions in an attempt to interfere with the genetic line' (Smith 1979, p.89). The application of the procedure to humans was similarly inappropriate, with Dr John Hunter, a Scottish anatomist and surgeon, reporting the use of artificial insemination in 1799 without the knowledge of the woman who was impregnated. Experimentation with the storage of human sperm also commenced in that century, when an Italian physiologist, Lazzaro Spallanzani, proposed freezing human sperm in 1776. Dr Marion Sims first reported success with artificial insemination in humans in 1866, when a baby was born from artificial insemination by husband's sperm (AIH). Reports later appeared in 1884 of a baby as resulting from artificial insemination by donor (DI) (Fisher 1989; Smith 1979).

AIH and DI are now regarded as the 'low-tech' procedures of assisted conception. Until June 1978, despite various attempts to overcome infertility problems, all children were born to their genetic mothers. However, the birth in 1978 of Louise Brown, the first baby born following *in vitro* fertilization (IVF), radically changed the issues related to assisted conception.

Today's assisted conception options have evolved from 'low-tech' procedures. While becoming pregnant and giving birth to a child no longer requires sexual intercourse, so far they still require male sperm, a female egg and a uterus in which the embryo must be implanted to develop.

Assisted conception procedures may now be combined with hormonal treatments to stimulate the ovaries, as well as with the basic method of IVF combined with embryo transfer. IVF requires egg retrieval, an invasive and quite complicated procedure in itself, and intense scheduling attention by patients and physicians. Following sperm collection, the fertilization procedure involves inseminating the processed egg in culture. Only if fertilization is achieved *in vitro* (the basis for the common-usage term of 'test-tube baby') are the resulting embryos (usually four- to eight-cell stage) transferred to the woman's uterus through the cervix. This procedure also requires careful timing to optimize the chance of successful implantation. Variations of these medically assisted conceptions include gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT). GIFT involves the use of a laparoscope – a fibre-optic instrument – to guide the transfer of eggs and sperm into the woman's fallopian tubes. ZIFT involves fertilizing the eggs in the laboratory and then using a laparoscope to guide the transfer of the fertilized eggs (zygotes) into the woman's fallopian tubes. If fertilization occurs in either GIFT or ZIFT, it takes place *in utero.* Intracytoplasmic sperm injection (ICSI), the injection of a single sperm into the egg (used when a man produces a very low number of sperm), is another recent advance in medically assisted conception.

These modern 'high-tech' methods of assisting conception not only eliminate any need for sexual intercourse but also provide the possibility of breaking the genetic connection between the child and the woman who bears him or her. First, the standard IVF technique allows any egg to be fertilized with any sperm, and allows the providers of the genetic material to remain anonymous to the recipients. One natural extension of IVF is the idea of surrogacy – the implanting of an embryo in the uterus of a woman who need not have any genetic connection with the embryo.

Surrogacy itself is not new. Some have cited biblical references such as Genesis 16: 2–3 and 30: 3–5 to practices that might be considered analogous with surrogacy (although, given that little regard appears to have been paid to the wishes of the 'surrogate' in either of these accounts, it is a moot point whether the appropriate analogy is with surrogacy or with rape and slavery).

Other practices whereby a child has been produced by a third party – or third parties – for an involuntarily childless couple – usually from within the family – are also 'time-honoured'. We read in the Bible (again): 'Then Judah said to Onan, lie with your brother's wife and fulfill your duty to her as brother-in-law to produce offspring for your brother' (Genesis 38: 8–10).

Similarly, traditional practices among Maori and other Pacific cultures have included giving a childless couple a child from within the extended family to raise as their own (Atkin and Reid 1994; Douthett and Bennett 1999; Interim National Ethics Committee on Assisted Reproductive Technologies 1995).

Contemporary versions of surrogacy may be described as either 'genetic' or 'gestational' surrogacy. Genetic surrogacy (which is also described as 'straight', 'complete' or 'genetic-gestational' surrogacy) is where the eggs of the surrogate (the woman carrying the pregnancy) have been used to create the child. Consequently, the surrogate is both the birth mother and the genetic mother of the child. Conception will usually have been achieved following insemination of the commissioning father's sperm (i.e. the man who intends to undertake the care of the child. Commissioning parents may also be described as 'intended' or 'social' parents). However, donated sperm could also be used, and some early accounts of surrogacy arrangements describe conception following sexual intercourse between the commissioning father and surrogate (see, for example, Blyth 1994). Gestational surrogacy (which may also be described as 'IVF', 'carrier' or 'host' surrogacy) is a surrogacy arrangement where the surrogate has no genetic relationship to the child she is carrying. Conception will usually have been achieved following IVF using the eggs and sperm of the commissioning parents, although donated gametes could also be used.

Surrogacy may be used for both 'medical' or for 'social' reasons. For example, medically-indicated surrogacy may occur where the commissioning mother has no uterus. If her ovaries are functioning normally, she may be able to produce the eggs required for a gestational surrogacy arrangement. There may also be circumstances where conception and/or pregnancy may put at risk the health of the mother and/or child. Where the commissioning mother has a past history of both hysterectomy and bilateral salpingo-oophorectory (where she has neither uterus nor ovaries) either a genetic or a gestational surrogacy arrangement using donor eggs may be indicated. Surrogacy may also be used for social reasons; for example, a woman may wish to avoid conception, carrying a pregnancy or giving birth.

Furthermore, now that eggs, sperm and embryos can be frozen, the time span between conception and birth has become dependent on social rather than purely biological variables and can extend to years. The freezing and thawing of sperm, eggs and embryos also enables pregnancy in post- menopausal women and fertilization of a person's gametes after his or her death. The latter enables the birth of a planned orphan (Landau 1999).

We have previously made a distinction between 'high-tech' and 'low-tech' procedures. The essential difference between the two is that while the effective performance of 'high-tech' procedures requires technical competence and sophisticated technological equipment – which are usually performed by qualified scientific and/or health care professionals – 'low-tech' procedures, self-evidently, require neither sophisticated technology nor expertise, and may be performed on a 'do-it-yourself' or 'self-help' basis. A further means of differentiating assisted conception techniques is the extent to which they rely on a third party to provide the necessary genetic material to enable conception to take place – sperm or eggs – or an embryo, or to provide the environment in which an embryo can be carried to term for another individual or couple, as in a surrogacy arrangement. Conventionally the providers of sperm, eggs or embryos have been described as 'donors' – irrespective of whether their 'donation' has been made altruistically or whether they have been remunerated in any way for their contribution. Except where legislation specifically precludes remuneration of donors, it is, in fact, commonplace for donors to be financially recompensed (for a notable exception see Daniels in this volume). Daniels (1998) and Shanner (1998) have noted the inherent contradiction in the concept of 'paid donation'. The distinction between altruistic and remunerated donation is blurred further by the practice of 'egg sharing', in which women who are themselves undergoing assisted conception procedures donate eggs to other women in return for subsidized or free treatment cycles (Blyth 2001, 2002).

While we note the validity of Daniels' and Shanner's critique, we have continued to use the terms 'donor', 'donation' etc. in this book not only to ensure consistency with existing literature and research, but also because of a failure to devise sufficiently succinct alternatives that command common acceptance. Surrogates have usually not been included with the designation of 'donor'. We have, therefore, used the generic term 'third party' assisted conception to embrace both the commonly accepted donor procedures of egg, sperm or embryo donation (sometimes described as embryo ‘adoption’) and surrogacy arrangements.

Each case of DI and IVF with sperm or egg donation involves a combination of a donor, a ‘genetic’ mother (who contributes the eggs) and a ‘biological’ mother who carries the pregnancy and gives birth to the child. In donor insemination and IVF with sperm donation, the same woman is usually both the genetic and biological mother of the offspring. The donor can be either known or anonymous, but – in practice – he is usually anonymous. In a heterosexual couple, the woman’s partner then becomes the child’s social, and usually also legal, father. In lesbian couples a second ‘mother’ completes the new family, whereas single mothers choose to retain full control of parenthood, despite the basic undisputed fact that each child has one genetic mother and one genetic father.

Third party assisted conception raises issues of anonymity and secrecy versus openness. The legal status and the practice regarding the relationship between the donor and the recipient individual or family and between the donor and child vary from country to country, as is illustrated by contributions to this volume. Secrecy is usually seen as a means of protecting an infertile man from the embarrassing disclosure of his infertility, the child from feeling that he/she does not fully belong to both parents, and the donor from any legal or moral responsibility for any resultant offspring. Therefore, in most countries DI or IVF using donated gametes is shrouded in a greater or lesser degree of secrecy and anonymity. However, the degree of secrecy or openness also varies with the situation of the recipients. Heterosexual couples usually keep the very fact of gamete donation secret from their donor-conceived child, although they may well tell someone else, such as a friend or family member (e.g. Bielawska-Batorowicz 1994; Brewaeys 1996; Brewaeys *et al.* 1993; Cook *et al.* 1995; Golombok *et al.* 1995, 1996, 2002a, 2002b; Gottlieb, Lalos and Lindblad 2000; McWhinnie 1996). Lesbian and single parent families are more likely to reveal the fact of DI to the child, but the donor’s identity remains unknown to all concerned (Brewaeys *et al.* 1993; Scheib, Riordan and Shaver 2000; Scheib, Riordan and Rubin 2003).

Nevertheless, even if the secrecy around donor assisted conception is well meant, it can be detrimental to the physical and mental health of the offspring. Without knowledge of one or both of their genetic parents, donor-conceived people are deprived of the information they need to develop a full sense of their identity (see, for example, Anonymous 2002;

Baran and Pannor 1993; Cordray 1999/2000; Donor Conception Support Group of Australia 1997; Franz and Allen 2001; Gollancz 2001; Hamilton 2002; Hewitt 2002; Landau 1998a, 1998b; McWhinnie 2001; Priday 2000; Rose 2001; Rubin 1983; Spencer 2000; Turner and Coyle 2000; Whipp 1998).

It has also been suggested that the failure to provide a donor-conceived person with information about his/her donor may run counter to rights afforded under international conventions such as the European *Convention for the Protection of Human Rights and Fundamental Freedoms* (Council of Europe 1950) and the *United Nations Convention on the Rights of the Child* (HMSO 1989). However, reliance on such conventions for access to donor information remains ambiguous at the present time – an issue to which we return in the Summary and Conclusions of this volume (see also Blyth 1998, 2002; Council of Europe 1989; Rose and Another versus Secretary of State for Health and Human Fertilisation and Embryology Authority 2002; United Nations Committee on the Rights of the Child 2002).

Similarly, it may be postulated that not all gamete donors necessarily support the maintenance of anonymity and secrecy and may wish to have information concerning the outcomes of their donations (Bromwich 1990; Daniels 1998; Fielding *et al.* 1998; Human Fertilisation and Embryology Authority 1994; Kalfoglou and Gittelsohn 2000; Rosenberg and Epstein 1995; Sauer *et al.* 1988; Schover *et al.* 1991, 1992; Söderström-Anttila 1995; Söderström-Anttila *et al.* 1998).

Some commentators have proposed a ‘compromise’ in respect of disclosure of donor identity. The so-called ‘double track’ policy (Department of Health 2001; Pennings 1997) allows a donor to decide whether to be anonymous or identifiable and so enable recipients to choose either an anonymous or identifiable donor. However, such a policy is not without difficulties. While it would give both prospective donors and recipients a choice regarding anonymity at the point of donation and at the outset of treatment, once this decision had been made, there would be no opportunity for a subsequent change of mind. Most significantly, however, the ‘double track’ policy affords no choice at all to the donor-conceived person and would create two classes of donor-conceived people – those who could ascertain the identity of their donor and those who could not (see also Haase and Blyth in this volume, in respect of policy developments in Canada and the United Kingdom respectively).

The asymmetrical relationship of heterosexual parents to a donor offspring also does not promise a problem-free situation; the adoption literature suggests that the couple will not simply 'forget' the existence of the genetic parent (Hartman 1993; Howe 1996; Schaffer and Diamond 1993; Snowden, Mitchell and Snowden 1983; Sorosky, Baran and Pannor 1984).

Thus, just as with conception after sexual intercourse, there is a lifelong relationship among the individuals involved in third party assisted conception (all parents and offspring) whether acknowledged or not. However, where there is a lack of clarity as to the parents' identity, there may be a breach of parental responsibility and the parent–child bond. Because the offspring cannot be asked to give prior consent to third party assisted conception, and because the mode of conception may affect an offspring's whole life, what weight to lay on considering the offspring's well-being has become one of the issues raised by third party assisted conception.

Defining the welfare needs of children is difficult and is often subject to personal, professional and cultural influences. One of the inherent problems in assessing welfare needs of children created using assisted conception is that when these may be first considered, the children do not yet exist and are unlikely to do so unless assisted conception procedures are used. The question therefore arises as to whether criteria for defining the needs of existing children are necessarily transferable to assisted conception. In addition, there is often little recognition that children born from assisted conception procedures will have a life beyond their childhood. This may result in short-term, protective types of criteria being used to define their needs.

These issues regarding third party assisted conception are differently interpreted, assessed and dealt with in various countries, based on their cultural, religious, political and economic values and preferences. Consequently, there are countries that forbid all forms of third party assisted conception, whereas others allow DI only, prohibiting egg or embryo donation or IVF with sperm donation. Some countries permit IVF with sperm donation but do not allow IVF with egg donation, differentiating between the means used to obtain sperm from a man and those to obtain eggs from a woman. There are also different attitudes to the fact that egg donation divides motherhood between the genetic and the biological mothers. The division between genetic and biological motherhood leads to surrogate motherhood. Some countries require surrogate mothers to be married while others prefer them to be single. In some countries, only gestational surrogacy is permitted while other countries place no restrictions in this matter. Still others do not allow surrogacy at all. Obviously, combinations of third party assisted conception – such as IVF involving both sperm and egg donation, or embryo donation – are also differently perceived in different countries.

A further quandary concerning third party assisted conception is the issue of funding. Should the IVF and embryo transfer cycles be paid by public funds? And if so, what, if any, limits should be imposed on the number of publicly funded treatment cycles? Who compensates the donor or donors? Is commercialization in third party assisted conception acceptable or not? Considering the additional health risk, should any limits related to the age of the recipients of treatments be imposed? Countries also differ in their legal approach to issues of third party assisted conception. There are countries where legislation is explicit in determining the formal legal limits of which types of assisted conception in general, and third party assisted conception in particular, are acceptable and which are not. In some countries third party assisted conception is not regulated by specific laws but by some kind of regulatory agency. Still other countries prefer a non-interventionist approach, leaving any oversight to relevant professional bodies.

In all third party assisted conception procedures, the medical profession fulfills the role of an intermediary. That is, although the medical profession applies advanced technologies, its role is still basically to assist achieving a pregnancy using sperm, eggs and uterus. However, new advances may change even this aspect of third party assisted conception. A recent endeavour uses IVF with pre-implantation diagnosis and germ line gene therapy to create babies for certain previously-defined purposes. The physicians examine one cell in a four- to ten-cell blastomere or pre-embryo and if its quality is acceptable they use the remaining cells of the pre-embryo for creating a child. In this case, the medical profession becomes a means in third party assisted conception in a new, different, and more active sense; physicians do not only assess the quality of the gametes to be implanted in the woman's uterus, they also assess the genetic composite of the embryo and make a selection according to given parameters. In this role, physicians take over responsibility for quality control of the reproductive results of third party assisted conception. The availability of, and the recent requests of parents to, carry out pre-implantation diagnosis in conjunction with IVF for medical as well as non-medical/social reasons have already turned this change into an actual issue with which we need to deal (Robertson, Kahn and Wagner 2002; Terry 2002).

This volume comprises a collection of chapters examining these legal, cultural, ethical, religious, political and economic aspects of third party assisted conception. It aims to provide information on third party assisted conception in countries that deal differently with these aspects of third party assisted conception, even as medical research makes impressive strides in the field of assisted conception. To allow the widest possible comparative analysis, we include reports and analyses from 13 countries from five continents that reflect different cultural, religious and political backgrounds: Africa (South Africa), Asia (Hong Kong, Israel and Singapore), Australia, New Zealand, Europe (Finland, Germany, Poland and the United Kingdom) and the Americas (Argentina, Canada and the United States). The contributors of this volume, experts in their fields, were requested to provide an overview of the main issues debated in their countries regarding third party assisted conception. All the chapters are new summaries commissioned by the editors.

We believe that the volume's international focus and broad scope will allow it to make a significant contribution to the developing knowledge-base in this area. In addition, we hope that cross-cultural comparison of the wide range of ethical issues raised by third party assisted conception – from the biological through psychosocial to the legal and economic issues – will form a systematic basis for discussing the new questions raised by current and future developments in third party assisted conception.

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CHAPTER 1

Argentina

Hopes, Results and Barriers

Luisa Barón

Introduction

Argentina is located in the southern end of South America; towards the south it extends between the Andes mountain range on the west, and the Atlantic Ocean on the east. With an area of almost 2,800,000 km^2, its population is a little over 37 million, who are primarily urban inhabitants. The largest urban area, Greater Buenos Aires, holds almost one-third of the country's population.

Most of the inhabitants (97 per cent) are of European descent (mainly Italian and Spanish) and belong to the Roman Catholic Church (92 per cent, although only 20 per cent are observant). As a result, Argentine society, especially in cities and more particularly in Buenos Aires, has a marked European and Latin inheritance, not only in its ethnic structure but also in its culture and way of life.

The fertility rate in Argentina is 2.44 children per woman (National Institute of Statistics and Census 2000).

The Catholic Church, the Argentine Association of Pharmaceutical Laboratories (Asociación Argentina de Laboratorios Farmacéuticos), the Industrial Argentine Union (Unión Industrial Argentina), the Argentine Rural Society (Sociedad Rural Argentina), together with political parties, trade unions and various entrepreneurial groups, operate as key pressure groups in respect of public opinion as well as in the political and legislative areas. The Roman Catholic Church is especially important, since Catholicism is Argentina's offical religion.

The Sociedad Argentina de Esterilidad y Fertilidad (SAEF) (Argentine Society of Sterility and Fertility), founded on 16 December 1970, and with an institutional and individual membership of 450, is a national body representing both assisted conception centres and professionals. SAEF is a subsidiary organisation of the Asociación Médica Argentina (Argentine Medical Association).

SAEF produces the regulations that govern assisted conception-related medical procedures, and adheres to the surveillance standards that provide statistical checks of clinic data by accreditation teams. The process was conducted most recently in all clinics between December 1999 and March 2000 and it is expected that every participating clinic will be reassessed every three years.

Since 1984, when the birth of an IVF baby was first reported in Latin America (SAEF and Latin American Registry 1984), assisted conception provision has spread throughout the entire region. Given the lack of national regulatory bodies and the reluctance to deal with controversial issues, very little is known about the number and type of procedures performed by each country. In 1990, a multinational registry of assisted conception, the *Registro Latinoamericano de Reproducción Asistida* (Latin American Registry) was initiated with three objectives:

1. To create an educational tool to allow couples to evaluate costs and benefits of assisted conception procedures.
2. To develop a comprehensive, regional database to serve as an external reference for each centre's self evaluation.
3. To provide a robust database, allowing for epidemiological research to be conducted.

According to the *Registro Latinoamericano de Reproducción Asistida*, there are 19 assisted conception centres in Argentina (located in the cities of Buenos Aires, Bahía Blanca, Mar del Plata, Córdoba, Mendoza Rosario and Salta among others), which have initiated a total of 3696 cycles (only surpassed by Brazil, with 7550 cycles in 2000) (SAEF 2000, p.13), accounting for 20.2 per cent of the total number of centres and 22.4 per cent of the total number of cycles in Latin America. Argentina is a member of the Latin American Infertility Network, which includes Bolivia, Brazil, Colombia, Costa Rica, Chile, Ecuador, Mexico, Peru, Uruguay and Venezuela. Established in 1995, the Network is a scientific and educational institution which brings together centres in Latin America engaged in assisted reproduction techniques. Until 2000, in the whole of Latin America, 98 centres had registered, having initiated a total of 16,188 cycles (SAEF 2000, p.13).

The first IVF baby in Argentina was born in 1984, although less complex assisted conception techniques, such as sperm donation had been practised before this. Initially, such procedures were strongly opposed by different sectors of Argentine society and, as a result, their practice was carefully concealed, even in the scientific sphere. Since then, the popular media, which was originally critical of assisted conception, has changed its approach. The media is currently supportive of assisted conception procedures and nowadays most assisted conception techniques are socially accepted.

However, third party assisted conception remains subject to much criticism and is strongly opposed within the community. Likewise, some women who undergo egg donation do so secretly, at least regarding the fact that they have used donor eggs.

The practice of third party assisted conception

Both egg and sperm donation are relatively common practices. Initially, people wondered whether children born as a result of gamete donation would be psychologically and physically different from other children, although initial research has provided no evidence of any such differences (Barón 1998a).

However, while donor-conceived people are no longer regarded as strange phenomena, social prejudice based partly on the lack of a defined legal status is still evident, as is explained below.

It is not possible to determine when artificial insemination by donor (DI) was first practised in Argentina, nor the number of children born as a consequence of DI. However, it is known that, because of its technical simplicity, DI has been practised for many decades in the privacy of doctors' surgeries and clinics, and no records have been kept. When the provision of DI became more systematic in the 1980s, a donors and donations log was established.

Currently there are two semen banks in Argentina. More semen banks operated in the past, but have since ceased to function. Sperm donation is almost exclusively anonymous although, infrequently, it may not be anonymous; for example where the donor is a relative or close friend of the recipient. As there is no law regarding donor conception in Argentina, it is customary practice for the mother of a donor-conceived child to register herself as the child's legal mother and for her husband to register himself as the child's legal father.

As Latin culture highlights strength as proof of male superiority, the acknowledgement of a deficiency that is strongly associated socially and culturally to sexual life such as the lack, or malfunctioning, of spermatozoa, may appear especially shameful to men. This is so pervasive that some women will be prepared to assume responsibility for an infertility problem and thus protect their husband's image in the eyes of others. Such attitudes reinforce the tendency in sexist societies not to disclose recourse to DI (Daniels and Haimes 1998).

The first successful egg donation in Argentina occurred in 1987; the result was the birth of a boy in February 1988. Since then, estimates show that between 1500 and 2000 children were conceived through egg donation (SAEF and Latin American Registry 2000). Because of concern expressed by SAEF about the lack of a systematic registry for egg donation, an egg donation registry operated by SAEF was set up in 2002.

Donor eggs are acquired from three main sources: women undergoing treatment who offer their eggs to other women being treated in the same centre, known donors, and women who provide eggs in exchange for money. The latter practice started in 2001 and, on the basis of informal discussions and consultations with patients and donors, appears to have been growing since the economic crisis in Argentina. However, it is a phenomenon that has not been subject to any research yet. Fees that are paid are subject to individual negotiation between the prospective recipient and donor.

Initially, egg donation was anonymous (Barón 1998c). However, more recently, some recipients have indicated an interest in knowing their donor. This has been facilitated by the proportion of donors who were not averse to being identified, particularly those who were donating because of economic reasons.

In the case of known egg donation, two variants are available: 'known/known' donation (where the recipient actually receives the egg(s) of her friend or relative) and 'known/anonymous' donation (where the eggs of the donor recruited by her friend or relative are given anonymously to another woman and the friend or relative of the donor goes to the head of the queue for women waiting for donated eggs). With some exceptions, most centres accept eggs donated by relatives and friends of the prospective recipient, although friends are preferred to relatives as donors. The practice of using a known donor primarily relates to the scarcity of donors. However, where priority is attached to knowledge of the genes and fear of the unknown genes that an anonymous donor might contribute, there is a view that donation between sisters is preferable to anonymous donation. In both known and anonymous donation psychological support interviews are recommended by professionals (Barón 1997, 1998b).

Embryo donation is rarely carried out. When it does take place, the embryos used in donation belong to couples who decide, for various reasons, not to use them for their own treatment and agree to donate them to other couples who cannot obtain viable embryos. At present, due to new drugs used to stimulate ovulation, egg production in each cycle has considerably decreased and therefore fewer embryos are available for donation. Also, in the early days, cryopreservation was considered a questionable practice that posed ethical dilemmas, and so many couples did not accept the opportunity of cryopreserving their embryos for any future attempt. Consequently, the number of embryos available for donation was reduced.

In general, Argentine centres are still not in favour of cryopreservation, because of the heavy responsibility involved in ensuring the security of cryopreserved embryos and because of fears about the uncertain implications of patients deciding not to transfer the cryopreserved embryos stored in the centres. Within the medical community, there is a very strong moral aversion of destroying cryopreserved embryos. Consequently, there is a general tendency not to produce ‘extra’ embryos, thus reducing the availability of such embryos for donation to other couples. Physicians prefer to produce sufficient embryos for transfer in a maximum of two cycles. Consequently, the donation of eggs and semen simultaneously to the same couple is more widespread than embryo donation (Barón 1996).

A growing number of post-menopausal women are seeking assisted conception treatment. Recently, the pregnancies of post-menopausal public personalities – extensively covered in magazines and TV programmes – have encouraged other women to inquire about such a possibility. The exposure of post-menopausal motherhood has had a relatively positive effect on public opinion and consequently social prejudices against it appear to be reduced.

Surrogacy is not commonly practised, and does not enjoy support either from the public or from professionals. On the very few occasions where a patient may have suggested surrogacy, physicians have advised against it because of legal uncertainty concerning its practice and how a surrogate’s refusal to hand over the baby would be handled in law, as well as the uncertain psychological consequences for the surrogate, commissioning parents and child.

There is little information about the treatment of lesbian couples or the posthumous use of gametes or embryos. Since clinics do not maintain contact with donors, it is possible that use may be made of cryopreserved semen and embryos of donors who have already died.

Provision of assisted conception services to single women is common and is performed with careful psychological support. In general, physicians are in favour of performing such procedures. The situation is further facilitated because Argentine law allows single women legally to adopt a child.

Legal overview

As there is no legislation in Argentina regulating assisted conception-related activities, no practices or procedures are expressly prohibited, and it is not possible to distinguish between those centres that are performing safely, efficaciously and reliably, and those that are not. Training courses have been developed by SAEF, which has also produced a list of accredited centres; but these initiatives depend entirely on the conscientiousness and goodwill of the centres and professionals involved.

Attempts to draft a national assisted conception law have so far been unsuccessful. In general, the Chamber of Deputies defends more progressive positions and passed one of the Bills presented. The Chamber of Senators, more conservative and more influenced by the Catholic Church, delays projects that eventually expire without being debated. From 1991 to date, several Bills have been presented that expired mainly for this reason. The first, a progressive Bill submitted by deputies Ricardo Laferriére and Conrado Storani in 2002, failed to attract sufficient support from lawmakers.

This Bill proposed that centres performing assisted conception procedures would be accredited by the Ministry of Health and Social Welfare; it is also proposed to establish a register of gamete donors, recipients and children born as a result of such procedures, providing a genetic and medical record and the donor's identity. Such a register would only be consulted by the child when (s)he reached the age of 18, the child's guardian or the judicial authority. Eligibility to these services is also restricted to heterosexual couples under a predetermined age, thus excluding lesbian couples. It prohibited the practice of surrogacy, as well as the use of gametes posthumously, although it permitted donation of cryopreserved embryos. The Bill also limited to three the number of donations that could be made by a semen donor and female patients were permitted to donate to no more than one recipient. It also determined that all donations should be free of charge and anonymous (except for the above-mentioned judicial instances).

After the failure of this attempt, other Bills were submitted to Parliament supporting various positions; however, none of them were passed. In 2002, deputy Jesús Rodríguez submitted a new Bill to regulate assisted conception, its main goal being that infertility be seen as a disease and thus be included in the list of conditions to be covered by the Plan Médico Obligatorio (Obligatory Medical Plan), an official provision that establishes the disorders and medical conditions that shall be covered by the Obras Sociales (medical care provided by the trade unions with workers' funds) and medical insurance companies.

The absence of any regulations since the initial development of assisted conception services in Argentina has generated contradictory alternatives. Within Parliament, there are groups in favour of non-restrictive laws and others which support more restrictive alternatives which, although they would not explicitly prohibit assisted conception, impose so many obstacles that they would turn it into an activity almost impossible to be performed successfully. For instance, one of the Bills prohibited, without exception, the transfer of more than two embryos; which dramatically reduces the possibility of pregnancy. The prohibition of gamete donation has also been advocated.

The possibility of such restrictive proposals becoming law means that many physicians providing assisted conception services and couples with fertility problems prefer the absence of a law to the existence of legislation that would prohibit many practices that are commonly available in other countries. In addition, overly prescriptive legislation closely specifying both permitted and prohibited procedures would also prevent the application of new techniques that continuously appear and could not be included in full detail in the legislation.

The resistance to law on assisted conception or, at least, support for extremely restrictive legislation, can be traced, to a large extent, to the action of the power groups affiliated to the Roman Catholic Church. It is the state's official religion and, as mentioned previously, 92 per cent of the Argentine population are of the Roman Catholic faith. Although most are not strictly observant in the religious sense, the moral frame within which all ethical issues are discussed in Argentine society is eminently Catholic, and all the maxims of the Roman Catholic Church are highly respected and observed.

The Roman Catholic Church, as an institution, specifically prohibits most fertility procedures, as it considers that life is a gift from God and couples should accept divine will. Presently, some individuals from within the religious communities have started to regard the issue as one of private ethics, and to individually support those who opt for these treatments, despite official Church rulings.

Due to the resistance of religious institutions against assisted conception techniques, many couples with fertility difficulties have to face considerable problems of conscience and feelings of guilt. Consequently, they sometimes opt to adopt a child (although adoption is not the first option of all infertile couples), merely because they do not want to breach religious rules. Because of the economic crisis in Argentina, many babies are available for adoption; but it may take three years for an adoption application to be formally approved by a court. However, the Catholic Church is actively involved in facilitating adoption arrangements between birth parents and prospective adopters. For other couples, the tension between religious principles and personal needs results in estrangement from religious structures and disappointment in them.

All opponents of assisted conception also hold a strong anti-abortion position. Debates on assisted conception in Argentina invariably expose underlying pro-choice or pro-life attitudes related to abortion. Thus, legislating on assisted conception inevitably leads to the dilemma of where the beginning of life should be defined, and many advocate that legally authorizing assisted conception would imply opening the possibilities to abortion, which is proscribed by law and strongly rejected by Argentine society.

In general, medical professionals wish for a non-restrictive law, and SAEF has struggled to obtain one, supporting every non-restrictive Bill submitted to Parliament.

Patients, both individually and through representative groups, support the passing of legislation. Apart from seeking protection against malpractice, legislation is required for the Obras Sociales and medical insurance schemes to cover treatment costs. On the other hand, patients fear that the passing of a restrictive law may ban the use of the cryopreserved embryos that many of them already have. Likewise, couples undergoing treatment who need donated eggs also fear that egg donation may be banned and they will lose what they have invested in the process, from both the psychological and the material points of view.

Currently, the members of the Fundación para la Investigatión Médico -Psicológica (IMPSI), an association of infertile patients, have just finished drafting a Bill to be submitted to the Congress in the near future. It is a non-restrictive and democratic project whose major principles are that:

1. People with fertility difficulties should be eligible for Obras Sociales support (see below for further discussion of Obras Sociales).
2. Infertility should be regarded as a disease in the list of the Obligatory Medical Plan.
3. A couple with fertility problems should be eligible for at least three treatment cycles.

The lack of legislation has major psychological consequences for patients, physicians and the children born as a result of assisted conception practices. Patients fear that their expectations will not be realized. Physicians are required to make decisions and face ethical dilemmas without the support of regulations that would guide them in their professional practice. Thus, patients needing gamete donation or some other more or less controversial assisted conception procedure, must often visit doctor after doctor until they are able to find one whose ethical stance on assisted conception coincides with their own.

Finally, discussions on gamete donation in the mass media expose the increasing number of children born as a result of such practices to learning that certain groups may consider their own existence outside the law. The lack of a law or, in other words, the 'illegal' status of these practices, generates in society a negative prejudice towards couples who have resorted to them and the children born as a result of them.

Medical care provision

The public health system in Argentina was a pioneering one and used to be one of the best in Latin America. Today it is affected by a deep crisis as a consequence of the country's economic difficulties.

The health needs of all Argentine workers (within the formal economy) and their families are met through the Obras Sociales. These institutions collect the funds for this purpose from compulsory contributions by employers and workers. There are also many medical insurance companies, which cover their members' medical needs on the payment of a monthly fee.

Assisted conception services in general, and gamete and embryo donations in particular, are performed and paid for privately: no medical care scheme, either public or private, covers their cost. In other words, patients must pay for the service privately, regardless of fees or contributions they have already paid to the medical insurance company. However, thanks to the private action of some physicians' and patients' associations, coverage has been obtained in exceptional cases, although these create no precedents for future funding decisions.

The absence of financial coverage of assisted conception procedures is due to the fact that Argentine law does not recognize infertility as a disease. If it did, it would be included in the Obligatory Medical Plan, and covered by the Obras Sociales and the medical insurance schemes. As mentioned above, the Bill submitted by deputy Jesús Rodríguez and the project drafted by infertility patients both propose that infertility be included in the list of diseases and conditions covered by the Obligatory Medical Plan.

A major implication of this situation is that neither the Obras Sociales nor the medical insurance schemes – including the most expensive ones – cover the pregnancies and deliveries resulting from assisted conception procedures. The reason given for this exclusion is primarily the increased expenditure involved in the higher proportion of multiple births resulting from assisted conception techniques. In order to ensure that their costs are covered by their health service provider, patients must conceal the fact that they have undergone assisted conception procedures.

Psychological support services

Psychological practice is widespread in Argentina, mainly in the capital city. In fact, Buenos Aires is the city with the largest number of psychologists per capita in the world. Thus, psychological treatment is very common, both at public and private levels, and is very often included as a part of medical treatment; not only in the case of assisted conception, but in most other specialized fields.

Psychological assistance for couples and patients who intend to undergo assisted conception procedures plays a major role in Argentina. In general, experts consider it necessary, although occasionally patients decline it. This service is generally provided by psychologists and psychiatrists who have specialized in fertility, either as members of the assisted conception centres' staff or as independent professionals who receive referrals. In Argentina, social workers and other counsellors have tended not to become involved in assisted conception. The training course for specialization in infertility given by SAEF includes a specialist section devoted to psychological interests. SAEF has also developed a chapter for mental health professionals. No single theoretical frame under which the psychological support of patients undergoing infertility treatment is provided is dominant, as in Argentina a strong psychoanalytical influence coexists with other lines of treatment, e.g. systemic. Consequently, not all the psychological practices performed around assisted conception can be termed 'counselling'. In spite of these differences, agreement exists on the absolute need for patients to be seen throughout the whole treatment, with aims focused exclusively on the patients' situation concerning fertility and the urgency it implies.

Although most professionals support the inclusion of psychological support in fertility treatment, not all recommend it. On occasions, a physician will not insist on the provision of psychological support in order not to increase treatment costs. On others, patients themselves rule this out for economic reasons or because they associate such interviews with severe psychological disorders. In general, those who participate in psychological interviews have faced previous treatment failure, or have undergone previous psychological treatment for other reasons, and value the benefit of psychological support.

There has been debate among professionals as to whether the psychological interview should be mandatory or not, and whether the fees for the psychological interview should be included or not in the total cost of the treatment, but no consensus on this has yet been reached.

Psychological support for patients ideally spans the entire treatment process, from diagnosis to termination of treatment, and takes account of both successful and unsuccessful outcomes.

The goal of the initial interview is to contribute information to the clinic team to ensure that the services offered are individualized to take account of patients' needs. In the initial interview, anxieties, phobias and other factors to be considered on undertaking the procedures might be discussed in detail. Similarly, it is also useful to examine the patient's motivations, to diagnose or rule out severe conditions in which the assisted conception procedure could trigger psychiatric pathology, and to detect critical associated situations (for instance, patients pressed by their partner to undergo treatment).

After the initial interview, patients may attend subsequent meetings to discuss their expectations of treatment in relation to the actual chances of success. In this way they can be guided to establish the best timing for undertaking particular procedures or decide whether to discontinue treatment to follow alternative routes, such as adoption or acceptance of their status as childless.

These psychological interviews serve to ensure the patients' well-being during treatment, prevent difficulties they may otherwise encounter, prepare them for the medical treatment and facing its possible failure, as well as the paternity resulting from success; or they may serve to determine whether they are in a position to face all the conflicts that third party assisted conception raises, and also to analyse their desires and fantasies around the possibility of forming a family on the basis of gamete or embryo donation.

Ethical concerns

Debates on donor anonymity and information on genetic origins are mainly confined to academic settings, SAEF, case presentations organized in fertility centres and the patients' associations. These issues have also been brought up in Parliament during debates on the successive Bills relating to assisted conception law.

Centres maintain a donor register (detailing the donor's name, age, address and phone number) for patients to use in case of a need to access information about the donor. This represents a weak point regarding the safe custody of the data and the guarding of donor anonymity. In general, centres and professionals tend to think that genetic origins data are the property of the patients; but because recipients and donors prefer anonymity, medical centres are left with the responsibility of keeping the only record available.

This problem needs regulation, which would consider the children's right to know their genetic origin and would facilitate their free access to such information. Some of the most progressive Bills have included the proposal that donor-conceived people reaching the age of 18 should be able to access this data in case their parents had refused to provide the information before that time.

The evolution from total secrecy to a more open position helps patients to accept more readily the need for a register, and the timely disclosure of genetic information.

The medical community is divided between those in favour of disclosure and those who advocate for secrecy. On the whole, the psychological community strongly supports disclosure, as they consider it to be the base for the mental health of the family involved and regard secrecy as a trigger of pathologies.

As for donors, some say that they would not be willing to donate if anonymity were not guaranteed, as they fear the legal and emotional consequences a future child could bring. This is yet another strong argument for legislation and regulation: disclosure cannot be discussed without a law to define the ensuing rights of different parties and how these will be guaranteed. The identity of one or both putative genetic parents may be confirmed easily through DNA tests, increasingly common in recent years.

On the other hand, DNA paternity tests have shown that the secrecy of adoption or third party conception is merely a façade that can be torn down easily. This technical reality may encourage couples undergoing donor conception to be keener on the disclosure of genetic origins. While only assisted conception centres hold genetic origins information relating to egg donation, in the case of DI, this information is sometimes kept in the semen banks. While most Argentine centres providing DI use samples from the two major sperm banks, some recruit their own donors. However, no studies of Argentine sperm donors have ever been undertaken. While donors are financially remunerated, there is no nationally agreed figure for reimbursement so the amounts paid to donors are likely to vary from clinic to clinic.

As egg donation is a more complex practice than DI, it is performed in a fertility centre and much more patient data are collected. Semen donation, on the other hand, is less complex and fewer data are gathered when obtaining the sample. The semen banks only take note of the donor's physical data (height, eye colour, skin colour and any history of hereditary or infectious diseases) and lack the quantity and quality of information from egg donors managed by the centres.

Initially, the media were not in favour of assisted conception techniques. The birth of Louise Brown was followed very closely, but was largely reported with negative connotations. Sometimes these negative opinions resulted from a genuine concern about the usefulness of, and risks involved in, such procedures; on other occasions they evidenced pressure brought by the power agents. In general, assisted conception procedures were described not only as contrary to religious belief but also as 'anti-natural'. And the professionals involved were, at least at the beginning, presented as transgressors. Currently, however, the media are generally strong supporters and disseminators of assisted conception techniques.

Along the same line, parliamentary debates about proposed assisted conception legislation generated strong rejection and protests from anti-abortion groups which, as previously stated, associate the promotion of assisted conception procedures with a more permissive approach towards abortion.

Conclusion

During the past two decades there has been substantial development in the area of assisted conception, particularly third party conception, and this has been characterized by both negative and positive aspects. Major negative factors relate to the lack of legal support to practise the specialty, ambiguities concerning the legal status of certain parties in assisted conception, and the lack of financial coverage by the Obras Sociales and medical insurance schemes that compel patients to pay for their treatment costs.

In spite of these difficulties there are a number of positive elements. The fact that developments took place without legislation compelled professionals to take responsibility for their own work, and to reflect and explore their own ideas of ethics on such delicate issues.

It also resulted in the promotion of the exchange of information and experiences among professionals and the establishment of informal supportive networks alongside the formalized professional associations.

Likewise, it has meant that many professionals have had to abandon their exclusive patient-serving role and become involved in social and political issues related to assisted conception, such as political meetings, congresses and seminars.

Today, in spite of the continuous opposition of many sectors of society, in general couples no longer conceal the way in which their children were conceived. And although third party conception does not yet involve full disclosure, media articles have appeared portraying individual donor-conceived children and their families. Also, patient groups such as IMPSI have appeared who, together with other organizations, commit in their solidarity to other infertile couples. The difficulties and society- imposed taboos faced by couples undertaking assisted conception procedures generated a particular strength and a pioneering feeling in these patients.

However, while at present almost everybody supports the case for legislation, a long road still lies ahead of us.

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CHAPTER 2

Australia

Choice and Diversity in Regulation and Record Keeping

Helen Szoke

There are many claims made for ‘world firsts’ in assisted conception. Such a claim does not seem, therefore, a good introduction to the Australian regulatory treatment of third party conception. Yet it is true to say that in terms of the protections afforded to the people born as a result of donor treatment procedures, some aspects of the Australian regulatory framework are in fact ‘world firsts’, and arguably will set the trend for other common law jurisdictions around the world.

Australia is a large geographical area, with a relatively small population. It has a population of about 19 million people, the majority of whom live in the urban centres on the country’s coastline. Australia is a federation, with a constitution which defines the division of powers between state and federal governments. The effect of this has been that some states have chosen to pass statutes regulating infertility treatment and all states have passed laws for defining the legal status of the child born. This chapter looks at the history and development of regulatory frameworks for donor-treatment procedures and surrogacy in Australia. It is not a straightforward account, as Australia is a federation, and with a federated system of government come diversity and challenges posed by state-based legislative regimes. Diversity provides headaches for regulators, but may also provide choices for consumers.

Every story has a history

The pursuit of the development of new life exemplifies the fascination with controlling the process of creation of human life, and the importance of having children in the context of our social structure. Childlessness has through history been a mark of distinction that was not happily worn by those with this experience. Fiske, in her account of woman's experiences of infertility, captures the desperation of one woman's experience: 'You think you are absolutely desperate to have a child and you think you could put yourself through absolutely anything' (Fiske 2001, p.80).

Dr Allan Grant established Australia's first fertility clinic, the Sterility Clinic, at the Crown Street Women's Hospital in Sydney in 1938 (Nicol 1989, p.5). Over the years it developed a reputation and a research profile around the problems of infertility:

> 'It was the first in Australia', said Grant. 'Then, during the war, it was recognised that there was a need for babies and the Government threw a lot of money around setting up these clinics all over the place.' (Nicol 1989, p.5)

There were up to six in Sydney after 1944. A fertility and sterility clinic was established at the Melbourne Royal Women's Hospital in 1945, and in 1960 it was combined with the Endocrinology Unit and the Cytology Unit. The effect of changing attitudes to infertility was also evident in Melbourne. The experience of the infertile at the Royal Women's Hospital in Melbourne is depicted thus: 'The 1950s were a decade awash with babies and the infertile suffered acutely. Phantom pregnancies were not uncommon…' (McCalman 1998, p.309). Whilst there is evidence of the use of artificial insemination in these early days, in fact the procedure did not become commonplace in veterinary science until after World War II; its applications to humans became commonplace at that time.

Social changes in the 1970s in Australia also hastened developments in infertility treatment. Abortion gained greater acceptance and, in some cases, became allowable under statute within certain conditions. Contraceptive measures also gained much greater acceptance and became more efficient in their application (Leeton 1980, p.67). In addition, single motherhood became more common, and was supported financially by the introduction of a single mother's pension or other forms of government support. The net effect of these measures meant that the number of babies available for adoption was significantly reduced.[1] Leeton reported at this time that:

> artificial donor insemination (DI) is gaining increasing acceptance in developed countries for three reasons: the increasing shortage of babies for adoption, the poor results of medical treatment for male infertility, and the growing emancipation of the attitudes of society to matters of sexuality and reproduction. (Leeton and Blackwell 1976, p.45)

He claims that the demand for DI was huge, and anticipated that there were about 50,000 marriages in Australia at that time which were barren as a result of male infertility (Leeton and Backwell 1976, p.46). Published works on the use of DI in the first instance took some time to be produced. In Australia it was claimed that there were no medical reports of the use of DI before 1970, and the first report in 1970 claimed that approximately 16 patients had been treated over the previous 22 years (Leeton 1980).

The combination of social changes and medical advances led to other changes. At the Royal Women's Hospital in Melbourne, the social work department was affected by developments in the technology, as the once busy area of adoption counselling and placements of babies gave way to other considerations.

> Men were admitted as patients to the hospital for the first time in 1968 and their compulsory attendance with their wives enabled the clinic to begin to understand the extent of male infertility and to develop, in the mid 1970s under Dr Gary Clark, Melbourne's first public Donor Insemination program. (McCalman 1998, p.361)

These couples were required to see the social worker, an important precursor to the later emphasis on counselling as a component of donor treatment.

Challenges posed by third party assisted conception

DI was offered first in Adelaide, and then in Sydney and Melbourne in the 1970s, as a regular treatment option for male factor infertility. At that time, fresh sperm was used, and very little attention was given to the recording of information about the donor providing the sperm. This was before HIV was detected, and hence the normal medical screening processes were not extensive. Patients were advised to keep the form of treatment to themselves, and donors were guaranteed anonymity. This was done for two reasons. DI was seen as a medical procedure to address a medical problem. The primary concern of the doctor was to resolve a difficulty for the patient, and this primary concern overrode other concerns. The second reason related to the legal status of the child. There was no legal protection for the donor as the biological father of the child. Nor was there any protection for the couple utilizing donor sperm against the donor making claims of parenthood or wishing to claim responsibility. The social father had to declare himself as the father on the birth certificate. This situation had to be addressed, particularly as sperm-freezing techniques improved and it became possible to store frozen sperm and thus control the treatment process to a much greater extent. In addition, *in vitro* fertilization (IVF) was developing and donor sperm and later egg donation became possible within IVF procedures.

Rapid technological developments propelled state and federal governments into looking at the use and consequences of third party assisted conception. The increasing use of DI had a significant impact. The Family Law Council of Australia was asked to address the issue of the legal status of children born as a result of this procedure (Family Law Council 1985). In its introductory comments to the report, the Family Law Council acknowledged the changing context which the use of these procedures had imposed on the lawmakers and the community.

> Given that the major purpose of reproductive technology is to create a child who would not otherwise have been conceived, and that a substantial allocation of public resources is required to enable this, it seems clear that the community has a particular responsibility to promote and protect the interests, needs and welfare of that child when born. (Family Law Council 1985, p.vii)

Changes were required in both state and federal laws to clarify the issue of parentage in donor procedures. Amendments were subsequently made to the Family Law Act 1975 (Commonwealth) recognizing the social parent in a donor procedure as the legal parent, thus severing the legal relationship between the biological parent and the child. This paved the way for the social father to be legally named on the birth certificate. The states quickly followed suit, with the Status of Children (Amendment) Act 1984 in Victoria, the Family Relationships Amendment Act 1984 in South Australia, the Artificial Conception Act 1984 in New South Wales, and amendment in 1985 to the Status of Children Act 1974 in Tasmania, the Artificial Conception Act 1985 in Queensland, and the Artificial Conception Act 1986 in Western Australia. The confused legal status faced by people utilizing donor gametes was addressed. The woman who gave birth to the child was the mother, and her partner was the father. The social parent, to all intents and purposes, became the legal parent. The changes also ensured that the donor had no legal rights, responsibilities or liabilities. These changes provided reassurance to the medical community offering these procedures, to recipients of donated gametes and to donors. They also provided the basis for important legislative initiatives to be brought into Victoria, where the state law incorporated a requirement that all donor births be recorded on a centrally managed birth origin register.

When the changes were made to the legislation at the federal and state level, there was an unanticipated consequence, which became apparent later. Surrogacy has not had a long tradition in Australia, but has a high public profile. Any form of surrogacy is complex, whether it is genetic or gestational surrogacy.

The legislative reforms which clarified the legal status of children born as a result of donor procedures in fact confused the legal status of children born as a result of surrogacy arrangements. As the woman who gives birth is considered in law to be the mother, this meant that the surrogate is the legal mother of any child born, irrespective of whether she has a biological relationship with the child. This has posed a significant dilemma for legislators and people utilizing surrogacy treatment since that time. This will be explored in greater detail below (see also Blyth in this volume).

Different statutory responses

By its very nature, the assisted creation of life is different from the development of other health technologies. Its development has challenged many of our previous understandings of family, marriage, procreation and kinship. These challenges drew different responses in the Australian states. Australian legislatures have not responded consistently. Most jurisdictions undertook extensive enquiries to review the implications of the development of IVF in the early 1980s. All of these enquiries inevitably addressed the issue of DI in the first instance and then donor gametes in other procedures, and surrogacy. Beyond clarifying the legal status arising from donor procedures, not all states moved to legislate in this area. It is not clear why some states did not move to statutory regulation, although arguably service provision in Queensland and Tasmania at that time was limited. However, New South Wales had a large IVF sector, but the government of the day resolved not to move hastily into legislation. Figure 2.1 is a map which outlines the legislative status of reproductive technologies in Australia and provides an

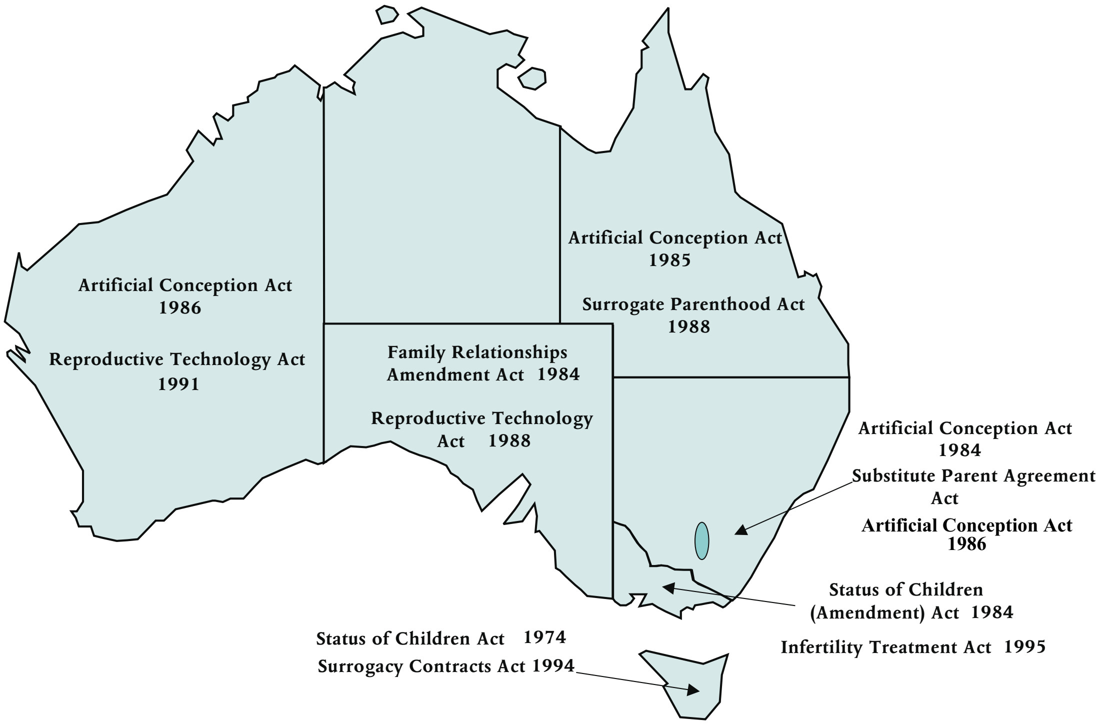

Figure 2.1 Australia's Regulatory Regime

overview of the diversity, and is supported by the detailed subsequent commentary.

Victoria

The most significant system of checks and balances associated with third party donor procedures exists in Victoria. Since 1988, this state has recorded every birth arising from a donor treatment procedure, whether this is from donor egg, sperm or embryos. Since that time, there has been an extensive process of counselling all prospective donors and recipient couples, prior to commencing a treatment procedure; and then a follow-up of pregnancies by clinic staff to ensure that any resulting live birth can be recorded on a central register of donor births. To my knowledge, this is the most comprehensive statutory protection of the interests of donor offspring in the world, notwithstanding the existence of legislation in Sweden and Austria which similarly requires the retention of information about donor-treatment procedures (Insemination Law 1985 (Sweden); Reproductive Medicine Law 1992 (Austria)). The UK's Human Fertilisation and Embryology Act 1990 also requires the collection of such information, but to date regulations have not been passed which allow release of that information (see Blyth in this volume).

The Victorian statutory experience started with the Waller Committee, which published a Report on Donor Gametes in IVF in 1983. This paper contained the far-reaching and insightful statement that:

> Whether or not a person pursues her or his origins, it should be possible for everyone to discover them. In this sense everyone has a strong interest in being able to discover some information about her or his origin. The Committee has therefore decided that children born as the result of the successful use of donor gametes in IVF should be able to discover some information about their origins. At the same time the Committee realizes that the child's parents cannot be compelled to provide this information, or even to tell the child anything which will prompt a search for it. (Waller 1983, p.26)

This view was strongly influenced by the adoption lobby, where legislative reforms were brought into the State Parliament in 1984 to provide access to information for adopted people. Complementing the legislative requirements were the requirements for all donors and recipient parents to be counselled and to receive information, not only on the legislative requirements, but also on the consequences of seeking family formation through this avenue, the likelihood of success and other possibilities for the family. The 1984 statute, the Infertility (Medical Procedures) Act 1984, made provision for the establishment of a central register to be maintained at that time by the Health Department, and for information which identifies a person on that register to be released only with the consent of the person about whom the information relates. These provisions were strengthened with the revision of the statute in 1995, when it was replaced with the Infertility Treatment Act 1995. These provisions were even stronger, providing the right to offspring born as a result of a donor procedure to access identifying information, if they so chose, when they attained the age of 18 years.

In the early days of this requirement for record keeping, the statutory initiative was not universally welcomed. The doctors, with a history of balancing the interests of the patients and the donors, were concerned that these requirements would result in a reduction in the number of men willing to donate sperm. It was also the continuation of the public policy tussle between private choice and public interest, and the role of government in intervening in private activities, or the doctor/patient relationship. The early reactions from the medical profession were extremely cautious. Dr Nicholas Tonti-Filippini[2] recalls Ian Johnston, a doctor from the Royal Women's Hospital, stating at a public meeting, 'If donor identification comes in I will destroy all our records!' and Louis Waller, soon to become the inaugural chair of the Standing Review Advisory Committee on Infertility, responded 'And we would see you put in gaol' (Tonti-Filippini 2000). In January 1984, the birth of a baby resulting from the use of a donor egg was announced (Kannegiesser 1988, p.89). This showed that it was possible to involve a woman as the third party in the reproductive process.

The Infertility Treatment Authority, established under the provisions of the Infertility Treatment Act 1995, continues to monitor the impact of the legislative initiative on recruitment of sperm donors. Figure 2.2 outlines the trends for recruitment of sperm donors, and should be viewed in the context of changing technology and the requirement for fewer donors once sperm freezing was instituted. In recent years there has also been a reduction in demand for donor sperm with the advent of ICSI as a means of addressing male infertility.

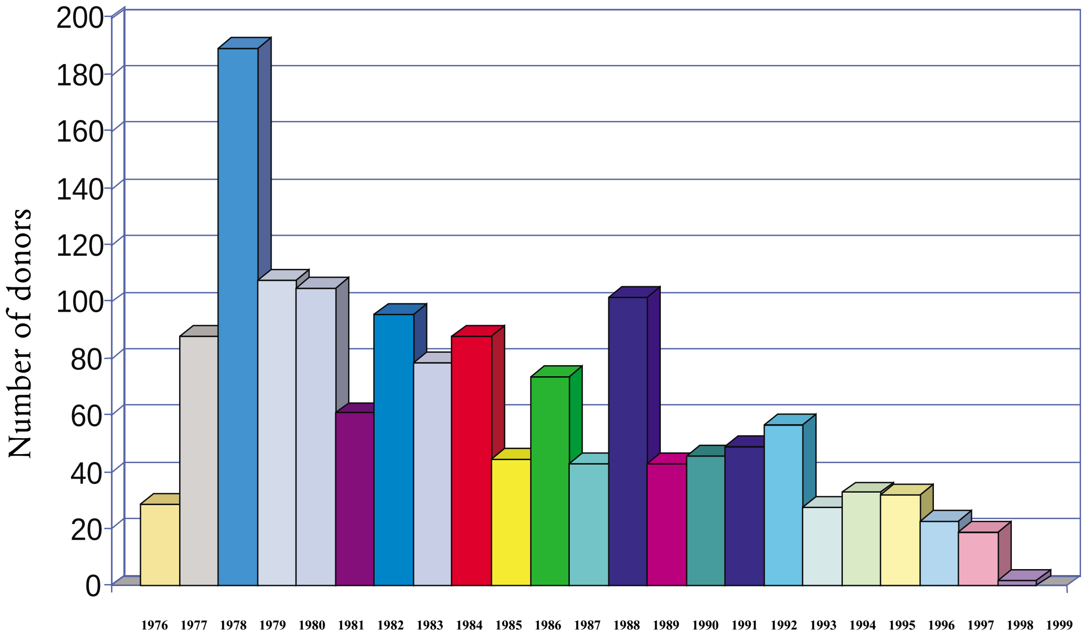

Figure 2.2 Donors recruited in Victoria, Australia
(Infertility Treatment Authority, Annual Report, 2000, p.17)

Table 2.1 Summary of birth origin registers maintained by the Infertility Treatment Authority (Victoria)

1984 Central Register	Established under the provisions of the Infertility (Medical Procedures) Act 1984 (now replaced by Infertility Treatment Act 1995)	Provides the requirement for all births resulting from a donor-treatment procedure to be registered. Registration details include identifying information about the donor, the person resulting and the parents of that person. Release of information which identifies can only be undertaken with the consent of the person about whom the information relates.
1995 Central Register	Established under the provisions of the Infertility Treatment Act 1995, it relates to all donor procedures where the consent to donation was given after 1 January 1998, the date at which the Act was proclaimed	Provides the requirement for all births resulting from a donor-treatment procedure to be registered. Registration details include identifying information about the donor, the person resulting and the parents of that person. Release of information to the person born is automatic on that person attaining the age of 18 years. Any other release of identifying information may only be undertaken with the consent of the person about whom the information relates.
Post-1988 Voluntary Register	Established under the provisions of the Infertility Treatment Act 1995	Relates to all donor procedures undertaken since 1 July 1988 (the date at which the original Act was proclaimed) and is a totally voluntary register which relies on linking, utilizing the donor code which is recorded on the Central Registers. Applicants can place messages, photos, etc. on this register and can stipulate conditions under which information can be released. The register does not mean a registration will result in an active search on the part of the Authority for a corresponding party.
Pre-1988 Voluntary Register	Established under the provisions of the Infertility Treatment Act – Amendment 2001	Relates to all donor procedures before 1 July 1988. It operates in a similar fashion to the Post-1988 Voluntary Register, but relies on the donor code being released from the treating clinic. The expectation is that the further back in time the less likelihood that identifying information will be located.

Victoria has had these statutory provisions for 14 years, and in that time there has been growing acceptance and education about the recording of such information. The statutory examples are being explored by South Australia, Western Australia and more recently New South Wales, where there has been no history of statutory regulation of infertility treatment. The impact of the changes is difficult to assess.

Currently, the Infertility Treatment Authority has four different types of birth origin registers. These are summarized in Table 2.1

Victoria has had birth registers since 1988. Yet there are parents who may not wish, or are unsure how, to divulge the story of their children's birth origins. This may require a generation change to reassure people involved with developing treatment procedures that all sorts of different birth stories are to be told. Parents' reservation over telling the children about their biological origins may be related to the experience of the infertile male. Kirkman, in her story about surrogacy, describes her husband's reaction to news of his infertility:

> Severn describes [the news of his infertility] as the most intense shock, the most bitter blow, of his adult life. It affected him so profoundly that he told no one apart from the specialists he consulted over the next few years in a vain search for a remedy. (Kirkman and Kirkman 1988, p.41)

The impact of the use of these procedures by single women or lesbian women, where it is not possible to disguise the source of sperm, may also have an effect in providing greater comfort to families of the past who utilized these procedures. Charlesworth, in commenting on egg donation, describes it thus:

> Forming a family by means of oocyte donation should also be seen within the broader context of the other various modes of family formation namely by donor insemination, adoption, surrogacy, etc. The concept of 'family' is a pluralistic one, as different forms of the family can coexist in our society. (Charlesworth 1992, p.605)

South Australia

South Australia has had comprehensive regulation of infertility treatment since 1988, with the passage of the Reproductive Technology Act 1988. The Northern Territory contracts services from South Australian providers, and therefore operates on the basis of the same legislative provisions as

South Australia. The statutory framework established the South Australia Council of Reproductive Technology (SACRT) with responsibility for administration of the Act. The SACRT has responsibility for the development of a code of ethical practice, which forms the basis for the provision of infertility treatment in that state. The code incorporates extensive requirements for counselling and the provision of information for all parties to the treatment process, including donors. The Act provides statutory protection for the anonymity of donors, with a penalty of AUS$5000 or six months' imprisonment if the identity of a donor is revealed without consent.

The statutory framework for the protection of donor anonymity has been subject to review recently. Recommendations were forwarded to the Minister for Human Services at the end of 2000, which would incorporate:

1. The ability of offspring to access identifying information about their donor.
2. A requirement on all prospective donors to consent to the release of information as a condition of their donation.
3. The establishment of a voluntary register for past donors.
4. Clinics seeking agreement with parents that their children will be advised of their donor origins. (SACRT 2001, p.5)

The SACRT has undergone a considered consultation and education campaign to promote the principles of disclosure. It is likely that these recommendations will be accepted.

Western Australia

Western Australia has had legislation regulating the provision of reproductive technologies since 1991. The Human Reproductive Technology Act 1991 requires that information about donor procedures be maintained at the clinics. Under the Act, a central register incorporating information about participants, procedures and any children born as a result of artificial fertilization procedures was also established in the Health Department (1991) (WA) ss. 44, 45, 46. This includes identifying information about donors. However, currently the Act limits the right of access to this information by offspring resulting from the use of those donors' gametes to non-identifying information. An extensive Parliamentary review of the Act in 1999 has proposed changes (Select Committee 1999).

The original Select Committee Report in Western Australia in 1988 recognized the need to address this issue, but found 'arguments for children to have the right to information which identifies their biological parents persuasive, but recognise[d] that this is a contentious issue which requires further public debate' (Select Committee 1988, p.19). The review of the legislation undertaken some eleven years after the first committee's report acknowledged the need to 'consider the rights and welfare of the offspring resulting from reproductive technologies with regard to access to information about genetic parentage' (Select Committee 1999, p.193). The committee has recommended that in future, access to donor identifying information will be available on request to any donor offspring upon attaining the age of 16 years, and that offspring have access to identifying information retrospectively where the donation was made after the commencement of the Human Reproductive Technology Act 1991, and there is an indication that the donor has been informed that disclosure of identifying information will occur. Its recommendation that a retrospective voluntary register be established based on mutual consent between the donor who donated prior to the Human Reproductive Technology Act 1991 and the donor offspring (Select Committee 1999, p.210) was implemented in 2002. However, the non-voluntary release of identifying information has not been mandated.

New South Wales

In 1986 the New South Wales Law Reform Commission produced its report *Human Artificial Insemination* (NSW Law Reform Commission 1986). It proposed that legal regulation should be imposed on those people or institutions providing DI, and that its provision should be restricted to medical practitioners, where the practice is being carried out in a public institution or for reward. However, no further action was taken in that state until 1997, when the discussion paper, *Review of the Human Tissue Act 1983*, was released (NSW Health 1997). Practitioners in New South Wales have strongly resisted a statutory regulatory framework for the provision of infertility treatment, and until recently there has not been the political will to pursue the directions foreshadowed in the subsequent consultative committee meetings established to discuss the outcome of the discussion paper findings. It is now mooted that New South Wales will also establish a birth register, but there is little information available yet about how that would operate.

Queensland, Tasmania and the Australian Capital Territory (ACT)

These jurisdictions, like New South Wales, held reviews in the early 1980s to determine whether reproductive technologies should be regulated (Chalmers 1985; Demack 1984). However, no specific state statutory protections were put in place, other than the appropriate amendments to the states' legislations clarifying the legal status of a child born as a result of the procedures (Artificial Conception Act 1985 (Queensland); Artificial Conception Act 1986 (ACT), Status of Children Act – Amendment 1985 (Tasmania)).

Should there be statutory protections for birth origin information?

Research is being undertaken to determine the extent to which parents are likely to disclose their birth origins to their children, even in such a statutory climate as exists in Victoria. A preliminary understanding would suggest that the issue is not with the sperm donor, as originally feared. The Victorian Infertility Treatment Authority receives many unsolicited calls from sperm donors involved with donations in the late 1970s and early 1980s wishing to apply to one of the state's voluntary registers. However, parents may be unwilling to tell their child about his or her conception. The research in this area is inconclusive, and arguably may be affected by the regulatory regime in place. Even in the Victorian context most parents do not tell their children about their birth origins (Blood 1998), and this view is reinforced in overseas research (Gottlieb, Lalos and Lindblad 2000). Other research, however, indicates alternative trends: the majority of South Australian parents surveyed by Looi were planning to discuss birth origins with their children (SACRT 1999, p.47) and more recent research by Golombok *et al.* (2002) in the UK indicates an apparently increasing number of parents of donor -conceived children intending to tell their children about their origins.

Some early research has been undertaken involving recipients of donor eggs, most of whom said they had no desire to meet the donor. The researchers comment:

> Within the sample there was an atypical group of couples who would always enshroud their involvement in the donor oocyte programme in secrecy, with the accepted principle that privacy and secrecy helped to ensure the intactness of their family unit. An impression gathered was that this maintenance of secrecy had changed the nature of their lives and

> had imposed the need for adaptive and defensive reactions which had become part of the family climate. This was further confirmed by the couples' anecdotes about the denial involved as they tried to conceal the origins of the conception from others. (Munro 1992, p.128)

As stated above, it may require a generation change to assure families that all sorts of different birth stories are to be told.

The use of DI, and then donor gametes in IVF, posed a major challenge to previous understandings of how new life can be created. It may not be possible accurately to measure the social impact of these interventions in the short term. What is important, however, is that the information is protected, and that public education continues, not only to encourage openness for the people involved with the procedures, but also to encourage familiarity and acceptance in the broader community of the view that families are formed in different ways and that this is acceptable. Australia now has a state jurisdiction, in Victoria, that has a long experience of maintaining a birth register, such regulation having been in place since 1988. Three other states, New South Wales, South Australia and Western Australia, are currently considering the establishment of a birth register, and Western Australia has recently established a voluntary register. While statutory registers will not have retrospective effect, they will begin to build protections for people born as a result of donor gametes and embryos. National data on the use of donor egg, sperm or embryo are outlined below.

Table 2.2 Outcomes of assisted conception pregnancies after use of donor gametes or donor embryos, 1999 – Australia

Outcome of pregnancy	Donor sperm	Donor oocytes	Donor embryos
Live birth	162	147	30

Source: Hurst and Lancaster 2001, p.52

Surrogacy

Surrogacy arrangements have been a feature of family formation for centuries. However, surrogacy has not been universally embraced as an acceptable way of allowing infertile couples to form a family, and the regulation of surrogacy in Australia has been dealt with in different ways.

Leeton estimated that the absolute indication of surrogacy, where a woman has functioning ovaries but no uterus, does not exceed 12 cases in Australia per year (Leeton 1991). He further estimates there are approximately six cases of genetic surrogacy in Australia per year. Media reports cite 28 infertile couples as having utilized the services of a US surrogacy agency in the past decade, paying commercial rates of around US$55,000 (Ferrari 1997). More recent reports state that between AUS$20,000 – AUS$ 120,000 has been paid in the US for others to have babies for Australian women. Victorian courts have dealt with about 20 cases of infants born through surrogacy arrangements to decide the legal custody of the child (Dunn 2001). On any count, the number of people seeking a surrogacy arrangement is small, but the impact of those arrangements has far-reaching legal, social and ethical consequences. Australia witnessed a most successful and public surrogacy arrangement by the Kirkman sisters in 1984 (Kirkman and Kirkman 1988, 2002). This arrangement influenced the move to address the need for regulation in this area.

Commercial surrogacy has no basis in any Australian jurisdiction, and legislative provisions exist in most Australian jurisdictions making any contracts in relation to a surrogacy agreement unenforceable and any payment for the soliciting of a surrogacy arrangement illegal (Reproductive Technology Act 1988 (South Australia), Surrogate Parenthood Act 1988 (Queensland), Human Reproductive Technology Act 1991 (Western Australia), Substitute Parent Agreement Act 1994 (Australian Capital Territory), Surrogate Contracts Act 1994 (Tasmania), Infertility Treatment Act 1995 (Victoria)). In practice this means that in some states, it is difficult legally to make a surrogacy arrangement. Even in states such as Victoria, South Australia and Western Australia, altruistic surrogacy is difficult to organize, as often the arrangements fall within the general regulation of infertility services.

The ACT is the only jurisdiction where altruistic gestational surrogacy is facilitated by statute. The practice occurs in New South Wales, but without statutory cover. Jurisdictional variations mean that couples wishing to pursue treatment will move to areas where this is possible. Of greater concern, however, is the lack of any statutory provision that clarifies the status of the child born as a result of a surrogacy arrangement. In the case of a surrogacy arrangement that is not organized within a family, the adoption process becomes difficult and complicated. The Commonwealth government lacks clear constitutional power to legislate on the issue of surrogacy (Janu 1996). The ACT is the only jurisdiction which has statutory arrangements in place which address the legal status of the child born following a surrogacy arrangement. The Artificial Conception (Amendment) Act (Australian Capital Territory 2000) requires that five conditions be met before the granting of a Parentage Order by the ACT Supreme Court:

1. At least six weeks and no more than six months must have elapsed since the birth of the child.
2. The child's home must be with the genetic parents.
3. The birth parents, with full understanding, must agree freely with the arrangement.
4. The genetic parents must be domiciled in the ACT when the application and order are made.
5. The genetic and birth couples must have received assessment and counselling from a service other than that which is carrying out the IVF procedure.

In 1998, the Family Court of Australia made its first parenting order in a case where a child was conceived through a private surrogacy arrangement in which the surrogate was inseminated with the commissioning father's sperm (*Re Evelyn* 1998). This case highlights how irreparably wrong such arrangements can go. This case involved a *de facto* arrangement between the couples concerned and highlights the risks that are taken in the absence of selection, counselling, screening and competent medical management. 'Evelyn' was born to a woman who lived in South Australia, and agreed to carry the child for a Queensland couple. However, the surrogate found she could not relinquish 'Evelyn' to her natural father and his wife. After Family Court proceedings, 'Evelyn' was returned to her birth mother (the surrogate) in South Australia, the court specifying the type and frequency of contact between 'Evelyn' and her biological father and his wife.

Little can be done to monitor the private arrangements made between couples organizing their own surrogacy arrangements. But, where assisted means are used, it may be better to have a monitored and regulated practice, containing checks and balances to ensure as far as possible the interest of all parties and, most important, of the child are protected. Much more public debate is required on this issue.

Ultimately, risk management and instituting checks and balances through statutory regulation can only be achieved where community acceptance exists. In most jurisdictions in Australia, there remains a significant gap between acceptance and legitimization of this practice, which would allow the facilitation of surrogacy through statutory cover.

Notes

1 In 1966 in Victoria, for example, there was a total of 1630 non-relative adoptions. By 1976, this figure had dropped to 476 non-relative adoptions. In 1996/97 there were 23 babies for adoption in Victoria (Department of Human Services 1998).

2 Dr Nicholas Tonti-Filippini is a consultant ethicist who had some involvement with the drafting of the Victorian Infertility Treatment Act 1995. He provided this anecdote in the context of an interview for the author's PhD research. Dr Tonti-Filippini has given his consent to the use of this quotation in this chapter.

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Status of Children (Amendment) Act 1984 (Victoria)

Artificial Conception Act 1985 (Queensland)

Insemination Law 1985 (Sweden)

Status of Children (Amendment) 1985 (Tasmania)

Artificial Conception Act 1986 (Western Australia)

Artificial Conception Act 1986 (ACT)

Reproductive Technology Act 1988 (South Australia)

Surrogate Parenthood Act 1988 (Queensland)

Human Fertilisation and Embryology Act 1990 (UK)

Human Reproductive Technology Act 1991 (Western Australia)

Reproductive Medicine Law 1992 (Austria)

Substitute Parent Agreement Act 1994 (Australian Capital Territory)

Surrogate Contracts Act 1994 (Tasmania)

Infertility Treatment Act 1995 (Victoria)

Artificial Conception (Amendment) Act 2000 (Australian Capital Territory)

Infertility Treatment (Amendment) Act 2001 (Victoria)

CHAPTER 3

Canada

The Long Road to Regulation

Jean Haase

Introduction

In many respects, innovations in assisted conception techniques have impacted Canada in a similar way to other developed nations. The personal impact of infertility, together with medical and scientific advances in assisted conception, has received wide publicity and led to an increased demand for medical help to create families. This includes the use of third party procedures such as gamete and embryo donation, as well as surrogacy arrangements. In keeping with developments internationally, scientific and medical innovations have preceded the social, ethical and legal responses to many of the questions raised by such new ways of forming families. Although Canada has not yet passed legislation in this field, it has been in various stages of development at the federal level for at least a decade.

Canada is a federation of ten provinces and three territories, with responsibility for health care shared between the national and provincial/territorial governments. Canada has a predominantly publicly-financed, privately-delivered health care system. The federal government is responsible for setting and administering national principles or standards for the health care system through the Canada Health Act (1985) and assisting in the financing of provincial health care services through fiscal transfers. The provinces and territories are responsible for managing and delivering health services to their residents.

Provinces and territories have some discretion as to which services are considered 'medically necessary'. Since the early 1990s, most have eliminated assisted conception procedures from funding support in response to declining federal transfers and health budget shortfalls, although in most provinces and territories medical tests and diagnostic procedures are government funded. Consequently, most assisted conception procedures in Canada are now provided within private health care, with a small minority of clinics remaining in public hospital settings. Of all provinces and territories, only Ontario, with about one-third of Canada's total population and the greatest number of fertility clinics, continues to fund some *in vitro* fertilization (IVF) treatment. Up to three completed IVF cycles are funded for women who have both of their fallopian tubes blocked or absent, except when there has been previous surgical sterilization.

This policy was adopted in Ontario in 1994 and was in keeping with recommendations of the Canadian Royal Commission on New Reproductive and Genetic Technologies (1993) (hereafter 'The Royal Commission'), which advised that IVF 'should only be offered as a treatment to women with a diagnosis of complete tubal blockage' (Recommendation 106, p.526) and that 'variations of IVF, and IVF for diagnoses other than fallopian tube blockage, be offered only in the context of research' (Recommendation 107, p.526). The commission's findings have subsequently been criticized as having been based on inaccurate studies of IVF outcomes. Furthermore, at the time that the Royal Commission was gathering information, IVF variations such as intra cytoplasmic sperm injection (ICSI) were not widely available.

An important implication of Ontario's funding policy is that insemination procedures – including those that utilize donor sperm – are government funded. Thus, financial realities may play a major role in recipients' decisions to use donor sperm for cases of male infertility, rather than opting for a procedure such as ICSI which offers the possibility of conceiving a child who is genetically linked to both parents.

In the general absence of public policy and regulation, assisted conception services have increasingly developed within the context of private medicine. Canada's proximity to the US, the base for a major fertility treatment industry, continues to have a steadily increasing influence. The media have given the apparently increasing trend of 'reproductive tourism' considerable attention in recent years (Lindgren 1999). The role played by internet communication in the marketing of private fertility clinics and gamete donation banks is also highly relevant for Canadians, given that most of these web sites and services are based in the US.

Aside from the high costs associated with private medicine, Canada's vast geographic size creates a further barrier to the accessibility of specialized fertility services. Of approximately 22 centres offering IVF treatment, over half are situated in Ontario, with some provinces and territories having no specialized clinics. Artificial insemination by donor (DI), however, is provided in a greater number of smaller medical settings such as family doctors' offices or gynaecology outpatient clinics. Health Canada currently lists over a hundred sites where donor sperm is processed, imported and/or used for inseminations; fewer than half this number are fertility clinics (Health Canada 2002). However, there are no statistics currently being collected for births from DI, a situation that will be rectified only when there is a mandate for both clinic licensing and data collection. The majority of clinics in Canada voluntarily report their IVF pregnancies and births to the Canadian Fertility and Andrology Society, but there is no auditing of such data for accuracy; statistics are released publicly in a national aggregate format and not as clinic-specific data. Information is also collected on donor sperm or eggs for the IVF database, although pregnancies and births are reported separately for donor egg cycles only. Overall, therefore, it is difficult to obtain accurate statistics or information as to the current nature and extent of third party assisted conception in Canada.

The Royal Commission found that the first recorded instance of DI in Canada was in 1950 (p.431) although the practice was believed to occur much earlier without formal records. Despite the advent of other forms of donor-assisted conception, DI continues to be the most widely used application of donor technologies. In 1992 it was estimated that between 1500 and 6000 children were born annually from DI (Achilles 1992), and although subsequent advances in treating male infertility may have reduced the demand for DI from heterosexual couples, it is increasingly sought by women with no male partner.

Approximately half of all Canadian IVF clinics offer egg donation, although in some places it is only available when recipients are able to provide their own donor. Some private fertility clinics offer 'egg sharing' arrangements, which the federal government has consistently indicated it proposes to prohibit (Minister of Health 1996a, 2002a). Embryo donation appears not to be widely available.

Milestones in the development of regulation and legislation

The evolution of legislation in Canada has been slow and protracted, affected by political change and a lengthy consultation process between the different levels of government and stakeholder groups.

1993: The Royal Commission on New Reproductive and Genetic Technologies

Following more than a decade of debate about new reproductive technologies, the Canadian government established the Royal Commission on New Reproductive and Genetic Technologies in 1989. The commission's mandate was to assess the impact of reproductive technology on society as a whole, and on specific groups such as women, children and the disabled. Public input was encouraged with forums being held in communities across the country, and over 40,000 stakeholder groups and individuals consulted. The estimated cost of the Royal Commission's work was CAN$28,000,000. Its final report, *Proceed with Care* (Royal Commission 1993b), recommended the prohibition of several practices including the commercialization of gamete and embryo donation and surrogacy. Practices such as IVF and DI were to be regulated under a newly-established governing and licensing body, which would also oversee future scientific developments. The Royal Commission also recommended the establishment of a birth register to record information on births from gamete and embryo donation. Although the commission supported sharing the facts about birth origins with children, there was ultimately disagreement among members as to the rights of donor-conceived people to learn the identity of their donor. While the majority view at that time was that non-identifying donor information only should be available, a dissenting member, Scorsone, advocated for the disclosure of donor identity (Royal Commission 1993b, pp.1113–1121).

1995: Interim Voluntary Moratorium

Announcing a 'phased approach' to policy development, Health Minister Dianne Marleau responded to *Proceed with Care* by introducing a voluntary moratorium on nine specific practices: sex selection for non-medical reasons; commercial surrogacy arrangements; buying or selling of gametes and embryos, egg sharing; germ line genetic alteration; ectogenesis; cloning of human embryos; formation of animal-human hybrids; retrieval of sperm or eggs from cadavers or foetuses for treatment or research (Marleau 1995).

Although the moratorium is presumed to remain in effect until legislation is enacted, compliance is generally viewed as having been very poor. Commercialization has flourished in the continued absence of government intervention, egg sharing is still offered at some clinics, and a recent media report suggested that surrogacy has increased considerably (Caldwell 2001).

1996: Bill C-47 The Human Reproductive and Genetic Technologies Act

The government introduced Bill C-47 in 1996 (Minister of Health 1996a). Considering a need for urgency, the government addressed only practices it intended to prohibit, deferring action on other issues raised by the Royal Commission. Bill C-47 was therefore criticized as being punitive, rather than setting an appropriate framework for properly regulated activities. Despite the stated urgency, this Bill subsequently died on the parliamentary order paper with the dissolution of Parliament in the spring of 1997. Although the Liberal party was returned to power and work continued on revamping Bill C-47, legislation was not re-introduced during the subsequent government's term of office. It took another five years for the government to draft a new Bill and a further year before its introduction in Parliament.

2001: Proposal for Legislation Governing Assisted Human Reproduction

Health Minister Allan Rock presented draft legislative proposals to the House of Commons Standing Committee on Health, calling for a report to be provided by the committee within eight months. In keeping with protocol, the committee was comprised of 16 members whose political affiliations were proportional to party representation in the House of Commons. Such standing committees would more routinely receive a Bill for consideration after its introduction and the first reading. However, reversing the normal routine in this case was seen as an important step in anticipating, and possibly circumventing, the degree of controversy expected when it was eventually introduced in the House of Commons. It also permitted further consultations to take place between the committee and individuals and stakeholder groups.

With respect to the issues most relevant to donor conception, this draft Bill proposed to permit expenses to be paid to donors; establish a birth register and provide non-identifying information to donor-conceived offspring. It recommended that identifying information could only be provided if a donor had willingly consented to this at the time of donation. The latter proposal, in which the interests of the donors were accorded precedence over those of offspring, was arguably in conflict with one of the guiding principles of this Bill: 'the paramount need for measures to protect and promote the best interests of children' (Minister of Health 2001, preamble p.1).

2001: Report of the Federal Standing Committee on Health

The House of Commons Standing Committee conducted several months of hearings with invited witnesses, and received hundreds of written submissions. The final report, *Assisted Human Reproduction: Building Families*, made 36 recommendations, some of which differed markedly from the terms of the draft Bill (Standing Committee on Health 2001). Taking a strong stand against an increasing trend towards the commercialization of human gametes and embryos, the committee recommended against the payment of *any* expenses to gamete donors – including payments 'in kind' as in egg sharing.

The committee recommended that surrogacy for commercial gain be prohibited and that 'surrogacy for non-commercial reasons should be discouraged but not criminalized' (Recommendation 9, p.12). It proposed that any form of consideration, incentive or compensation should be prohibited. This was to include parties providing medical, legal or psychological services (Recommendations 10–11, p.13).

The committee also recommended that 'provinces and territories be encouraged to provide mandatory counselling to the commissioning couple, surrogate mother and her partner through existing publicly-funded services available for adoption, and to amend relevant family law to recognize the birth mother as the legal mother' (Recommendation 12, p.13). Furthermore, the committee advised that: 'Individuals who seek to add a child to their family through surrogacy must be subject to the same scrutiny as individuals who seek to adopt a child' (Recommendation 11, p.13).

One of the committee's most significant recommendations advocated an end to anonymous donation:

> We were particularly moved by the arguments for an open donation system that would not treat children as commodities to be negotiated among participating adults such as parents, donors and physicians… In moving to an open system that eliminates secrecy, the Committee would like to see a strategy that combines legislation and education, focussing particu-

> larly on physicians and others who facilitate the process of donation. (Recommendation 19, p.21)

To date, this report is the only official government document which has recommended the elimination of donor anonymity.

2002: Bill C-56 An Act Respecting Assisted Human Reproduction and Bill C-13 An Act Respecting Assisted Human Reproductive Technologies and Related Research

In May 2002, the federal government finally introduced Bill C-56 in Parliament, having ultimately rejected some important standing committee recommendations. Of key significance, Health Minister Anne McLellan rejected the committee's advice on donor anonymity and reverted to the original position set out in the 2001 draft Bill giving donors the option of remaining anonymous. The provision for offspring to have non-identifying information remained, as did the option for donors or surrogate mothers to receive expenses. The Bill included proposals to establish a regulatory body operating independently of Health Canada, and reporting directly to the Minister of Health.

In defending its rejection of some of the committee's recommendations, the government indicated that non-reimbursement of surrogacy-related medical expenses would contravene the Canadian Charter of Rights and Freedoms which allows universal access to health care; that non- reimbursement of donors' expenses would compromise the continued availability of services; and that permitting donors to be identified only with written consent was similar to the provisions for information sharing in provincial and territorial adoption models (Health Canada 2002).

Following the introduction of this Bill, Parliament was prorogued and most legislation died on the order paper. However, with the consent of all political parties, Bill C-56 – subsequently known as Bill C-13 – was returned to the Health Committee for further consideration and possible amendment. A third and final reading of the Bill is currently under way at the time of writing. The opposition right-wing Canadian Alliance party has challenged the continuation of donor anonymity, although much of the debate about the Bill is mired in the contentious aspects of using 'spare' embryos for stem cell research. If Bill C-13 passes the third reading it will subsequently progress to examination and assent by the Senate.

The legal status of parties involved in third party assisted conception

Complicating the issue of federal regulation is the reality that legal parentage issues fall under provincial/territorial jurisdiction. Both the Ontario Law Reform Commission (1985) and the Royal Commission (1993) recommended that where donated gametes are used, the birth mother should be recognized as the legal mother and her social partner as the legal father, regardless of any prior contracts related to the gestational role or to the gamete donation. Despite this, few provinces or territories have introduced legislation clarifying the status of the parties involved in donor conception, nor is there any legislation determining the parentage of a child born as a result of a surrogacy arrangement. In the case of gamete donation, only Quebec (Quebec Civil Code, 2002, Sections 538–542), Newfoundland (Newfoundland Welfare of the Child Act Part II, 1990) and the Yukon (Yukon Children's Act Part I, 1992) have legislation which delineates the status, rights and responsibilities of donors, parents and offspring. Quebec has recently revised its legislation regarding parentage to cover only 'medically assisted procreation' (Quebec Civil Code 2002, Section 538–542). Thus sperm donors and recipients making informal arrangements are not covered by this legislation.

In surrogacy, the commissioning parents – whether genetically related to the child or not – are usually advised to pursue a private adoption in order to secure legal guardianship once the child has been born. This would be recommended regardless of the existence of a genetic relationship between either of the commissioning parents and resulting child.

This omission of status legislation in most provinces is significant, not only because it fails to recognise legally most families who already owe their existence to third party assisted conception: it is cited as a necessary protection for donors in arguments endorsing the continuation of donor anonymity. Where egg donation is concerned, it is quite common for the donor and recipient parties to be advised or required by clinics to seek the services of a lawyer to draw up a contract. Despite the absence of legal statute, no such contract has yet been tested in Canada.

Access to third party assisted conception

The issue of recipient access or selection for third party assisted conception has created relatively little attention or controversy in Canada. Professional organizations such as the Canadian Andrology and Fertility Society have no specific guidelines related to non-medical criteria for recipient or donor access.

The Ontario Law Reform Commission recommended that fertility treatment be offered only to 'stable men and stable women in stable relationships' but did not define this any further (Ontario Law Reform Commission 1985, p.120). In principle, the commission was not opposed to surrogacy – at that time a fairly recent development – but recommended that existing child welfare and protective services could be used to screen the parties involved (Ontario Law Reform Commission 1985, p.247).

The Royal Commission identified a need to improve access to fertility treatments, going so far as to recommend that screened sperm should be available for self-insemination when recipients preferred an alternative to DI provided in a medical setting (Royal Commission 1993b, p.459). The commission also found that access to assisted insemination was limited for certain groups such as single and lesbian women and advised that:

> non-discrimination in the provision of public services is a clear requirement under the Canadian Charter and federal and provincial human rights legislation, which prohibit discrimination on the basis of such historically disadvantaging factors as sex, marital status, sexual orientation, and social or economic status. (Royal Commission 1993b, p.455)

However, it is likely that the availability of DI for single and lesbian women has increased since the publication of *Proceed with Care.* Most of the major assisted conception units appear to offer services to single and lesbian women, although there are anecdotal accounts of individual physicians who deny treatment to these groups.

Commercialization in third party assisted conception

Canada has consistently rejected the principle of payment for donations of organ, body tissue and blood, although community attitudes towards the sale and purchase of gametes, a practice well-established as regards donated sperm, have been less well defined. The federal government has been quite consistent, however, in its stated intention to remove commercialization from gamete and embryo donation, and from surrogacy (Minister of Health 1996b).

Shanner (1998) has also noted that compensation for eggs or sperm appears to contravene the Human Tissue Gift Act of Ontario, although this has never been subject to legal challenge.

The Royal Commission (1993b, pp.55–56 and pp.695–728) similarly took a strong stance against commercialization, and argued that payment for gametes devalues human life and those directly involved, including those conceived as a result. These arguments have also been made against egg sharing since, in this arrangement, eggs are used as a form of currency or bartering for services. Egg sharers are likely to be less affluent and less able to afford the costs of assisted conception treatment than recipients, thus creating financial coercion and unknown long-term emotional adjustment issues.

It would appear, however, that despite the government's stated intent to eliminate commercialization in gamete donation, the delay in regulation has permitted an increased level of trade and commodification in this field. Although egg donation was initially more likely to be altruistically motivated and to involve the use of a known donor, a widespread scarcity of donors has led to quite open financial inducements to potential donors through internet web sites and advertisements in university newspapers (Cheney 1998). A media report identified at least one Canadian clinic that was recruiting US donors and charging patients up to CAN$27,000 (Harvey 1998). The internet is now increasingly used to link prospective egg donors and surrogates with potential recipients.

Screening of donor sperm

Of all assisted conception practices, only the medical screening of semen for donation is currently subject to federal regulation. Canada's only reported case of transmission of HIV through donor sperm occurred in 1985 and concerned a single woman who was inseminated with fresh sperm from a donor who had not been screened for HIV (Canadian Bioethics Report 1997).

Achilles (1992) noted that adherence to professional body guidance on semen screening remained poor in the early 1990s. This led the chair of the Royal Commission to issue a public safety warning prior to the publication of the final report (Royal Commission 1993a). The introduction of semen screening regulations by Health Canada in 1996 (revised in 2000) has subsequently addressed most safety concerns, and there is now an annual federal inspection of clinics and sperm banks to monitor and enforce compliance.

The transmission of HIV and Hepatitis C in the donated blood supply created a national scandal in Canada, and standards for blood and tissue donation were subsequently tightened. Changes to semen-screening regulations that were applied retroactively by Health Canada in 2000 impacted negatively on the availability of existing cryopreserved sperm, most of which was desired by prospective recipients to conceive a genetically matched sibling for an existing child. Much cryopreserved sperm previously tested and approved under old guidelines had to be destroyed, although Health Canada has ultimately permitted limited access to some stored sperm providing it is to be used for family completion and recipients agree to sign a release (Health Canada Bureau of Biologics Donor Semen Special Access Program 2000).

Finding the new screening regulations both expensive to apply and complex to interpret, Canadian clinics have increased their reliance on commercial sperm banks based in the US. The fact that relatively few sperm banks are supplying the majority of Canadian clinics has implications that remain unresolved in the absence of Canadian legislation or regulation. Some of the most concerning aspects of this legislative vacuum are the lack of mechanisms for either data collection on donor births or for limitations on the number of offspring permitted per donor. Health Canada regulations do not address the issue of the number of offspring permitted from each donor, and commercial sperm banks which claim to limit the number of offspring are themselves reliant on clinics voluntarily providing information about DI outcomes.

Broader ethical issues related to Canada's reliance on the supply of donor gametes from outside the country have been raised in the media, but so far have not been addressed to any substantial degree by either government or clinics (Farley 2001; Moyle 2001). Bill C-13 does not specifically prohibit the importation of donor sperm. However, if a birth register is to become mandatory it is assumed that all donors, regardless of the source, will have to provide their names to the register and comply with all aspects of the regulations, including reimbursement of expenses only.

In highlighting screening standards for donors, it should be noted that current regulations address only medical and health issues. Acceptance criteria for sperm donors focus exclusively on health history and infectious disease status and there are no standards relating to psychosocial assessment or counselling for sperm donors. The widespread reliance on US sperm banks removes the opportunity for direct contact between donors and the clinics that use their gametes, and significantly reduces the potential for any voluntary information exchange, such as updated health information. In turn, sperm banks may have little accurate information as to where pregnancies and births might have occurred.

Welfare of the child in third party assisted conception

Historically, consideration of the welfare of children resulting from assisted conception has been neglected, with the focus of treatments directed towards the interests of the adult parties involved, particularly the recipients and clinics. Canadian medical groups have been notably silent on children's welfare, although other lobby groups of donor parents, donor offspring and some adoption advocacy groups have highlighted the need to consider the interests and rights of those born from donor assisted conception.

The Standing Committee on Health (2001) gave unequivocal support to the paramountcy of children's interests, stating:

> the legislation must protect the physical and emotional health as well as the essential dignity of the children who are the intended and desired result of these procedures…our thinking is directed by the feeling that children conceived through assisted human reproduction warrant even greater consideration than the adults seeking to build families or the physicians or researchers seeking new knowledge. (Section 2A, p.4)

Similarly, the declaration of principles in Bill C-13 states that: 'the health and well-being of children born through the application of these technologies must be given priority in all decisions respecting their use' (Minister of Health 2002b, Section 2b).

While identifying the need to consider the welfare of those born from assisted conception, these interests have not yet been clearly defined, nor have any proposals been developed as to how welfare needs might be assessed (see Blyth in this volume). Furthermore, a mandated focus on children's welfare should identify the roles and credentials of professionals responsible for making such assessments.

Donor anonymity

Generally, considerable effort has been expended to ensure the anonymity of donors and the confidentiality of recipient parents. Current legislative proposals provide gamete donors with the choice of withholding or revealing their identity (Minister of Health 2002b, Section 15:4) and thus give the wishes and desires of donors priority over those of any resulting offspring. This stance may well be open to future challenge under Canada's Charter of Rights, although this 'double track' approach is supported by the Canadian Fertility and Andrology Society (2002).

There have, however, been subtle shifts in attitudes towards anonymity. Despite arguments against commercialization, commercial sperm banks rather than clinics have responded to increasing demands by recipients for information and 'donor profiles' (see Blyth and Benward in this volume). What is unclear is whether the desire for detailed donor profiles is an indicator of increasing numbers of parents intending to share the facts about donor conception with their children. The need for such information may also reflect the desire for greater control over the outcome of the process by selecting certain physical and character traits of the donor. Indeed, both motivations may be relevant.

The past decade has witnessed a growing interest in the ethical and psychosocial issues related to third party assisted conception, often driven by participants and by advocacy groups. One such Canadian organization, Infertility Network, has promoted the interests of donor-conceived people and sponsored several symposia addressing the ethical and psychosocial aspects of donor-assisted conception. A public forum in Toronto in August 2000, 'Let the Offspring Speak', is believed to have been the first in North America devoted exclusively to the issues faced by donor-conceived offspring (Franz and Allen 2001). As long ago as 1987 a group of parents in British Columbia launched an advocacy group to lobby for their children's rights to access information about their donors (New Reproductive Alternatives Society 1987). A Canadian film-maker, who was himself conceived through DI in the UK in the 1950s, has recently made an award-winning documentary film about his search for birth origins information (Stevens 2001) and this has also received widespread publicity. National magazines and newspapers continue to feature stories about the issues faced by donor offspring and their families, and in the development of legislation, adult offspring and parents who have utilized donor gametes have made important contributions to government consultations (Hawaleshka 1998; McLelland 2002; Pittaway 2000).

There is no evidence to suggest that the possibility of donors and their offspring being identified to one another – other than in circumstances of known donation – has yet been acknowledged by most Canadian fertility clinics. However, it seems likely that requests for information by parents, offspring and even donors will occur in the future. Protocols for dealing with such requests will need to be developed, as will policies regarding the preservation of existing records. Once a mandated birth register has been developed, it also seems likely that there will be some demand for voluntary registers to be established, as has occurred in Australia (see Szoke in this volume) and the UK (see Blyth in this volume).

Surrogacy

The current prevalence of surrogacy in Canada – and community attitudes towards surrogacy – are unclear. As with all forms of assisted conception, surrogacy is currently unregulated and its practice is not formally documented. Between 8 and 20 clinics are believed to offer a surrogacy service, although commissioning parents are usually expected to provide their own surrogate. At least one agency in Ontario openly advertises a 'brokerage service' to connect prospective parties with one another (Canadian Surrogacy Options) and a small number of lawyers claim to specialize in arranging surrogacy contracts (Infertility Network 2002).

Despite the lack of hard data, there is anecdotal evidence to suggest that surrogacy has increased considerably since *Proceed with Care* concluded that: 'preconception arrangements are unacceptable and do not warrant state support in any form that would signal acceptance or encouragement of them' (Royal Commission 1993b, p.689), views that extended to non-commercial preconception arrangements between family members or close friends.

The voluntary moratorium mentions only the prohibition of 'commercial surrogacy' while Bill C-47 proposed to ban payment to surrogates, and to prohibit the role of intermediaries acting as brokers. However, under the provisions of Bill C-13, payment of receipted expenses will be permitted under regulations yet to be developed (Minister of Health 2002b, Section 12:1, 2).

As already noted, the Standing Committee on Health took a particularly strong stand against surrogacy and, while not recommending an outright ban, proposed to eliminate payment for any services by professionals such as physicians, lawyers and counsellors as well as to surrogacy brokers or to surrogate mothers (Standing Committee on Health 2001, Recommendations 10, 11, p.37):

> Commercial surrogacy treats children as objects and the reproductive capacity of women as an economic activity. Non-commercial (altruistic) surrogacy arrangements can also be socially harmful for the resulting child and place the health of women at risk. (Standing Committee on Health 2001, p.12)

Bills C-56 and C-13 have subsequently taken a less adversarial position, the government citing Canadian Charter considerations as the main reason why medical expenses could not be prohibited since this would contravene the principle of universal access to health care. Bills C-56 and C-13 therefore propose to allow surrogacy under strictly controlled conditions, but prohibit financial inducement to surrogates (Minister of Health 2002a, Section 6, 1–4; Section 7, 1). However, the complexity of establishing and monitoring what constitutes legitimate expenses will be an important concern of the regulatory body, once established.

The role of counselling

The growing use of third party assisted conception raises multiple issues that are not medical in nature, and that are more appropriately addressed by a counselling professional specializing in infertility. However, the availability of specialized infertility counselling is currently limited (Haase 1999), despite the Royal Commission's endorsement of the need for such services to be more widely available (Royal Commission 1993b).

The Standing Committee on Health (2001) also recognized the importance of counselling as a component of informed choice and called for 'mandatory independent counselling for all assisted human reproduction' (Recommendation 36a, p.33) and for the development of regulated standards regarding the counselling provided to donors and recipients (Recommendation 15c). Bill C-13 requires licencees to provide 'professional counselling services in accordance with the regulations' (Minister of Health 2002b, Section 14b, p.9), although the codification of appropriate guidelines will have to await passage of the Bill and establishment of the regulatory body.

Whether or not counselling becomes a mandated activity, the need to expand its availability and to develop professional standards has been identified by Health Canada as requiring urgent attention according to its senior policy analyst (Manseau 2002).

Many of the most challenging issues arising from donor assisted conception may become apparent only after the birth of a child, and thus the role of counsellors could extend beyond any initial clinic contact with prospective parents. Counselling services could also play a key role in the development of any future information-sharing policies related to the birth register.

Conclusions

Third party assisted conception creates the possibility of constructing a family using a combination of social, biological and genetic ties, and consequently provides many of the most challenging social and ethical dilemmas in the field of assisted conception. However, in Canada these issues have not yet received the same degree of attention as in some other countries. Government policy has been very slow to develop and while legislation has been tabled, it has not yet been passed. Other than health and medical screening regulations related to donor semen, there are no regulations governing assisted conception.

Most medical procedures occur within the context of private medicine, resulting in financial barriers to accessibility and an increasing commercialization of services. Despite medical opposition to government legislation and regulation, Canada stands on the threshold of major changes arising from a stated national commitment to policy development in assisted conception. Delays in progressing such legislative initiatives have perhaps had some benefit in that Canada has had an opportunity to learn from the impact of existing regulation in other countries.

Canada's geographical position inevitably involves the potential for Canadians to access US assisted conception services, and this may increase – especially if planned legislation is seen as excessively restrictive. Heavy reliance upon the US for sperm supply will also have long-term implications for the future information needs of those born following donor conception. While there has been slow recognition of the rights and interests of donor-conceived people, there is evidence that this is changing and that advocacy efforts by a comparative few in Canada are increasingly effective in terms of raising awareness in both the public and legislative domains.

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CHAPTER 4

Finland

Unregulated Practices, Familiarity and Legality

Maili Malin and Riitta Burrell

Introduction

Finland is the only Nordic state yet to implement legislation and regulation concerning assisted conception (Hazekamp 1996) although, as we show in this chapter, there has been debate about legislation and the need to impose limits on Finland's liberal regime for almost twenty years.

Assisted conception in the context of the Finnish health care system

The Finnish national health care system emphasizes primary and preventive services, is funded through general taxation and provides good access to care for the whole population of five million. The public health care system is administered locally through municipalities, which are required by law to provide primary, secondary and tertiary health care. (Hermansson, Aro and Bennett 1994). Basic outpatient health care is given in health care centres by public health nurses and general physicians. Finland is divided into hospital districts each of which has a central hospital; five of these are university hospitals offering the most specialized forms of health care. Except in cases of emergency, access to specialist medical care requires referral by a physician. Salaried hospital-based physicians provide specialist care in public hospitals. All citizens have access to care at public hospitals for a small fee (Health Care in Finland 1999).

In infertility care, first contact can be made with a GP in a health care centre or in a private gynaecological clinic. If necessary, referral for specialized care can be made to either a public district hospital where limited assisted conception procedures are available (i.e. basic investigations, medication and some surgery; although one public district hospital does provide IVF-related services); or to one of the five public university hospitals where a wider range of services is available (including IVF-related and donor-assisted procedures). In public clinics there are some restrictions regarding access to services due to scarce resources. Waiting lists are common and there are upper age limits of between 38 and 40 years for the woman and a maximum limit of two to five IVF treatment cycles per couple (Malin Silverio and Hemminki 1996).

In addition to these public infertility clinics, there were twelve private assisted conception units in 2001 (Gissler 2002). Private services are available on a fee-paying basis, although the universal national health insurance scheme reimburses part of the cost of treatment in the private sector (Hermansson *et al.* 1994). In private clinics fertility specialists work almost exclusively in infertility care, whereas in the public hospitals the doctors also provide other forms of gynaecological care. The organization of the Finnish health care system enables many assisted conception specialists to practise simultaneously in both the public and private sectors. However, some of the pioneer fertility specialists have established their own private clinics in which they work exclusively (Malin Silverio and Hemminki 1996).

Private centres are more liberal than the more bureaucratic public centres. Private centres impose no specific age limits for women and no limit on the number of treatment cycles that may be offered (Malin Silverio and Hemminki 1996). Additionally, some new procedures, for example egg and embryo donation, have been first introduced in private centres and mainly performed there (Gissler and Tiitinen 2001). Artificial donor insemination (DI) for single women and lesbians and surrogacy arrangements have been offered in private but not in public centres (Mikkonen 2002).

In 2001 there were 18 IVF centres in Finland (Gissler 2002), and Finnish private IVF centres have been established in Russia, Portugal and Spain in 2001 (Aarnio 2001).

The origins of third party assisted conception

In Finland artificial insemination by husband (AIH) and DI have been provided to infertile heterosexual married couples for decades, usually in private centres but also in some public university hospitals (Elfving 1969, 1979). In the 1970s physicians were advised to proceed with DI only after thorough consideration (Hovatta *et al.* 1979). They were perceived as having the responsibility to ensure the selection of couples with a genuine desire to have a child and for selecting the right donor for each couple (Elfving 1969, 1979). Physicians were warned not to offer DI if there was any suspicion that the couple was trying to improve their marriage with the help of the newborn or if only one partner of the couple wanted to have a child (Elfving 1979).

Additionally, it was claimed that DI was a private affair between the physician and the couple and the precondition for DI was absolute secrecy (Elfving 1979). Neither the donor nor the recipient should be able to learn the other's identity. However, as fresh semen was used before the development of cryopreservation, secrecy was difficult to achieve in practice in either public hospitals or private centres because of the need to provide separate waiting rooms for donors and recipients (Elfving 1979).

Male donors were required to be mentally and physically healthy, to have a healthy family background and to have one or two healthy children (Elfving 1979; Hovatta *et al.* 1979). Furthermore, there should be nothing untoward in the donor's appearance, i.e. he should look like an 'ordinary Finnish man' (Elfving 1979). It was also claimed that the donor should have an above-average IQ level and 'positive' (i.e. socially appropriated and valued) personal characteristics, although such characteristics were not made explicit (Elfving 1979). At the same time it was recognized that it would be difficult to ensure these requirements since the physician would have to know the donor very well. If the donor was married it was also stipulated that his wife must consent to him becoming a donor. The IQ and 'positive traits' requirements changed in formal documents in 1989 when the ethical guidelines for physicians provided by Lääkärin Etiikka (the Finnish Medical Association) explicitly stated: 'As regards mental characteristics of the donor, no selection can be undertaken' (Lääkärin Etiikka 1989, p.35 – authors' translation from original Finnish text). The next editions of the guidelines imposed an explicit prohibition on employing eugenic criteria in donor selection (Lääkärin Etiikka 1992, p.10; 1996, p.19), while the 2000 edition made no mention of this issue.

But there was some – at least rhetorical – tendency toward positive eugenics in the 1980s (when the first Finnish IVF children were born) when two leading IVF specialists legitimated assisted conception procedures by claiming that while there are so few 'own race children for adoption', it is good that the artificial reproductive technologies (ART) are available for the infertile couples (Seppälä and Koskimies 1985). Additionally, these same clinicians legitimated their practices by claiming to help increase the number of Finns in an era of decreasing population growth (Koskimies and Seppälä 1988).

Ethical guidelines for physicians

The first Finnish medical ethics booklet appeared in 1956 (Palmén 1956) and this contained some discussion of AIH and DI. It stated that the first precondition for AIH or DI was medically diagnosed male factor infertility. Second, AIH was not perceived as presenting any ethical problems. Third, total anonymity was recommended for DI. In addition, the donor would never learn the outcome of any donation and would have no rights or responsibilities for the child. Palmén acknowledged that there may be some theoretical considerations concerning the rights of child, but that they did not concern the physician (Palmén 1956, p.69).

Subsequently, the Finnish Medical Association has provided ethical recommendations for the medical profession in Finland, *Medical Ethics* (www.laakariliitto.fi). The structure and content of these recommendations have changed over time to take account of sociocultural change within Finland, the development of medical technology and particularly controversial issues in assisted conception.

The 1978 and 1980 editions of *Medical Ethics* (Lääkärin Etiikka 1978, 1980) provided no reference to assisted conception. In 1982 a book on medical ethics made brief reference to DI which it described as a 'biologically excellent solution in the families with hereditary diseases' (Norio 1982, p.144 – authors' translation of original Finnish text). In the absence of legislation, the social status of the DI-child was considered poor if his or her donor parents' marriage ended. Additionally, DI was considered to pose psychological risks as a potential source of both marital conflict between the recipient parents and identity crisis for the DI-child. In order to be successful and ethical DI was said to require a 'very solid base', i.e. mature and coherent family relationships (Norio 1982).

In the next edition of *Medical Ethics* (Lääkärin Etiikka 1989) it was stated that DI posed no ethical problems, but that it required the consent of both parties in the recipient couple. Recourse to DI was considered acceptable in cases of medically defined infertility and where it was administered in a clinic headed by a physician. The characteristics of the donor should match as closely as possible those of the child's social father. Additionally, use of frozen semen was recommended in DI to ensure that the semen was free of infection. While there was some discussion about the potential merits and disadvantages of anonymity, opinion remained firmly in support of anonymity.

The 1992 edition of *Medical Ethics* discussed the abolition of donor anonymity in Sweden (Lääkärin Etiikka 1992). While it was evident that the medical profession continued to endorse anonymity, the possibility that some couples would like to have a known donor, for example using the semen of the husband's brother or the eggs of the wife's sister, was raised for the first time. Physicians were advised to accede to such wishes after detailed consideration in each case (Lääkärin Etiikka 1992, pp.9–10). No changes concerning assisted conception were contained in the 1996 edition of *Medical Ethics* (Lääkärin Etiikka 1996).

The most recent edition of *Medical Ethics* (Lääkärin Etiikka 2000) noted that medical technology could help almost every infertile couple with a diagnosis of impaired fertility to have a child and recommended follow-up studies of the health of children born following assisted conception (see Gissler, Malin Silverio and Hemminki 1995; Klemetti, Gissler and Hemminki 2002; Koivurova *et al.* 2002). Assisted conception should be made available only to married or cohabitating heterosexual couples to ensure that the child will have both a father and a mother. Although it was recommended that couples should be offered psychosocial counselling, physicians' inability to determine the couple's capacity for parenthood was acknowledged. Since this was not to be performed by any other professionals, no evaluation of parental capacity would be undertaken. However, a different view was given by IVF physicians in a recent empirical study, who indicated that they would be prepared to request psychiatric evaluation of couples with obvious psychosocial problems and delay or refuse to provide assisted conception procedures (Malin 2003).

Available forms of third party conception

There are no central records of births resulting from assisted conception, other than for IVF and related technologies. A national IVF register was set up in 1993 with the cooperation of the Helsinki University gynaecological department and the National Research and Development Centre for Welfare and Health (STAKES). The aim of the register is to monitor the outcomes of

IVF and related technologies where the gametes have been prepared outside the female body (IVF, intra cytoplasmic sperm injection (ICSI), frozen embryo transfer (FET)). The IVF register includes also information about egg and embryo donation treatment cycles, and clinical outcomes by clinics are published annually.

One study of DI conducted in 1995 compared the prevalence of AIH and DI (STAKES 1996). During 1995 3803 AIH cycles and 731 DI cycles were performed throughout Finland. It is estimated that about 400 children are born annually in Finland following both AIH and DI (STAKES 1996, p.8). The demand for DI has decreased among heterosexual couples as a result of the increasing availability and use of ICSI. There is no information about the demand of DI among single women or lesbian couples. One semi-private centre in Helsinki, the infertility clinic of the Finnish Family Federation (one of whose public aims is to increase the Finnish population – see www.vaestoliitto.fi), openly provided DI for single women and lesbians between 1999 and 2001 but withdrew this service pending the outcome of the legislation process. During this time 60 women were provided with DI, but it is not known how many conceived a child (Mikkonen 2002).

Finland's first egg donation birth occurred in 1991 (Tiitinen *et al.* 1998). Egg donation was started in private centres but became available in public hospitals during the 1990s, albeit on a limited scale. In 1999, 403 egg donation cycles were performed of which 21 per cent resulted in live births (National Centre for Welfare and Health 2001, Table 2).

Viveca Söderström-Anttila, an internationally-renowned Finnish clinician specializing in egg and embryo donation, has undertaken a number of studies. In one study of obstetric and prenatal outcomes, 61 egg donation pregnancies (61 children subsequently born) were compared with a control group of IVF patients (97 pregnancies, 126 infants) (Söderström-Anttila *et al.* 1998a). Compared with IVF pregnancies, egg donation pregnancies were associated with an increased risk of first trimester bleeding, pregnancy-induced hypertension, and caesarean section. Furthermore the prenatal mortality was higher among the egg donation group than the IVF-group (3.3 per cent vs. none) (Söderström-Anttila 2001; Söderström-Anttila *et al.* 1998a).

Fifty-nine children conceived following egg donation were followed up at the ages of 6 months and 4 years and their health, growth and development were compared with a group of children conceived following IVF (Söderström-Anttila *et al.* 1998b). This study concluded that the general health of the egg donation children is at least as good as that of IVF children and the growth and development in both groups of children is similar to that of the general population. The IVF mothers more frequently expressed concern about the child's behaviour than did the egg donation mothers. Thirty-eight per cent of the egg donation parents and 60 per cent of the IVF parents intended to tell the child about the nature of his or her conception.

In another study, Söderström-Anttila investigated the experiences and attitudes of 30 anonymous Finnish egg donors (Söderström-Anttila 1995). The donors were recruited by advertising in newspapers. Most donors were very satisfied with their experience. The side effects of the treatment were slight and tolerable; 15 per cent reported some subsequent gynaecological problems. A majority of the donors would have liked to know if their donation had resulted in a pregnancy, had thought about the possibility of the birth of a child, and would like some information about the child or the recipient couple. Over half thought that a child should be told about its origins and one-third agreed that a child should receive identifying information about the donor. In sum, 78 per cent of the women said they would be prepared to donate their eggs again and no-one regretted doing it.

There is very little published information about sperm donation in Finland, but according to one study (Iirola and Niemi 1991) at the beginning of the 1980s most donors were unmarried students, whereas by the end of the 1980s about half of the donors were married and working class. The mean age of donors was 28 and, on average, each made 15 donations. There is an informal limit of five children per donor. Prospective donors who admitted to being homosexual or were thought to be sexually promiscuous were not accepted since they were considered to be at risk of sexually transmitted diseases.

The IVF physicians interviewed by Malin (unpublished information) speculated that sperm donors are motivated by financial reward, wanting to help people to have a child, and knowing that they have children somewhere. The IVF physicians thought that egg and embryo donation was a more moral activity than sperm donation, since women donated altruistically between 'sisters' and may even suffer emotionally and physically when helping another woman to conceive. The donation of gametes between women does not have the same connotation of sexual rivalry as gamete donation between men. One unofficial criterion for female donors in 1993 was that the woman had to have at least one child of her own, the assumption being that a mother knows that she can conceive and have a child and would understand the implications of what she is doing.

Each private centre recruits its own egg donors and donors receive remuneration of approximately 1000 euros per cycle. However, there is a continual shortage of donated eggs and recently IVF clinics have recruited donors in the press and on their internet pages. The main preconditions for donating eggs are that that the woman should be younger than 35, healthy and without any history of hereditary diseases (for example see in www.vaestoliitto.fi). Additionally, it is preferred that the prospective donor should have children of her own.

The IVF register for 1997 shows that donated embryos were used in 39 transfer cycles. Of these, nine resulted in pregnancies and live birth (Gissler and Tiitinen 1999, Table 7). According to one social scientific study (Malin 2002), the Finnish IVF physicians' preferred treatment of infertility is to use a couple's own gametes, their second choice is to use donated Finnish gametes or embryos, and the last solution is a social one, i.e. adoption (which, since there is very little indigenous adoption, usually means intercountry adoption). Finnish gametes or embryos were preferred by couples since, compared to adoption, these provided greater certainty about the health and social acceptability of the child.

Söderström-Anttila *et al.* (2001) investigated attitudes to, and outcomes of, embryo donation among 27 couples who went through 54 treatment cycles. The clinical pregnancy rate was 27.8 per cent per embryo transfer. Significantly more recipients of donated embryos than embryo donors considered that the child should know later the manner of his or her conception (69 per cent and 47 per cent respectively). One-third of the recipients agreed that the child should receive identifying information concerning the donor couple (42 per cent of the donors).

In 1992 *Medical Ethics* highlighted a new issue: that some couples would like to have a known donor; for example, they would like to use the semen of the husband's brother or the eggs of the wife's sister (Lääkärin Etiikka 1992). Subsequently, surrogacy arrangements have been agreed where the surrogate mother and commissioning parents are already known to each other (Söderström-Anttila *et al.* 2002). A characteristic of Finnish assisted conception practices is that some couples with fertility problems want to use the gametes of family members or want a family member to act as a surrogate mother. It seems to be important for some Finnish people that the child is genetically familiar and thus controllable rather than being genetically unknown.

The first documented birth resulting from a surrogacy arrangement in Finland occurred in 1995 (Tiitinen *et al.* 1998), although long before that both the Finnish Medical Association and leading IVF physicians (for example Hovatta 1988) have been positively oriented towards surrogacy, despite its proscription in other Nordic countries.

Medical Ethics first considered surrogacy in 1989 (Lääkärin Etiikka 1989) and considered that surrogacy was acceptable only in medically determined cases and without commercial contracts. The Finnish Medical Association adopted the World Medical Association's acceptance of gestational surrogacy which emphasized the need to take into consideration the best interests of the child subsequently born (World Medical Association 1987).

In principle, the Finnish Medical Association has always endorsed surrogacy arrangements. When the government was considering the most recent proposal for legislation for assisted conception, two clinicians of the Finnish Family Federation's infertility clinic, who supported medically-indicated surrogacy, wrote in the main Finnish national newspaper:

> In Finland 17 infertile couples have been treated by means of surrogacy over the past ten years. Most of these have been treated in the infertility clinic of the Finnish Family Federation in Helsinki. These couples have found their own surrogate mother in their family circles (the mother, aunt or close friend of the woman). This surrogate mother has agreed to this arrangement for solely altruistic reasons and she has not received any monetary benefits. All surrogate mothers had their own biological children. (Vilska and Söderström-Anttila 2002 – authors' translation from original Finnish text)

According to the clinicians, four private clinics provide surrogacy and have reported the births of 11 healthy children as a result of gestational surrogacy (28 treatment cycles for 17 surrogate mothers). No serious side effects were reported, and only two surrogate mothers were said to suffer postnatal depression. Interestingly, most surrogate mothers were family members; six were sisters, three were mothers of the female partners, one was the husband's sister, one was a cousin, four were friends and three were 'other volunteers' (Söderström-Anttila *et al.* 2002). In order to regularize their parental relationship with the child, commissioning parents are required to apply to adopt the child after his or her birth.

Proposed legislation

There is currently no legislation regulating assisted conception in Finland, although there have been several proposals to introduce legislation since the 1980s. The principal reason for the absence of legislation is the persistent controversy about three issues: the anonymity of the donor (or the prospective child's right to learn the identity of the donor), the provision of services to single and lesbian women, and surrogacy arrangements. The basic tenet underlying regulation, nevertheless, has remained the same throughout the almost two decades of law drafting: the requirement that the welfare of the prospective child be taken into account. However, the question of how best to satisfy this requirement has produced a variety of answers. In the following section, we will present in outline the proposed legislation, with an emphasis on the issues mentioned above.

The first comprehensive proposal on assisted conception in Finland was drafted by a working party appointed by the Ministry of Justice in 1987. The working party reported in 1988 (Oikeusministeriön työryhmä 1988), recommending that 'artificial reproductive technologies' should be subject to the licensing authority of the (former) National Board of Health. The proposal restricted access to married or cohabiting heterosexual couples who were involuntarily childless or whose offspring were likely to inherit a serious disease. Furthermore, the welfare of the prospective child would be required to be taken into account. Permitted techniques included insemination, IVF, embryo transfer and the use of donated gametes. The donation of gametes would establish no legal relationship between the donor and the prospective child. The donor would not be given any information on the recipients or the child. The child, however, upon attaining 18 years of age, would have a legal right to learn the identity of the donor. In addition, donors would not be allowed to receive compensation other than reimbursement of their expenses.

In Finland, opinions by interested parties and experts are routinely requested for proposed laws. The expert opinions[1] on this proposal were strongly divided on the issues of recipient eligibility and donor anonymity and the working party concluded that the proposal needed further work.

A second proposal (Oikeusministeriön työryhmä 1990) was developed by another Ministry of Justice working party appointed in 1989. The major difference between the 1988 and 1990 proposals was that the latter recommended that the child should have no legal right to discover the donor's identity. In other relevant aspects, the 1990 proposal was the same as the previous one. Because a disagreement in the working party on donor anonymity prevented the proposal being presented to Parliament, the process of drafting the legislation continued at the Ministry of Justice. This resulted in an unpublished report dated 24 June 1993. For reasons that have not been revealed, this report was not presented to the Government. However, parts of the report were made public, although not until later. The report proposed a compromise on donor anonymity in which the National Authority for Medicolegal Affairs[2] would be given the discretion of deciding whether or not the identity of the donor was to be disclosed to the child upon reaching the age of 18, but only in cases where the child's health or well-being required such disclosure (HE 76/2002, 24–25).

Since none of the proposals thus far had led to a government Bill, STAKES produced a proposal of its own. The STAKES *Working Group Proposal to Hasten the Drafting of an Act on Infertility Treatments* (STAKES 1996) suggested a 'double track' approach to the issue of donor anonymity. The STAKES working group also revised the terms employed in the proposals arguing that, among other things, the term 'artificial reproduction' was outdated and misleading and should be substituted with the term 'infertility treatment'.

Consequently, a third Ministry of Justice working party was appointed in 1996. The published version of the working party's proposal, *The Use of Gametes and Embryos in Medical Fertility Treatment*, was published in October 1997 (Oikeusministeriön työryhmä 1997; for a critical assessment on the proposal, see Turunen 1998). The third working party proposed three significant changes to the previous proposals. First, terminology was updated. 'Artificial reproduction' was dropped and 'fertility treatment' became the prevalent term from then on. Second, a rather complicated provision on the access of the prospective child to donor information was drawn up. It read that the child, upon attaining 18 years of age, would have a right to learn the donor's identity provided that the donor had consented at the time of the donation or had consented after being informed by the National Authority for Medicolegal Affairs that such a request had been made by the child. Even in the absence of donor consent, the child would be entitled to know the donor's identity when the donor had been dead for ten years. Upon attaining 18 years of age, the child would also be entitled to receive a self- description written by the donor and which the donor would be required to provide at the time of donation. Third, the working party suggested that surrogacy arrangements be permitted under certain conditions. The 'use of a surrogate', as worded by the working party, required that:

1. The National Authority for Medicolegal Affairs had given its authorization to the arrangement.
2. Both the surrogate and the intended parents were each at least 25 years of age.
3. The husband of the surrogate had consented to the arrangement, in cases where the surrogate was married.
4. The surrogate had given her informed consent to the procedure.
5. Her motivation was an altruistic one.
6. She was reimbursed only for the direct expenses associated with her participation.

Unlike the previous proposals, the 1997 proposal resulted in a vigorous public discussion centred, somewhat surprisingly, on the issue of access of single and lesbian women to assisted conception. Public interest on the issue was unexpected since the eligibility criteria had remained the same since the very first paper proposing legislation. The newly awakened public interest was due, in part, to the fact that in the course of the 1990s other Nordic countries had passed legislation allowing couples in same-sex relationships to register their partnership in a manner and with effects similar to those of a marriage. Although more conservative than its Scandinavian neighbours, Finland was following suit. The Act on Registered Partnerships of 2001 (950/2001) was under preparation in Finland at the time, drawing public attention to the legal status and rights of homosexual couples.[3]

The requested expert opinions were strongly divided on the issues of recipient eligibility and surrogacy arrangements. Also, the existing controversy on donor anonymity persisted. Several experts pointed out that not including single and lesbian women within the provision of assisted conception amounted to a violation of the prohibition of discrimination laid down both in the Constitution of Finland and in the Act on the Status and Rights of the Patient. About half of the expert opinions opposed surrogacy arrangements on various grounds. It was pointed out that surrogacy was banned in most European countries and, more significant, in all the other Nordic countries. Were Finland to permit surrogacy, it would not only mark a deviation from the principle of legal uniformity among the Nordic countries but also expose the country to a legitimate market in reproductive tourism (a phenomenon which already exists in Finland as Swedish couples seek DI in Finland to escape the provision in Swedish law that enables a donor-conceived person to learn the identity of the donor). Already some surrogacy arrangements commissioned by Swedish, Danish, and Norwegian couples have been carried out in Finnish clinics. It was further argued that it would be next to impossible to verify that the surrogate's decision to participate was based solely on altruistic motives (Oikeusministeriön työryhmä 1998).

Consequently, in an unpublished proposal of 1998 by a joint working party drawn from the Ministry of Justice and Ministry of Social Affairs and Health, (Oikeusministeriön työryhmä 1998), several provisions were modified. Because of the practical as well as ethical problems surrounding surrogacy arrangements, the working party concluded that surrogacy should not be permitted. In addition, there was a shift for the first time on the issue of eligibility. The working party proposed that a single or lesbian woman could be eligible for fertility treatment on two conditions:

1. She was involuntarily childless (i.e. infertile).
2. The man whose gametes were used in the fertility treatment (i.e. the donor and biological father) had consented to the treatment with the knowledge that he may later be declared, on the basis of his consent, to be the child's legal father.

This is a major change from earlier proposals which had explicitly refuted the establishment of a legal relationship between the donor and the child. If paternity, in accordance to the 1998 proposal, were established at the request of the mother, the biological father, or the child him- or herself upon reaching the age of 15,[4] the biological father would assume all the rights and responsibilities of legal parentage.

According to Markku Helin, an official at the Ministry of Justice and chairman of the working party, the second eligibility criterion was formulated to satisfy the Ministry of Justice's requirement that the legal status of a child born to a single woman or to a lesbian couple be the same as that of a child born as a result of natural procreation, i.e. that the child have a legal father. This requirement accorded with the fundamental position held by the ministry throughout the two decades of law drafting – that the welfare of the prospective child be safeguarded by the legislature since the child is unable to look after his or her own interests (Helin 2001).

Further, Finnish health law expert Raimo Lahti has argued that the exclusive focus on the welfare of the child has diverted attention from other important issues. In recent years, there has been a movement to develop the area of medical law in Finland that would combine elements from various existing branches of law such as family law, administrative law and criminal law with medical ethics and biomedical science. Thus a proposed law on assisted conception from one single traditional legal approach would probably miss important principles and developments in other areas. For example, a traditional legal approach might well miss consideration of human rights in the area of assisted conception. A medical law approach, however, would include a consideration of human rights and thus a consideration of both the welfare of the prospective child (a prevalent theme in family law) and the rights of the prospective parents (an emerging human rights consideration) and that any conflicts between them must be dealt with (Lahti 2001).

The Finnish Medical Association, representing the views of the medical profession, forcefully opposed the provision giving the child the right to learn the identity of the donor, mainly out of fear of diminishing the donor pool; which opinion was seen also in the *Medical Ethics* booklets. Furthermore, physicians in general were averse to governmental regulation on assisted conception. This view was expressed, for example, in the 1996 STAKES report stating that strict control would prevent the introduction of new treatment methods and deter medical progress in assisted conception (STAKES 1996). The Medical Association's position was of crucial importance because of the central role professional organizations play in the law-drafting process in Finland (Lahti 2001). Eventually, however, physicians changed their position, beginning to favour legislation for a number of reasons. First, the lack of regulation had caused a partial standstill in the provision of assisted conception services; second, the lack of regulation was perceived to be a source of embarrassment in the international arena; and third, there was a genuine need for authoritative legal guidance (Helin 2001).

Since the Minister of Health and Social Services (the Green Party minister in the governmental coalition) objected to the proposition regarding single and lesbian women, the 1998 proposal was removed from the process (Helin 2001). In May 2001, in negotiations held between the Minister of Justice and the Minister of Health and Social Services, it was decided that the proposal was to be returned to the officials at the Ministry of Justice and Ministry of Social Affairs and Health for further work. In the course of spring 2002 the required modifications were finalized and, on 5 June 2002, the *Government Proposal to the Parliament for the Act on the Use of Gametes and Embryos in Fertility Treatment and the Amendment to the Paternity Act* (HE 76/2002) was submitted to Parliament.

The main features of the proposal were the following:

1. Assisted conception services may be provided for a couple who are involuntarily childless or whose offspring is likely to inherit a serious disease.
2. 'Couple', in this context, refers to a man and a woman who are either married to each other or cohabiting.
3. The use of the couple's own gametes and embryos as well as donated gametes and embryos is permitted.
4. Assisted conception services may be provided for a single woman or to a lesbian in a registered partnership[5] under the condition that the man whose gametes are being used consented to the treatment with the knowledge that he may later be declared, on the basis of his consent, to be the child's legal father. Paternity may be established by the request of the mother or the child him or herself upon reaching the age of 15.
5. Surrogacy arrangements are prohibited.
6. The service provider has to maintain an archive which contains information on the donor's ethnic origin, height, and eye, hair and skin colour, the donor's self-description and the donor's consent form. The consent form includes, among other things, information on any conditions the donor may have prior to the use of her or his donation. In case the donor has consented to have her or his identity disclosed to the child, this consent must be included in the form. While the consent to donation may be withdrawn at any time, the donor's consent to have her or his identity disclosed to the child may not be withdrawn.
7. The National Authority for Medicolegal Affairs maintains a register of all gamete and embryo donations.

8. The child, upon reaching the age of 18, has the right to learn the identity of the donor provided that the donor had consented to it at the time of the donation or consents to it after being informed by the National Authority for Medicolegal Affairs that such a request has been made by the child. Even in the absence of donor consent, the child is entitled to learn the identity of the donor after the donor has been dead for one year. Upon reaching 18 years of age, the child is also entitled to receive the donor's self-description.

After the preliminary debate in Parliament, the proposal was referred to the Legal Affairs Committee on 10 June 2002. The committee gave its report (LaVM 29/2002 vp) on 5 February 2003, having made two significant changes to the proposed Act. First, upon reaching the age of 18, every donor-conceived child, without exception, would have the legal right to learn the identity of the donor. Any other outcome, according to the committee, would violate the child's constitutionally guaranteed right to privacy. Second, only married or cohabiting heterosexual couples would be eligible for fertility treatment. For its decision to exclude single women and lesbian couples from the provision of fertility services, the committee offered a two-fold explanation. First, a legislative outcome that allowed the birth of fatherless children would seriously undermine the importance of fatherhood as a cultural and social institution. Second, the requirement that every child has two parents, a mother and a father, falls in line with the single most important principle of the almost two decades of law drafting – the welfare of the prospective child must be safeguarded.

Although the report of the Legal Affairs Committee made no mention of it, the decision to restrict access to assisted conception to heterosexual couples would have made the provision of services to single or lesbian women a crime punishable by up to one year's imprisonment. This, however, was unacceptable to the Cabinet. In its meeting on 11 February 2003 the Cabinet decided to withdraw its proposal from Parliament. The fate of the proposal will be decided by the new Parliament, elected in March 2003.

Conclusion

In the absence of legislation, Finland offers a broad range of assisted conception procedures subject to professional ethical standards. At the time of writing, after Denmark and Iceland, Finland provides the highest level of access to assisted conception procedures to women of reproductive age within Europe (Gissler *et al.* 2002, p.10). Finland also offers one of the most permissive regimes regarding assisted conception. As we have shown, however, prospective legislation will ensure that, in future, Finland will fall into line with the more conservative practices of its Nordic neighbours.

In sum, assisted conception has changed and also made stronger the cultural practices related to having a child – in the Finnish context it is important to have a child 'made in Finland' (Malin 2002). One question remains unanswered: what are the experiences of the children born following assisted conception?

Notes

1 A request for expert opinions by a ministry in charge of drafting a law is a routine part of the law-drafting process in Finland. In this case, the Ministry of Justice requested opinions from the law faculties at the University of Helsinki, University of Turku, the Lappi University, STAKES, The National Infertility Association Lapsettomien Tuki ry, the Equality Ombudsman, the Council for Equality, The Finnish Medical Association, The Finnish Psychologists' Association, The Finnish Nurses' Association, and others.

2 The National Authority for Medicolegal Affairs is an agency under the Ministry of Social Affairs and Health. It is responsible for maintaining and promoting patient safety and for safeguarding the quality of health care services. According to the *Government Proposal to the Parliament Regarding the Use of Gametes and Embryos in Fertility Treatment and the Amendment to the Paternity Act* (HE 76/2002), *inter alia* the authority must maintain a register of all gamete and embryo donations (Section 23) and has the authority to license a facility to store gametes and embryos and to offer fertility treatments (Section 26), to order inspections in such facilities, and to revoke a licence (Section 29).

3 According to the Act on Registered Partnerships 2001, '(t)he partnership of two persons of the same sex and over 18 years of age may be registered as provided in this Act' (Paternity Act 1975 (700/1975) Chapter 6, section 43 (3)). The legal effects of a registered partnership are similar to those of marriage.

4 The age of 15 is in accordance with the Paternity Act of 1975 which stipulates that the determination of paternity cannot be carried out against the wishes of a child over 15 years of age.

5 According to the Act on Registered Partnerships of 2001, '(t)he partnership of two persons of the same sex and over 18 years of age may be registered as provided in this Act.' (Chapter 1, section 1). The legal effects of a registered partnership are similar to those of marriage.

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CHAPTER 5

Germany

The Changing Legal and Social Culture

Petra Thorn

Introduction

Artificial insemination by donor (DI) has been practised in Germany for many decades, the first reports in the German Federal Republic (FRG) dating back to 1956 (Krause 1985) and in the German Democratic Republic (GDR) to 1970 (Günther 1987). In 1959 the German Medical Commission (Deutscher Ärztetag) took the decision to condemn DI as contrary to the medical code of practice. According to Strunden (2002) this negative attitude reflected the fear of being reproached for re-establishing selective procreation such as the 'Lebensborn' (state institutions fostering the procreation of so-called 'high-quality Germans') carried out during the Nazi regime and the disapproving position of the Roman Catholic Church. In the 1960s this resulted in a controversial debate on the ethical, social and psychological standing of DI (Brähler and Meyhöfer 1986; Krause 1985). DI was intended to be included in the reform of penal law and subject to sanctions, but this was not implemented. Three physicians were said to have offered DI at that time. It was presumably Gerhard Ockel, a liberal gynaecologist and one of the first authors of books on sex education for children (Ockel 1960), who was the first medical professional to talk about DI in public when in 1967 he reported on more than 10 years of DI practice (Krause 1985). These early pioneers of DI feared exclusion from their professional body and therefore provided this service under absolute confidentiality. During the International Legal Meeting in The Hague in 1964, Germany was criticized for moral arrogance and sanctioning DI

(Wille 1985). In 1973 the German Medical Commission accepted DI as a medical treatment and at the beginning of the 1980s, Walter (1983) listed six clinics offering DI services. This included one service located within a university-provided service (teaching hospital).

Currently, approximately 40 clinics provide DI, including one teaching hospital. The lack of legal clarification has discouraged teaching hospitals from providing DI services. According to Schilling (1995) this is also likely to have had a negative impact on the pursuit of scientific research in this area.

In 1996, the DIR (Deutsches IVF Register – 'German Register for IVF'), a voluntary register for assisted conception treatments such as *in vitro* fertilization (IVF) or intra cytoplasmic sperm injection (ICSI) was introduced in Germany (Ärztekammer Schleswig-Holstein 2000) and, according to medical guidelines, clinics are to report their data to this register (Bundesärztekammer 1998). However, there is no official or compulsory register for DI. Therefore, the number of treatments with DI cycles and DI outcome figures can only be estimated. Schilling (1999) estimates that over 50,000 children have been born as a result of DI in Germany since the 1970s. The only figures available are those based on the so-called 'National Register' of the former GDR. Just prior to the reunification of Germany in 1990, Weller, Sobeslavsky and Guzy (1989) stated that between 1973 and 1985, 1373 pregnancies had resulted from 2693 DI cycles. A more recent survey suggests that currently at least 500 children are born annually following DI (Thorn and Daniels 2000). These figures, again, are only estimates. They indicate a decline in DI which is likely to be the result of more advanced treatment options such as ICSI (Katzorke 2001a) becoming available.

Development of legislation and professional guidelines

The first guidelines for DI were developed in the former GDR. In 1980, Graf and Glander (1980, p.774) published a treatment plan and suggested that 'only married couples with a stable personality and relationship can be expected to shoulder these burdens [resulting from family building with DI]'. In 1983, this treatment plan, together with further medical provisions, resulted in the 'Suggestion for Guidelines to Carry out Artificial Donor Insemination (ADI)' (Glander *et al.* 1983). In 1989, Seikowsi and Glander published a survey on 460 married couples prior to DI and suggested the following issues should be explored in a pre-treatment screening process: the quality of the wish for a child, the couple's way of managing infertility specifically and problems in general and their ability to compromise and cooperate within their partnership. Diagnostic tests were also administered to couples in the former FRG (Brähler, Weiss and Meyhöfer, 1987; Meyhöfer and Weiss 1988). However, they were not compulsory and in contrast to the former GDR, there was no attempt in the FRG to develop professional guidelines at that time.

In 1991, after the reunification, the Embryo Protection Act (Embryonenschutzgesetz – ESchG) was introduced. Prior to this Act, there was much debate concerning assisted conception in general as well as DI specifically. Reference was made to the fact that DI was strongly opposed in the 1960s. In addition, there were concerns that DI might lead to ethical difficulties as the donor is selected by the physician, he does not assume social responsibility, the husband of the wife may reject the child because of the lack of genetic connection and cryopreservation of semen can result in children being born into different generations (Starck 1986).

Despite these unfavourable discussions, the final report of the State-Federation Work Group, 'Reproductive Medicine', (Bundesminister der Justiz 1989) stipulated that DI should be permitted and issued the following comprehensive recommendations:

1. The presence of male infertility which cannot be cured otherwise.
2. Account is taken of the welfare of the child.
3. Mandatory pre-treatment psychosocial counselling is undertaken.
4. A central register is established.
5. DI is performed only in registered clinics.

Däubler-Gmelin (1986), Minister of Justice at that time, in addition to the above, demanded clarification of the legal responsibilities of the social father, the donor and the physicians. She also spoke out for the rights of offspring to access information about their biological origins. These recommendations, however, were not included in the ESchG. The Act permits insemination but does not differentiate between insemination using the husband's and the donor's semen. DI is thus permissible but without any further legal provisions.

DI was considered only to 'mimic a natural procedure, whereas oocyte donation would be a step far away from natural procreation' (Bundesminister der Justiz 1989, p. 21). In contrast to semen donation, therefore, the ESchG penalizes egg donation. The final report leading to the Act described egg donation as a deep incision into the human and cultural self-image which includes the unambiguity of motherhood. There were major concerns that separating motherhood into its genetic and gestational components might result in identity problems for the child. In addition, a potential conflict between the gestational mother and the child was assumed as the egg donor might continue to be interested in the development of the child.

Although surrogacy was considered a viable option for some couples to have a child genetically related to the father or to both parents, it was also considered inimical to the welfare of the child to separate the psychosocial relationship between the gestational woman and the child. Surrogacy, like egg donation, was deemed to result in identity problems for the child and to be associated with uncertainty and potential psychological conflicts for all parties involved. These conflicts were believed to emerge in commercial surrogacy arrangements, but to an even greater degree in altruistic surrogacy arrangements involving friends or family members, and resulted in penalizing altruistic and commercial surrogacy arrangements (Bundesminister der Justiz 1989). As both egg donation and surrogacy are prohibited in Germany, this chapter will focus solely on DI.

In 1995 the Medical Association for Donor Insemination (Arbeitskreis für donogene Insemination e.V.) was established, initially only consisting of physicians. In 1996 the association published guidelines for medical treatment with DI and the recruitment of semen providers as well as for semen storage (Arbeitskreis 1996). These are voluntary guidelines binding to members of the association only. Membership of the association is not compulsory in order to carry out DI in Germany; approximately 80 per cent of the physicians offering DI have joined the association. In 2000 the author was invited to become a member of the association and make regular presentations on the psychosocial aspects of DI. As a result of this involvement, a survey of DI practice in Germany was carried out (Thorn and Daniels 2000).

Access to and funding of donor insemination

The ESchG does not regulate access to assisted conception services. According to guidelines binding on all medical professionals, access to services is primarily granted to married couples. Cohabiting heterosexual couples have to obtain permission of a standing commission of the Medical Chamber

(Ärztekammer). Treatment of single women and couples in same-sex relationships is not permissible as this is considered detrimental for the welfare of the child. In addition, access to DI also requires the approval of the Medical Chamber (Bundes@rztekammer 1998).

Since reform of the Children's Rights Act (Kindschaftsrechtsreformgesetz) in 1998, no differentiation is made between children born to cohabiting couples and those born to married couples. They enjoy the same rights concerning paternity of the male partner of the mother. The Children's Rights Improvement Act (Kindschaftsrechtsverbesserungsgesetz), introduced in 2002, represented the first acknowledgement in German legislation of family building by DI. This reform stipulates that paternity cannot be contested by the man or the mother if the man and the mother have agreed to artificial insemination by a third party donor (BGB 1600, Abs. 2); such an agreement is required by almost all doctors (Thorn and Daniels 2000). The terminology used in this reform ('man' rather than 'husband') also indicates that this does not only refer to married but also to cohabiting couples. In practice, only few physicians have treated cohabiting couples and there are very few who treat single women or women in a same-sex relationship because the guidelines are so discouraging. The most recent legislative changes are likely to grant cohabiting couples easier access to DI services.

In contrast to most other methods of assisted conception, the cost of DI is not reimbursed by the German health insurance system. According to the Social Legislation Code, the cost of assisted conception is only reimbursed if a married couple use their own gametes (Sozialgesetzbuch V, §27a (1) 4). Cohabiting couples are not reimbursed for assisted conception treatments because the German constitution provides special protection for marriage and family (Grundgesetz Art. 6, Abs. 1) and it is assumed that a family is founded on the basis of a marriage (Bundesärztekammer 1998). Despite the legal changes since 1998 this has not been challenged.

Access to information on genetic origin

The German Citizen Code (Bürgerliches Gesetzbuch – BGB §1600 d) defines the husband of the mother or the man who was having sexual relations with the mother at the time of conception as the father of the child. Before the Children's Rights Improvement Act, father, mother and child had the right to contest paternity. Since then, only the child enjoys this right. Quantius (1998) argues that the failure of the marriage or aberrant behaviour by the father (such as neglect or abuse of the child) may provide the offspring with the right to do so. In order for the child to be able to contest paternity, however, (s)he has to be informed of his/her biological origin, and the lack of this information is in many cases a de facto obstacle. As only few parents disclose the nature of the child's conception to the child, unsurprisingly there have been no exemplary court cases in which donor-conceived people have attempted to gain access to this information. However, in a court case concerning the right to knowledge of biological origin of a child born out of wedlock, the German Constitutional Court (Bundesverfassungsgericht) ruled in a principal decision that the right to personality encompasses the right of access to information on biological origin. In this case, the mother had to inform her daughter of the identity of her biological genitor (Bundesverfassungsgericht 1988). Interestingly, in BGB §1591 of the Reform of the Children's Rights Act, the gestational woman was defined as the mother in the legal sense although egg donation and surrogacy are both prohibited in Germany and thus there was no need to clarify this (Störle 1998). However, the rights and responsibilities of social fathers following DI were only clarified after the Children's Rights Improvement Act four years later and there is no explicit legal definition of the rights and responsibilities of donors.

A further contentious issue is the length of time that medical records must be maintained. According to current medical guidelines (Hessisches Ärzteblatt 1998), such records may be destroyed after a period of 10 years. This also includes records on donors and recipients. Approximately 50 per cent of medical practitioners responding to Thorn and Daniels' (2000) survey destroy their records after this period. This is not only in contrast to the principal decision of the Constitutional Court but also in contrast to the medical guidelines on assisted conception which stipulate that:

> a child conceived by donor insemination has a right to be informed about his/her biological father, as biological paternity is of significant importance, for example in terms of marrying or the health of this child and his/her offspring. (Bundesärztekammer 1998, Appendix 1.4)

The guidelines of the Medical Association on DI make no effort to resolve this dilemma. They stipulate that:

> every treatment has to be documented thoroughly. The documents of the couple to be treated are subject to the legal period of documentation. The

> documents of the donor and the stored semen are documented and kept according to the same principles. (Arbeitskreis 1996)

Planned legislation

In 2000 a new Act on assisted conception (Fortpflanzungsmedizingesetz) was prepared and publicly discussed. This Act would either supplement the ESchG or replace it completely (Bundesministerium für Gesundheit 2001). Many professionals involved in preparing this new Act and other physicians, and legal and psychosocial experts in the area of assisted conception have argued that legal clarification of DI should be provided (Günther and Fritzsche 2000; Katzorke 2001a; Neidert 1998; Nieschlag 2001; Thorn and Daniels 2000). Katzorke (2001a) claims that under the current legislation there is insufficient information on the semen stored, regulation of the type and period of documentation is not standardized, the question of donor anonymity is not resolved and there is no legal clarity for the physician, donor and the couple to be treated.

During the debate on this new Act, Zumstein (2001) encouraged the development of a federal documentation centre to register identifiable information on the donor for a period of 30 years. Coester-Waltjen (2001) proposed a very liberal stance and suggested that procreation is a very personal and intimate matter and individuals must be able to take decisions without any state or legislative constraints. According to her, there is no right to procreate as such, but there is a right to procreate without legislative limitations. However, during this public debate there were also voices advocating a ban on DI services and to prohibit gamete donation in general. Baumann-Hölzle (2001) explained that DI compromises the welfare of the child because it is instrumentalized and procreation is carried out as a technical act only, thus lacking personal responsibility. Mieth (2001) advocated linking procreation to natural and biological ability, as anything else would deviate from biological and social norms. Accordingly, single women and couples in same-sex relationships should not be granted access to assisted conception and Mieth saw no need to extend current legislation. Some of these contributions expressed fears voiced previously in the 1960s. According to Derleder (2001), DI promotes eugenic thinking and is too closely linked to an extra-marital affair. Both Derleder (2001) and Baumann-Hölzle (2001) proposed that the new Act should prohibit DI altogether.

Discussion on this new Act was discontinued when the Minister of Health, Andrea Fischer, who was critical of assisted conception and one of the proponents of new legislation, resigned. At the time of writing, discussion for this legislation had not yet been resumed. In 2002, there was a controversial debate concerning the right to give birth to a child anonymously (Bockenheimer-Lucius 2002). 'Anonymous birth' is considered helpful for any mother experiencing severe personal difficulties and who may, as a result of her problems, be unable to take care of the baby adequately, may even seriously neglect it or take the baby's life and may be unable to seek adequate help. However, critics argue that knowing one's genetic origin is a fundamental right, which should be protected by all means and that there is little guarantee that mothers in such a crisis would be in a situation to seek help in hospitals by giving birth anonymously. Despite some fundamental differences between this and DI, one of the issues in common is access to information on biological origins and it is possible that a legal clarification in this area will have implications on the legal framework of DI.

The above shows how critically third party assisted conception was and still is viewed by some parties, the controversial discussions prior to the Embryo Protection Act leading to banning egg donation and surrogacy but tolerating DI. In her essay on the legal approaches to assisted conception in Germany, Hanschel (2000) poignantly stated that the ESchG is less concerned with the protection of the embryo than with the protection of accredited forms of family planning; the same seems to apply to medical guidelines. Despite some changes, there is still a lack of a coherent legal and/or professional framework for DI, especially concerning the right of access to biological origins information, documentation of records and the rights and responsibilities of donors. In his analysis of international legislation of assisted conception and third party assisted conception, Blank voices concern that the failure to provide legal protection to the parties involved may be a conscious decision to discourage this type of family building: 'in those jurisdictions where a sperm donor is not explicitly given the legal protection against paternity, artificial insemination by donor (AID) becomes more problematic' (Blank 1990 p.174f). Couples in Germany have confirmed this concern and expressed apprehension that the lack of legal clarity concerning DI may contribute to the uncertain social status of the practice (Thorn and Daniels 2002). Physicians also do not only believe that there is a need for legal clarification but speak in favour of providing more information and increasing public awareness about DI in order to remove the stigma associated with it (Thorn and Daniels 2000). Providing a legal framework and/or binding professional guidelines for DI would, contrarily, imply protection for and more social acceptance of this form of family building. The discussions prior to the new Act seem to have generated two opposing attitudes towards third party assisted conception: one more conservative, wanting to maintain traditional family compositions, and one more liberal, accepting individual choices and family diversity. It remains to be seen whether this debate will be influenced by new legislation in Germany's neighbour, Switzerland – which introduced comprehensive legislation regulating DI in 2001 (Switzerland 1998) – and the discussions in countries such as the UK (see Blyth in this volume) concerning revision of legislation.

Psychosocial research

Psychosocial research into DI has been carried out since the 1970s. Both in the former GDR and in the FRG, studies at that time concentrated on evaluating couples' preparedness to manage the issues resulting from DI. In publications in the former GDR, it was assumed that the donor's anonymity would be maintained forever, and according to legislation, all inseminations and pregnancies were documented in the National Register. Graf and Glander (1980) proposed a screening process of couples prior to DI, which comprised anamnestic information, psychological individual and couple exploration, a second physician's consultation, a four-month period of reflection for the couple and a written agreement between the physician who carries out the treatment and the couple. In 1983 these proposals, together with further medical provisions, resulted in 'Suggestion for Guidelines to Carry Out Artificial Donor Insemination (ADI)' ('Vorschlag für eine Richtlinie zur Durchführung der artefiziellen donogenen Insemination (ADI)') (Glander *et al.* 1983) which were later expanded by Seikowsi and Glander (1989). Just prior to reunification, Weller *et al.* (1989) referred to the National Register and published the figures described above about DI treatment in the GDR. A pretreatment psycho-diagnostic test measuring parental abilities was administered to each of these couples and the authors stressed that these couples' marriages indicated greater stability than the norm. In this survey, the parents were also asked whether they would share the information about their child's conception with the child. Just under 9 per cent intended to share the information, approximately 26 per cent did not intend to do so, approximately 45 per cent had not yet formed a decision. Approximately 20 per cent wanted to delay the decision until the child had reached the age of 18 and they had consulted with a doctor and a psychologist.

In 1980, Katzorke *et al.* published results on DI treatment in their clinic in the FRG. Two hundred and ninety couples were treated over a four-year period and in almost 50 per cent (144 women) pregnancy was established. From 1985 on, couples embarking on DI began to be examined from a psychoanalytical perspective. Several authors such as Stauber (1985) and Brähler (1990) expected dysfunctional patterns in these couples. In 1990, Brähler reported on a survey of 190 couples and concluded that:

> anal and phallic-narcissistic patterns of relationships dominate… These results make it clear that DI cannot contribute to stabilise gender identity, but that it is mainly used by couples who attempt to compensate the narcissistic damage to the self-esteem caused by sterility by above-average personal performance. (1990, p.180f)

She favoured pre-treatment counselling as well as the provision of sufficient time to mourn the loss of a child biologically linked to both parents before starting DI treatment. Brähler feared that the position of the father might be insecure and was in favour of informing the children of their genetic origin: 'Thus, social fatherhood would weigh more heavily and the irritations of a family secret would be avoided' (1990, p.196). Other authors criticized the psychoanalytical literature on couples seeking DI and concluded that there was no evidence of pathological patterns in couples seeking DI (Goebel and Lübke 1987).

Goebel and Lübke (1987) described the psychosocial development of DI children as normal and the selection of suitable couples prior to treatment was seen as an important factor contributing to the healthy development of these children (Seikowski and Glander 1990). In 1992 Schaible published his findings of a survey of 46 families following DI. In this study, parents were asked to assess their children's development. All of them described their relationship to and the development of their children as normal. In 1995 Schilling examined the management of family secrets in couples prior to, during and five years following, DI. He contends that, prior to DI, 34 out of a total of 40 couples did not intend to share the fact of DI even with their closest family member and 10 of these couples felt a considerable burden as a result of this secret. After five years, 26 of the 40 couples had conceived. Only two of this group had decided to tell their child about his/her origin. In Schaible's survey, 98 per cent of parents did not intend to share this information with their children. In 1999 Schilling concluded in a follow-up study of 22 parents six years post-treatment that they judged their children as being close to their self-ideal. He described that there was neither an indication of a withdrawal of the social father nor of a dysfunctional family development.

Thorn and Daniels (2002) evaluated a series of preparation seminars, carried out between 1998 and 2000 for couples interested in DI, which aimed to provide information and support as well as the opportunity for participants to meet others in the same position. The authors concluded that the seminars contributed significantly towards increasing the confidence of the participants. Although these results are preliminary, as most couples had not yet conceived, in contrast to the couples in Schaible's study most of them intended to acknowledge openly their way of building a family and planned to share this with their future children.

This indicates a move towards depathologizing DI. Whereas in the 1970s and 1980s, several researchers described DI as a problematic way of forming a family and expected dysfunctional patterns, research projects of the 1990s indicate both normal relationships in these families and normal development of the children. Given the lack of legal certainty and the morally doubtful status of DI, it is not surprising that the vast majority of German parents decide not to share the truth about conception with their child. The educational approach used by Thorn and Daniels, however, indicates that couples' attitudes can change despite an unfavourable cultural context.

Social attitudes towards DI

As in many countries, DI in Germany has been viewed with reservation and dismissal. Both the Roman Catholic Church and the Protestant Church, the two major religious denominations in Germany, strongly argue against DI (Lexikon der Bioethik 1998). DI is seen to neglect the inner bond of conception with personal sexuality and therefore destroy the unity of marriage. In its most recent pronouncement in 1987, the Protestant Church described DI as 'an incursion into marriage and therefore damag[ing] the exclusiveness of marital relationships' (Evangelischen Kirche 1987, p.12). A similar attitude is expressed by the two major political parties, the Christian Democrat Union and the Social Party of Germany (Schaible 1992) and by feminist groups (Fränznich and Wieners 1996; Winkler 1994).

Medical and psychological professionals with a psychoanalytic orientation voiced similar concerns in the 1980s. Stauber (1985) considered the typical interactional pattern of 'submissive man – dominant woman' examined by him as a risk factor for DI. He also feared neurotic projections and psychotic delusions and viewed third party conception very critically. Amendt (1988) described all forms of assisted conception as 'autistic conceptions', i.e. conceptions without interpersonal involvement. The author feared that the pseudo-harmony of technically induced parenthood and an extra-marital conception using a physician and a second man down-graded to an anonymous semen provider would be deeply unsettling once the child had the right of access to his or her biological origin.

As in many countries, there has been a vast increase in the acceptance of non-traditional families since the 1980s. There is a wealth of books for and research on step-families, single-mother families and, of course, families created by adoption. In Germany, families resulting from DI, however, are still excluded from this development. These families are rarely talked about, there is little literature (Hellmund and Rohde 1998) and little research on them. In some general books on infertility, DI is omitted (Köhle1997; Strowitzki 1998) or referred to derogatively (Fechting 1997). There is little understanding on social attitudes towards family building with DI or other forms of third party assisted conception. The traditional stance towards secrecy and donor anonymity, taken for granted for many decades and still supported by some medical societies (Katzorke 2001b), is, however, beginning to be challenged by others (Deutsche Gesellschaft für Gynäkologische Endokrinologie und Fortpflanzungsmedizin *et al.* 2001).

In recent years, there have also been developments in the patient community and in the infertility counselling area. A German patient organization for infertility was founded in 1995; a similar organization for DI was established in 1999. The latter group provides information and support for individuals and couples interested in DI on a national basis. It has developed a web site, disseminates leaflets on DI and organizes regular meetings. So far, only a few members of this group have spoken out in public, which is indicative of their anxiety about being associated with DI and stigmatized. In 2000, a network of infertility counsellors was founded. Amongst these counsellors are some who specialize in counselling couples interested in DI. Recently, some physicians have begun to request that couples undergo counselling before embarking on DI.

Interestingly, neither in research nor in legislative debates have comparisons between the rights and psychosocial needs of adopted children and donor-conceived children been made. This seems primarily due to the fact that DI is carried out in the medical sector with a focus on the immediate medical condition of a couple, whereas adoption is located within the psychosocial arena with the centre of attention on the short- and long-term needs of the adopted child. Open adoption has been the norm in Germany for well over 10 years, a reform of law granting adopted children the right to access to their biological origin going back to 1977 (Beyme 1993). Openness in DI family building is far from being the norm in Germany, but the educational approach suggested by Thorn and Daniels (2002) indicates an impressive attitudinal change. Together with the formation of a support group as well as professional groups and bodies speaking out for acceptance and regulating DI, this may result in slow changes towards challenging the secrecy which has traditionally surrounded DI.

There are anecdotal reports of lesbian and single women seeking treatment abroad because of doctors' reservation about the legal uncertainties arising from treating these groups. For a variety of reasons, some heterosexual couples prefer do-it-yourself-insemination with semen provided by a sperm bank from abroad. These reasons include the lack of a nearby provider, the option of individual choice of donor and access to identifiable donors. In addition, some couples go abroad for treatment not available in Germany, such as preimplantation genetic diagnosis. Some also seek DI abroad because they are unaware that it is legal and available in Germany.

Conclusion

In many countries, including Germany, DI was considered a very controversial way of building a family for many decades. The aura of secrecy surrounding it has been changing slowly. Research has mainly concentrated on the evaluation of couples prior to treatment and parental functioning after successful treatment. Little is known about the motivation of German sperm donors and the cultural acceptance of DI. There is also a potential for developing resources and educational material for couples and individuals seeking treatment as well as for families resulting from DI. If DI is to become an accredited way of building a family, the legal framework will have to be clarified. Whether the discussion on new legislation will continue, and what changes may follow, remain to be seen.

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CHAPTER 6

Hong Kong

A Social, Legal and Clinical Overview

Ernest Ng, Athena Liu, Cecilia Chan and Celia Chan

Introduction

With the widespread practice of assisted conception and increasing public acceptance of newly evolved family types, people can make use of technologies to meet their personal desires to produce their own children. The pressures to have a child or children reveal a strong societal value on human beings and reproduction. This chapter discusses the social, legal and clinical aspects of third party assisted conception in Hong Kong, especially with respect to those cultures that have special societal sensitivities on the importance of reproduction and a strong familial orientation such as the Chinese.

In Hong Kong, assisted conception services are available in three government hospitals and in five private hospitals or clinics. Patients can obtain government-funded treatment if they fulfil the recruitment criteria issued by the Hospital Authority. They have to be younger than 40 years old at the time of treatment and a maximum of three treatment cycles will be offered. Some patients seek private-sector treatment because they are not eligible for government treatment or to avoid the waiting lists for publicly-funded treatment.

Social background

Assisted conception is designed to help involuntarily childless people to construct a family. Practices and regulation of assisted conception therefore rely heavily on 'family' values. It is essential to appreciate the cultural roots of family value, so as to understand different perspectives on assisted conception. A family with children is highly valued in many cultures including the Chinese. The concept of family could be revealed from the Chinese word *jia*. *Jia* is the Chinese equivalent of 'family', and its Chinese calligraphy is a pig under a roof (Figure 6.1). Thus the ideal family should bear many children, as pigs do. This word does not only correspond to the English word 'family', but to a kind of extended family with two or three generations, based on the nuclear family (Fei 1947). The preferred mode is to have five generations living together. In societies upholding a strong belief in intergenerational families, children play a crucial role in the extension and continuation of the family. Therefore, married couples bear heavy social and moral responsibilities to produce new members to extend the family tree.

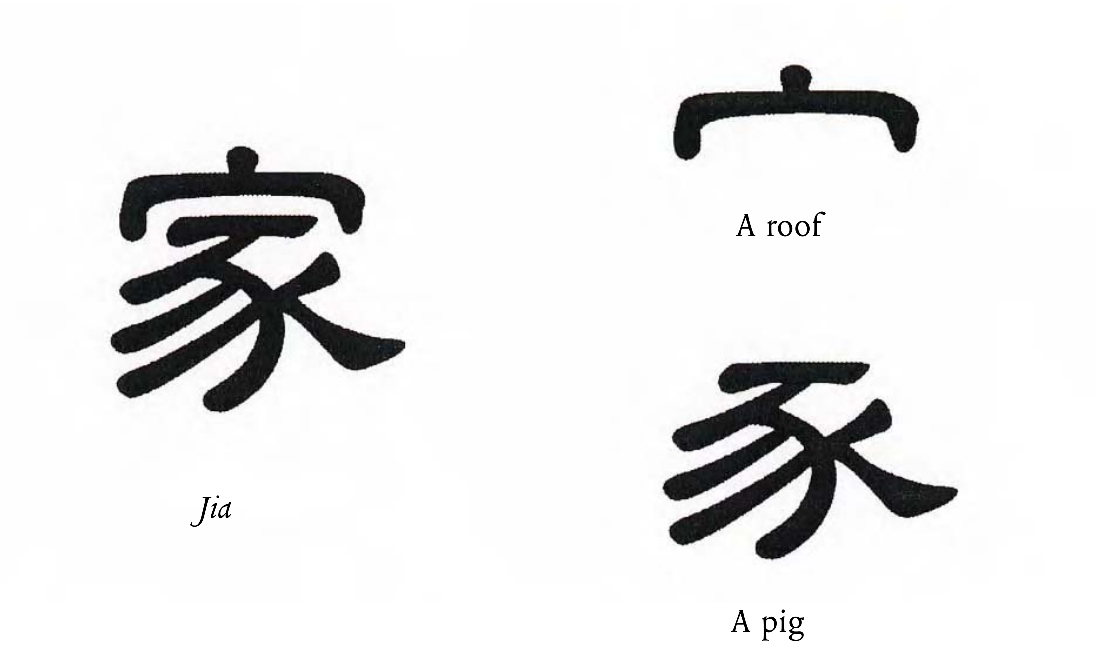

Figure 6.1 The Chinese calligraphy for the word 'family'

Because of the strong imperative to produce the next generation, before the availability of technological assistance infertile couples, especially wives, experienced strong pressure from their family. Childlessness was considered as a curse on the family. Since there was inadequate medical knowledge about fertilization, elderly parents would attribute the problem of childlessness to the women. Based on such attribution, the husband of a childless couple could divorce his wife or marry a second wife who could bear him a child. Actually, many couples chose to resolve their childlessness by involving a third party. In traditional Chinese culture, a common practice was the husband–concubine marriage, where a married man married one or more women for the purpose of producing more descendants, regardless of the wishes of his first wife (Saso 1999). A man who could afford 'three wives and four concubines' was regarded as a lucky man in Chinese societies before polygamy was abolished in Hong Kong in 1971 under the Marriage Reform Ordinance.

Family name is a manifestation of the continuity of the family tree. Offspring carry the family name of their father. In some traditional Chinese societies, couples who are unable to bear children still choose *guo ji*. This is a form of adoption where a male heir is adopted into the family from a close relative and obliged to carry that family's name. This ensures the generational extension of the family tree, which a female heir cannot fulfil. Families that have only daughters would also try to find a husband for their adult daughter who would be willing to promise that their children will bear the name of the wife's family. Very few men were willing to do this, as they would be selling their right to bear children to extend their own family tree. Buying a child from a poor family who could not afford to raise their children was quite common in traditional Chinese societies. Some women in poor areas were also willing to be paid to act as surrogate mothers. However, due to the preference for a male baby, some families would refuse payment if the infant was found to be a girl.

Blood relationships tie family members together. Relatedness is created through blood and marriage (Edwards 1999). In many cultures, it is important for men to sow the seed for the family, to extend the family tree. In Chinese culture, the word *qin* represents the blood relation between two persons who are biologically related. *Qin sheng* means the blood connection between the parents and the child. Countries emphasizing the blood tie uphold the belief that the genetic relationship is much more important than the social relationship, placing on married couples the burden of producing the next generation.

As mentioned above, the Chinese have a strong sense of the continuity of the family tree. This feeling of belonging to the family is often revealed in a couple's decision-making prior to their seeking assisted conception. Biological and genetic connections are highly emphasized within Chinese societies. The child who is *qin sheng* (biologically and genetically connected), especially a son, is still given high status in the extended family. This child has an obligation to extend the family to the next generation. An infertile couple try to get their own child so as not to block their family tree. An infertile wife unable to conceive a child may experience strong guilt feelings because of her inability to fulfil her responsibility towards her husband to provide him with children, as indicated by a 36-year-old patient diagnosed with female-factor infertility:

> I hope my treatment is successful. If I still cannot give birth to our own child, I would suggest that my husband got a second wife, so that I would not be responsible for this crime of being infertile in the family. I am now discriminated [against] by my mother-in-law, who treated her other daughters-in-law better.

Of all forms of assisted conception, the use of a couple's own gametes within a legal marriage is most widely accepted in Chinese societies. This is because the child born as a result is the genetic child of the married couple, and his or her birth maintains the blood tie and fulfils the obligations to the family. For those experiencing male infertility, assisted conception procedures such as DI would be a solution, although using donated sperm is still not widely accepted. Couples need to overcome many cultural and social barriers to using DI. Generally speaking, DI is only used as a last resort. On the other hand, few people would donate their sperm to a sperm bank or adopt children. Observations from, first, a 38-year-old patient whose husband has a diagnosed fertility difficulty and, second, from a 42-year-old man with fertility difficulties, reveal the strong obsession with blood relationship in Chinese families:

> It seems that the child does not belong to my husband and myself. Although the child is still conceived by me, I am afraid that the child does not look like my husband and others might ask about that.

> It is quite absurd to use another man's sperm to inject into my wife's body. There must be something wrong with those who donate their sperm. To me, although it's my problem, I cannot accept using another man's sperm. I would prefer remaining childless.

Surrogacy is gaining popularity in the West. In eastern countries, however, it is still not widely accepted because of the strong sense of blood ties within the family. Of all family relationships, the parent–child relationship is the most important. Surrogacy means requesting another woman to give birth to the child by carrying the embryo of a couple. The emotional connectedness between the carrying mother and the infant is strong, although the infant has the blood of the genetic mother. However, surrogacy weakens the blood tie and it somehow threatens the status of married wives within the family. Therefore, it is extremely uncommon for infertile couples to choose this form of assisted conception.

Legislative overview

In Hong Kong, the Family Planning Association established its sperm bank in 1981 (Family Planning Association 2002). The first baby from *in vitro* fertilization (IVF) was born in the Hong Kong Sanatorium Hospital in 1986. In light of these developments, in 1987 the Secretary for Health and Welfare set up a multidisciplinary Committee on Scientifically Assisted Human Reproduction to advise the government on the social, moral, ethical and legal issues arising from assisted conception. Its interim report was published in July 1989. The committee's final report, with 22 recommendations, was endorsed by the Executive Council in October 1993, the general consensus being that assisted conception procedures should be regulated through a licensing system and the establishment of a statutory council. In 1995, the Secretary for Health and Welfare appointed a Provisional Council on Reproductive Technology to advise on the regulatory framework for assisted conception and to draw up a code of practice. The Provisional Council was a multidisciplinary body comprising 21 non-official members (including medical practitioners, social workers, lawyers, a theologian, a sociologist, a nurse and government representatives). The Human Reproductive Technology Bill was introduced into the Legislative Council in January 1997. It was enacted on 29 June 2000. At the time of writing, the bulk of the Human Reproductive Technology Ordinance is not in force (except that which relates to the establishment of the Council on Human Reproductive Technology). The reason for this is that the mechanism for licensing is yet to be established and it is envisaged that such a system will be in place by 2004. In the meantime, there is no statutory regime governing the practice of assisted conception; although the legal status of children born as a result of assisted conception is now governed by the Parent and Child Ordinance (Liu 2000).

The Human Reproductive Technologies Ordinance (Law of Hong-Kong Cap. 561) is divided into five main parts: 'Establishment of Council on Human Reproductive Technology', 'Prohibitions', 'Licences', 'Access to Information' and 'Enforcement and Offences'.

Under s.5 of the Ordinance, the Council on Human Reproductive Technology is required to:

- Keep under review information developments concerning various aspects on assisted conception.
- Publish lists of premises at which assisted conception procedures are carried out.
- Publish statistics and summaries concerning assisted conception procedures.
- Provide information for actual and potential service providers and patients.
- Promote informed public debate on the medical, social, moral, ethical and legal issues arising from assisted conception procedures.
- Liaise and cooperate with its counterparts outside Hong Kong on current developments.
- Prepare and maintain a code of practice giving guidance about the proper conduct of any assisted conception procedure to the licence holder.

The council has since established three committees – the Ethics Committee, Inspection Committee and an Investigation Committee – and two working groups – the working group on the code of practice and the working group on new developments in reproductive technology.

The functions of the Ethics Committee are to:

- Seek the views of the public on any of the social, moral, ethical and legal issues that arise from assisted conception.
- Provide advice to the council on any of those issues.
- Liaise and cooperate with any other committee.

The functions of the Inspection Committee are to:

- Conduct inspections of premises for the purposes of deciding whether to grant a licence.
- Make recommendations to the council on the granting of a licence.

- Investigate any matter concerning the revocation or temporary suspension of a licence.

The stipulation in s.5 that the Council may carry out research into the social consequences of assisted conception and promote research into the cause of human infertility is unprecedented. This means that the legislature recognizes the unique role the council plays both in understanding the social implications of assisted conception and pursuing medical advances and scientific development.

The ordinance prohibits certain activities by stipulating that no person may carry out a 'relevant activity' without a licence (s.13). 'Relevant activity' is defined as 'the provision of a reproductive technology procedure; the conducting of embryo research or the handling, storing or disposing of a gamete or embryo used or intended to be used in connection with a reproductive technology procedure or embryo research' (s.2).

Apart from using licensing as a regulatory framework, the ordinance also prohibits certain activities that could be used to help an individual or couple to have a child; activities which no licence can authorize. These include the creation of embryos, the keeping and use of foetal ovarian and foetal testicular tissue, sex selection, limitations on eligibility for assisted conception services, commercial activities relating to foetal ovarian and foetal testicular tissue and surrogacy.

Much assisted conception involves the creation of an embryo as well as its manipulation outside the womb. This has been limited by s.15, which prohibits:

- For purposes of research, the creation of embryos, or combining human and non-human gametes or embryos or any part thereof such as to give rise to a two-cell zygote.
- The keeping or using of an embryo beyond 14 days.
- The placing of non-human gametes or embryo in any human or vice versa.
- The replacing of the nucleus of a cell of an embryo with a nucleus taken from any other cell.
- The cloning of any embryo.

Recently, there has been much debate on the use of foetal ovarian and foetal testicular tissue for reproductive purposes. The keeping or using of any foetal ovarian or foetal testicular tissue for any assisted conception procedure is also prohibited under s.15.

Sex selection became a topical issue in light of the cultural emphasis on a male offspring to perpetuate the family name. The importance of a male offspring is evident in light of the Peoples' Republic of China's experience with the 'one child' policy (which resulted in the practice of female infanticide or the use of abortion for sex-selection purposes). Sex selection for non-medical reasons may also be a real concern in light of the fact that many couples have only one child (Chan *et al.* 2002; *South China Morning Post* 2003).

The intention of the Ordinance is to prohibit sex selection for non-medical reasons. According to s.15(3), sex selection, by means of a 'reproductive technology procedure', that causes the sex of an embryo to be selected, whether directly or indirectly (including by the implantation of an embryo of a particular sex in the body of a woman) is now prohibited unless it is carried out for the purpose of avoiding a 'sex-linked genetic disease' which 'may prejudice the health of the embryo' and at least two registered medical practitioners state in writing that 'such selection is for that purpose and such disease would be sufficiently severe to a person suffering it to justify such selection'.

'Reproductive technology procedure' means 'a medical, surgical, obstetric or other procedure…assisting or otherwise bringing about human reproduction by artificial means, and includes:

- *in vitro* fertilization
- artificial insemination
- the obtaining of gametes
- the manipulation of embryos or gametes outside the body
- a procedure specified in a notice and
- a gender selection achieved or intended to be achieved by means of a procedure which falls within this definition'. (s.2(1))

On the basis that pre-implantation genetic diagnosis is a form of manipulation of the embryo outside the body, this technique is now prohibited when used for sex selection by implanting 'an embryo of a particular sex'. Sperm sorting as a gender-selection technique is arguably caught by the prohibition. However, as the technique involves merely increasing the chance that any embryo formed will be of a particular sex, it remains to be considered how far the chances have to be tipped in favour of a particular outcome before it could be said to amount to 'causing the sex of an embryo to be selected, whether directly or indirectly'.

On eligibility for treatment, the Ordinance stipulates that no person may provide assisted conception procedures to persons who are not parties to a marriage. This aims to prohibit the placing of gametes or an embryo into the body of a woman who is no longer a party to a marriage, but it does not prohibit the continuation of an assisted conception procedure when gametes or an embryo were placed at the time when she was a party to a marriage. There are exceptions to this general prohibition: the provision of assisted conception to an unmarried surrogate mother and the obtaining of gametes from an unmarried person e.g. for storage.[1]

On the question of foetal ovarian and foetal testicular tissue, s.15 prohibits the keeping or using of any foetal ovarian or foetal testicular tissue for assisted conception. Under s.16 commercial dealing in gametes, embryos, foetal ovarian or foetal testicular tissue for the purposes of supplying them for any assisted conception procedure, embryo research or surrogacy arrangement is prohibited. However, 'payment' here excludes the cost of removing, transporting or storing an embryo or gamete to be supplied and any expenses or loss of earning incurred by a donor.

Surrogacy arrangements on a commercial basis are prohibited under s.17(1). Thus, a person is not permitted to receive payment for initiating negotiation with a view to the making of a surrogacy arrangement. This, however, does not prohibit a woman from agreeing with a commissioning couple to become a surrogate mother for them. Indeed, a surrogate mother may be reimbursed for any expenses incurred for any assisted conception procedures plus medical expenses arising from her pregnancy and delivery of a child. But she may not be reimbursed for any loss of income arising from acting as a surrogate mother. The publication or distribution of an advertisement relating to a surrogacy arrangement is prohibited under s.17(2). A surrogacy agreement remains unenforceable. To avoid complicated emotional and parentage issues, s.14 prohibits the use of gametes other than those of the commissioning couples for the purposes of a surrogacy arrangement.

Under s.33, the Council is required to keep and maintain a register containing information about assisted conception procedures involving the use of donated gametes or donated embryos.[2] On reaching 16 years of age, a donor-conceived person may require the Council to give him or her notice stating whether or not the information contained in the register shows that he or she has an unknown parent and, if so, to confirm that he or she was or may have been conceived as a result of donor-assisted conception and to state whether or not the information shows that the person whom he or she proposes to marry would or might be related.

This provision, unlike its counterpart in the United Kingdom's Human Fertilisation and Embryology Act 1990, covers the situation only where information shows that the applicant was or may have been conceived as a result of donor gametes. Further, the Council may not give any identifying information on the donor, but what kind of information will be given is still a matter to be decided.

The current practice appears to be that couples may not report successful pregnancies or births resulting from assisted conception procedures. Those who actually do report may choose not to tell their offspring. Thus, although the purpose of the provision was intended to balance the interest of resultant children with that of the secrecy desired by the couple and donor, its usefulness depends on the degree of openness that the parties to assisted conception procedures are prepared to engage in.[3]

The Council is given extensive powers to carry out its functions. A member of the Council or of a committee or a designated public officer has powers to enter licensed premises and take possession of anything (s.37) which he or she has reasonable grounds to believe may be required for the purposes of the Council's licensing function or for use in evidence for an offence. Entry may be effected using such force as is reasonably necessary if it is supported by a warrant (s.38).

It is an offence for a person to be involved in prohibited activities. However, two defences are available. A person charged with committing a prohibited act except pursuant to a licence can be defended if it is shown that he or she was acting under the direction of another and he or she reasonably believed that the other person was at the material time the 'person responsible' (i.e. a suitably qualified individual who is named on the licence to supervise relevant assisted conception procedures) and that he or she was authorized by virtue of licence or directions to commit that act. It is also a defence for a defendant to show that he or she took all such steps as were reasonable and exercised all due diligence to avoid committing the offence (s.39(6)).

Where the 'person responsible' has committed an offence, the licensee shall be guilty of the like offence unless the licensee shows that the act or omission took place without his or her knowledge or consent (s.39(9)). Further, no proceedings for an offence against this Ordinance shall be instituted except by or with the consent of the Secretary for Justice.

In sum, the ordinance has provided a general legal framework for the practice of assisted conception (Brazier 1999). Although much has been said about protecting patients and children by way of pre-treatment and post-treatment counselling (*South China Morning Post* 2002), it remains to be seen how their interests may be advanced in the code of practice as well as in subsidiary legislation yet to be drafted.

Clinical aspects

Clinical aspects of sperm and egg donation and surrogacy in Hong Kong presented here are based on the *Code of Practice on Reproductive Technology and Embryo Research* recently published on 30 December 2002 (Council on Human Reproductive Technology 2002) and experience from local centres.

Centres providing DI must ensure that all donors are carefully screened to prevent the transmission of infectious diseases and assessed for any personal or family history of hereditary disorders. Guidelines for the screening of sperm donors in Hong Kong are modified from those issued in 1993 by the American Fertility Society (American Fertility Society 1993). In addition to providing a medical history and undergoing a physical examination, potential donors are screened for syphilis serology, Hepatitis B antigen, Hepatitis C antibody, HIV antibodies and cytomegalovirus antibody in serum. Semen or urethral cultures for *Neisseria gonorrhea* and urethral testing for *Chlamydia trachomatis* should be obtained. These tests are repeated six months later to confirm that donors were not infectious at the time of donation. Then, frozen semen samples can be used for insemination after thawing.

Sperm donors should be above the age of 18 and under 55. The lower age limit of 18 aims to protect minors who may not be mature enough fully to understand the implications of sperm donation, whereas the upper age limit is set to protect the recipients from an increased risk of chromosomal abnormalities. Donors may not have a history of fathering a child before but the semen samples should be of good quality such as: volume ≥2ml; concentration ≥50 million/ml; forward motility ≥60 per cent, normal forms ≥60 per cent and cryosurvival ≥30 per cent. Most sperm donation is anonymous even though named known sperm donation may still be practised in some private clinics. Information on the donors is recorded in the register as a requirement under the Ordinance. They can be reassured of anonymity and would not be regarded as parents of any child born under Hong Kong law.

DI recipients are counselled to consider both their own feelings and their spouse's feelings about the husband not being the genetic parent of the child. They must be made aware that a child might be born disabled as a result of the donor's failure to disclose defects despite all the screening tests available. The written consent of the commissioning woman's husband must be obtained to avoid any dispute about the fatherhood of the child born following DI. Recipients are strongly advised to report to the centre any successful births so that sperm donated by the same donor will not be used to bring about more than three pregnancies, thus avoiding the possibility of incest. This advice is different from the ten pregnancies given by the American Society of Reproductive Medicine (1994) because of the much smaller population of Hong Kong compared to that of the US. DI recipients can decide whether they would like to reveal the history of sperm donation to their future child and inform their future child of the right to check information in the register before marriage to avoid possible incest.

Although a few private clinics provide a DI service, the Family Planning Association in Hong Kong has taken a major role since 1981 in recruiting potential donors, counselling couples requesting DI and carrying out the insemination procedures. Successful donors will receive HK$200 for each donation and then HK$100 six months later when they return to repeat the necessary blood tests. However, the recruitment rate of sperm donors is low and couples have to wait for a long time because of the very limited supply of donor semen. According to the Family Planning Association, between 1981 and 2000 only 433 women received 1777 DI cycles, resulting in 153 pregnancies (Family Planning Association 2003).

Guidelines for screening egg donors in Hong Kong are more or less similar to those for sperm donors. As very poor results are obtained with freezing of eggs, eggs are not frozen and quarantined prior to use. Egg donors must have been screened negative for HIV status before the donation. Couples entering the egg donor programme should be counselled about the following options:

1. Whether they wish to assume the low risk of acquiring HIV by using fresh embryos; or
2. Whether they wish to have donated eggs fertilized, the embryos frozen and quarantined, the donor recalled for retesting for HIV six months later and only then to undergo embryo transfer.

Egg donors should be between the age of 18 and 35 and the upper age limit is to avoid the increased risk of chromosomal abnormalities in the babies of recipients. Women who have delivered children before are usually preferred because of potential risks from ovarian stimulation and egg collection. Information on the donors is also registered as a requirement under the Ordinance. Anonymity is maintained in the case of anonymous donation, although known egg donation is also practised in Hong Kong. Donors are not regarded as parents of any child born under the laws of Hong Kong. As with sperm donation, eggs donated by the same donor will not be used to bring about more than three pregnancies to avoid the possibility of incest.

There is no particular organization coordinating egg donation in Hong Kong as egg donors are even more limited than sperm donors. Some private clinics may ask infertile patients undergoing assisted conception procedures to donate some of their eggs to those who need them as an egg-sharing programme. Even though there are no precise figures, the scale is still small compared with the number of women awaiting egg donation. Donor egg recipients must be made aware that a child might be born disabled as a result of the donor's failure to disclose defects despite all the screening tests available. Embryo donation is another option as some couples who have completed their family following IVF may prefer to donate any remaining frozen embryos to other couples. Currently, embryos can be frozen for a maximum period of ten years.

In Hong Kong, commercial surrogacy is prohibited by the Ordinance. This means that there should be no financial inducement to encourage surrogacy arrangements and third parties should not profit from making such arrangements. To publish or distribute advertisements relating to surrogacy arrangements is also prohibited and can be a criminal offence under the ordinance. Genetic surrogacy is not allowed under the ordinance. No gametes other than the gametes of the commissioning couple, who must be the parties to a marriage, can be used for the purposes of a surrogacy arrangement.

A surrogacy arrangement is not enforceable in law. This means that the surrogate mother is not bound to hand over the child after birth to the commissioning couple and the surrogate mother has the final choice about whether or not to hand over the child to the commissioning parents. The commissioning couple and surrogate mother should be informed of this position.

Although the surrogate mother is expected to take good care of her pregnancy and the obstetrician in charge of the surrogate mother should advise her to maintain a healthy life style, neither the commissioning couple nor anyone else has the right to control the surrogate mother as to her lifetyle during pregnancy, including nutrition, drinking habits, sexual behaviour or the use of drugs. The commissioning couple cannot dictate the antenatal care received by the surrogate mother or force her to undergo either invasive or non-invasive perinatal procedures such as amniocentesis against her own will.

The surrogate mother has the right to choose or refuse any medical treatment or procedure during pregnancy including termination of pregnancy (subject to the law governing termination of pregnancy).

By law, the surrogate mother is the mother of the baby. The commissioning couple will only become the legal parents of the baby upon the making of a parental order by the court under the Parent and Child Ordinance (Chapter 429). They must apply for this within six months of the birth of the baby. If the surrogate mother and her husband (if she is married) do not agree, the court will not make a parental order.

Because of the ethical concerns and the complexity involved in the arrangement, no case of surrogacy has been reported in Hong Kong.

Adjustment to third party assisted conception

As there are no reported instances of surrogacy arrangements and very few reported instances of egg donation in Hong Kong, the following discussion will focus on sperm donation. Couples who rely on sperm donation may experience denial, frustration, shame, guilt, blame, helplessness, hopelessness and other emotional distress. For couples who have established effective mutual communication and support, the marital relationship could improve and intimacy could be enhanced as they have to work closely together as a team.

From our clinical experience, a husband may find it hard to accept that his physical limitations, such as a low sperm count, may lead to unsuccessful fertilization. The cultural shame associated with male infertility can be devastating as the man concerned may experience strong self-denial, guilt over his failure to continue the family tree and self-blame for being ‘unfilial’ towards his parents and elders in the extended family system. Women who sought counselling reported frustration as their husbands were seen as unsupportive, refusing to discuss the issue and becoming depressed or angry because of the stresses related to infertility. Counselling for both partners is made available so as to help them cope with the emotional distress accompanying diagnosis and treatment.

Counselling is offered to potential users of assisted conception services, potential donors of gametes or embryos and potential recipients of gametes or embryos. While counselling is not compulsory, it is generally recognized as beneficial. Support counselling is also available to help clients to cope with consequences of infertility and assisted conception services. Counselling is also offered to support infertile people who are not suitable for treatment or those whose treatment has failed. Psychosocial support for couples facilitates communication between husband and wife. The shame, guilt, blame and fear that the child may not look like the social father can be worked through by counselling and support.

Conclusion

The cultural burden of infertility among the Chinese seems like an invisible cage that puts couples in bondage. The ethical and filial concerns are translated into legislation and professional code of practice which have only been enacted in recent years.

The long-term effects of third party assisted conception are not known. The design of assisted conception has moved towards holistic multi-disciplinary collaboration to ensure total bio-psycho-social-moral-ethical-legal care. Continuous and long-term follow-up on the families created following assisted conception procedures will be crucial to foster our understanding on this issue.

Notes

1 The Ordinance restricts eligibility for treatment to married women. So the basic principle must be that when such a woman is separated or divorced or her marriage ends with the death of the husband, no further gametes or embryos (including her husband’s sperm) may be placed into her. The last eventuality (death of a spouse bringing a marriage to an end) concerns the acceptability of posthumous birth and overlaps with the issue of storage of gametes/embryos, although posthumous conception is only one dimension concerning the eligibility of a single woman to

receive treatment. But the two issues (treating an unmarried person and establishing a posthumous conception) are not always clearly visualized. For instance, the code of practice sample consent form (1) 'Consent to Freezing and Storage of Sperm (for Own Subsequent Use)' states that 'my stored sperm can be used for insemination...only when I am married'. Also, sample consent form (2) 'Consent to Freezing and Storage of Embryo (for Married Couples' Own Use)' states that 'our stored embryos can only be used for reproductive technology procedures when we are the parties to a marriage...upon death of either of us, our stored embryos cannot be used by the surviving spouse to bring about (a) posthumous child(ren).' (See also para. 10.15–10.16 of the code of practice.) On the basis of consent form (1), posthumous birth as in the English case of *R* v *Human Fertilization and Embryology Authority ex parte Blood* [1997] 2 All ER 687 (see Blyth in this volume) would not occur in Hong Kong. This restriction on the use of gametes or embryos which may result in a posthumous conception does not apply to anonymous donation (as can be seen in the code of practice sample consent forms (3), (4) and (5) as it may be practically impossible to ascertain if the donor is still alive at the time of use of the sperm.

2 No date has been set for the register to become operational. A code of practice has been issued for voluntary compliance. It provides for information collection by the Council. For instance, the donor information form (COP DC Form (5)) collates personal details including the donor's address, height, weight, ethnic group, eye and hair colour and occupation. However, the Ordinance makes it clear that no identifying information may be given to any resulting children. Consent form (3) 'Consent to Anonymous Donation of Sperm' makes provision for a donor to consent to be approached some years later.

3 In Hong Kong, parents still tend to keep the child in the dark about his or her origin. This is evidenced by the fact that even an adopted person may not know about his or her origin. An adopted person has no right to a copy of his original birth certificate (Liu 1999, 2000; Working Group on Review of the Adoption Ordinance 1999).

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CHAPTER 7

Israel

Every Person has the Right to Have Children

Ruth Landau

Introduction

Israel has the world's highest *per capita* rate of *in vitro* fertilization (IVF) clinics; IVF is offered by over 20 clinics in public hospitals and by a number of private clinics. Despite this, few data on fertility treatments have been collected by the Israeli Ministry of Health. Furthermore, the Ministry of Health does not collect or reveal any data on third party assisted conception. According to the most recently published data, in 1999, 16,536 treatment cycles resulted in 3190 live births (16.5 per cent deliveries per treatment cycle). Considering that there has been a 50 per cent increase in IVF treatments between 1995 and 2000, it is not surprising that 2.4 per cent of all live births in the country result from IVF (Ministry of Health 2001a). This figure compares with only 1 per cent of births in the UK (HFEA 1996) and 0.2 per cent in the US (McClure 1996).

Israel's IVF data, however, should be viewed within the general context of Israel's fertility rate, which is unique among the developed countries. Israel is a small country in the Middle East, 280 miles long and 10 miles wide at its narrowest point. The total population is about 6.5 million, of whom 80 per cent are Jewish, 15 per cent Muslim, 3 per cent Christian and 2 per cent Druze. It is a highly urban and industrialized country, thus placing Israel among the developed Western countries despite its geographical location. Yet Israel's total fertility rate of approximately 2.9 children per woman in the last decade is significantly higher than, for example, 2.1 in the US, 2.0 in Sweden, 1.8 in the UK and 1.3 in Germany (Yaffe 1999).

This total fertility rate in Israel disguises a heterogeneous and complex picture. During the last 30 years, the total fertility rate of Arab Muslim women has decreased dramatically by half to 4.6 births per woman, while the Jewish population has maintained a more or less constant total fertility rate of 2.8 children per woman (Keysar *et al.* 1992). Yet there are significant differences among different parts of the Jewish population: the fertility rate of the secular Jewish population is almost the same as that of other developed countries, whereas the average fertility rate among ultra-Orthodox Jews may be as high as 7–7.5 births per woman (Remmennick 1996). In between, the average rate in the national religious population is about 4.5 births per woman (Friedlander and Feldman 1993). The overall fertility rate as well as the variance in fertility rates of the different sectors of the Israeli population apparently reflect certain cultural values that may affect attitudes towards third party assisted conception.

Israel is a parliamentary democracy, where jurisdiction in matters of personal status, such as marriage and divorce, is vested in the judicial institutions of the respective religious communities: the rabbinical Jewish court, the Muslim religious court, and the religious courts of the Druze and of the Christian communities (State of Israel 1997). Thus third party assisted conception in Israel cannot be discussed without referring to at least the Jewish religion and the impact of its formal institutions on the legislation dealing with assisted conception.

Human conception in Jewish and Islamic law

The duty of procreation, the mandate to 'be fruitful and multiply', has the popular distinction of being called the 'first mitzva' [commandment] of the Jewish Torah. The minimal fulfilment of this biblical command is regarded as the birth of one son and one daughter; i.e. when a couple 'replaces' itself (Feldman 1968, p.46). The imperative to have families of good size is basic to the Jewish view of life, if only to be spared the blight of childlessness (Feldman 1968, p.48).

Jewish attitudes toward infertility derive from this commandment. The imperative to have children is so strong that a marriage can be dissolved if the couple is unable to reproduce (Goldberg 1999). According to Jewish law, an infertile couple must undergo diagnosis and treatment as a single unit (Schenker 2000). Furthermore, Jewish rabbis do not disapprove of artificial insemination for single women (Kahn 2000). Moreover Judaism, unlike Christianity, Islam and Buddhism, approves of human cloning if this is the only way for a couple to have children (Lipschutz 1999) or to continue a genetic line (Cohen 1999). Despite this view, the Israeli chief rabbis have suggested that Israel should not rush to allow human cloning before it has been approved elsewhere (Shenker and Ben Shushan 1998).

Most rabbis allow sperm to be obtained from the husband both for analysis and insemination, but the practice of assisted conception with a donor is much more complicated. Judaism allows surrogacy under certain conditions. From the religious perspective, the child is the child of the man who provided the sperm and the woman who gave birth. In addition, only the offspring of a Jewish mother is regarded as Jewish. As the recipient mother is regarded as the mother if the recipient of the donated gametes is Jewish, the child is Jewish (Schenker 2000). These basic concepts of the Jewish religious law directly affect Israeli civil law in its perception of family and reproduction.

Procreation is similarly important in Islam and attempts to address infertility are therefore not only permissible but also a duty. IVF is therefore acceptable but only if it involves both husband and wife. A third party donor is unacceptable under any circumstances (Schenker 2000).

Civil attitudes to third party assisted conception in Israel

The term 'family' is not uniformly defined in Israeli law. However: 'Every person has the right to form a family and have children' [ACR 240/95 *Nahmani* v. *Nahmani*, Takdin-Supreme vol. 96(3) 526] and 'The right to become a parent is a fundamental human right to which everyone is entitled' [CA 451/88 *Anonymous* v. *The State of Israel*, PD vol. 44 (1), 330, 337].

Reproductive rights are viewed as part of Israelis' health rights. Since January 1995, health services in Israel have been provided according to the National Health Insurance Law (1994), under which all residents are insured with one of the four authorized health funds. There is no explicit and comprehensive parliamentary legislation on medically assisted conception in Israel, except for surrogacy. However, according to the National Health Insurance Law (1994), treatment for assisted conception is an integral part of the 'health basket' funded by this law. The health funds are required to fund fertility treatments of all types up to the birth of two living children (according to the regulations of the Ministry of Health from 1987 and subsequently amended periodically). The 'health basket' thus includes all the laboratory and fertility tests for both women and men, infertility assessment and treatments, including hormonal therapy, and the use of all available advanced medical technologies to achieve pregnancy.

IVF treatments started in Israel in 1982 under the surveillance of the Supreme Committee for Experiments using Human Subjects. Two IVF units were initially approved, one at the Sheba Medical Center in Ramat Gan and the other at the Hadassa Medical Center in Jerusalem. The Ministry of Health Regulations on IVF were influenced by the report of the Public–Professional Committee to Investigate *In Vitro* Fertilization appointed in 1991 by the Ministers of Health and Justice to investigate the entire matter of medically assisted conception (Ministry of Justice 1994). However, the specific recommendations of the committee as such were not applied until now. Since 1999, however, the Ministry of Health has restricted access to IVF treatment in Israel; until then it had been amongst the most liberal schemes in the world (Siegel-Itzkovich 1999). According to the latest regulations, *The People's Health Regulations [Assisted Human Reproduction – Amendments]* (Ministry of Health 1999a), in order to prevent futile medical treatments, the maximum age for IVF treatments should not exceed 45 years for women using their own eggs, the total number of treatment cycles should not exceed six cycles per year and IVF treatments involving egg donations should not be provided for women over the age of 51. Compliance with these recommendations, however, can be seriously questioned. As there is no limit to the total number of treatment cycles available to each woman, theoretically a woman can start at any age and continue to undergo six cycles per year until she reaches the age of 51 years.

Forms of third party assisted conception

DI and IVF with sperm donation

Although artificial donor insemination (DI) has been practised in Israel for over 50 years, due to lack of central registration no data on pregnancies from this type of third party assisted conception are available (Ministry of Justice 1994, p.119). Similarly no data are available for egg donations.

The regulations of the Israeli Ministry of Health on DI and donor-assisted IVF from 1979 (Ministry of Health 1979) were the first legal documents that aimed to regulate this area of human reproduction. The regulations included the rules by which sperm banks in Israel are still by and large run, although the rules were updated in 1989 and 1990. These explicitly indicate that sperm donors must be healthy, single men with sperm of good quality. The sperm donors must undergo basic physical health examinations, a chest x-ray and blood tests, including tests for HIV, Hepatitis B, Tay-Sachs and sexually transmitted diseases. In addition, the potential donor is interviewed about the occurrence of mental and genetic diseases in his family of origin. Finally, he is required to sign a declaration of his health status and a waiver of any claim for fatherhood or contact with the woman inseminated with his sperm. Most sperm donors are students paid for their services (Paz 1989). Although the regulations do not explicitly limit the number of donations from one donor, they use rather obscure language to note that the sperm bank director should restrain him/herself from receiving too many donations from one donor.

The sperm bank is legally committed to full secrecy and to protect the donor's anonymity. Identification data are kept in a special safe and are accessible only to the sperm bank physician.

These rules also specify that DI is to be performed only in hospitals which have sperm banks. Banks provide frozen and fresh sperm donations. To insure that sperm is not infected by HIV or Hepatitis B, it is first frozen for six months and is used for fertility treatments only if found negative for these diseases after this period. However, the regulations explicitly note that pregnancy rates are higher with fresh sperm donations than with frozen sperm. The regulations specify that couples should be informed about both the advantages and disadvantages of using donations of fresh sperm and an explanation about the possibility (limited at this time [the wording of the regulations]) of being infected by AIDS. In other words, the regulations convey the message that if a pregnancy is very desired, then perhaps the remote possibility of AIDS infection should be contemplated. In contrast, Leitman (1996) notes that the increased number of fertility treatments following DI or IVF treatment using frozen sperm is a plausible 'price' to exclude possible exposure to AIDS.

According to the Ministry of Health regulations (1979), couples interested in DI are requested to sign an agreement to undergo the procedure. They must sign that they are aware of the fact that the woman may be affected by HIV if choosing to use a donation of fresh sperm. On signing the agreement form, the woman's spouse becomes the child's legal father. The regulations also advise that, where possible, the donor's sperm be mixed with that of the woman's spouse in order to allow the possibility of achieving the pregnancy by the spouse's sperm. Since December 1989 the regulations refer not to the woman's spouse but to her partner, and single women are also given access to DI. Religious women apply to sperm banks only after receiving permission to do so by a rabbi (Paz 1989). Some rabbis allow the use of donation but insist on a non-Jewish donor in order to exclude the possibility of future incest.

Counselling for potential recipients of DI is not mentioned. However, if the treating gynaecologist questions the suitability of the patients from a health, mental, cognitive or social point of view, he or she may consult a specialist in psychiatry, psychology or social work.

A change in the regulations in 1989 allows sperm to be stored indefinitely instead of for two years. However, the sperm of a deceased man is to be destroyed within one year of his death unless his wife requests in writing that the sperm be kept.

Egg donation

According to a circular letter of the Ministry of Health (1986), egg donation was already allowed in principle in Israel that year, although implementation was postponed until regulations were formally published in 1987 (Ministry of Health 1987). Due to lack of central registration, no data on pregnancies resulting from egg donation are available. However, the number of egg recipients as reported in research studies gives an idea of the number of these attempts to conceive in Israel. Between January 1989 and March 1994, 152 patients who were older than 45 applied to one public clinic for infertility treatment. Ninety-six women received donated eggs (Yaron *et al.* 1995). In another study, one private clinic initiated 1001 egg donation cycles provided to 423 recipients over a six-year period (Yaron *et al.* 1998).

The *Report of the Public–Professional Committee to Investigate the Various Aspects of* In Vitro *Fertilization* (Ministry of Justice 1994) indicated that certain clinics were giving ‘incentives’ to women undergoing IVF treatments to encourage them to ‘share’ their eggs (p.29). The committee claimed that egg sharing was inconsistent with the norm that eggs should be voluntarily donated without any payment. They also felt that there may be an abuse of the egg donor who herself is in a difficult situation. The committee concluded that there is no need to limit egg donation to women who themselves are receiving fertility treatments, as the regulations require. The committee asserted that payments should be allowed to both egg and sperm donors, not for the gametes themselves but in recompense for time, inconvenience, suffering, etc. The committee negated the custom of providing ‘incentives’ to women in fertility treatments to donate eggs.

According to the current Ministry of Health regulations for IVF (1987), egg retrieval from a woman is legally allowed only if she is undergoing fertility treatment and egg retrieval will benefit her fertility treatment. The egg of a donor can only be inseminated by sperm of a woman's husband if these conditions are met and both the recipient and her husband give their written consent.

No donated egg is to be implanted in a woman unless it is fertilized with the semen of the recipient's husband. A single woman may use only her own eggs except where a social worker's assessment supports the woman's request for use of a donor egg. Eggs are not to be retrieved from a married woman after her death. However, a woman whose husband has died can donate eggs to another woman. No fertilized egg is to be implanted in a woman unless the donor, single or married, has agreed to donate the egg before her death. Women are not to receive egg donations from donors with whom they are in a family relationship. The identity of the egg donor remains secret. In practice, only a few women undergoing IVF treatment agree to donate eggs and then only when a large number of eggs are retrieved (Dor and Seidman 1996).

Given the demand for egg donation, a new law was proposed in March 2001, based on the work of the Public–Professional Committee for the Examination of Egg Donations (Ministry of Health 2001b). The aim of the proposal was to increase the number of egg donations in Israel significantly and it allowed women who are not themselves undergoing egg retrieval procedures to donate eggs (Ministry of Health 2001c).

Under the terms of this proposal, egg donors are to be unmarried Israeli citizens aged between 20 and 35. The egg recipient must not be older than 51. Donation is allowed only if fewer than seven offspring were born from the woman's donations and if she has undergone fewer than three previous egg retrievals. The eggs from one retrieval must not be implanted in more than three women. Donor and recipient are to be of the same religion unless both agree otherwise. Separate written agreements are to be signed between the coordination unit and the donor and recipient.

The proposed law also advocated the establishment of a national unit for the coordination and supervision of egg donations. This would pay the donors and receive payments from the recipients. It would also provide insurance for the donors in case of harm due to the egg donation. The fact that the committee considered the need for insurance shows that the possibility of harm to a woman undergoing egg donation cannot be disregarded.

Yet the committee was willing to risk allowing a woman to undergo the procedure up to three times. A volunteer donor is to be compensated for any harm, suffering, loss of time, loss of income or temporary loss of the ability to work. A donor who is in fertility treatment herself will be compensated for the possibility of indirect harm that might decrease her own chances of conception. Her entitlement to compensation will be half that paid to a volunteer donor.

Neither the donor nor recipient are allowed to know each other's identity. A registration centre is to be established to protect the information on the genetic origins of the offspring and to prevent marriage between genetic siblings. If saving a life depends on it, the registration centre can locate the egg donor or the offspring and request their agreement to relinquish their anonymity. Adults over the age of 18 are to be allowed to ask the registration centre whether they were born from egg donation. If the answer is negative, the registration centre is to send a written answer; if positive, the answer must be given personally. Individual women and men who intend to become couples will be eligible to ask the registration centre whether they are genetically close relatives. The answers are to be provided as described above.

The payments received for the donation will be tax exempt, but a woman can receive this exemption only three times.

Embryo donation

Cryopreservation of embryos has been available in Israel since 1986. However, according to the Ministry of Health regulations from 1987, embryo donations are prohibited in Israel. The *Report of the Public-Professional Committee to Investigate* In Vitro *Fertilization* (Ministry of Justice 1994) surmises that this is due to an apprehension pertaining to the family genealogy or to the fact that embryo donation is genetically virtually the same as adopting a child without any genetic ties to any of the parents. Thus the law allows the combination of sperm and egg donation but not embryo donation. According to a circular letter from the Office of the Legal Advisor of the Ministry of Health (Ministry of Health 2001d), the importation of cryopreserved human embryos to Israel is prohibited too.

Surrogacy

The Surrogacy Arrangement Act (1996), enacted in Israel, was the first law of its kind in the world. All surrogacy arrangements must be approved by the Special Committee to Authorize Surrogacy Agreements (Authorization Committee) comprised of two gynaecologists, a specialist in internal medicine, a clinical psychologist, a social worker, a representative of the religion of those involved in the process and a jurist. The parties interested in surrogacy must submit the following documents to the Authorization Committee:

1. A proposal for an agreement between the parties.
2. A medical assessment of the commissioning mother's inability to conceive and carry the pregnancy or to the effect that the pregnancy may significantly jeopardize her health.
3. A medical assessment of the adequacy of both parties to the agreement for the process of surrogacy.
4. A psychological evaluation of the adequacy of both parties to the agreement for the process of surrogacy.
5. Confirmation by a psychologist or a social worker that the commissioning parents have received appropriate professional counselling, including on other possibilities for parenthood.

If the proposed agreement is the result of a mediating agency, the agreement must also include details about the agency. The Authorization Committee authorizes the surrogacy agreement only if:

1. All parties to the agreement gave their informed and free consent and understand its meaning and implications.
2. There is no fear of harm to the health of the surrogate or to the well-being of the future offspring.
3. The agreement does not include harmful or discriminative conditions for any of the parties.

According to the law, the surrogate should be single, although the Authorization Committee is allowed to approve an agreement with a married woman if the committee is convinced that the commissioning parents made sufficient effort to make an agreement with a single woman. The surrogate cannot be a relative of either of the commissioning parents. She must be aged between 22 and 40, and have undergone no more than two caesarean sections and no more than five births. Surrogacy is authorized provided that the sperm used in the procedure is that of the commissioning father and the egg is not of the surrogate mother. Sperm donation is forbidden in this form of third party assisted conception since, according to Jewish law it would make the child 'illegitimate'. In general, the surrogate mother and the commissioning parents should be of the same religion.

The Authorization Committee can approve monthly payments to the surrogate mother to cover her actual expenses arising from the agreement, including expenses for legal advice and insurance fees, as well as compensation for time, loss of income, temporary inability to work, or any other reasonable grounds for compensation.

From birth, the newborn child remains with the commissioning parents and they hold parental responsibility towards the child. However, they must formally adopt the child by means of court order, since Jewish law declares the birth mother to be the child's legal mother even if the child is genetically unrelated to her. Until completion of the adoption process and determination of the child's status, the child is under the guardianship of the welfare officer representing the State. An adoption order will be made unless a welfare officer's report indicates that this would be inconsistent with the child's well-being. The surrogate is not permitted to reconsider her decision to part with the child unless the welfare officer's report reveals a change in circumstances that justify the surrogate's change of mind and states that this will not be detrimental to the child in any way. The surrogacy agreement does not eliminate the surrogate mother's right to any medical treatment according to her wishes, including abortion.

According to a circular letter of the Ministry of Health dated September 1996 (Ministry of Health 1996), the cost of the treatment for both the commissioning and the surrogate, including IVF, is to be covered by the health fund in accordance with the National Health Insurance Law (1994). However, the commissioning parents must cover the cost of any egg donation.

In 2002 the High Court considered an appeal submitted by the organization New Family on behalf of a single woman whose request to enter into a surrogacy arrangement had been refused by the Authorization Committee (Sinai 2002). Prior to undergoing a hysterectomy, the woman had arranged for her eggs to be retrieved and cryopreserved. She now desired to inseminate them and to implant them in a surrogate mother. The appeal claimed that the Authorization Committee's decision was incongruent with Israeli law that promotes individual autonomy and that it discriminated against single parents despite the fact that state laws have recognized this family form for a long time. In response, the State claimed the Surrogacy Act 1996 to be one of the more advanced laws in the world.

While it seems that the critical issue for the Court was whether to give precedence to the Surrogacy Arrangement Act 1996 or the legal status of single-parent families, one should not overlook the possibility that the next petition could be by single men claiming that the surrogacy law discriminates against men (Honig, Nave and Adam 2000).

In December 2002 the High Court decided that the Surrogacy Arrangement Act 1996 does not enable single women to enter into a surrogacy arrangement. The Court, however, acknowledged the discrimination against single women, and recommended the legislators to consider their suffering of being deprived of motherhood without access to surrogacy arrangements (Reinfeld 2002).

Nevertheless, despite a larger volume of inquiries, during the last six years there have been only around 100 applications to the Authorization Committee to approve surrogacy agreements in accordance with the Surrogacy Act 1996. Eighty applications were authorized and 40 children were born (Sinai 2002). The current basic ‘compensation’ for surrogacy is about US$25,000 per agreement, not including various expenses, such as the willingness to carry twins that add a further US$10,000 to the cost of surrogacy (Honig *et al.* 2000).

The application process for surrogacy, as reflected by the Authorization Committee’s published guidelines, is undergoing constant change. For example, in response to problems with payments to the surrogates, the committee now requires that the funds covering the surrogate’s payment are deposited in a trust fund prior to the beginning of treatment (Honig *et al.* 2000). Furthermore, according to a form of the Authorization Committee from July 2000, the surrogate is eligible to receive legal advice from a lawyer funded by the commissioning parents. Life insurance for the period of the treatment and until three months after the delivery funded by the commissioning parents is also mandatory. The number of embryo transfers (not more than seven) and the time limit for the treatments (not more than 18 months) are also to be specified in the agreement. Psychological counselling for the surrogate’s children is also to be included.

Posthumous conception

Artificial conception not only allows conception using gametes of individuals who do not know each other, it also allows conception long after the retrieval of sperm and egg. Consequently, posthumous conception with or without donated gametes is now possible. Posthumous conception combined with surrogacy is also possible using the eggs of a deceased woman or the sperm of a deceased man who had no partner. In this case at least one gamete donor is a deceased person at the time of fertilization. The Public–Professional Committee to Investigate *In Vitro* Fertilization (Ministry of Justice 1994) recommended that patients write their wishes as to the use of their gametes after death in their wills. In 1994, the first boy was born in Israel from the frozen sperm of his mother's deceased spouse. In 1995, the husband of a young woman immigrant to Israel was injured in an automobile accident and suffered brain death one day after their arrival in Israel. The woman requested posthumous retrieval and freezing of his sperm for later insemination (Landau 1999). In this particular case the request was denied but in subsequent cases permission was granted. Thus, we have not only reached the situation of posthumous conception but also posthumous retrieval of gametes.

The current regulations permit a widow to be inseminated with either her deceased husband's sperm or with donor sperm. In a circular issued in April 1997, the Director General of the Ministry of Health recommended that widows wishing to undergo insemination earlier than three months after their partner's death should be assessed by a social worker who should confirm that the request represents the widow's free will and is not the result of emotional stress (Ministry of Health 1997). Prior to this regulation at least a year had to pass between sperm retrieval and insemination. However, there is a differentiation between the gametes of deceased married men and women. If the deceased is a man, his sperm may be used for insemination; if the deceased is a married woman, her eggs or an embryo using her eggs cannot be used. If the deceased is a single woman, her eggs or embryo may be used provided that she consented to donate her gametes prior to her death.

A more recent development in this context is the request of close relatives of deceased men to retrieve sperm for later insemination. The posthumous retrieval of sperm for the insemination of the widow raises legal and ethical questions regarding prior consent of the partner, the legal status of the offspring and her or his well-being (Landau 1999). Further issues are raised by parents requesting posthumous retrieval of their son's sperm. Posthumous retrieval of sperm from single men for later insemination involves third parties because of the need for eggs and uterus. In other words, parents of deceased single men who insist on the continuity of their genetic line need a surrogate.

This scenario is not futuristic. The Israeli Defence Forces were recently sued by parents claiming that when their unmarried son died during military service they were not notified about the possibility of posthumously retrieving his sperm for later insemination (22 May 2002, Van Leer Institute, Jerusalem, author's report). The Attorney General, Professor Rubinstein, speaking at a conference on this issue, shared with the audience the view being considered in the Ministry of Justice that posthumous sperm retrieval (with and without prior consent) for the purpose of insemination requested by widows will probably be legalized in Israel. However, posthumous sperm retrieval of sperm from single men, based on the request of the remaining parents will probably not be approved. Landau (1999) has argued for discouraging planned orphanhood on the grounds of psychosocial harm to all involved, particularly the offspring.

Interested parties in the debate on third party assisted conception

The Israeli media appear very quick in reporting each success in the area of fertility treatments. They give the impression that nowadays assisted conception is a pure success story: women can decide when they want to have children and if nature does not work, technology will certainly resolve the problem. Consequently – and since there is no general familiarity with the details of all the types of fertility treatments, including third party assisted conception, and their success rate – the public seems very much in favour of assisted conception of any type.

In the book *An Unusual Pregnancy* (Almog and Ben Zeev 1996), which focuses on the medical, psychosocial, legal and ethical aspects of IVF and third party assisted conception for the Israeli public, the psychologist Gilai-Ginor (1996) indicates that unusual pregnancies raise questions regarding the bond between parents and offspring. This alone thus justifies thorough research in this area. However, few social scientists are involved in the study of IVF and particularly in third party assisted conception.

The medical profession is obviously very involved in the debate. Representatives of the medical profession are central members of committees making decisions on issues of fertility treatment. The *Report of the Public–Professional Committee to Investigate* In Vitro *Fertilization* (Ministry of Justice 1994), for example, hints that allowing donor-conceived children access to genetic information may be detrimental to donor availability and therefore a danger to the entire third party assisted conception programme. It is this concern that seems to underlie the vague fears of 'error' and inappropriate access raised by a central registrar (Landau 1998a). Halperin, gynaecologist *cum* rabbi and principal dissenting voice in this committee's report, claims elsewhere that the most pragmatic argument against change in the current situation is its convenience (Halperin 1999). Without a central authority for the registration of donations, there is no way of keeping the number of donations per donor to a minimum.

The Jewish religious standpoint is particularly concerned with the problem of illegitimacy and that of half-siblings marrying in ignorance of their genetic relationship. In addition, the child of a married woman and a man other than the husband is seen as a 'bastard' or 'outcast' in terms of the Jewish law. Because marriages in Israel are registered by the religious institutions, such an offspring is unable to marry formally in the country. Therefore, the religious institutions do their utmost to preclude any possibillity of resemblance to this situation in third party assisted conception. They are similarly very explicit on the issue of possible incest. Thus, their primary focus is on procreation provided that the issues of illegitimacy and danger of incest are seriously considered.

The proposed new law concerning egg donation (Ministry of Health 2001b) clearly exemplifies this attitude: the suggested central register of gamete donors is designed to prevent the unwanted consequences of egg donation as perceived by the Jewish religion but not to give full information to the offspring as recommended elsewhere (Landau 1998b).

The eminent philosophers identified with the debate on IVF and third party assisted conception issues in Israel hold the view that individuals reproduce mainly due to egoistic reasons, regardless of whether they reproduce naturally or with third party assisted conception. All decisions in reproduction thus fall within their autonomy and privacy as adults and should be respected. However, they claim that individuals should be allowed to create other human beings without any limitations based on the child's interests or the idea of preserving humankind as we know it (Ben Zeev 1996; Heyd 1996). Similar views are also held by some legal experts (Almog and Bendor 1996). These philosophers also claim that the assertion of the 'child's best interests' is morally and logically acceptable only for an already existing individual and not for a potential child, regardless of the nature of the child's conception. Consequently, the well-being of the potential offspring cannot be evaluated before the birth. This approach (Heyd 1996) was adopted by the Public–Professional Committee to Investigate *In Vitro* Fertilization (Ministry of Justice 1994), of which Heyd was a member.

The feminist standpoint focuses mainly on securing free access to various forms of third party assisted conception for women while, at the same time, alleviating harm to women. The feminist groups frequently join human rights groups who claim rights for minority groups, such as single, lesbian and post-menopausal women. Representatives of these groups are active in appeals to the High Court which have resulted in many of the changes in the regulations on third party assisted conception. One such appeal resulted in access to third party assisted conception for single and lesbian women and waiving their need to undergo an assessment by a social worker to determine their suitability for parenthood. Some feminists, however, have opposed the Surrogacy Arrangement Act (1996). Shalev, initially supported the view that women, as rational human beings, are able to sign a contract concerning their intention to carry a pregnancy for another party (1989). However, in her later papers Shalev (1996a, 1996b) is concerned less with women's theoretical autonomy and more with the potential abuse of women perceived as subjects whose primary aim in life is to procreate.

The well-being of the offspring was raised as a consideration in determining policy on assisted conception during the work of the Public–Professional Committee to Investigate *In Vitro* Fertilization (Ministry of Justice 1994). In spite of this, and in contrast to Israel's adoption practices, current and planned regulations deny donor-conceived individuals the right to know the identity of their genetic parents. Landau (1998a) has provided a critique of the preference for secrecy over openness.

Conclusions

Third party assisted conception in Israel must be seen in terms of the astonishing desire of the population to achieve parenthood. Israeli policies and practices regarding third party assisted conception reflect both this wish for offspring and the supportive approach of the dominant Jewish religion. Accordingly, access to all known types of third party assisted conception is granted to almost all individuals in the population with very little interference from any external sources. Access to third party assisted conception in Israel means that all fertility treatments, including IVF, whether with own or donated gametes, are funded by the health funds for the first two offspring thus achieved. While commercialization as such in the area of third party assisted conception is perceived to be prohibited, financial compensation – not for the gametes, but for suffering, loss of time, loss of ability to work, inconvenience, etc. – is accepted.

Despite the relatively large volume of third party assisted conception in Israel, counselling is not an integral part of the fertility services offered to those interested in them (Landau 2001). Since there is no psychosocial preparation either for success or for failure, there is also no systematic decision-making about the end of treatment. Most individuals involved in the process continue until all options have been maximally utilized. The current policies and practices still place the adults' wishes and interests above the well-being and the best interests of the offspring. However, considering the growing number of children born in Israel as a result of third party assisted conception, there is a great need to focus on the impact of third party assisted conception on the resulting children.

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CHAPTER 8

New Zealand

From Secrecy and Shame to Openness and Acceptance

Ken Daniels

Introduction

The two-person committee appointed by the Minister of Justice to study and report on assisted reproductive technologies in New Zealand, said in the Executive Summary of its report:

> One of our guiding principles is the right to know genetic origins. In considering the question of access to genetic and birth information where there has been donation of gametes or embryos, we found the great weight of submissions and oral expressions of opinion favoured a policy of openness, rather than secrecy. (Ministerial Committee on Assisted Reproductive Technology 1994, p.8)

This statement is significant for two reasons. The first is that it was written in 1994 and, in comparison with most other countries, suggests that New Zealand was in the advance guard in addressing and supporting the sharing of information in third party reproduction (Daniels, Lewis and Curson 1997). The second factor was that the Ministerial Committee on Assisted Reproductive Technology (MCART) was, in effect, endorsing the 'culture' that had been in operation for some time – it was not advocating a change in direction.

While New Zealand policy and practice developed in contrast to that of Sweden, it needs to be acknowledged that the Swedish legislation had an important impact on the development of thinking concerning artificial donor insemination (DI) in New Zealand (Daniels 1994a; Daniels and Lalos 1995).

New Zealand's early move to adopt information sharing was almost certainly assisted by three factors.

Whakapapa

Following the arrival and settlement of immigrants from the UK, the Treaty of Waitangi was signed between the indigenous people, the Maori, and the British Crown in 1840. The Treaty of Waitangi provides for Maori to express their authority, responsibilities and expectations.

The only legislation in New Zealand concerning assisted conception, the Status of Children Amendment Act (New Zealand Government 1987), provides that the couple seeking donor procedures are the legal parents of any child born following such procedures. This legislation conflicts with Maori values and norms, specifically in respect to *Whakapapa* (ancestral line/genealogy) (Manatu Maori 1994).

Whakapapa has been described as 'The mechanism by which individual *whanau* [family] members establish ascent to an eponymous ancestor' (Manatu Maori 1994, p.5). This element establishes and determines an individual's status and also formalizes the relationships between those who are able to trace their ascent to a common ancestor.

A vital step in this process is having full knowledge of, and access to, information concerning people with the same biological connections. *Whakapapa* makes explicit the real and undisputed knowledge that children have two genetic parents and that the child is the offspring of the *whanau* (extended family), *hapu* (sub-tribe) and *iwi* (tribe).

The very nature of assisted conception utilizing gametes provided by anonymous donors, together with the Status of Children Amendment Act 1987, undermines an individual's birthright and claim to *Whakapapa* and thus their right of full access to their cultural heritage. Protection of *Whakapapa* requires that all children born as a result of third party assisted conception have unconstrained access to information identifying their genetic parents (Manatu Maori 1994).

The need for all public policies and practices to incorporate Maori values has been a dominant factor in New Zealand's social and political development over the last 20 years. The importance of *Whakapapa* and the need to protect it are part of this wider movement. While the recognition of *Whakapapa* has been an important factor in the movement to an access-to-information culture, it is appropriate to see it as reinforcing rather than creating the movement.

Adoption policy and practice

New Zealand's policy and practice in relation to adoption was also an influencing factor in the development of information sharing in third party assisted conception. In 1881 New Zealand became the first country of the Commonwealth to enact adoption legislation (Law Commission 2000).

In the late 1970s and early 1980s, challenges to conventional practice that gave 'strong support to ignorance, secrecy and concealment' (Else 1999, p.59) began to emerge, leading to an open adoption system and to New Zealand 'leading Western adoption practice with respect to openness' (Grotevant and McRoy 1998).

Since 1985, the Adult Adoption Information Act 1985 has provided for adopted persons (when aged 20) to apply for information to assist them in identifying their birth parents. The birth parents have similar rights but the Act also provides for any of the involved persons to enact a veto, limiting access to information. Current practice has evolved to the point where open adoption is the norm.

Open adoption 'is much more in tune with traditional Maori practice' (Hall and Metge 2002, p.63) and has been influential in the debates concerning DI and access to information.

It should also be noted that three of the key professionals who were actively involved in assisted conception and who argued strongly for access to information for DI offspring had personal experiences of adoption. There is little doubt that their advocacy within the assisted conception teams they worked in or were associated with was very influential.

Population

The size of the New Zealand population (four million) is almost certainly another factor that has encouraged openness. Most professionals know each other and the informality that tends to characterize relationships, both professional and personal (e.g. the widespread use of first names), makes for an easier exchange of views. This is particularly noticeable in Fertility New Zealand (previously the New Zealand Infertility Society), which provides a forum for professionals and consumers to come together and exchange ideas at yearly conferences and workshops. In such an environment, consumers have had an important impact on the thinking of professionals, particularly doctors.

The origins of third party assisted conception in New Zealand

DI has been practised in New Zealand for at least 58 years. This information is available as a result of a telephone conversation with an anonymous lawyer, who contacted the author to discuss a situation regarding clients who had conceived three children in the 1940s as a result of DI. The fact that the lawyer wished to remain anonymous himself indicates something of the secrecy that permeated DI in the 1940s.

As far as can be ascertained, the earliest paper on DI to appear in a New Zealand journal was written in 1958, in which Northey comments, 'in New Zealand it seems that few physicians are prepared to carry out the treatment. Under the law as it stands at present, their caution is more than justified' (Northey 1958, p.533).

While the lack of an appropriate legal framework was important in contributing to the culture of secrecy, it is almost certain that the social stigma associated with male infertility and the dubious moral status of DI at the time (Commission Appointed by His Grace the Archbishop of Canterbury 1948) were also factors.

The first paper reporting on the practice of DI in New Zealand was written by MacLean and his colleagues (1984) and described the DI programme that had been operating in Christchurch since 1974. In the paper it was said there was a growing waiting list and:

> [t]he future of donor insemination would depend on a satisfactory supply of donors, the availability of clinical and laboratory personnel and provision of appropriate funding... The future of the service may depend upon community attitudes, the issue of confidentiality of donor identity and the many other social and legal aspects arising from such programmes. (MacLean *et al.* 1984, p.486)

The year 1984 also saw an escalation in the consideration of the social, legal and ethical dimensions of assisted conception, not because of the paper or because of DI but, rather, because of the birth of the first child in New Zealand to be conceived by *in vitro* fertilization (IVF). There was widespread concern expressed about this development and its implications. This led to a group, comprising the Royal Society of New Zealand, the New Zealand Law Society, the Medical Council of New Zealand, the Medical Research

Council of New Zealand and the Medical Association of New Zealand, requesting the government to appoint a standing committee to consider the legal, moral and social issues arising from IVF, DI and related developments in biotechnology (Royal Society of New Zealand 1985).

What is of interest is that in New Zealand, as elsewhere (Daniels 2003a), doctors and scientists associated with the advent of IVF were very keen to let the world know of their success. Medical science's ability to overcome infertility was, and remains, a very newsworthy topic. The contrast between the high technology intervention needed for IVF and associated procedures and the relatively low technology associated with DI is marked, and may be a significant factor contributing to the degree to which doctors and scientists promote these different areas in the media.

The year after New Zealand's first IVF birth, the National Women's Hospital (the treating hospital) announced that it had a six-year waiting list (Graham *et al.* 1985). The publicity had been successful in informing the public of the availability of IVF and increasing the demand.

Literature on the psychosocial dimensions of DI and infertility began appearing in the early 1980s. The first paper to specifically address these issues was published in 1982 (Daniels 1982). The same year, Ellis (1982) wrote about 'Infertility as an emotional crisis: The role of counselling' and two years later, a group of Christchurch social workers published a paper in the *New Zealand Medical Journal*, 'Issues and problems for the infertile couple' (Daniels *et al.* 1984).

From this beginning, there has been a rapid and continuing growth of New Zealand literature covering studies of the psychosocial aspects of DI and assisted conception. There have been many published papers discussing the social, legal and ethical issues associated with third party assisted conception (for a review of these, see the database at http://cantma.canterbury.ac.nz:591/sowk_web).

The practice of third party assisted conception

New Zealand has both public and private health care systems. In addition to providing the bulk of hospital-based services, the public system also purchases services from the private sector. This is the case in relation to assisted conception with the consequence that those clinics/hospitals (five) providing a full range of assisted conception procedures have both publicly and privately funded patients. There are several limitations, e.g. the number of IVF cycles, that apply to publicly funded patients. As might be expected, waiting lists are longer in the public than the private system. In addition to these services there are five specialists operating from their private consulting rooms who provide DI services only.

Services are located in all the major cities (two service providers being in Auckland, the largest city in New Zealand) and a number of secondary cities.

There has also been an extension of available services, in that egg donation programmes have become available from the four main providers since 1992. Non-commercial altruistic surrogacy using IVF as a treatment was approved by the National Ethics Committee on Assisted Human Reproduction (NECAHR) in 1997. NECAHR has adopted a case-by-case approval system and 18 of the 21 applications received from clinics since 1997 have been approved (Daniels 2003a).

Embryo donation is currently being considered by NECAHR and it seems likely that this procedure will be approved in the near future.

The only study reporting the extent of DI practice in New Zealand was carried out in 1984 (Daniels 1985) and showed that doctors providing DI services had received 224 requests or referrals in the previous 12 months. Approximately 159 women had been inseminated, with approximately 68 (43 per cent) conceptions taking place and results awaited for a further 14 (9 per cent). Forty-two live births had been recorded, with a further 18 awaiting delivery. While the study did not specifically seek information on the views of doctors regarding the availability of DI to single women and women in same sex relationships, it appears that at the time only married couples were being treated.

As yet, there remains no centralized system in New Zealand for recording the number of children born as a result of DI. Nor has there been any pressure or demand for such a system. This is in sharp contrast to other areas of assisted conception. Figures relating to the number of conceptions and live births resulting from IVF, intra cytoplasmic sperm injection (ICSI) and egg donation are collected and reported on annually by clinics. The resultant report (Hurst and Lancaster 2001) covers both New Zealand and Australia but specifically does not include figures for DI. The pending legislation (New Zealand Government 1998) will require service providers to report birth details and this will in effect lead to a national database.

The lack of previous data may be due to the fact that all the other reported procedures are carried out in clinics – in contrast to physicians' private offices – and that it is very difficult to ascertain which private practitioners are providing DI. It may also be partially related to the earlier comment concerning the interest in the more high-technology procedures.

The policy context

Coney and Else (1999) have noted:

> Despite many calls from the professionals involved and from other concerned groups, New Zealand continues to lack a comprehensive and regulatory framework to govern the provision, use and outcomes of ART. In the absence of such a framework, an ill-assorted patchwork of existing laws, codes and sets of regulations is being applied. (Coney and Else 1999, p.1)

Scientific and medical advances in the treatment of infertility have tended to be greeted with a mixture of excitement and apprehension by the public. In response to the apprehension and, in some situations, outright opposition, governments in many countries have initiated reviews/enquiries designed to explore the most appropriate ways in which they might respond to developments in assisted conception, given that this is recognized as a matter of public policy.

It was apprehension which led the influential New Zealand group of academics and professionals (Royal Society of New Zealand 1985) to ask the government to review this area. Clearly, the desire was for the non-medical and non-scientific factors to be fully considered. The New Zealand government recognized and accepted there were public policy issues associated with these developments and, through the Law Reform Division of the Department of Justice, produced *New Birth Technologies: An Issues Paper on AID, IVF and Surrogate Motherhood* (Department of Justice (Law Reform Division) 1985).

Inappropriately and incorrectly named (as the issues concerned conception, rather than birth), *New Birth Technologies* was prepared in the main by a government official and drew heavily on reports recently prepared in the UK (Department of Health and Social Security 1984) and the State of Victoria in Australia (Waller 1982). It was designed to encourage public discussion and debate and to ascertain possible options the government might consider. Clearly the focus was broader than third party assisted conception.

One hundred and sixty four submissions were received from individuals and groups and as a result of these the government decided to appoint an interdepartmental monitoring committee, which would be a repository for information, monitor the issues associated with assisted conception and provide advice to government ministers. As Daniels and Caldwell (2002) have said:

> Such a committee had not been envisaged by a substantial number of groups and persons who had made submissions in response to the Issues Paper. These submitters had called for a committee that would consist of medical, legal, theological and lay members (and thus be representative of public and professionals' thinking and interests) and they had proposed that the committee's functions would include recommending guidelines, monitoring services, authorising research and making recommendations for legislative changes. They had also suggested that by receiving submissions and investigating the social implications of alternative reproductive technology, the committee could act as a focus for public debate and education. (Daniels and Caldwell 2002, p.205)

Despite those various submissions, the Justice Department document had concluded:

> [T]here are many ways in which public opinion can manifest itself in New Zealand. An appropriate avenue in the health field, for example, is through elections for hospital boards, and area health boards. Another means, which is sometimes available, is through a committee appointed to advise the government. A number of submissions called for the establishment of a committee in this area, although there was little consensus on the status and purpose of the committee. (Department of Justice (Law Reform Division) 1985, p.40)

The identified lack of consensus was predictable, as the various groups and individuals had not conferred; if they had, a consensus may well have emerged.

The desire for some form of regulation/legislation/monitoring also emerged from a survey of obstetricians and gynaecologists (Daniels 1985), 86 per cent of whom considered that there was a need for some kind of legislation or regulatory framework for assisted conception in New Zealand.

The only sampling of public opinion on the desire/need for regulation showed that 81 per cent of the 1400 respondents to a women's magazine survey believed there was a need for some kind of legislation or rules to control and manage developments in assisted conception (Daniels 1988).

The decision by the Minister of Justice in 1993 to appoint a two-person Ministerial Committee on Assisted Reproductive Technologies (MCART) was seen as significant and long overdue, as this was the first investigation carried out by non-government officials. The committee was asked to:

1. Find out what was happening in the field of assisted reproductive technologies in New Zealand.
2. Talk to interested groups and individuals to get their views on what is happening here and what should happen here.
3. Gather information from the literature available in New Zealand about developments in other countries.
4. Report to the Minister of Justice with options on the ways ahead for New Zealand in this field.

(Ministerial Committee on Assisted Reproductive Technology 1994, p.1)

The MCART report said '[t]he State has a proper protective role to ensure that all parties are protected' and 'given the mobile state of knowledge and scientific discovery, it is essential that we have transparent, yet flexible structures in place' (Ministerial Committee on Assisted Reproductive Technology 1994, p.1). The committee's principal recommendation was that an advisory and overseeing body, a council on assisted human reproduction, be established which would be the focus for policy development and would include in its tasks the preparation of codes of practice and guidelines to assist providers, consumers and the general public.

Other recommendations included legislation to ban cloning, the creation of animal/human hybrids, the implantation of human and animal embryos in the opposite species and the buying or selling of gametes and embryos. Furthermore, it was recommended that there be a requirement that only medical practitioners could practise assisted conception but that a New Zealand licensing scheme for clinics or doctors should not be established.

To the surprise of many, a second round of consultations then took place, following the publication of the report. This came about because the government asked an Officials Committee to comment on the MCART report and they were not in favour of the establishment of the proposed council or a number of other recommendations.

The Minister of Justice released the Officials paper (Department of Justice 1995) and responses were invited. Nothing is publicly known about the responses that were made and there was little, if any, government action until

1998, when a Bill (New Zealand Government 1998) was introduced to Parliament and this will be discussed later in the chapter.

Policy developments in assisted conception in New Zealand have been significantly influenced by the establishment in 1993 of the Interim National Ethics Committee on Assisted Reproductive Technologies (INECART), which was subsequently reconstituted in 1995 as the National Ethics Committee on Assisted Human Reproduction (NECAHR). This initiative from the Minister of Health arose because of clinics seeking approval for innovative treatments and the established ethics committees (regionally based) expressing concern that a national approach was needed to respond to the emerging issues.

It needs to be noted that the previous policy initiatives in New Zealand had come from the Minister of Justice, whereas this initiative was from the Minister of Health. NECAHR was established under the Health and Disability Act (New Zealand Government 1993). NECAHR has the following terms of reference:

1. To review assisted human reproductive proposals (including health research and innovative treatment) to determine whether they are ethical and, in particular, to determine whether:
    - (a) The rights of the people involved will be protected.
    - (b) Proper account will be taken of the ethical perspectives of Maori and other cultural, ethnic, religious and social groups in New Zealand.
2. To develop for providers protocols and guidelines relating to the ethical issues involved with aspects of assisted human reproduction.
3. To advise the Minister of Health on ethical issues relating to assisted human reproduction.
4. To consider any other matters relating to assisted human reproduction the Minister of Health from time to time determines.

Another part of the ‘patchwork’ of New Zealand provisions that is closely associated with NECAHR is the system of professional self-regulation. While there are Acts of Parliament covering registration and, for example, discipline for professionals, all assisted conception units and individual service providers are accredited through an Australasian system, the Australian Reproductive Technology Accreditation Committee (RTAC), which is a committee of the Fertility Society of Australia (FSA), the professional organization for those working in assisted conception.

Given the lack of a professional self-regulation system in New Zealand, one of the major clinics asked to be included in the accrediting function of RTAC and this later became the established system for all New Zealand clinics. RTAC has established a Code of Practice (Fertility Society of Australia 1997), against which clinic policies and practices are examined. The MCART report argued that in a country the size of New Zealand it would be inappropriate to establish a licensing system when this self-regulation system seemed to be working well.

One of RTAC's standards requires clinics to obtain ethical approval for any innovative treatment. In the case of New Zealand, NECAHR fulfils the function of providing approvals and, in so doing, determines what new practices/treatments are acceptable. In this sense, NECAHR has become the group that determines policy on new treatments.

This was very clearly reflected in the debate concerning the approval of non-commercial altruistic gestational surrogacy (Daniels 2003b). INECART twice rejected applications for approval from a clinic. When INECART was reconstituted as NECAHR, and following extensive debates, it agreed to permit non-commercial altruistic gestational surrogacy, subject to certain conditions and restrictions; the most notable of which was that every application needed to be approved by NECAHR. The committee determined that no applications for commercial surrogacy would be considered and this has become the accepted position in New Zealand.

The position of NECAHR – with its focus on ethics – is pivotal in terms of future policy development. Whereas MCART had recommended the establishment of a separate council to oversee assisted conception, the Department of Justice Officials Committee argued that NECAHR could satisfactorily perform the tasks proposed for the new council 'with no more than a modest expansion of its functions' and that 'it is important not to duplicate scarce resources' (Department of Justice 1995, p.9). Clearly, pragmatic considerations were to the fore in their thinking.

In 1996, partly out of frustration with the lack of a legislative framework and partly out of concern about the development of new techniques and procedures, Member of Parliament Dianne Yates introduced a Private Members Bill – the Human Assisted Reproductive Technology Bill 1996.

This Bill provided for the establishment of a Human Assisted Reproductive Technology Authority that would in many ways mirror the United Kingdom's HFEA. A New Zealand licensing system for clinics was to be established, a code of practice set up and maintained and the authority was to be given powers to set regulations. Certain practices were to be outlawed, a central register for information relating to third party conception was to be established and no surrogacy of any kind was to be permitted.

Two years later, the Minister of Justice introduced the Assisted Human Reproduction Bill (New Zealand Government 1998) to provide a statutory basis for NECAHR, making it a Parliamentary rather than a ministerial committee. It was envisaged that its functions would be extended and thus meet the recommendations that the Officials Committee had made in 1995. The Bill would also ban certain procedures, e.g. cloning, trading in human gametes and embryos etc., and provide for the establishment of a national register which would include identifying information relating to third party assisted conception. The Bill set out rights governing access to the information on the register by the involved parties and provided for the mandatory right of access by donor-conceived adults when they had reached the age of 18.

Select Committee hearings on both the Private Members and Government Bills were held in 2002 and, as a result, officials from the Ministry of Health and the Ministry of Justice, with assistance from the Ministry of Science, Research and Technology, were asked to look at a 'merging' of the two Bills. A Supplementary Order Paper (SOP) was presented to the House of Representatives on 29th April 2003 and at the time of writing select committee hearings were in progress on this and the other two pieces of legislation. The SOP includes the establishment of a national register of information for those involved in third party assisted conception and provisions for access to that information. This includes access to identifying information and will, in effect, endorse/continue the system currently operated by clinics. The major change, of course, is that there will be statutory provision regarding an information register and access to that register.

In 1987 the Government clarified the legal responsibilities between donors, parents and the offspring, where third party gametes were utilized (New Zealand Government 1987). This legislation certainly contributed to the move towards greater information sharing as there was no threat of donors being sued by the offspring.

The social and ethical perspectives have been major considerations in the move to focus on a biopsychosocial approach, rather than just a biomedical model, of third party reproduction (Daniels 2000). The way in which children's rights and needs have always been to the fore in any consideration of new treatments (e.g. surrogacy, posthumous conception) is an indication that the focus has not just been on the infertile couple or individual. In this connection, it is of note that the draft guidelines concerning the use of surrogacy and posthumous conception proposed by NECAHR[1] include clauses such as:

> Consider the benefits and risks for children…
>
> The child's right to know his/her origins
>
> The potential child's rights should be considered in any decision…
>
> The risk of rejection of a child for any reason…
>
> The availability of a permanent, accurate record of conception for the child
>
> The likely impact of the surrogacy arrangement on any existing children…

Such clauses convey a nationwide concern for children and particularly those children who may be regarded as potentially vulnerable. The involvement of social workers and counsellors as integral members of assisted conception teams has been significant in this.

The social work focus gives prominence to children and their families and, drawing on a biopsychosocial model, looks at the future implications of any particular intervention for families.

Obstacles to developing a comprehensive policy

New Zealand, despite its progressive approach to information sharing, has shown a reluctance to legislate and establish comprehensive policy in assisted conception. Several factors seem to have contributed to this.

There is little doubt that developing policy in any area that is regarded as morally contentious is difficult (Kirby 1990). While there have not been extensive debates in New Zealand regarding the morality of, for example, surrogacy (in contrast to some other countries) or the availability of services for single persons and lesbian couples,[2] the apprehension and concern is evident in the way in which successive governments have sought to 'manage' such areas: i.e. no legislative involvement, appointment of NECAHR as a policy and ethics group, and professional self-regulation.

There has been a clear recognition that assisted conception, and the issues that arise from it, are matters that need to be addressed as part of public policy. The challenge has been to determine how they should be addressed. Related to this was the expressed view of the officials from the Department of Justice, that New Zealand 'can afford to adopt a wait and watch developments' approach (Department of Justice 1985). New Zealand could monitor the impact of legislation in other countries before deciding what it should do.

A third factor has been a minimalist view of legislation in assisted conception. Informally, officials have argued that changing social attitudes and rapid scientific advances would require regular amendment of any legislation. This is undesirable and so legislation should be kept to a minimum.

The opposition of officials to the MCART recommendation for the establishment of a regulatory council can also be understood in terms of the desire to restrict the emergence of new structures that had a degree of independence from officials and their departments but, nevertheless, drew on their personnel and financial resources.

It also needs to be noted that when the first public consultation was undertaken (Department of Justice (Law Reform Division) 1985), the official given responsibility for preparing the Issues Paper was from the then Law Reform Division of the Department of Justice. I have suggested elsewhere (Daniels 1994b) that the direction of policy development in New Zealand would have been significantly different had officials from the policy division undertaken this task.

Developments in relation to access to information

New Zealand will almost certainly have legislation enacted in 2003 or 2004 that will see the establishment of a central registry to record information concerning parents, offspring and donors. The register will include provisions concerning how that information can be accessed and by whom. The availability of identifying information will be a central aspect of the legislation.

It is highly unlikely that there will be any objection to this proposal. There may be some debate concerning the detailed provisions, but on the matter of principle there will almost certainly be unanimous agreement. The main reason for this is that the legislation will, in effect, confirm and endorse current practice. Rumball and Adair (1999) surveyed the views of New Zealand parents of donor-conceived children and found that 83 per cent of parents had told or intended to tell, with the remaining 17 per cent having made the decision not to tell. This contrasts with a Swedish study (Gottlieb, Lalos and Lindblad 2000) which found that, despite the Swedish legislation, only 52 per cent of the parents surveyed had told, or intended to tell, their child about the nature of his or her conception. This highlights the fact that while public policy may provide for, and indeed encourage, information sharing, translating this into parental practice may be an entirely different matter.

Again, in comparison to studies in other countries – the UK (Cook *et al.* 1995), the US (Klock, Jacob and Maier 1994) and the Netherlands (Brewaeys *et al.* 1997) – the number of parents who have shared, or intend to share, information with their donor-conceived children concerning their conception is much higher in New Zealand, and is almost certainly due to the current culture concerning information sharing. Part of that culture is reflected in the 'educational approach' (Daniels 2003a) that is adopted by counsellors and clinic staff in general concerning the issues for families and their children that are associated with sharing, or not sharing, information.

It is highly unlikely that the proposed legislation will include any provision covering retrospective access to information. The fact that for approximately the last ten years, most clinics have only been recruiting donors prepared to be identified (should the offspring want this) means that many offspring will be able access information via the clinics. It has also been the practice in most clinics that, if a donor-conceived adult wishes to have information – often non-identifying – and the donor was recruited under the promise of an anonymity system, then the clinic will seek to trace and make contact with the donor on behalf of the offspring. In this respect, the need for the establishment of a voluntary register, as has happened in the Australian states of Victoria and Western Australia (see Szoke in this volume), may not be particularly great.

Where records have been destroyed, as is known to be the case in one New Zealand clinic, little can be done. Publicity designed to get previous donors to contact 'their' clinic may be one way of trying to make contact. A recent documentary, *Are You My Father?*, recording the search by Rebecca Hamilton for her donor, was screened on television in New Zealand in 2001 and shows that some donors had come forward (Documentary New Zealand 2001). Since the screening, others have made contact with Rebecca, suggesting that at least some previous donors do wish to assist by providing information and possible contact.

Some heterosexual couples and, increasingly, single women and lesbian couples, have used personal donors. Some of these arrangements have involved clinics and some have been a matter of private arrangement, including self-insemination. Where clinics have been involved, the counsellors have played a significant part in the preparation and, in many cases, assessment, of the different parties and their relationships.

In surrogacy arrangements, a similar situation has been in operation for some time, in that the commissioning couple are required to 'find' their own surrogate mother. Extensive counselling of all the parties, separately and together, and involving, where age-appropriate, any offspring of any of the partners, is required. Counsellors' anonymized reports must be submitted to NECAHR for approval to proceed. NECAHR expects the surrogate to be a relative or close friend, thus ensuring a climate of openness.

A similar pattern is beginning to emerge in egg donation. Because there are insufficient donors – common to the situation in virtually all countries – clinics and individuals will sometimes advertise, asking prospective donors to make contact either with the individual or the clinic. Donors are not paid in New Zealand and forthcoming legislation will almost certainly confirm this policy. Most clinics do not offer expenses and, further, they report that they are almost never asked about expenses or payment.

Clearly in all these situations, access to information is not the issue it used to be. That is not to suggest, however, that the issues concerning future contact between the involved parties do not need to be clarified.

The availability of donors prepared to contribute their gametes to others remains problematic – there is a shortage. This is not due to the policy of information sharing but, rather, to the significance and importance of donating one's genetic material to others.

While there has been widespread support in New Zealand for a policy of access to information in third party assisted conception from Maori, government reports, government departments, professional bodies and commissions, the most powerful influences have undoubtedly been the parents of donor-conceived children and the professionals involved. Parents, through their involvement with Fertility New Zealand, have long advocated for a system that took account of both their own and their children's needs. The fact that over the last 15 years, they have found the professionals involved to be increasingly responsive has contributed significantly to New Zealand's development in this area.

Conclusion

This chapter has sought to describe and analyse the developments that have occurred in, and contributed to, the culture of third party assisted conception in New Zealand. While most of the developments have been highlighted in relation to DI – because of its longer history – the advent of egg donation and surrogacy and the expected advent of embryo donation all embrace a strong policy and practice of openness in relation to the sharing of information. The way in which the legal, social and ethical perspectives have contributed to this has been highlighted. It is in fact these perspectives and driving forces that have contributed most to the dramatic change from a system based on secrecy, shame and stigma, to one based on openness and acceptance.

Notes

1 Non-commercial altruistic surrogacy is permitted in New Zealand. Fertility clinics are required to make application on a case-by-case basis. Guidelines have been prepared to cover the medical, legal and psychosocial considerations and reports from doctors, lawyers and counsellors are required concerning all the involved parties. The legal status of the child is provided for in that the commissioning couple have to apply to adopt the child. This situation is currently under review. Posthumous conception can be carried out when specific written consents exist. Where this is not the case an application has to be made to NECAHR.

2 Under New Zealand's human rights legislation it is an offence to withhold treatment on the grounds of gender or marital status. Single persons and lesbian couples are treated both from a medical and a psychosocial point of view in the same way as all other patients.

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CHAPTER 9

Poland

Provision and Guidelines for Third Party Assisted Conception

Eleonora Bielawska-Batorowicz

Origins and forms of third party assisted conception

It is estimated that between 15 per cent (Szamatowicz 1997; Szamatowicz and Grochowski 1994) and 20 to 25 per cent of couples (Slomko 1997) in Poland experience fertility difficulties. The demand for assisted conception services has increased mostly due to the belief that effective therapies are available.

Poland's first IVF child was born in 1987 (Szamatowicz and Grochowski 1994). Since then *in vitro* fertilization (IVF), gamete intrafallopian transfer (GIFT) and intra cytoplasmic sperm injection (ICSI) have been available in some state medical schools and in private clinics. Data available from the Association for Improvement of Contemporary Methods of Infertility Diagnosis and Treatment 'Child' (Stowarzyszenie na rzecz doskonalenia wspólczesnych metod diagnostyki i leczenia nieplodności 'Dziecko') indicate that IVF is offered in six medical schools (Bialystok, Bydgoszcz, Bytom, Poznań, Szczecin, Warsaw). Five of them (except Warsaw) offer also ICSI. According to data provided by the Polish Press Agency (PAP on 25 July 2002) there are 17 centres in Poland that offer IVF and about 2,000 IVF cycles per year are performed.

The origins of artificial donor insemination (DI) in Poland are unclear. To the author's knowledge, there is no record of the first case of DI in Poland. There is no national documentation system that would enable exact recording of the number of donors, their characteristics and the outcome of insemination nationwide (Semczuk and Kurpisz 1998). Thus, the available data allow only for a rough estimation of the number of donors, couples treated with DI and children born following DI. The number of children born as a result of DI prior to 1967 was fewer than 10,000 (Safjan 1990). More recent data indicate, however, that DI is frequently practised. In the Bialystok clinic – one of the largest in Poland – 800 children were born following DI between 1990 and 1997, thus giving an annual average of more than 100 births. Samples of semen from 300 donors have been preserved in this clinic (Semczuk and Kurpisz 1998). In a clinic in Łódź, semen samples from 42 donors are kept and 86 female patients were inseminated in 2001 alone. Data available on internet web pages indicate that besides Łòdź and Bialystok, clinics offering DI are located in Warsaw, Poznań, Szczecin and Kraków. If statistics for all these centres were similar, then the average number of children born after DI treatment in all these centres would be around 600 per year. The true figure is probably smaller as the number of inseminations differs between centres. The exact number of children born after DI is difficult to estimate as treatment centres seldom provide exact figures. Patients often travel across the country and report treatment outcome to the centre infrequently. Therefore, it may not be known whether a woman conceived and delivered a baby.

Data concerning the origins of egg and embryo donation are even more elusive. In some centres offering assisted conception, egg donation is practised very rarely (two cases in a 7-year-long history of one of the clinics – Jerzy Radwan 2002) and only in a family context, i.e. where the donor is a relative of the recipient woman. The information provided to potential patients in leaflets and on web pages does not mention egg donation, however. Therefore it is difficult to estimate the availability of eggs from donors and the extent of such donations. As in the case of semen donation, there is no central documentation system.

The practice of third party assisted conception in Poland is quite ‘conservative’: DI is not offered to single women or lesbian couples, and neither posthumous conception nor postmenopausal conception are available. Furthermore, abortion following a multiple pregnancy, which may be offered in other countries, is not available in Poland. It is worth noting that under Polish law abortion is permitted only in the following situations: when continuation of the pregnancy would endanger woman’s health and/or life, when the foetus is malformed, or when the pregnancy has resulted from a criminal offence (Nesterowicz 2001). To avoid multiple pregnancy the practice of transferring a maximum of two embryos (three when a woman is aged over 35 years) has been introduced (Grochowski *et al.* 1996).

It is impossible to say whether surrogacy takes place in Poland and it has been suggested that surrogacy may not even exist in Poland (Boloz 1997, p.61). It is equally likely, though, that surrogacy agreements may have been made, but not revealed, in some cases of very early adoption.

Ethical debates around third party assisted conception

An interesting point of discussion, in the cases of countries like Poland that experienced major political transformation at the end of the 1980s, is whether these changes have impacted on debates around assisted conception and on service provision. It should be remembered that Poland's first IVF child was born well before the actual political changes. The same is true for DI procedures, reflecting the relatively close contact of Polish scientists and physicians with the main developments in reproductive medicine around the world. At present it is difficult to say whether this contact would be closer under a different political regime. The change of government has resulted, however, in more open discussion on ethical issues and in more open presentation of religious views. The Roman Catholic Church – Polish society's strong moral authority during the communist era – was enabled to express its ethical views not only through teaching confined to churches, but also through widely distributed publications, radio and television programmes. This activity has not only influenced ethical awareness in Polish society but has also had an impact on legislation, e.g. the post-communist Family Planning Act 1993 prohibits abortion on demand.

Third party assisted conception has been widely discussed by different professions. These include lawyers (Nesterowicz 2001, 2002; Safjan 1990; Smyczyński 1996a), physicians (Brzeziński, 2002), psychologists (Bielawska-Batorowicz 1998; Kornas-Biela 1999) and philosophers (Boloz 1997; Katolo 2000; Ślipko 1994; Tokarczyk 1988). Ethical discusions around third party assisted conception are immersed in a wider debate on bioethics and new reproductive technology. There are many views in that debate including those based on religion, secularity and feminism. Generally speaking, third party assisted conception is either totally rejected or at best criticized and regarded as controversial. There is hardly any Polish publication expressing unconditional acceptance of third party assisted conception.

Those representing a religious standpoint usually refer to specific criteria when evaluating third party assisted conception. The most extensive listing of such criteria is given by Ślipko (1994). It includes the absence of a marital relationship between a donor and a recipient, the method of obtaining gametes, the separation of fertilization from a sexual act, the safety of gametes and embryos during conception and preservation, the question of surplus embryos and surrogacy. In this and other publications (Boloz 1997; Dobiosch 1991; Katolo 2000) reference is often made to a document released by the Roman Catholic Church, *Instruction on Respect for Human Life and Its Origin and on the Dignity of Procreation: Replies to Certain Questions of the Day* (The Congregation for the Doctrine of the Faith 1987) which regards all methods of assisted conception as immoral. The *Instruction* presents the views of the Vatican and therefore is reflected in Roman Catholic teaching in Poland and should be used by all Catholics as a guideline.

DI is considered immoral for several reasons. First of all, the use of a gamete from a donor violates marital relationships and a child's rights to be born within a marriage (Boloz 1997; Dobiosch 1991; Katolo 2000; Ślipko 1994). Second, it requires masturbation to obtain semen and such practice is considered immoral in traditional Roman Catholic ethics. Surgical methods to obtain semen that would not require masturbation seem more ethically acceptable. However, the fact that semen originates from a donor still violates marital relationships and genetic links within a family (Ślipko 1994). Moreover, a semen donor might in fact be a semen vendor. Any practices of selling gametes are regarded as unethical (Boloz 1997; Piechowiak 1996a). Masturbation and artificial insemination detached from the marital sexual act create circumstances that make insemination with a husband's semen equally unacceptable (Boloz 1997; Ślipko 1994). Third, the methods of semen conservation carry the risk of damaging the gametes and thus may affect the health of resulting children. Any activity that could jeopardize the life of another human being is morally unacceptable (Dobiosch 1991; Olejnik 1994; Ślipko 1994). The same line of argument is applied when donated material is used in IVF procedures. In these circumstances, damage might occur to eggs, semen or embryos and, additionally, the disposal or destruction of surplus embryos is also seen as problematic (Katolo 2000; Olejnik 1994). Any embryo, including a surplus one, is given the status of a human being and as such should be protected. Therefore, any practices that may result in annihilation of a human being are considered immoral (Katolo 2000; Olejnik 1994; Ślipko 1994).

Arguments advanced by those who analyse third party assisted conception from a secular point of view concentrate on different issues. Assisted conception is regarded as a method of infertility treatment and as such is acceptable providing that informed consent is given by all parties involved (Kozakiewicz 1985; Popielski 1985; Tokarczyk 1988). From a theological perspective, any technical intervention that assists conception leads to the dehumanization of reproduction. In secular views, more important are the difficulties in establishing the civil status of a child (Popielski 1985). Equally important is the question whether emotional links between a child and his or her parents would develop in the same way as in a genetically-related family. The anonymity of donors and recipients of donated material is often discussed in the context of preventing donors from claiming rights to their genetic offspring and thus violating the established family structure. The possibility that a child's mother or a child him- or herself could claim any kind of financial support from the donor is also discussed but regarded as unacceptable. On the other hand, a child's right to know about his or her genetic origin is acknowledged (Popielski 1985). It is thought that the child should be able to learn the identity of the donor, but it is not indicated whether the child should have this information while still a child or only when (s)he becomes an adult (Popielski 1985).

Feminist analyses of third party assisted conception have generally been unfavourable. The argument that women may be under strong social pressure to use available assisted conception procedures is often advanced (Bielawska-Batorowicz 1998; Sobczyńska and Bilska 1997). The possibility of eugenic abuse of assisted conception to select the gender of an offspring is strongly criticized. Gamete donation and surrogacy are also criticized because of the violation of clear family links and the potential exploitation of women in surrogacy arrangements. With surrogacy and egg donation it is no longer clear who is the mother, thus one of the simplest and well-defined relationships in human life is compromised (Sobczyńska and Bilska 1997).

One form of assisted conception that has been condemned and rejected by all protagonists in the ethical debate is posthumous conception – with or without the use of donor gametes (Boloz 1997; Nesterowicz 1987, 2002; Ślipko 1994; Tokarczyk 1988). Concern surrounds the issue of a donor's consent for his or her gametes to be used after his or her death. Usually, such consent does not exist, but even if it does, it is not regarded as legally valid (Dyoniak 1996a; Nesterowicz 1987, 2002). Assent to posthumous conception would mean approving the intentional creation of a child even though his or her family would be incomplete from the outset and thus that child's development would be impaired. This is contrary to all views that any child has a right to be born in a family (Boloz 1997; Ślipko 1994). Dyoniak (1996a) has also analysed the issue of inheritance when a child's genetic parents were married, but one of them died before conception. If a child is born long after a parent's death arrangements for providing for that child are not clear, especially when all the inheritance procedures have already been completed.

Social attitudes towards third party assisted conception

Attitudes of patients who undergo infertility treatment have been analysed in several studies, with inconsistent results. Attitudes towards DI are usually less positive than those towards IVF and artificial insemination by husband (AIH) (Łepecka-Klusek 1997; Łuczak *et al.* 1991; Sendecka, Łepecka-Klusek and Bokiniec 1987). Only if no other options are available, is DI accepted in most cases. In such cases, women were three times more often in favour of DI than men (Kostyk 1996). Patients who had analysed all options available for them, decided to proceed with DI and come to a clinic for treatment, regarded DI as both an acceptable and safe procedure that additionally was much better for their family life than adoption since, in the case of DI, the mother has genetic links with the child (Bielawska-Batorowicz 1994).

Some studies have investigated attitudes of future professionals – students of law, medicine and psychology. One of these studies (Tomczyńska 1999) indicates that knowledge about methods of reproductive technology is 'professionally based', i.e. medical students know much more about infertility and treatment methods than students of psychology or management. However, the level of knowledge was not at all related to the level of acceptance; those who knew more about the procedure were no more likely to accept it. In general, female students were more in favour of IVF, DI and even surrogacy than males. Those who described themselves as strongly committed to religion revealed a similar level of acceptance of reproductive technology as less religious students.

Other researchers have reported similar findings. Smyczyński (1996b) compared attitudes of law students with those of medical students. Very few from either group opposed any form of assisted conception. Generally, women were more positive than men, and law students were more positive than medical students. DI was regarded as less acceptable than AIH but more acceptable than surrogacy. As in Tomczyńska's study, assisted conception was also accepted by students who described themselves as committed to religion and religious practices. A recent study with infertile couples (Janczak 2002) revealed that Church opinion on assisted conception was not considered when making a decision about DI.

However controversial, therefore, assisted conception – including third party procedures – is accepted by actual and potential recipients and by potential providers. This relatively strong level of acceptance may have an impact on provision, standards of services and legislative procedures.

Legislation

At present, Poland has no legislation to regulate assisted conception. However, there has been legal debate that has identified and discussed several problems:

1. Whether assisted conception, including third party assisted conception, should at all be regarded as medical treatment.
2. The issue of family links and the question of who should be regarded as the child's father (when sperm is donated) or as the child's mother (when an egg is donated or when a surrogacy arrangement is made).
3. Whether a partner who has agreed to the use of donated material can renounce his or her parental status and responsibilities towards a child.
4. Whether posthumous conception should be permitted.
5. Whether surrogacy arrangements are legally valid.

Most legal commentators regard assisted conception as medical treatment offered to restore the possibility of conceiving a child or at least to overcome the difficulties in becoming a parent (Boratyńska and Konieczniak 2001; Nesterowicz 2001; Piechowiak 1996a; Popielski 1987). A contrary view is that these techniques in fact do not restore the natural reproductive potential, but only satisfy a couple's wish to become parents and therefore should not be considered as medical treatment for infertility (Safjan 1998). However, Safjan favours legislation that would define clearly which procedures are legal and permitted. Boratyńska and Konieczniak (2001) argue that the controversies surrounding assisted conception are insufficient as a reason to claim that such practices are not medical treatment altogether.

The question of who is the parent of a child conceived with donated gametes is addressed in a way that protects the welfare of a resulting child and the family created. There is no specific legislation regulating issues of parentage following assisted conception. Any decision and solution are therefore based on rules already present in the Polish legal system, usually in the Family Code. These rules determine the civil status of a child and thus define that child's father and mother. In the case of third party assisted conception, the application of these rules is complicated by the relationship between genetic and legal parentage. As far as DI is concerned, the literature is inconsistent on the legal status of a parent under Polish law.

In general, a man who is married to a child's mother is recognized by the Family Code as that child's father (the putative father rule). This rule applies also when a child has been born within 300 days of the dissolution of a marriage. It does not apply, however, if a child has been born within 180 days of the couple's marriage and a woman's husband has renounced his fatherhood (Safjan 1990; Zieliński 2000). In cases of DI, several commentators suggest that this rule implies that a recipient's husband should be recognized as the legal father of the child (Dyoniak 1996b; Dzialyńska 1996a; Nesterowicz 1987, 2001; Safjan 1990). An alternative viewpoint recognizes the donor as the child's father. This is based on the assumption that objective truth is crucial and so consistency between biological links and civil status should be maintained (Walaszek 1960 – cited in Safjan 1990). However, this opinion appears to be a minority view as more recent observations favour the universal recognition of a woman's husband as the child's father (Smyczyński 1996c).

The Polish legal system so far does not distinguish between a genetic and legal mother as it does in the case of genetic and legal fatherhood. According to the law, a woman who has delivered a child should be recognized as that child's mother (Dzialyńska 1996b; Safjan 1990). Priority given to birth emphasizes the prenatal period and psychological and social factors involved in childbearing that are considered more important than genetic links only (Safjan 1990). This clarifies the situation in egg donation. An egg donor would not be considered the mother of the child since she did not deliver that child. However, such solutions pose problems for surrogacy arrangements as the surrogate would be considered the child's legal mother. Dzialyńska (1996b) suggests that a more child-oriented approach to surrogacy would give priority to the importance of genetic links. According to Dzial~yńska, a commissioning mother who provides an egg which is fertilized by her husband's sperm should be recognized as the legal mother, even if she did not carry the child. This would provide a more secure basis for the child than the current situation where the child's legal mother would be a woman who delivers a child genetically not related to her and conceived with the semen of a man to whom she is not close emotionally (Dzialyńska 1996b).

However, under present legislation, the only way to change the civil status of a child born following a gestational surrogacy arrangement and establish legal links with his or her genetic mother is to bring the case to court (Dzialyńska 1996b; Zieliński 2000).

The next issue discussed by the legal profession concerns the consent for third party assisted conception to be performed and the possibility of subsequent renunciation of any responsibility towards a child conceived in this way. Both the recipient of donated genetic material and her partner should agree to pursue third party assisted conception. They can withdraw their consent at any time before the procedure is effected and a child is conceived (Popielski 1987; Safjan 1990). A statement concerning DI issued by the Supreme Court on 27 October 1983 makes it clear that when DI is performed with the consent of the recipient's husband, he is recognized as the child's father (Nesterowicz 2001; Safjan 1990). If the husband of a recipient of DI seeks to renounce his fatherhood, then his case should be dismissed. Several arguments underlie this view. First, revealing the objective truth would not be in the interest of a family in general and a child in particular. What is more, when a husband renounces fatherhood, the child is left with no father at all because the donor remains anonymous. Second, in giving consent to DI, both partners have agreed to undertake parental responsibilities. This line of reasoning is debated by some authors who suggest that consent to DI should be distinguished from accepting a child and parental responsibilities (Safjan 1990) but, in general, the Supreme Court statement is accepted and applied in practice.

Debates on posthumous conception mostly concern cases of insemination with a deceased husband's semen. Legal concerns focus on the validity of consent to use gametes after the donor's death and on the child's civil status. According to many commentators, a donor's consent to use his or her gametes should be regarded invalid after his or her death (Dyoniak 1996a; Nesterowicz 1987, 2001, 2002; Safjan 1990). The same applies to the consent given to DI. When a spouse dies, both the marriage and the procreative function of that marriage are terminated. Therefore, insemination should not be performed; neither should a wife be obliged to fulfil her husband's will and receive insemination (Dyoniak 1996a; Nesterowicz 2002). If, however, a woman was inseminated after her husband's death or an embryo was implanted into the womb of a widow, providing that the birth occurred within 300 days of her husband's death, the child should be regarded as his offspring. In such circumstances, a child has all legal rights of an offspring, including inheritance. However, if the child is born after this time period, (s)he does not have the legal rights of an offspring (Dyoniak 1996a). Others claim that the civil status of a child should always be declared by a court. If a child is born to a woman who was inseminated with her dead husband's semen the court should declare the husband as that child's father irrespective of the length of time elapsing between the death of the father and the birth of the child (Nesterowicz 2002).

The law regarding the determination of a child's mother impacts on surrogacy insofar as no surrogacy agreement can possibly amend the civil status of a child. Furthermore, surrogacy agreements are considered invalid as it is not legally possible to determine the civil status of a person who is not yet born (Dyoniak 1996b; Safjan 1990).

Third party assisted conception is also discussed in the context of criminal offences (Holyst 2000; Piechowiak 1996b); for instance, when insemination or embryo transfer are performed without the consent of a recipient, when gametes are traded, when women are forced into surrogacy. As there is no specific legislation pertaining to assisted conception it is difficult, though, to define violations of the law.

In light of these debates Smyczyński (1996c) has proposed model legislation. His rather rigorous proposals would restrict assisted conception to married couples in specific medically-approved circumstances. Smyczyński also discusses several less rigorous options that could be taken into consideration and lists solutions that should not be made illegal. It is worth adding that those who discuss legal aspects of assisted conception in Poland often refer to Council of Europe recommendations, including the Biomedical Convention (Council of Europe 1996), even though this has not yet been ratified by Poland (Filar 2000; Safjan 1999). Smyczyński's (1996c) key proposals are:

1. Assisted conception should be used to overcome infertility problems experienced by a married couple or when there is a risk of passing on a genetically transmitted disease to a child. More liberal provisions, such as offering treatment to cohabiting heterosexual couples in a stable relationships (i.e. longer than three years), are also regarded as acceptable.
2. The creation of an embryo for experimental purposes should be prohibited. Moreover, the creation of more embryos than can be implanted into the womb in one treatment cycle should be prohibited. While the possibility of freezing surplus embryos for later transfer is also acknowledged, this is questioned because of the risk of damage to, or destruction of, cryopreserved embryos. It is therefore proposed that surplus embryos should not be created.
3. The interest of a conceived child should be given priority and the family situation of that child considered. Therefore, assisted conception should not be offered to single women or homosexual couples.
4. Implanting a donated embryo into the womb of a woman who intends to care for the child should be permitted. Gestational surrogacy, however, should not be allowed.
5. Posthumous conception should not be permitted. Thus insemination using a husband’s sperm following his death, use of donor sperm following the donor’s death and use of gametes from aborted foetuses are considered unacceptable.
6. The informed consent in writing from both husband and wife should be required before the decision on assisted conception is made. Medical examination and assessment of the couple’s circumstances are necessary. Smyczyński does not indicate who should make this assessment. Before a decision is made, the couple should be informed about the legal consequences of assisted conception and their legal obligations towards a child. Consent could be withdrawn at any time before the procedure is performed. If a married couple requests assisted conception, the medical professional should decide whether such procedures could be performed. In the case of a cohabiting couple, a court is

required to give prior approval to secure the interests of any child that might be born.

7. The anonymity of a semen donor should be protected to secure the stability of a family created through DI and also to protect the donor from any attempts to trace him. In such circumstances the identity both of a donor not wishing to maintain contact with a child and of a donor wishing to be protected from a child seeking to learn his or her identity will be protected. A husband who consents to his wife's insemination with donor sperm should not be allowed to renounce his fatherhood. Anonymity would jeopardize a person's right to know his or her origin. It is thought, however, that revealing information about insemination and the donor would not be in the best interest of a child. Medical personnel should be required to keep secret all data concerning persons involved in assisted conception.
8. The life of a child created through assisted conception should be highly protected at all time. Abortion after assisted conception should only be permitted when there is a threat to the woman's life. The renunciation of parental responsibility towards an ill or disabled child should be prohibited; this concerns cases when parents might try to renounce their parentage on the basis of lack of genetic links with their 'defective' offspring. In other respects parents have the same rights as biological parents to use child welfare services.

In the absence of specific legislation governing assisted conception, the matter is currently regarded as a medical procedure and is therefore treated in line with legislation dealing with the duties of the medical profession and the functioning of medical institutions (Nesterowicz 2001). At the moment, it is not possible to predict which of the assumptions described above would be considered in any future legislation on assisted conception and also when such legislation might be passed by Parliament. There is no pressure within Poland for the introduction of such legislation. There are, however, several authors who have urged the development and implementation of relevant legislation (Filar 2000; Safjan 1999). To the author's knowledge such legislation is neither being prepared nor has been proposed to Parliament. Although the Biomedical Convention was signed by the Polish Minister of Justice in 1999, at the time of writing it remains to be ratified in Poland.

Professional body guidelines

Two kinds of guidelines for assisted conception are accepted in Poland – the recommendations of European bodies such as the European Society for Human Reproduction and Embryology and the guidelines of the Polish Gynaecological Society (Polskie Towarzystwo Ginekologiczne 1996).

The national society recommends that third party assisted conception should be performed only when both partners consent to it. This consent should be given in writing and include the statement that a child born as a result of treatment will be accepted by both partners as their offspring. Medical screening of semen donors should be performed before gametes are used in assisted conception. This screening should include microbiological and serological tests. Each of these tests should be repeated, and so only use of frozen semen is recommended. Semen should be tested and preserved in sperm banks supervised and controlled by scientific societies, professional bodies and ethical committees. The number of pregnancies from any one donor should not exceed five (Semczuk and Kurpisz 1998; Walewski 2002).

The guidelines exclude gestational surrogacy, but regard egg donation as acceptable. They also indicate that gametes should not be preserved after the donor's death. The importance of the anonymity of donors and recipients is stressed. It is recommended, however, that the full medical documentation of treatment including assisted conception procedures should be kept for 25 years.

Financial aspects

At present, all the costs involved in treatment are covered by patients and are not reimbursed by medical insurance (Walewski 2002). Since the costs of treatment are high in comparison to average wages, it has been argued that government funding should be made available to make assisted conception more readily accessible (Szamatowicz and Grochowski 1994). At the time of writing, the costs of one IVF cycle range from 1850 to 5000 zlotys if drugs are included (from 460 to 1250 euros, with the exchange rate of four zlotys to one euro). For ICSI these costs range from 2450 to 6600 zlotys (from 620 to 1650 euros) and for DI from 450 to 1800 zlotys (about 110 to 450 euros). (All these figures are given according to price lists revealed by the Association for Improvement of Contemporary Methods of Infertility Diagnosis and Treatment 'Child' and by treatment centres.) In comparison the average wage in the fourth quarter of 2002 was 2372 zlotys (593 euros) per month (data provided by the Central Statistical Office (Główny Urząd Statystyczny)).

The issue of whether state funds should be used to cover assisted conception is considered in the framework of necessary provision to all consumers of state health services. Some authors (i.e. Piechowiak 1996b) argue that infertility treatment should not be subsidized by the state when other health needs of the population, probably more important, remain unmet (Piechowiak 1996b). Assisted conception has always been regarded as a non-standard procedure and, in contrast to more traditional methods of infertility diagnosis and treatment, is not covered by state funds. Between 1999 and 2003, regional health authorities (Kasy Chorych) decided about medical procedures subsidised by their funds. None of these authorities reimbursed costs of assisted conception such as IVF and DI and few covered the costs of infertility diagnosis. An initiative to introduce state subsidies for infertility treatment was recently undertaken by a group of members of Parliament (PAP 27 July 2002). The national health system was re-organized in February 2003, although it is unclear how this will affect assisted conception services.

It is possible that some aspects of the financial issue will be resolved in a similar way to those in other legislation, such as the Transplant Act, which prohibits the sale of organs for transplantation and forbids anyone to derive financial profit from transplantation (Holyst 1999). Such a proposal does not preclude individuals from paying all the costs of treatment for infertility. Rather, it pertains to issues such as paying a fee to gamete donors in addition to any expenses incurred by the donor, or the inflated profits of treatment centres. The question of reimbursement for costs related to fertility drugs, equipment and medical staff remains unanswered. The Polish Gynaecological Society guidelines (Polskie Towarzystwo Ginekologiczne 1996) recommend that the expenses of both semen and egg donors should be reimbursed. They do not indicate, however, what expenses are considered legitimate or whether egg donors should be paid more because of the extra risk they take.

Access to services and counselling during treatment

The lack of legislation results in ambiguity concerning when and to whom assisted conception should be offered. The ethical code of the medical profession (Nesterowicz 2001) requires that a physician should be ultimately responsible in case of any reproductive problem and its treatment. (S)he should provide extensive information to patients and act according to the latest knowledge on the subject. While performing their professional duties physicians should be allowed to consider their consciences and thus refrain from pursuing procedures they consider to be immoral. Such rules permit a doctor to refuse to offer assisted conception to recipients who would not satisfy the criteria of the 'typical' family (i.e. single women, couples in same sex relationships, post-menopausal women) or demonstrate family stability (i.e. couples in conflict or with serious health problems). Therefore assisted conception in Poland is quite 'conservative', for all the procedures are usually offered only to married couples and only as a method to overcome their fertility problems.

At present, centres offering assisted conception are located in major cities, often in clinics attached to medical schools. Access to services is thus limited, but proper standards of treatment are ensured. It is also consistent with a general rule that assisted conception should be supervised by scientific bodies and ethical commissions (Semczuk and Kurpisz 1998; Walewski 2002).

Treatment centres do not always employ psychologists, social workers or counsellors among their professional staff. The emotional needs of patients are nevertheless recognized and attended to by medical professionals although they are not always competent enough to do this. If, however, a psychologist or a counsellor is involved, it is usually during the initial stage, when patients' motives for seeking treatment are evaluated and a decision to pursue assisted conception is made. At this stage the family's relationships are also considered and the situation of a prospective child is evaluated. The results of the psychological assessment of a recipient couple are taken into account in the decision to proceed with assisted conception (Bielawska-Batorowicz *et al.* 1993), although such procedures occur only in a minority of centres.

Availability of genetic information and debates on provision of such information

Current practice and suggestions for future legislation demonstrate a tendency to preserve the anonymity of gamete donors (Semczuk and Kurpisz 1998; Smyczyński 1996c). The arguments for such proposals relate to the stability of the family. It is argued that revealing information about a genetic parent might not be in the best interest of a child and his or her legal parents (Smyczyński 1996c). Disclosure of this information is often related to emotional turmoil in the family, an offspring's efforts to find a genetic parent that might not be successful and also to difficulties in a donor's family once a secret of a past donation is revealed. Studies on the attitudes of semen donors (Bielawska-Batorowicz, Czechowski and Salata 1996) and of recipient couples (Bielawska-Batorowicz 1994) show that neither group is interested in disclosing to children the nature of their conception. Reasons for reluctance to endorse openness about semen donation have been discussed elsewhere (Bielawska-Batorowicz 1993). Some of these reasons are still important and might apply to other forms of third party assisted conception also. Conception with gamete donation is usually regarded as the least acceptable method of infertility treatment (Łepecka-Klusek 1997; Łuczak *et al.* 1991). Moreover, genetic links with an offspring are still regarded as more important than social links that are created through the contacts with a child. Consequently, recipient couples might not be keen to speak openly about their infertility and its treatment.

For genetic information to be available, appropriate legal procedures must be designed and implemented. Such procedures related to third party assisted conception have not yet been introduced. Moreover, there are some legal solutions designed for adoption that create a possibility of concealing the lack of genetic links (Dyoniak 1996b). That is the case of so-called full adoption (*adoptio plenissima*), when the civil status of a child is changed and in all documents the name of the adoptive parents is given as the name of that child's mother and father. However, after reaching adulthood the child can ask for details of his or her genetic parents. In that way the secrecy concerning adoption is preserved and a person's rights to know his or her identity are maintained (Zieliński 2000). In other adoption procedures (i.e. *adoptio plena*, *adoptio minus plena*) (Zieliński 2000) there is also a possibility of discovering the identity of one's birth mother. That differentiates Polish adoption procedures from 'sealed record' adoption (a legal procedure when it is not possible to trace any record of biological parents) in Canada and the US.

Claims stressing a donor-conceived person's rights to know his or her genetic origins are present in the literature (Popielski 1985), but are not frequent. It is difficult to predict how the issue of availability of genetic information will be resolved. If the prevailing tendency described above is maintained, access to information about genetic parents will not be easy.

Conclusions

Third party assisted conception has been practised in Poland in a 'traditional' fashion, DI being the most prevalent form of third party involvement in assisted conception. In a way, this method of conception is widely available, as medical centres offering different forms of infertility treatment are located across the country. On the other hand, such treatment is limited to certain groups of recipients. First, it requires financial input from patients, which may create a barrier for those with insufficient material resources. Second, it is offered only as an infertility treatment to childless couples in stable marital relationships. Third, it is performed only when both partners give informed consent to it. Thus, it cannot be regarded as a course of action that would enable single persons or couples in same sex relationships to become parents.

Assisted conception has been accepted in many parts of Polish society; however, it is still regarded as very controversial, especially in the context of recent media coverage of human cloning. Criticism of assisted conception in general and third party assisted conception in particular originates in ethical and legal debates. Lack of relevant legislation creates situations in which infertile persons' wish for a child as well as the interests of a child can be abused. The necessity to introduce unified legal procedures has been stressed by both the legal and medical professions. It seems, however, that at present Polish society is unready for increased openness towards third party assisted conception. While Polish society would accept it as a method of assistance in conceiving a child and thus a method of concealing a couple's fertility problem, it would be less inclined to allow precise recording of donors' data so that they could be made available later to genetic offspring. There are, however, centres offering DI that keep a record of donors' blood group, age, height, weight, colour of eyes, type of hair and education. At present this information is usually used to help to choose a donor. Once social attitudes change such information might be also provided to an offspring.

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CHAPTER 10

Singapore

Practice and Challenges

Rosaleen Ow

Social and cultural perspectives

Singapore has an area of 641 square kilometres and a population of slightly over four million, about 76.8 per cent of whom have an ethnic Chinese background, 7.9 per cent have origins from India, 13.9 per cent are from the Malay archipelago and about 1.4 per cent are from other ethnic backgrounds, including Eurasian. Singapore can be considered a religious society and sensitivity to different religious beliefs is preserved by the Maintenance of Religious Harmony Act 1991. Of the resident population aged 15 years and above in 2000, 51 per cent were Buddhist or Taoist (the traditional Chinese religions); 15 per cent Christian; 14.9 per cent Muslim (consisting primarily of Malays and a few Indians and Chinese) and 4 per cent Hindu, mainly from the Indian population. Only about 15 per cent reported no religious affiliation (Singapore Census of Population 2000a). Social policies are therefore always conceptualized from a multicultural perspective and sensitivity to differences associated with a variety of belief systems and cultures is as important as the search for commonalities (Ow 1999).

Among the Chinese, regardless of religious affiliation, family and the value of children are tied to the patrilineal system of social organization. Although modernization has impacted traditional views related to kin association, genetic purity is still valued especially as regards the male line among the more traditional Chinese. Dr Ng, Head of Genetic Service and the Department of Paediatric Medicine at the Kerdang Kerbau Women and Children's Hospital, Singapore, was reported as saying that 'The Chinese community tends to be so cautious that it is common for Chinese couples with the same surname to seek genetic counselling' and that the Chinese tend to be more concerned if the couple are related through their fathers than mothers since offspring of such marriages are perceived to have a greater risk of birth defects or genetic diseases (Ng 2002, p.3). Consequently, a Chinese couple may prefer procedures that permit genetic certainty of the sperm over procedures involving donor sperm, where the risk of a consanguineous relationship cannot be entirely ruled out.

A conservative attitude in Singapore towards infertility and childlessness is clearly expressed in the following media comment on the State's concern for the low fertility rate:

> Many reasons have been cited, such as fewer, and later, marriages; not enough time, money, energy or commitment to have children; and insufficient childcare facilities. There is one reason, though, which is seldom mentioned, and over which hangs an enormous cloud of communal bashfulness. Social nicety dictates that if mentioned at all, it is done only in hushed tones. It is infertility – the inability to produce a baby, either on the part of the woman, or the man. We hear anecdotes here and there, of how so-and-so is having problems conceiving, and we commiserate with the couple, oh so gently, so delicately, as if the situation is some terminal ailment or tragic bereavement. Culturally, and anthropologically there are reasons for this attitude. But these, I submit, have not kept up with the times. (Chua 2000, p.4)

Buddhists believe that life is not created but comes from the cycle of reincarnation. As such, third party assisted conception, in so far as it enables life and does not kill or harm life, is acceptable. Although there have been no reported public debates on third party assisted conception in Singapore, Shi Xianda, representing a non-theistic Buddhist view, likened the donation of human organs, cells or embryos for stem-cell research with the intention of giving life, not the intention to kill, as a 'sacred contribution' (Shi Xianda 2002, p.3), the 'action is that of a Bodhisattva, the acts of offering himself/herself to benefit sentient beings' (Shi Xianda 2002, p.4). The only concern may be related to the disposal of unused embryos since Buddhism defines the beginning of life as when sperm and egg fuse. If applied to third party assisted conception, such an argument could mean that donated gametes are not deemed to have life but can give life and are therefore not subject to the same probitions as donated embryos.

Among Christians the Roman Catholic Church is particularly influential. Church teaching, as reported by the Catholic Medical Guild of Singapore (2002, p.1, para.3), observes that 'various techniques of artificial reproduction, apparently at the service of life, actually open the door to new attacks on life'. Separating procreation from the conjugal act is considered morally unacceptable, especially when these techniques are subject to a high failure rate and place embryos at high risk of destruction. Embryo reduction is equated to artificial selection through abortion and considered a case of 'special moral gravity', illicit in the normal course of marital relations but 'doubly reprehensible when they [*sic*] are the result of artificial procreation' (Catholic Medical Guide of Singapore 2002, p.2, para.4). Hence:

> [t]hose who resort to artificial methods must be held responsible for illicit conception, but whatever the mode of conception – once it happens – the child conceived must be absolutely respected. The life of the fetus must be protected, defended and nurtured in the mother's womb because of its inherent dignity which is not something conferred or granted by others, whether the genetic parents, the medical personnel or the State. (Catholic Medical Guild of Singapore 2002, p.2, para.4)

Therefore, while third party assisted conception procedures are available for those who meet the criteria set out by the Ministry of Health, they may, in effect, become inaccessible on moral and religious grounds to devout Roman Catholics.

Islam is ingrained in Malay culture and everyday life. However, a search in the literature and databases related to Islamic laws in Singapore revealed no reference to third party assisted conception, although Islamic views have been expressed. According to Serour (1998), though medically assisted conception is not specifically addressed in the Syariah (Muslim law) marriage, family formation and procreation are important and thus treatment of the infertile couple is encouraged. The basic concept of Islam is to avoid mixing genes as Islam enjoins the purity of genes and heredity. Each child should relate to a known father and mother. Blood relationship is very important under the laws of inheritance for Malays. Muslim law as administered by the Syariah Court in Singapore states specifically that a beneficiary of the estate of a deceased person must be a Muslim, able to prove connections either as a direct descendant through blood relationship or through marriage. Marriage is a contract between the wife and the husband during the validity of the marriage and no third party may intrude into the marital functions of sex and procreation as this may amount to a form of adultery. In the treatment of infertility, a third party, whether providing an egg, sperm or a uterus, is unacceptable to Muslims. Therefore for the childless Malay couple in Singapore, neither gamete nor embryo donation nor surrogacy is allowed. In such a situation, one may expect that excess frozen embryos, for example, may only be transferred to the same wife during the validity of the marriage but embryo transfer would not be permitted if the marriage has ended through divorce or the husband's death. Multifoetal pregnancy reduction is permissible only if the likelihood of carrying the pregnancy to full term is very low or the life or health of the mother is endangered. Postmenopausal assisted conception is prohibited since that would involve egg donation, increased maternal risks and the practical problems of raising a child so conceived. This issue is covered by the current upper age limit of 45 set by the Ministry of Health (2001, para. 4.2.1). There are no reported cases of Muslim couples seeking treatment for third party assisted conception in Singapore or overseas. In a childless marriage, the Muslim couple have the options to remain child-free, choose to adopt or marry again. Under the Syariah Court in Singapore, a Muslim man is allowed to have four wives with the consent of the existing wives and proof that he is able to take care of all his wives equally well.

The declining fertility rate of the Singapore population, which is currently below population replacement levels, is another important factor in the discourse on assisted conception. Childlessness is particularly pronounced among university-educated women. Physiological limitations and the stringent medical guidelines for third party assisted conception services mean that it is much harder for older women to access treatment. Given the ageing population, decreasing fertility rate and the data indicating that a large number of ever-married women over 40-years-old either have one child or no children, there seems to be an urgent need for public education on both the physiological and clinical limits to assisted conception.

Origins of assisted conception treatment in Singapore

The *in vitro* fertilization (IVF) programme at the Department of Obstetrics and Gynaecology at the National University of Singapore began in July 1982. The first phase of the programme began in July 1986 resulting in one pregnancy out of eight embryo replacements (a success rate of 12.5 per cent). In the second phase, eleven pregnancies resulted from 59 replacements (a success rate of 18.6 per cent). Of these, five were singleton pregnancies that delivered normal children at term (Ng 1987). Singapore's (and Asia's) first IVF baby, a healthy boy, was delivered in 1983 (Ng 1987). Reasons for inclusion in the IVF programme were tubal blockage or disease in the female, male infertility, idiopathic infertility and other miscellaneous conditions such as immunologic infertility and endometriosis (Ng 1987). When the department was relocated to the National University Hospital in 1985, gamete intra-fallopian transfer (GIFT) became available (Ng 1987). Asia's first GIFT baby was delivered in Singapore in June 1986; Asia's first frozen embryo baby in June 1987 and Asia's second tubal embryo transfer delivery in January 1989. Micromanipulation using subzonal sperm injection (SUZI) was started in 1988 with the world's first SUZI baby delivered in April 1989 in Singapore. The world's first twins resulting from co-culture, a technique where embryos are grown on a bed of cells collected from the inner lining of a human fallopian tube, were born in May 1991. This technique with a reported pregnancy rate almost double that obtained through conventional IVF for patients over 35 years of age with previous failed attempts, was pioneered at the National University Hospital (Bongso 1996). In December 2000, Thomson Medical Centre, a private hospital in Singapore, reported the world's first birth of twins conceived from frozen eggs and sperm (Khalik 2000). The deputy chairman of the centre, however, announced that they had no plans to make the treatment routine or to launch an egg bank, given the absence of clear guidelines for such developments, and that they would consult the government whenever the treatment was clinically indicated (Reuters 2000).

The incidence of subfertility is estimated at between 15 and 20 per cent of the population (Ng and Kumar 2000). In addition to the services provided at the National University Hospital, there are currently five other assisted conception centres in Singapore. Two of these are public hospital-based centres and the other three centres are in private hospitals. All centres offer most of the procedures listed above (Ng and Kumar 2000). However, since assisted conception is categorized as non-standard medical care, no state subsidy for treatment is available.

Medical guidelines for third party assisted conception services

Although there is no specific legislation, a fairly comprehensive government system for monitoring and regulating assisted conception services exists in Singapore and is managed by the Ministry of Health. An Advisory Committee on Human Reproduction and Embryology was established by the

Ministry of Health to produce guidelines for the practice of human embryology and IVF. Its terms of reference are to advise the Ministry of Health on all professional, technical and ethical aspects of assisted conception; to assess the qualifications and training of doctors and embryologists applying to the ministry for authorization to perform assisted conception procedures; to review guidelines in the light of advances in the field; and to assist the ministry in planning and auditing of centres providing assisted conception in order to ensure high standards of practice. At the moment neither the Ministry of Health *Guidelines for Assisted Reproductive Services* (2001) nor the *Report of the Sub-Committee on the Status of Children Born Through Artificial Conception* (Law Reform Committee 1997) distinguishes between procedures using donated gametes or embryos and those where the couple's own gametes or embryos are used. Except for clinical procedures, other issues such as respecting the confidentiality of medical records are applicable to both third party assisted conception and assisted conception using the couple's own gametes. Surrogacy arrangements are not legal in Singapore.

The Ministry of Health's first guidelines were formulated and published in December 1990 (Ng and Kumar 2000) based mainly on the recommendations of the Waller Committee in Victoria (Waller 1982) and the UK's Warnock Committee (Department of Health and Social Security 1984). Subsequent revisions were made and the most recent version was published in March 2001 (Ministry of Health 2001). While the Advisory Committee sets the guidelines, the administration, management and supervision of the practice of third party assisted conception in Singapore is carried out by the Ministry of Health.

The guidelines cover issues related to the establishment of assisted conception centres; personnel; and clinical and laboratory practices as well as other legal and social considerations associated with the donation, storage and disposal of gametes and embryos. Assisted conception includes:

> all treatments or procedures involving the handling of human oocytes or embryos and other related procedures including the removal or attempted removal from a woman of oocytes with the view of reintroducing them, whether fertilised or otherwise into the body. (Ministry of Health 2001, para. 1)

Each licensed assisted conception unit must have a minimum of one medical practitioner and one embryologist authorized to perform clinical and laboratory work respectively. The director of the centre must be an authorized medical practitioner with at least five years' experience in an assisted conception centre. In addition, centres must provide for the delivery and care of high-risk pregnancies in a hospital with neonatal intensive care facilities.

Assisted conception services may be provided only where there are sufficient clinical indications for the procedure. Assisted conception services can only be made available to a married woman and only with the consent of her husband, regardless of whether the husband's sperm is used or not. The director of the centre is responsible for ascertaining documentary proof of the patient's marital status. Women aged 45 years and over may not receive any assisted conception services. In addition, no IVF or related assisted conception services may be performed unless the woman and her husband have been adequately counselled on:

1. The possible medical, social and financial consequences, and they have given written consent.
2. The reduced chances of success for women over 40 years old and the higher risks of complications.
3. The risks of genetic anomalies for patients above 35 years old at the estimated date of delivery.
4. The estimated total charges for treatment and compulsory insurance for neonatal care.

Counselling is usually carried out by the clinicians and nurses focusing mainly on the medical procedures and financial costs involved in the treatment. Although the stress and need for psychosocial support involved in assisted conception are recognized (Lee and Ow 2000; Ow, Kumar and Leo 2002), social and emotional support services are not offered as a general rule and, at the moment, only the National University Hospital has a full-time counsellor trained in social work.

Women who enter the assisted conception programme aged 40 or younger are permitted a maximum of 10 stimulated and/or natural cycles reaching the stage of embryo transfer. These 10 stimulated and/or natural cycles refer to consecutive cycles in a nulliparous woman or following a live birth and include those performed in one or more local/overseas assisted conception centres. While women are to be strongly discouraged from further attempts after five cycles without achieving pregnancy, there are no definite ways of checking treatment received overseas.

Women over 40 are permitted a maximum of five stimulated and/or natural cycles reaching the stage of embryo transfer. Treatment must not, however, be provided when the woman turns 45 years of age, even if she has not completed the five cycles.

No more than three eggs or embryos may be replaced at any one time. However, up to a maximum of four eggs or embryos can be replaced if three conditions are satisfied:

1. All children conceived as a result of the procedure will be delivered and cared for in a hospital which has neonatal intensive care facilities.
2. The patient has undergone at least two previous unsuccessful stimulated assisted conception cycles.
3. The patient is older than 35.

While donor procedures are available, egg donors must be aged under 35 years. To prevent incest, and regardless of age, no woman is allowed to use eggs donated by her husband's sister. Wherever possible, a genetic link to one of the parents of the child should be maintained, although embryo donation is permissible. In such cases, the signed consent of the donor of both the egg and the sperm must be obtained and any recipient of donated gametes or embryos and her spouse must not only give their written consent for such treatment but must also sign a disclaimer absolving the donor from any financial commitment towards any child that may be born.

Guidelines also exist for the storage, disposal and transfer of gametes and embryos. Before the commencement of assisted conception procedures, written instructions from each couple must be obtained regarding storage and future plans for the gametes or embryos. These include specifications on:

1. The maximum period of freezing the gametes or embryos.
2. The provisions for the disposal of gametes or embryos in the event of separation of the couple (e.g. divorce or the premature death of a partner).
3. The preferred method for disposal of gametes or embryos in the event of incapacitation of one or both partners.

There are no specific clinical or legal guidelines on posthumous conception and the written instructions of the couple whose gametes or embryos are to be stored are respected. Except in exceptional circumstances, embryos should not ordinarily be stored beyond five years after the date of their fertilization. Cryopreserved embryos should be destroyed after ten years.

If no clear instructions were obtained from a couple whose embryos were stored prior to the release of the ministry's guidelines and the couple cannot be traced, the centre must inform the Director of Medical Services of all actions or measures that have been taken regarding the disposal of the embryos. This requirement is important since there are restrictions on activities relating specifically to the management of gametes or embryos, such as prohibitions on buying and selling them.

The transfer of embryos between local centres and between local and overseas centres is allowed, but it is the responsibility of the receiving centre to ensure that effective consent has been given for the use and storage of any gametes or embryos transferred to them. All centres are held responsible for ensuring the quality and security of genetic material whenever and wherever the material happens to be on their premises.

There are no commercial sperm banks in Singapore. Sperm is provided by volunteer donors and is screened for Hepatitis B, HIV, syphilis, chlamydia, gonorrhoea, thalassemia and blood group. Two types of sperm donor exist in Singapore: first, men donating for altruistic reasons and who are unknown to any potential recipients; second, 'exchange donors' who are recruited by a childless couple. Once the sperm from an exchange donor is screened, it will be used by a couple unknown to the exchange donor, and another previously-screened donor's sperm will be provided for the couple who recruited the exchange donor. This process ensures confidentiality and the maintenance of a sperm supply.

A register of children conceived and delivered in Singapore through assisted conception must be kept at each centre and the children can be identified by their birth certificate number. Although couples have to be informed of the type of information recorded by each centre, these records are kept under secure conditions and accessible only to authorized medical personnel. There are no provisions for the parents or the children to have access to this information. To prevent unauthorized access, each centre must maintain a record of all personnel authorized to access the records and document the security measures taken.

Legal status of children born through third party assisted conception

The context in which reproductive choice is made involves the interaction of sexual morals, cultural expectations, religious values and the official stance of the particular society. Given the accessibility of knowledge and the ease with which discussion fora can be held over the internet, influences external to one's own culture may also be involved in reproductive choice. In multicultural Singapore, diverse cultural and religious orientations towards life and procreation have important significance for the formulation of medical guidelines for assisted conception as well as for the laws on the status of children born from assisted conception.

Given the popularity of and growing frequency at which assisted conception is carried out both in Singapore and abroad, the Sub-Committee on the Status of Children Born Through Artificial Conception was established by the Law Reform Committee of the Singapore Academy of Law on 2 December 1995 to determine whether Singapore legislation required updating. The report of the sub-committee (Law Reform Committee 1997) focused attention on the status of the parties involved with a view to clarifying their legal status in relation to each other. It concluded that 'the status of children born through artificial conception is as much in doubt and subject to uncertainty in statutory law as it is in the common law' (Law Reform Committee 1997, para. 2.7). Some of the definitions and deliberations of the sub-committee's landmark report are reported below.

In view of the variety of permutations possible within medically assisted conception, para. 1.2.2 of the report defines the term 'artificial conception' as any of the following procedures in which there is either a possibility or certainty (in the absence of genetic testing) that a child is not the genetic product of *both* the gestational mother and the father:

1. Where a gestational mother is delivered of a child who has been conceived as a result of the gestational mother having her own eggs fertilized with the sperm of a donor in a procedure involving either *in vitro* or *in vivo* fertilization.
2. Where a child is conceived as a result of the gestational mother having her own egg fertilized with the sperm of a donor mixed with the sperm of the father in a procedure involving either *in vitro* or *in vivo* fertilization.
3. Where a child is conceived as a result of the gestational mother receiving for gestation in her body an egg or eggs donated by a donor, which eggs have been or are subsequently fertilized *in vitro* or *in vivo* with sperm donated by the husband.

4. Where a child is conceived as a result of the gestational mother receiving for gestation in her body an egg or eggs donated by a donor, which eggs have been or are subsequently fertilized *in vitro* or *in vivo* with sperm donated by a donor.
5. Where a child is conceived as a result of the gestational mother receiving for gestation in her body an egg or eggs donated by a donor, which eggs have been or are subsequently fertilized *in vitro* or *in vivo* with the sperm of a donor mixed with the sperm of the father.

In recognition that some of the procedures, notably surrogacy, have generated some controversy and that it was not within the remit of the sub-committee to decide on the limits of morality in the field of assisted conception, it decided to exclude from consideration situations and procedures involving surrogacy arrangements. However, procedures 4 and 5 described above are distinguished from surrogacy arrangements on the basis that 'the gestational mother enters into the procedure with the consent of the father, with the intention that the child should be conceived and carried *in utero* by the gestational mother to be brought up by the gestational mother and the father as a child of their marriage' (Law Reform Committee 1997, para. 1.4). However, in the context of Singapore's social, cultural and ethical mores, it recommended further study on surrogacy to determine whether it should be permitted in Singapore and, if so, the conditions under which it could be permitted. As far as is known, no such study has been conducted. Since para. 4.11.1 (ii) of the Ministry of Health guidelines (2001) specifically lists surrogacy as one of the activities that cannot be carried out in any licensed assisted conception centre, it is highly unlikely that any surrogacy arrangements have been entered into in Singapore. Legal issues relating to surrogacy have therefore not attracted any academic or public debate, unlike the ethical debates on the use of embryos and stem-cell culture.

Where the gametes of both parties to a marriage have been used to conceive a child, where both parties have consented to assisted conception procedures, and where the child is carried by the gestational mother, there seems no difficulty either in common law or statutory law in defining the status of the child.

Difficulties arise where the child is conceived as a result of a procedure in which neither or only one of the parties to the marriage is the provider of the gametes used in the procedure. The common law is inadequate in situations where there is uncertainty regarding the genetic paternity of the child and the legitimacy of a child may be challenged by the father at common law if it can be demonstrated (for example, by genetic testing or proof of impossibility of conjugal access during the relevant period) that the father was not the genetic father of the child. Notwithstanding his consent, this could happen following the break down of marriage. The sub-committee believes that while there are no recorded cases in Singapore dealing with the legal status of children born under such circumstances, there is still scope for challenge on issues of legitimacy under the common law if the child is conceived following egg donation.

Currently, no legislation deals specifically with the status of children born following assisted conception. This, and the rights between parent and child, are dealt with in a number of legislative provisions.

The general rule as to the presumption of legitimacy is laid down under section 114 of the Evidence Act 1997. A child who is born to a married couple, or within 280 days of the dissolution of a marriage, will be considered the legitimate child of 'that man, unless it can be shown that the parties had no access to each other at any time when he could have been begotten' (The Evidence Act, Revised Edition 1997 (Chapter 97)). This can be taken to include a child born within 280 days of the father's death provided that the conditions related to access and the marriage being in force at the time of death are fulfilled.

The scope of current law is ambiguous since it is not clear whether a father could subsequently dispute the child's paternity, even after giving consent to his wife's insemination with donor sperm. In addition, section 114 of the Evidence Act 1997, does not address the status of the gestational mother in egg donation. Although under the common law it is accepted that the gestational mother is presumed to be the lawful mother of the child, it is equally conceivable that the egg donor – or the intended adoptive mother in a surrogacy arrangement – may have a claim to custody entitlement. Currently, section 114 is, therefore, only clear in its application to children conceived through sexual intercourse between spouses during the existence of a marriage.

Section 3 of the Intestate Succession Act 1967 defines 'child' as a 'legitimate child and includes any child adopted by virtue of an order of court'; however, the meaning of 'legitimate' is undefined. Section 84 (Part IX) of the Women's Charter 1961 defines 'a child of the marriage' as any child of the husband and wife including any adopted child and any other child who was a member of the family of the husband and wife at the time when they ceased to live together or at the time immediately preceding the institution of divorce proceedings. Section 3 of the Adoption of Children Act 1939 (Chapter 4) provides for the adoption of an infant by the mother or father of the infant without defining the term 'mother'.

As can be observed, the legal status of a child conceived following third party assisted conception is not directly addressed. These provisions were drafted largely or wholly before third party assisted conception procedures became available in Singapore.

Several implications may arise from such uncertainty. First, a married couple unable to conceive a child might be discouraged from seeking medical help. Second, potential sperm donors might be discouraged by the possibility that the common law might hold them responsible for a child conceived with their sperm in spite of the disclaimer absolving the donor from any financial commitment to the offspring, under para. 4.6.5 of the Ministry of Health guidelines (2001). It would also seem unjust to the mother if the father, who had previously given his consent, subsequently sought to exploit the uncertainty at common law to challenge the paternity and legitimacy of the child (and thus also his legal responsibilities and duties as a parent). In such situations, although the common law regards the welfare of the child as the first and paramount consideration, the infliction of trauma on innocent parties such as the child or the gestational mother would not be lessened or prevented.

Although no publicly released figures are available (Chua 2000), the Centre for Assisted Reproduction at the Singapore General Hospital (2002) reported 1300 new infertility cases annually. Since assisted conception procedures have been available for some time and many children have been conceived through such procedures, the sub-committee deemed it appropriate to regularize the legal status of such children in keeping with the intentions of their genetic and social parents and recommended the introduction of legislation to clarify the status of children born following assisted conception.

Funding of services for third party assisted conception

Procedures for third party assisted conception are not considered standard medical treatment under the State's subsidized medical services. Couples enrolled in third party assisted reproduction programmes have to bear the full cost of the treatment. Currently, the full IVF procedure may cost between

S$3500 and S$4500 depending on the clinical treatment required. In addition, the couple also pays for the cost of hormone injections, blood tests, semen analysis and theatre fees for day surgery. As the sale of donor gametes or embryos is not permitted, donor procedures incur no additional costs. Excluding the costs for consultation, delivery and neonatal care, the total cost for each cycle resulting in a live birth may be as high as S$10,000.

The financial costs can therefore become an invisible constraint on couples who may wish to enrol on the programme or to avail themselves of the maximum number of cycles permitted by the ministry's guidelines. The couple is allowed to utilize up to S$4000 for payment from Medisave, which is part of the Central Provident Fund, a compulsory social security programme. This sum was increased from S$3000 by the government in response to appeals from the public and is perceived as a form of support for more couples to have children in view of the current below-replacement fertility rate in Singapore. However, the country's low fertility rate is primarily attributed to a change in attitudes towards marriage and family, such as the priority placed on achieving financial and career goals and delaying marriage, rather than to the problem of infertility *per se* (Cheung 2002).

Alternative treatment for subfertility

In Singapore, the use of traditional medicine, especially Chinese traditional medicine, is widely accepted, especially for health problems that are not perceived as life threatening (Lim and Bishop 2000; Tan and Bishop 1996). A number of traditional Chinese medicine (TCM) centres have been recently established by health care groups that are already significant providers of Western health care services (Tan 2001). In recent years, the interest in traditional cures has given rise to the establishment of specialist clinics, including fertility clinics. There is a dearth of literature in English on the use and effectiveness of TCM in infertility treatment in Singapore, but the web site of the Singapore Thong Chai Medical Institution (2002) provides a fairly comprehensive report of current research and treatment undertaken by the institution's infertility clinic. Both Western and Chinese approaches to diagnosis and treatment are employed. Prescription of herbal remedies is based on an overall analysis of the illness and the patient's physical condition in conjunction with modern medical diagnosis. However, no reports have been found of infertility treatment by traditional Chinese medicine involving donor gametes and/or embryos.

Counselling services

Counselling in relation to the procedures, costs and risks prior to enrolment on any assisted conception programme must be provided to couples under the Ministry of Health's guidelines. Currently, patients primarily receive counselling on medical issues from the clinicians and nurses and are usually referred to the IVF counsellor or medical social worker if there is an obvious need for their services. Counselling for psychosocial support by counsellors is not compulsory and the service is still in its infancy. 'Counselling' is generally not very well understood locally and connotes a sense of inadequacy on the part of the service user. In a recent telephone survey, 50 IVF patients expressed feelings of stigma and embarrassment about seeing a counsellor (Quek 2002). However, 74 per cent of the respondents felt that the patient should meet the counsellor at least once and preferably before treatment or at the start of the treatment, and other reports indicate positive feedback on counselling from IVF patients (Lee and Ow 2000; Ow, Kumar and Leo 2002).

Issues and concerns

In Singapore, given the diversity of values and beliefs, future issues and concerns would be those that need to distinguish between medical ethics and humanitarian needs on the one hand, and religious teachings and national laws on the other. Ethical issues involve the acceptability of stem-cell culture as it relates to the moral rights and protection of the embryo *vis á vis* the benefits to improving the quality of life for humankind; medical concerns about the risks of assisted reproduction (Yu 1998) and increased utilization of assisted conception in the light of declining fertility rates.

A major problem specific to third party assisted conception is that the number of sperm donors is decreasing. Agence France Press (2001) cited a study by the defunct tabloid, *Project Eyeball*, that the National University Hospital had 40–50 donors between 1990 and 1994 but for the three years before 2001 this fell to 15. In this same report, Dr Chong Yap Seng, coordinator of the National University Hospital sperm bank, was cited as saying that it was hard to convince Singaporean men to donate sperm and that many people still see the problem of not being able to conceive as one of fate. A mini-poll by *Project Eyeball* also found that four in ten men would donate sperm for money; however, the sperm banks are against commercializing donations. Apart from the lack of cash incentives, the screening procedures might act as an additional disincentive to recruitment, while Agence France

Presse (2001) also reported the fear of consanguinity or matching between close relatives – although doctors thought this is a very remote possibility.

With a multicultural population, the social, cultural and religious factors impinging on family life and the social acceptance of assisted conception procedures have implications for future regulations associated with issues such as third party assisted conception, surrogacy, the legal status of the child, and the legal framework regulating the practice of assisted conception. Apart from sensitivity to the wider implications of racial and social harmony for the nation, regulations have to cater to the needs of couples at the personal level. Issues, such as whether the anonymity of donors should be maintained, whether a child born following assisted conception techniques has a right to be informed of his or her origin, and the commercialization of sperm banks and payment for donation of gametes and/or embryos for third party assisted conception treatment, continue to be a challenge as Singapore society moves in tandem with new technologies that may not fit traditional views on the role of the family unit and the nature of procreation.

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CHAPTER 11

South Africa

Cultural Diversity

Charlene Laurence Carbonatto

Introduction

South Africa is both a developing and a developed country, experiencing a variety of pressing health issues, such as HIV/AIDS, TB, malnutrition, teenage pregnancy, rape, violence and child abuse. Infertility and third party assisted conception are, therefore, not seen as priority health issues. Assisted conception services are expensive. In the major South African cities, Pretoria, Johannesburg, Durban, Cape Town and Bloemfontein, there is at least one assisted conception unit at each of the academic or training hospitals, and at least two or more private clinics or practices specializing in assisted conception (Fairall 2002, p.81).

South African health policy and services

Primary care provides the major focus of public health care services in South Africa (White Paper for the Transformation of the Health System 1997). The focus of this policy is the provision of facilities that are affordable, accessible, effective, equitable and efficient. Specific health care goals include:

1. Education on prevailing health issues and prevention.
2. Providing women and children with basic health services, including family planning, safe water and basic sanitation, nutrition and food supply.
3. Essential medicine, control of endemic diseases, immunization and treatment of common diseases and injuries.

Of a population of 42 million, 4.2 million South Africans were HIV positive in 2000 (Whiteside and Sunter 2000, p.53). Approximately 2000 new HIV/ AIDS infections are reported each day. In Kwa-Zulu Natal, one of the hardest-hit provinces in South Africa, the AIDS mortality rate is higher than the province's birth rate (*Pretoria News* 1999). Consequently, HIV/AIDS is a major priority for the country's health system, as are TB, sexually transmitted diseases, infant mortality, child abuse, malnutrition, the care of people with disabilities or chronic illnesses, the care of the elderly and women's health issues, including reproductive health (specifically family planning, teenage pregnancy and abortion), cervical cancer and rape (African National Congress 1994; White Paper for Social Welfare 1997; White Paper for the Transformation of the Health System in South Africa 1997). Infertility and third party assisted conception are not identified in any Department of Health policy documents.

Both publicly-funded and private health care are available in South Africa. People in employment usually contribute to a private medical-aid fund to cover their medical expenses. Private health care is only available to those who have contributed to a medical fund and any treatment needs to be approved by the fund. State hospitals are utilized mainly by people who are not members of private medical-aid schemes or who are unemployed. These hospitals function at three different levels: community hospitals and district clinics (primary level), regional hospitals (secondary level) and training or academic hospitals (tertiary level). Women and children aged under six years, as well as the elderly, are entitled to free treatment at state hospitals. For others, an assessment of means is made, the State subsidizing treatment according to the individual's level of income. Many state hospitals, especially rural hospitals, are in a poor condition and lack essential equipment because of inadequate government funding. Thus it is difficult to attract professional staff, resulting in a 'brain drain' of medical and nursing staff to better-paid jobs abroad. The government attempted to resolve this staff shortage by requiring all South African medical graduates to commit to two years' compulsory community service in rural hospitals before they be allowed to practise privately. However, many have refused to do this and are emigrating. Changes within the system are currently enabling state hospitals to benefit financially by opening private wards for private patients, mainly for treating chronic conditions.

Private assisted conception services are provided by physicians in their own offices or at assisted conception units in private hospitals. However, the private medical-aid funds do not pay for any assisted conception services, putting the cost of such services beyond the reach of many people; although some of the public university teaching hospitals also have assisted conception units offering lower cost services than the private centres. The cost of a single artificial donor insemination (DI) cycle ranges from R10,000 to R15,000 (£1 = 12 rand at the time of publication). An *in vitro* fertilization (IVF) treatment cycle costs between R20,000 and R30,000, while the cost of an intra cytoplasmic sperm injection (ICSI) cycle ranges between R20,000 to R25,000 (Fairall 2002, p.81). This compares with the prescribed minimum monthly wage for an unskilled labourer in South Africa of R1500. However, with the high unemployment rate, poverty and lack of education, the average monthly income for those in lower socio- economic groups could be as low as between R500 and R1,500. Average monthly salaries for administrative personnel range between R3000 and R5000, while entry level salaries for professions such as social work, nursing, physiotherapy and occupational therapy range between R5000 and R6000 a month. Monthly earnings for professionals in the private sector, such as medical practitioners, engineers, lawyers and chartered accountants, can range between R15,000 and R30,000 or more. Thus a vast difference exists and assisted conception services in private hospitals or practices are mainly available to those in the middle- to upper-class occupations, of any race or religion, who contribute to a medical-aid fund and/or who can afford to pay for the majority of the expenses themselves, as medical-aid funds only cover a minimal portion of this treatment, if anything. Those who cannot afford private services or who do not contribute to a medical-aid fund, must utilize state-subsidized services at an academic hospital where third party assisted conception services are offered, of which there are at least seven centres in South Africa.

History and cultural diversity

In South Africa there are many different cultures, each with its own norms and practices. There are four main racial groups in South Africa: African, white/European, coloured and Asian. Within the African population there are 11 different ethnic groups, each with their own language and cultural practices, which differ vastly from each other. South Africa's white/European population consists of the Afrikaans-speaking persons (descendants from Dutch and German settlers) and English-speaking persons (descendants from the British, French and Portuguese settlers), all descendants of European settlers who began to settle here in the seventeenth century.

South Africans of mixed racial origin are referred to within South Africa as ‘coloureds’, and are descendents from various intercultural relationships. The first sub-group is descended from settlers from sub-Saharan Africa and European relationships (Reader’s Digest 1994, p.12). A second sub-group is descended from European and Khoisan relationships. Khoikhoi people were herders and San people were hunter-gatherers who had been native to Southern Africa 2300 years ago, eventually settling in the Northern Cape (Reader’s Digest 1994, p.12). These Khoisan people also later mixed with people from coloured or African origins, forming a third sub-group. The fourth sub-group is descended from sexual encounters between slaves working in brothels and passing sailors, as well as relationships and marriages between European settlers and slaves (Reader’s Digest 1994, p.40). Slaves were brought into the country in the mid-seventeenth century and originated mainly from West Africa and later from Mozambique and Madagascar, although the most highly prized slaves were from the Far East (Reader’s Digest 1994, pp.48–50).

Later, Asian slaves were brought from India, mainly to work in the sugar cane fields. This contributed to the formation of the third racial group in South Africa. By 1911, 152,000 Indians had already arrived from India (Reader’s Digest 1994, p.79). Consequently, many different religions are practised and there are 11 official languages in South Africa.

Indigenous healing and fertility problems

Africans prefer to utilize traditional medicine or indigenous healing, which is more holistic than Western medicine. Traditional healers include the *sangoma* (diviner or witchdoctor) and the *inyanga* (herbalist) (Buijs 1995; Mkhwanazi 1994).

According to Buijs (1995) the *sangoma* is called to the vocation by the ancestors. Signs of this summoning include frequent sneezing, hiccups, pain in the shoulder or being restless at night. Training entails an apprenticeship within a diviner’s home; a long, arduous process, lasting from five to seven years (Mkhwanazi 1994). Once training is complete the apprentice must have acquired the ability to quiver or shake, which is associated with the ability to divine. Clairvoyant powers are said to be bestowed on the diviner by his or her ancestors (Mkhwanzi 1994). The ancestors are also consulted during sessions. Bones, shells and dice are cast during rituals for diagnostic purposes. The client does not tell the diviner what is wrong, as it is part of the diviner’s task to determine what is wrong and who has brought this omen to this person. The bones, shells and dice are interpreted according to the way they fall, depicting a specific problem or diagnosis, including fertility problems. The medicine or *muti* which is prescribed usually consists of herbs, plants, roots, tree bark, animal tissue, bones, hide, blood or organs. Sometimes human tissue or body parts, such as hair, bone or genitals, are used. These are mostly obtained by means of stealing body parts from corpses in a graveyard or from cadavers at universities; or by means of murder for the sole purpose of cutting off certain body parts for *muti*, referred to as 'muti murder'. *Muti* remains a controversial issue in South Africa.

Anyone may become an *inyanga* (herbalist), but in practice it is mostly hereditary (Buijs 1995). The herbalist is concerned solely with powers residing in the medicine. Training is via apprenticeship to a practising *inyanga* and the herbalist's skills will also often be passed to the children who show an interest (Mkhwanazi 1994). Clients will describe their ailment to the herbalist who will prescribe herbal medicine. They will thus have a specific mixture used to treat infertility, for example.

According to Buijs (1995), the cause or source of suffering first has to be traced; there must also be harmony in the home for the *muti* to be effective. Suffering, medicine and morality are therefore all perceived as being closely inter-related. Mkhwanazi (1994) similarly states that illness in African medicine is caused by witchcraft, sorcery or ancestral displeasure, and does not respond to Western types of treatment.

Sewpaul (1999) also mentions in the findings from her South African study on culture and religion in infertility that there are unique differences between the African and Indian views compared to those of coloureds and whites. The impact of religion, however, showed similarities across different religious groups. The most pervasive theme was that infertility was seen as punishment for wrongdoing.

Within African culture, premarital sexual relations are acceptable; pregnancy being a proof of fertility and children being a sign of wealth. Conversely, people who are childless are considered to be 'poor'. The cultural norm is to prove fertility before marriage or forming a permanent relationship. Consequently, the use of contraceptives is culturally discouraged (with implications for abortion and the transmission of HIV/AIDS).

The cultural presumption is that women rather than men have fertility problems. Women are held responsible for a failure to produce children and they are ostracized from the relationship and often from the community. However, if it is suspected that a man has a fertility problem, he must be protected from this knowledge and others must not be allowed to suspect it. Traditionally the infertile man's mother will arrange for his brother or another male relative to have sexual intercourse with her daughter-in-law. At the same time the infertile man will have been referred to the African traditional healer and prescribed *muti* to help boost his fertility and virility. If his wife conceives he will believe that he has fathered the child with the assistance of the *muti*. Only his mother, his wife, the male impregnator and possibly the traditional healer would know the truth.

Alternatively, more Westernized, urban and educated Africans will seek Western treatment for fertility difficulties – even though it is contrary to their cultural beliefs and norms. However, they are likely to keep their problems and treatment secret, for fear of being rejected by their family because of their inability to produce children.

Thus it is important within the South African context to remain sensitive to cultural and religious differences in the provision of assisted conception services.

Legislation

The first request for DI in South Africa was in 1948 (Van Delft 1983) and it was implemented for the first time in 1952. The Human Tissue Act (Act 65 of 1983) was the first piece of domestic legislation to regulate DI. The Act specifies:

1. The purpose of sperm removal and consent to removal.
2. Professionals who may perform DI and approval of physicians to perform DI.
3. Permission for insemination procedures.
4. Conditions for the import or export of sperm.
5. Arrangements for the inspection of premises in which DI takes place.
6. Annual reporting of the inspector to the Director General of Health.
7. Arrangements for the adoption of the child by the spouse of the recipient.
8. Donor and recipient anonymity and a prohibition on publishing any details of persons involved in donating or receiving gametes.

More specific and comprehensive guidelines were subsequently included in the 1986 Regulations Regarding Artificial Insemination of Persons and Related Matters which paved the way for the increased practice of third party assisted conception in South Africa. The regulations detail the following particulars:

1. Who is responsible for the removal of gametes and for what purpose.
2. Verification that the donor has undergone all the prescribed tests; the test results; details of previous donations by the donor and consent to donation from the donor's spouse.
3. Consent by the donor for all the examinations, the donation, the recording of details on file and the provision of details to the Director General of Health.
4. The provision of non-identifying information to the recipients.
5. That a maximum of five children are produced from the donor's gametes, after which no further use of the gametes is allowed.
6. The recording of donor information, including biographical details, physical particulars, family medical history and wishes regarding the number of inseminations; the ethnicity and religion of the recipients; and the details of each donation, each insemination and the child/children born of such an insemination and any defect or disorder present.
7. The screening of donors, the medical tests, test results and other particulars to be kept in the donor's file.
8. Evaluation of the donor's psychological suitability. However, responsibility for performing this task is not specified and remains a potential loophole in this legislation.
9. Particulars on the recipient's file, such as biographical details, family medical history, medical tests and results.
10. Restriction of eligibility to DI to married couples.
11. Written consent of the recipient couple for the examinations, tests, artificial insemination and the provision of details to the Director General of Health.

12. The provision of information to the recipient couple from appropriate experts concerning the implications of DI; the chances of success; the problems that exist concerning DI; financial aspects; consequences to the marriage; ethical, legal, psychosocial and educational implications; risks of genetic properties attached to the gamete and the prognosis concerning the child.
13. The biological, physical, social and psychological suitability of the recipient couple. However, as with donors, noted above, responsibility for undertaking assessment is not specified in the legislation.
14. The wishes of the recipient couple regarding the ethnicity and religious affiliation of the donor.
15. The matching of donors and recipients.
16. The approval of the application by the physician to perform DI and the approval of the premises.
17. That the physician who attended the birth must inform the physician who performed the insemination within 30 days of the birth of such a child (this is difficult, however, because the physician attending the birth does not necessarily know that the child was conceived as a result of DI).
18. That where the birth is not attended by the physician who performed the insemination, the mother should inform the physician within 30 days of the birth and of any disability or disorder the child may have.
19. That if the child suffers any disability or disorder, the physician should try to determine the cause. Provision is made for criminal prosecution if any relevant information has been withheld by the donor.
20. The prohibition of donor remuneration and limit of five live births per donor.

While the regulations dealt with a number of significant omissions from the Human Tissue Act 1983, issues still not covered included the status of the child and of the partner of the recipient, as well as spousal consents.

Furthermore, while the list of terms acknowledges the existence of a female donor, regulations otherwise merely refer to the term gametes, inseminations and donor with no specific reference to female donors or egg or embryo donation.

Even though the Act and regulations restrict eligibility to assisted conception services to married couples, proof of marriage is not specifically required, and the production of a valid marriage certificate is rarely demanded before assisted conception services are offered (Lourens 2002).

The Children's Status Act (Act No. 82 of 1987) makes provision for the status of children conceived following third party assisted conception and amends the provisions in the Human Tissue Act which permits the spouse of a DI recipient formally to adopt the child. The Children's Status Act provides that, once recipients for DI procedure have given their written consent, the child is their legitimate child and the donor has no right, duty or obligation in respect of the child.

Further Regulations for Artificial Fertilization of Persons and Related Matters (1991) have been drafted but have still not been finalized to date, demonstrating the government's limited commitment to assisted conception. The draft regulations make provision for other procedures to be regulated, such as IVF and egg donation and include provisions for:

1. Control over, removal or withdrawal and use of gametes and the storage of zygotes.
2. Restricting to five the maximum number of children that be conceived per donor.
3. Specific details to be kept on donor and recipient files.
4. The availability of information and the destroying of gametes.
5. The storage, freezing and destruction of zygotes.
6. Prerequisites for treatment.
7. The reporting of births, disorders or defects.
8. Penalties for not abiding by the law.

In comparison to DI, recourse to egg and embryo donation has been relatively infrequent. Eggs donated by relatives are usually preferred to those donated by anonymous strangers, and donor embryos are more often used by couples with genetic abnormalities. With the high rate of HIV/AIDS in

South Africa, some HIV-positive couples wanting children are now requesting donor treatment to prevent the possibility of transmission of HIV to their children. However, this remains a controversial issue as most physicians are hesitant to treat these couples because of their shorter lifespan and the fact that these children will eventually be orphaned (Lourens 2002).

Sharing a similar fate with the 1991 draft regulations, a Proposed Bill on Surrogate Motherhood was drafted in 1992 but has still not been approved. Key proposals in the Bill cover the surrogate mother's medical and maternity expenses, prohibit payment to the surrogate mother and identify criteria under which a surrogacy arrangement could take place. As with legislation in force in Israel (see Landau in this volume) the Bill proposes prior court approval of the suitability of the proposed arrangement. In practice, only a handful of couples have embarked on a surrogacy arrangement. The surrogate mother is usually a relative or friend of the couple: one of South Africa's first surrogate mothers was a 47-year-old woman who gave birth to her grandchildren triplets in 1988 created using the gametes of her daughter and son-in-law (Michelow *et al.* 1988).

Unmarried medical, veterinary, dentistry and agricultural university students are the most common source of anonymous sperm donors. Egg donors are usually family or friends of the recipient or women undergoing their own treatment who are willing to donate eggs for the treatment of others (Lourens 2002).

Recipient–donor matching is required under the 1986 regulations, taking account of physical features and educational and religious background.

Donor embryos are usually obtained from patients who have completed IVF treatment and are willing to donate any 'surplus' frozen embryos to other couples in the programme. Sperm and ovum banks are located in spermatology departments in private pathology laboratories.

Couples can request the same donor for all their children, so that all their children would be full-blood siblings. According to Lourens (2002) one couple has five DI-conceived children, each of whom was conceived using the sperm from the same donor.

South Africa is a fairly conservative society and secrecy and anonymity surround donor treatment. Disclosure to the child is also a secretive, controversial topic. Research on third party assisted conception is limited in South Africa. Only two studies have been conducted to date, Van Delft (1983) and Carbonatto (1996). Attempts by both researchers to request Central Registry statistics from the Director General of Health for research purposes were to no avail. Van Delft (1983) compared adoption and DI as options for infertile couples in South Africa. Carbonatto (1996) studied 15 couples who, at the commencement of the study, were on a waiting list for DI at the infertility clinic at a teaching hospital in Pretoria and, by the end of the study, had up to two children, the eldest being six years old. Each of these couples had kept the donor origins of their child a secret. Nine couples did not intend informing anyone and six planned never to tell the child.

A statutory donor registry has been in existence in South Africa since 1986. Assisted conception units and physicians offering DI are required each year to provide the Director General of Health with details of donor gametes used and the identity of the donor, recipient and child, together with information about any disability or illness experienced by the child. The latter requirement is to monitor any abnormalities that may result from donor conception. In certain circumstances, such as where a child has developed a rare disease necessitating contact with the donor for further tests, the Director General of Health may authorize disclosure of the donor's identity on the written request of the physician who performed the procedure. If the donor consents, the child may also be given permission to meet the donor. Otherwise donor anonymity is preserved under South African law.

While it is not a third party assisted conception procedure, adoption is of potential relevance to this discussion. As a result of the legalization of abortion in South Africa, namely the Choice on Termination of Pregnancy Act 1996, fewer healthy babies are available for adoption and welfare organizations that place children for adoption have lengthy waiting lists, extending to several years. There are many HIV babies available for adoption, but a limited number of people are willing to adopt them. In 2002 the High Court, probably influenced by the number of HIV babies awaiting adoption placements, ruled that gay and lesbian couples would be permitted to adopt. The High Court is also considering whether gay and lesbian marriages should be permitted (*Pretoria News* 2002). This could possibly pave the way for lesbian and single women's access to assisted conception services.

Counselling in third party assisted conception

In South Africa only a few social workers or psychologists in private practice offer a third party assisted conception counselling service. Social workers working with infertility and adoption are usually employed by non-governmental welfare organizations. Social workers working with couples undergoing infertility evaluation and/or treatment work mainly in state or private hospitals which have an assisted conception unit. Third party assisted conception is most often dealt with in private practice, and referrals of couples for screening, selection and for donor-assisted conception are made by a gynaecologist or spermatologist to a social worker or psychologist in private practice. Unfortunately, there is minimal collaboration amongst these professionals. In Pretoria, for example, the author is aware of two social workers, including herself, as well as two psychologists, who specialize in third party assisted conception counselling.

Limited research has been performed on the preparation of couples for third party assisted conception in South Africa. Carbonatto addressed this in doctoral research and developed guidelines for the preparation of couples for third party assisted conception (Carbonatto 1996; Carbonatto and Du Preez 2001). These are discussed below.

Preparation of recipient couples

The holistic preparation of couples for third party assisted conception is imperative and a definite prerequisite for donor procedures. Various authors refer to the need for patient preparation (Kovacs *et al.* 1988; Mahlstedt 1994; Olshansky and Sammons 1985), supporting the requirements regarding couple preparation specified in the 1996 regulations.

In Carbonatto's (1996) study, respondents' evaluations of the preparation sessions included the following comments on preparation: it made them more realistic about treatment; it helped them to make an informed decision; it gave them a more thorough perspective of third party assisted conception; it informed them of the advantages and disadvantages; it prepared them for treatment and clarified relevant issues. However, it was recommended that the preparation period should consist of more sessions, highlighting the need for preparation, as well as the importance of providing couples with sufficient information to enable them to reach an informed decision and give informed consent.

The details of this preparation session include the infertility diagnosis, motives, and medical, legal, ethical-moral, religious and psychosocial aspects regarding third party assisted conception in a South African context, as described in the following sections.

Diagnosis and motives for choosing third party procedures

The details of the diagnosis, the causes and couples' experiences of infertility must be discussed with the couple to determine whether they have come to terms with their infertility and have understood the diagnosis. The alternatives the couple have considered, i.e. adoption, childlessness or third party assisted conception, must be discussed, concentrating on their viewpoint regarding these alternatives and why they have made their particular choice.

Medical aspects

The gynaecologist or andrologist discusses the medical information with the couple. The social worker can assess their understanding of this information, in conjunction with the gynaecologist, and explain it again using lay terms, which are more understandable to the couple. The following medical aspects can be discussed:

1. Their diagnosis and the causes of their infertility.
2. Recipient selection.
3. Donor selection and preparation and the number of children per donor.
4. Recipient–donor matching and the criteria used in the matching process.
5. The various methods of third party assisted conception.

Legal, ethical and religious aspects

The detailed information on South African legislation on third party assisted conception should be discussed. Couples need to be prepared on the legal aspects so that they are aware of the relevant regulations affecting the rights and protection of the child, the donor and themselves.

Various ethical-moral issues regarding third party assisted conception should be addressed during the preparation session. It is important that couples are aware of the issues that they might confront and that they use this opportunity to raise and discuss any dilemmas they have in this regard, for example:

1. Arrangements for selecting donors.
2. The compensation of donors and the commercialization of gamete supply.

3. The creation of children in the laboratory.
4. Views around masturbation.
5. Whether donor assisted conception is perceived as intruding into the marital relationship.
6. Issues regarding the child and the donor's anonymity, and the views that the child may have about her or his conception, her or his parents and the donor.

Each of these issues is controversial, and should be discussed during the session. Couples should be encouraged to raise their own ethical-moral uncertainties and questions during this session.

It is important that the perspectives of different religions regarding third party assisted conception are discussed during the preparation session. The couple's own religion must also be taken into consideration and specific attention given to their religious doctrine and philosophy as far as possible. Some issues concerning this form of treatment that are unacceptable to most religions include: masturbation to obtain sperm; depersonalization of sex; third party intrusion in marriage; adultery; invading God's territory; the unpredictability factor; incest in the event of consanguineous marriages between genetically-related offspring; anonymity of the donor; the responsibility factor and the fact that the donor relinquishes all responsibility towards his or her offspring (Louw 1985, pp.10–21; Roy 1980, p.502).

It is important that couples have an opportunity to raise their own religious uncertainties or fears. It is recommended that they should also consult a theologian in this regard, to help them in their final decision-making process.

Psychosocial aspects

There are various psychosocial aspects which should be discussed with couples during the preparation session, including their motives for a child and parenthood, as well as their motives for a child by means of third party assisted conception and their viewpoint on the motives of the donor. It is recommended that the decision-making period and process should take place over an extended period of time – at least three months' duration. The couple must have resolved their infertility crisis, completed their grieving process and come to terms with their infertility. Furthermore, they must redefine their marital relationship, reconstruct their sexual identity and their idea of a traditional genetically linked family. They have to make a paradigm shift from genetic parenthood to social parenthood. Couples must also make a combined informed decision.

The possible psychosocial impact of third party assisted conception on the individuals involved should be discussed, such as the recipient husband and wife, the donor and the donor partner or spouse. This discussion can include the possible psychosocial impact on the marital relationship, the paramount importance of a stable marital relationship and the importance of mutual support. The possible effect on the sexual relationship and the potential for marital conflict to be evoked, as well as feelings of resentment and jealousy, can be mentioned. Other aspects which can be covered include the pregnancy and childbirth, parenthood and the child. This discussion can include the resemblance of the child to the recipients; the physical, psychomotor, psychosocial and intellectual development of the child and the incidence of abnormalities. Furthermore, secrecy and anonymity regarding recipients and donors should be discussed, including whether the parents plan to maintain the secret or disclose it to others. Their reasons for secrecy, the advantages and disadvantages of secrecy need to be discussed, as well as the anonymity of the donor. The couple need to be made aware that they can request non-identifying information about the donor. Disclosure to family members and friends is important, and how the couple will go about it and the reactions they could expect should be explored. Furthermore, disclosure to the child, their reasons in favour of or against telling the child and ways of telling the child are important subjects to be debated. The emotional reactions resulting from treatment are another significant aspect, as stress is usually experienced during the treatment stage. Mutual support should be encouraged and ways of enhancing the couple's coping mechanisms discussed. The family created by third party assisted conception compared to a traditional genetically linked family and the paradigm shift in this regard, should be debated.

The psychosocial preparation for third party assisted conception should also include issues such as non-disclosure to other family members and the family's possible reaction if disclosure is made.

Thus, the part of the preparation session concerning the psychosocial aspects of third party assisted conception is comprehensive and very important in helping to prepare these couples for all the possible experiences and implications regarding this alternative. This information will ensure that they gain sufficient knowledge and are more realistic in terms of what they could experience. It will also help them in their final decision-making process.

Long-term counselling

Following the preparation stage, couples must be provided with long-term counselling services. These include sessions as needed at various stages in the process. Carbonatto (1996) proposes the following stages of counselling in third party assisted conception:

1. The selection stage – couples undergo an assessment interview.
2. The preparation stage – the preparation of couples, as discussed.
3. The decision-making stage – couples are supported through the difficult decision-making process.
4. The treatment stage – it is essential to offer emotional support during each treatment cycle.
5. The pregnancy and birth stage – emotional support can be offered during the pregnancy, birth and postnatal stage. Many questions often arise during this stage, specifically related to the health and physical appearance of the baby, as well as uncertainties related to parenthood.
6. The family stage – it is important to offer emotional support in the long term where necessary and to have an open-door policy, should any problems arise.

During each of these stages, the couple will need ongoing emotional support. Intervention can be provided as needs and problems arise at each stage. Often the social worker is the only person besides the medical practitioner who is aware of their secret and he or she can play a very important supportive role in their lives.

Conclusion

Third party assisted conception is an option available in South Africa for couples who cannot conceive using their own gametes. It is still a somewhat controversial topic, with many ethical and religious aspects involved. Since the legislation on abortion has been introduced, the number of babies available for adoption has decreased. Adoption is therefore becoming more difficult, with longer waiting lists. Infertile couples are thus being confronted more directly with the alternative of third party assisted conception in South Africa as an option.

Counsellors need to become more knowledgeable and skilled in working with couples opting for this alternative. This chapter has included a framework for counsellors working with recipient couples for third party assisted conception at the preparatory session, and recommendations for intervention in the various stages of the process.

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CHAPTER 12

The United Kingdom

Evolution of a Statutory Regulatory Approach

Eric Blyth

The origins of third party assisted conception in the UK

Artificial donor insemination (DI) has taken place in the UK since at least the late 1930s (Nachtigall 1993); two pioneering doctors, Mary Barton and Margaret Jackson, being the main protagonists of DI provision (Barton, Walker and Wiesner 1945; Snowden and Mitchell 1981; Snowden, Mitchell and Snowden 1983). While surrogacy has probably occurred in the UK for many years, its practice has really only impacted on the national consciousness following the birth of 'baby Cotton' in 1985 (Cotton and Winn 1985).

As in most of the developed world, assisted conception involving eggs and embryos (i.e. including egg and embryo 'donation' and gestational surrogacy) have only been readily available since the 1980s with the development of the necessary technology and clinical and scientific expertise.

Specific historical, political, economic, religious and cultural factors impinging on service provision and availability

Most forms of donor-assisted conception have been readily available in the UK, although at varying times they have been subject to moral approbation. In 1948, the Archbishop of Canterbury (the head of the established church in England) set up a commission to inquire into 'artificial insemination' that advocated the criminalization of DI (Archbishop of Canterbury 1948). Twelve years later, a government committee provided a somewhat less condemnatory overview of DI but still recommended that 'the practice should be discouraged' (Feversham Committee 1960, p.46). In 1982, in response to emerging concerns about actual and potential developments in assisted conception, the UK government established a Committee of Inquiry (the 'Warnock' Committee), which recommended legislation to regulate certain forms of assisted conception treatment and associated research (Department of Health and Social Security 1984). The committee endorsed all forms of third party assisted conception with the exception of surrogacy. Although all committee members shared concerns about the risks of exploitation and disapproved of commercial surrogacy 'for convenience', they failed to agree a common view on surrogacy *per se.* A majority of the committee, objecting to surrogacy on principle, recommended the prohibition of all surrogacy agencies (whether profit-making or not) and that the establishment of a surrogate pregnancy should be subjected to criminal sanctions, although commissioning parents and surrogate mothers should be exempt from criminal liability. However, two members of the committee, believing surrogacy was acceptable as a 'last resort', considered that it should be permitted subject to 'stringent care and control' (Department of Health and Social Security 1984, p.87). In practice, although the government expressly endorsed neither option, it tacitly accepted the minority view on the acceptability of surrogacy, but failed to subject it to their recommended controls (Brazier, Golombok and Campbell 1998).

The regulatory framework for third party assisted conception in the UK

After several years' deliberation on the Committee's recommendations (Department of Health and Social Security 1986, 1987), the government introduced the Human Fertilisation and Embryology Act 1990 (hereafter 'The 1990 Act'). In the meantime, the medical profession established a *voluntary* regulatory body, initially called the Voluntary Licensing Authority (subsequently the Interim Licensing Authority) that was in operation by 1985 and continued to operate until 1991 when a statutory regulatory body, the Human Fertilisation and Embryology Authority (HFEA) was set up under the 1990 Act. However, the Voluntary/Interim Licensing Authority did not cover any donor procedures unless they also involved IVF or gamete intra-fallopian transfer (GIFT).

The 1990 Act permits the provision of a wide range of assisted conception procedures, including sperm, egg and embryo 'donation', and both genetic and gestational surrogacy. All centres that provide treatment services that involve donor gametes or extra corporeal fertilization of gametes are required to be licensed by the HFEA. 'Do-it-yourself' practices, such as self-insemination or genetic surrogacy are, therefore, permitted by legislation, although operating outwith the regulatory framework. Included among the relatively few prohibitions are cloning for reproductive purposes and certain commercial activities associated with surrogacy. The HFEA limits to ten the number of live births that may result from using the gametes of any one donor; however, any twin or triplet birth is counted as a single birth (Deech 2000).

The key legislative imposition on access to services is that a licensed treatment centre must not provide any treatment to a woman 'unless account has been taken of the welfare of any child who may be born as a result of the treatment (including the need of that child for a father), and of any other child who may be affected by the birth' (section 13 (5)).

The HFEA, in its *Code of Practice*, which provides guidance to centres, emphasizes the particular significance that welfare considerations should play in determining whether to offer donor procedures: 'the degree of consideration necessary will be greater if the treatment is required to be licensed under the HFE Act and particularly if it involves the use of donated gametes' (Human Fertilisation and Embryology Authority 2001, para. 3.9, p.16).

In practice, implementation of the welfare of the child requirement has been problematic. Nearly a decade after implementation of the Act, the British Fertility Society (1999), the UK's main specialist professional body, claimed that: 'a definition of the meaning of the "welfare of the child" has not yet been agreed and in its absence, implementing the assessment is, in practice, the subject of confusion and debate' (p.85).

Of greater concern have been claims that the welfare of the child requirement is 'really a smokescreen for the more unpalatable reality of weeding out unfit parents' (Tizzard 1999, p.3) – with age, marital status and sexual orientation providing a major basis for the determination of 'suitability' (see Deech undated; Douglas 1993).

Several key limitations flow from this interpretation of welfare. First, consideration of the welfare of a child who is yet unborn must be subject to speculation. Second, scant consideration is afforded either to the welfare of the individual beyond his or her childhood or to issues other than parenting competence. Third, the welfare of the child is not afforded any priority; it merely requires that account be taken of it, but mandates no further action. Fourth, the HFEA implies differential application of welfare considerations.

Fifth, the requirement to take into account the welfare of 'any other child who may be affected by the birth' simply adds to the range of potentially competing interests, including those of existing children, children yet to be born and prospective parents, that centres must consider when deciding whether to offer treatment to a particular individual.

Key to the provision and regulation of third party assisted conception procedures are the Act's provisions for the determination of legal parentage.

A sperm donor will have no parental obligations or rights in respect of any resultant child, so long as the 1990 Act's consent requirements have been met (section 28 (6) (a)) . Consequently, a sperm donor could be treated as the child's legal father if his sperm is used other than in accordance with the Act's consent provisions (i.e. when a woman conceives following self- or 'DIY' insemination) *and* the woman receiving his sperm is either unmarried *or* her husband or partner (if she has one) either did not consent to her insemination or the couple were judicially separated when the woman was inseminated.

The Act defines the child's birth mother as his or her legal mother, whether or not she is also the child's genetic mother or whether or not she intends to undertake the child's future care (section 27). The implications for a surrogacy arrangement are that the 'surrogate' mother is regarded as the child's legal mother and, if she is married, her husband will be regarded as the child's legal father – irrespective of any genetic relationship with the child. Neither commissioning parent, whatever their genetic relationship to the child, has any legal relationship with the child. However, the Act does provide a means by which the commissioning parents may acquire legal parentage – a Parental Order, issued by a court (section 30) (Blyth 1993).

Under the 1990 Act a man's sperm may be used after his death for assisted conception treatment, although he will not be treated as the child's father (section 28 (6) (b)). Potential problems with this provision emerged in 1995, when a young man, Steven Blood, suffered a fatal illness. At the time, he and his wife were actively trying for a family, although not by means of assisted conception. While Mr Blood remained in a coma, from which he never regained consciousness, Mrs Blood arranged for a sample of his sperm to be obtained so that she could use this to achieve a pregnancy. Crucially, Mr Blood had not consented to the storage of his sperm, as required under the provisions of the 1990 Act. When Mrs Blood later wished to conceive using her husband's sperm the HFEA initially refused her permission to do so, although she was granted permission following legal action (*R* v *Human*

Fertilisation and Embryology Authority ex parte *Blood* 1997). Following successful insemination, Mrs Blood gave birth to a son in December 1998. However, even though Mr Blood indisputably was the boy's genetic father, it was not possible for him to be registered as the child's father, because he had died prior to the baby's conception.

In response to the Blood case, the Government commissioned a review of the consent provisions within the 1990 Act that recommended that section 28(6) of the Act should be amended to allow for a deceased father to be named on a birth certificate in circumstances similar to those of the Blood family (McLean 1998). In 2001, an attempt to change the law to give effect to these recommendations failed to complete its parliamentary passage before the general election was called. However a second attempt to introduce this legislation was more successful and the Human Fertilization and Embryology (Deceased Fathers) Bill received royal assent in September 2003.

Payment to donors was an established practice when the HFEA was set up. Under the 1990 Act payment to a donor may only be made if authorized by the HFEA (section 12 (c)). While the authority allowed existing centres to continue to pay donors a maximum of £15 in addition to the reimbursement of expenses, it made clear its objection to payment 'in principle', prohibiting new centres established since 1991 from paying donors, and planned to withdraw payment altogether (Human Fertilisation and Embryology Authority 1998). However, this was abandoned in the face of claims that removal of payment could undermine donor procedures; all centres are now allowed to pay donors up to £15 in addition to expenses (Deech 1998). This ruling does not preclude British citizens from receiving higher levels of remuneration in exchange for gametes and there is evidence that some young British women, motivated at least in part by student debt, have sold eggs to American agencies for between £3800 and £10,000 ('Julie' 2003; Quaintance 2002).

In consequence of its decision on payment to donors, the HFEA also authorized 'egg sharing' – a practice to which it was initially opposed, but which consultation showed enjoyed some measure of support (Blyth 2002a).

The 1990 Act permits surrogacy, with few limitations. Restriction of payment to 'reasonable' expenses arises only in respect of an application made by the commissioning parents for a parental order. Consequently, scrutiny of any payment made to the surrogate mother is undertaken only *after* the child's birth and the commissioning parents have *de facto* custody of the child (section 30). In practice, the 'reasonable expenses' model has effectively led to the development of a commercial surrogacy market. In 1998, a government review recommended both increased restrictions regarding the payment of expenses and the establishment of a new regulatory framework (Brazier *et al.* 1998). Although the government proposed further consultation on the review's recommendations, there has been no further government action and surrogacy continues relatively unchecked.

Funding of services

In the UK, assisted conception services are provided both by the publicly funded National Health Service (NHS) and private services. Neither the 1990 Act itself, nor any other legislation, mandates the provision of publicly funded assisted conception services, and research evidence consistently indicates regional variations both in the nature of NHS-funded assisted conception services and ineligibility for receipt of NHS-funded treatment (College of Health 1993; Kennelly and Reisel 1998; Stone and Reisel 1997; Wiles and Gordon 1994; Wiles and Oddos 1996; Wiles and Patel 1995). Centres providing NHS treatment are more likely than their private counterparts to operate a rationing policy and impose more restrictive eligibility criteria. In contrast, private centres may provide treatment to whomsoever they choose with virtual impunity (Bennett and Harris 2001; Brazier 1999; Levitt 2001). The considerable regional variability both in the level and range of publicly funded assisted conception services highlighted by these studies has been described as 'patently arbitrary and totally unethical' (Brown 2000, p. 268). Local health purchasing authorities within the NHS have been able to determine their own priorities. While most forms of treatment are funded under the NHS, some NHS purchasing authorities have determined not to fund assisted conception treatment at all; while others apply strict eligibility criteria relating to the age, sexual orientation and marital status of applicants and whether or not they already have a child. Self-evidently, these criteria will impact particularly on procedures using donor gametes or embryos. On the other hand, some surrogacy arrangements have been funded by the NHS (Foxcroft 1997). More than 75 per cent of people seeking assisted conception services self-fund their treatment (Deech undated; Kerr, Balen and Brown 1999), thus circumventing NHS waiting lists and eligibility criteria.

Decision-making about the end of treatment and the place of counselling

The Warnock Committee's recommendations that 'non-directional' counselling 'should be available to all "infertile couples" and third parties at any stage of the treatment' (Department of Health and Social Security 1984, para. 3.4, p.16) were largely incorporated within the 1990 Act, requiring that 'proper' counselling be made available to people considering treatment (section 13 (6)), those intending to be donors (Schedule 3 para. 3 (1) (a)) and to donor-conceived individuals seeking information about their genetic origins from the HFEA Register of Information (section 31 (3) (b); section 31 (6) (b)).

Prior to the implementation of the 1990 Act, much counselling in treatment centres was focused on treatment failure and was provided by medical and nursing staff who not only possessed no specialist counselling training, but who were also responsible for providing the (failed) treatment (Frew 1989). The government has endorsed a model of counselling that: 'should be distinct from discussions with a doctor of any medical treatment he [*sic*] proposes and should be carried out by somebody different, preferably a qualified counsellor' (Department of Health and Social Security 1987, para. 77, p.13).

However, the government also linked counselling with assessment for eligibility to treatment – albeit ambiguously (Department of Health and Social Security 1987, para. 78, p.13) and, during parliamentary passage of the Human Fertilisation and Embryology Bill, the potential role of counsellors in 'dissuading' some people from proceeding with treatment was identified (Mackay 1990).

Once legislation had been passed, and given that infertility counselling was not a developed specialty, the government commissioned the King's Fund Centre, an independent health-research organization, to assist the HFEA in defining the nature and role of 'proper counselling' (King's Fund Centre 1991).

The King's Fund Centre (1991, p.13) saw a clear role for counselling and the protection of the child's interests: 'In our view it will be impossible to separate the process of counselling from consideration of the welfare of the child'. The King's Fund Centre provided a mandate for counsellors to be involved in welfare assessments, and later research underscored their competence to do so:

> trained counsellors may well be more likely than the medical team to have the skills and knowledge to carry out a welfare assessment, and more likely to obtain a real understanding of the patient than the doctor could do in a fairly brief consultation. (Douglas 1993, p.67)

Despite promotion of the 'non-directive' model for counselling (Human Fertilisation and Embryology Authority 1991) and efforts to maintain a distinction between counselling and the process of assessing prospective treatment recipients or donors (Human Fertilisation and Embryology Authority 2001, para. 8.2, p.36), section 13 (5) meant that some mechanism had to be developed to enable the child's welfare to be taken into account. The *Code of Practice* advises: 'the views of all those at the centre who have been involved with the prospective parents should be taken into account when deciding whether or not to offer treatment' (Human Fertilisation and Embryology Authority 2001, para.3.25, p.18).

In addition to making suggestions about the nature, content and role of infertility counselling, the King's Fund Centre recommended that all licensed treatment centres should employ at least one person trained in infertility counselling and that a training programme should be instituted to ensure necessary expertise. In the event, the HFEA imposed less stringent demands, requiring licensed centres providing treatment to ensure that either 'at least one of its staff' held a recognized social work qualification, was a chartered psychologist or was a formally accredited counsellor, '*or that a person with such a qualification is available as an advisor* to counselling staff and as a counsellor to clients as required' (Human Fertilisation and Embryology Authority 1993, para. 1.10, p.5 – emphasis added).

The King's Fund Centre's modest targets for the introduction of specialized training and accreditation for infertility counsellors were not met. While a training and accreditation programme was subsequently developed and produced the 'first fully accredited infertility counsellors in the world' (Monach 2001, p.7), it did not do so until October 2001. Resource limitations have imposed significant restrictions on the pace of development of accreditation and at present, over a decade following the implementation of the 1990 Act, only a handful of infertility counsellors who, in the opinion of relevant professional bodies, possess the necessary experience and qualifications, will be offering a service in the UK. There is no time scale to ensure nationwide provision.

In recognition of the new accreditation programme, the HFEA modified its qualification requirements for counsellors in its most recently revised *Code* *of Practice* (Human Fertilisation and Embryology Authority 2001, para. 1.10, p.10), although in practice this still means that a suitably qualified counsellor as defined by the HFEA may never actually see a patient or donor, as they need only be 'available'.

In practice, the demands of providing 'independent' and 'non-directional' counselling, the counsellor's membership of the centre's multidisciplinary team and the need to take account of the welfare of the child continue to exert tension within the counsellor's role. Counsellors themselves are ambivalent about their role in assessment (e.g. Blyth and Hunt 1998; Williams and Irving 1998). Research studies have identified both the development of *de facto* compulsory counselling as an integral element of a centre's assessment processes, especially for certain social groups such as single women and lesbians, or for people seeking certain types of treatment such as donor conception, egg sharing and surrogacy, and the difficulty of making welfare assessments (Blyth 1995; Douglas and Young 1992). Finally, empirical evidence indicates low levels of uptake of counselling (Boivin, Scanlan and Walker 1999; Hernon *et al.* 1995; Kerr *et al.* 1999). When so few prospective donors and service recipients access counselling, the extent to which it can be seen 'as part of normal routine' remains questionable (Human Fertilisation and Embryology Authority 2001, para.8.5, p.36).

Availability of information about outcomes of third party assisted conception

The HFEA is required to maintain a record of licensed treatments, including a register of information containing details of donors of gametes and embryos used for the treatment of others, recipients of donated gametes or embryos and children born following donor treatments (section 31). In its annual reports published between 1992 and 2000, the HFEA provided statistical information about the outcome of IVF and donor treatments. This showed that, up to 31 March 1999, 15, 313 children had been born following DI, 2086 following egg donation and 450 following embryo donation. Progressively more detailed information has been produced by the HFEA, including live birth rates for treatment recipients at different ages and for different types of treatment; clinical pregnancy, live birth, multiple pregnancy and multiple birth rates for different types of treatment; gender of children born following regulated treatment; and developmental defects and syndromes in children born following licensed treatments. The HFEA also produces patient guides to centres offering IVF and DI that provide information concerning each centre's live birth rates for the treatments offered; live birth rate data are provided for all patients treated and separately for patients aged below 38 years. Other key treatment data include the number of patients offered treatment and the number of singleton, twin and triplet births.

'Technical problems [with] the quality of data for the period 2000–2001' meant that the HFEA's 2001 annual report did not include any outcome data, including outcomes for donor treatment (Human Fertilisation and Embryology Authority 2002, p.11). The HFEA has taken action to ensure the integrity of its database before providing further outcome data (Tellis 2003).

While the number of surrogacy births is not specifically recorded, the self-help group, Childlessness Overcome Through Surrogacy (COTS), claims knowledge of 435 births in the UK but estimates there have been at least 'another 200' (COTS 2002).

The 1990 Act generally preserves the anonymity of the donor (section 31 (5)), although a court could order disclosure of a donor's identity, either in the 'interests of justice' (section 34) or where a child conceived following donor treatment is born with a congenital disability (section 35). However, the Act does provide for a donor-conceived person to receive some information concerning his or her conception.

In order to reduce the risks of consanguinity, the Act permits an individual intending to marry to ascertain whether the register provides any evidence of a genetic relationship to his or her intended spouse (section 31 (6) (7)). (As the minimum age for marriage in the UK is 16, the earliest at which such information could be accessed is 2008.) An individual who has reached the age of 18 may enquire whether the register shows that his or her birth resulted from donor treatment (section 31 (3)). The Act also permits the government to issue regulations authorizing the disclosure of other information relating to the donor to an individual who was conceived following donor treatment and who has reached the age of 18 (section 31 (4)). While no regulations have yet been issued, in December 2001 the government instituted a consultation on whether – and, if so, what – any such information should be made available (Department of Health 2001). While this information could include the donor's identity, the Act specifically precludes retrospective disclosure of donor identity under the regulations (section 31 (5)).

In its consultation paper, the government provided a framework for future policy regarding access to information by inviting comments on whether non-identifying information should be made available; if so, what the nature of this information should be; whether identifying information should be made available; whether donors should be able to choose whether to be identifiable or not. Primarily because of the way in which the provisions of the 1990 Act determined the nature of this consultation, it did not discuss:

1. Access to any information that may be held by treatment centres that operated before implementation of the 1990 Act.
2. Obtaining further non-identifying information about donors.
3. Retrospective disclosure of the identity of an anonymous donor with the donor's consent.
4. Arrangements for people who may have half-siblings as a result of donor conception about whom they may wish to find out information.

To locate the current debate within its historical context, I will start with the Warnock Report. The Warnock Committee acknowledged that secrets could 'undermine the whole network of family relationships' and that it was 'wrong to deceive children about their origins' (Department of Health and Social Security 1984, p.21). However, the committee was also convinced that total anonymity should characterize the relationship between, on the one hand, the donor and, on the other, the recipient (and her partner if any) and any child, to protect the donor from parental liability for any child (without which too few men might be prepared to donate) and to 'minimis[e] the invasion of the third party into the family' (Department of Health and Social Security 1984, p.25). That the child might also benefit from donor anonymity was subsequently articulated by one committee member who wondered 'whether it was really in the child's interests to confront someone who had masturbated off as a donor' (cited in Haimes 1992, p.129). However, the committee recommended that, at the age of 18, a donor-conceived person should have a legal right of access to 'basic information about the donor's ethnic origins and genetic health' (Department of Health and Social Security 1984, p.24).

The 1990 Act generally supports the Warnock position. Efforts by some legislators to permit the disclosure of donor identity were discounted by assertions that it was in donor-conceived children's best interests not to know anything about the circumstances of their origins, that anonymity was supported by patients and that the removal of donor anonymity in Sweden in the 1980s had resulted in a reduction in donor recruitment (Primarolo 1990) – even though the information concerning Sweden was out of date and no longer accurate even then (Daniels and Lalos 1995; Gottlieb 2001; Jonsson 1988).

In the absence of any legislative specification of donor information to be collected for the register, determination of this has been left to the HFEA. Consideration of the welfare of donor-conceived people did not play any significant part in the HFEA deliberations. This information was perceived as:

> the *minimum necessary* to allow the Authority to answer questions from children born as a consequence of treatment services about their genetic backgrounds... Great importance was given in the design of the data collection system to *avoid unnecessary intrusion into the personal lives of patients and donors, and to avoid unnecessary cost to centres and to the Authority.* (Human Fertilisation and Embryology Authority 1992, p.23 – emphasis added)

Initially, the HFEA obtained information about the donor's height, weight, ethnic group, eye colour, hair colour, skin colour, occupation and interests and whether the donor has any children of her or his own. There was also provision for a donor to provide 'a brief description' of him- or herself that could be given to recipients and to any child subsequently born. In 1999, the HFEA changed the donor details it wished to record. Now, information about the donor's height or weight is not sought, but information about the donor's religion is requested. The HFEA has advised treatment centres to encourage donors: 'to provide as much...non-identifying biographical information about themselves as they wish, to be made available to prospective parents and any resulting child' (Human Fertilisation and Embryology Authority 2001, para. 4.4, p.20).

A small number of research studies have shown that the nature and quality of donor information collected by the HFEA, which provides the basis for any information that may subsequently be disclosed to a donor-conceived person, are variable (Abdalla, Shenfield and Latarche 1998; Blyth and Hunt 1998; Maclean and Maclean 1996).

Provisions for a donor-conceived individual to obtain information about his or her genetic origins stand in contrast to arrangements for an individual born as a result of a surrogacy arrangement and subject to a Parental Order. Here, the government applied a modified version of existing adoption procedures, which allow an adopted person access to his or her original birth record. A further anomaly arises from the different legal systems within the UK – in Scotland this information can be accessed when the applicant reaches the age of 16, but not until the age of 18 elsewhere in the UK. An applicant in Scotland is also able to access more information than other UK applicants (Douglas, Lavery and Plumtree 1998).

As in other countries, the debate on access to genetic origins information following donor-assisted conception has been hotly contested in the UK. Research evidence indicates that the majority of parents with children conceived following donor-assisted conception do not intend to tell their children about their origins (e.g. Cook *et al.* 1995). Notwithstanding this, a good proportion of these parents have told someone else, thus raising the possibility that the child may discover information about her or his origins from someone other than her or his parents – either deliberately or unintentionally (Golombok *et al.* 2002).

Some service providers and users have argued that removal of donor anonymity would adversely impact on donor recruitment and would, therefore, compromise service provision (e.g. British Fertility Society 2002; British Medical Association 2002).

However, both donor-conceived people themselves (e.g. Anonymous 2002; Gollancz 2001; Norton 2000; Priday 2000; Whipp 1998) and support groups for parents with donor-conceived children (Donor Conception Network 2001;[1] DI Network 1999/2000; Francis 2000; Hunter, Salter-Ling and Glover 2000) are demanding greater access to information, including the lifting of donor anonymity. While, as indicated above, the government consultation does not extend to provisions permitting donor-conceived adults to find out about any half-siblings, the possibility of a voluntary 'donor-sibling contact register' has been suggested by the mother of a donor-conceived child (Engel 2001; 2001/2002).

Key campaigners for the removal of donor anonymity include the HFEA (2002c) and Baroness Mary Warnock, who chaired the 1984 government Committee of Inquiry (Blyth 2002b). In the first attempt to judge views of the general public, over 80 per cent of respondents to a poll commissioned by the Children's Society, a leading British children's charity, said that donor-conceived people should have a statutory right to learn the identity of their donor (Children's Society 2002). In July 2002, an English High Court judge determined that the UK's Human Rights Act 1998 could be applied to donor-conceived people denied information about their genetic origins. While the case was adjourned pending conclusion of the government's consultation, the judge stated that the wishes of the two donor-conceived people who had brought the case to obtain information about their donor 'goes to the very heart of their identity' and was an essential element of 'private life' protected by the European Convention on Human Rights. He added:

> It is to my mind entirely understandable that AID children [*sic*] should wish to know about their origins and in particular to learn what they can about their biological father or, in the case, of egg donation, their biological mother…an AID child [*sic*] is entitled to establish a picture of his identity as much as anyone else (*Rose and Another* v. *Secretary of State for Health and Human Fertilisation and Embryology Authority* 2002).

In October 2002, in its review of progress on implementing the United Nations Convention on the Rights of the Child in the UK, the UN Committee on the Rights of the Child expressed concern about the lack of rights of donor-conceived people to know the identity of their donor (United Nations Committee on the Rights of the Child 2002, paras 31–32).

In January 2003, the government announced its initial response to the Department of Health consultation on donor information (Department of Health 2003). The government acknowledged 'a strong argument in principle for children conceived using donated sperm, eggs or embryos being able to find out the identity of their donor', but decided to defer a substantive decision on this matter for six months during which time it would seek more information from assisted conception units and donors in the UK, overseas jurisdictions that had removed donor anonymity and clinics overseas with experience of recruiting identifiable donors, to ascertain the potential impact on donor recruitment of the abolition of donor anonymity. The government also announced that it would commission a feasibility study regarding the possible establishment of a voluntary contact register to enable donor-conceived people conceived before implementation of the 1990 Act, their donors and any half-siblings to make contact with each other if they wish (UK Donor Link).

Conclusion

Policy on third party assisted conception in the UK is at a crucial stage of development. It remains to be seen whether the UK government will join the still-small, but increasing number of jurisdictions allowing donor-conceived people to learn the identity of the donor; whether other developments, such as a voluntary donor contact register will be promoted and, if so, what the impact of these might be. As is in many countries, there is still little empirical data about the experiences of families that have been created using donor gametes or embryos, although a small number of studies are in progress at the time of writing.

Note

1 The DI Network changed its title to 'Donor Conception Network' in 2000.

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CHAPTER 13

The United States of America

Regulation, Technology and the Marketplace

Eric Blyth with Jean Benward

Introduction

Since the late 1800s, it has been estimated that hundreds of thousands of children were born in the US following artificial donor insemination (DI). However, little is formally recorded about its practice. While one text was published in 1934 (Rohleder 1934), a search of relevant abstracts revealed fewer than two dozen articles on DI published prior to 1960.

The origins of third party assisted conception in the United States

The first known case of DI occurred in Philadelphia in 1884. Professor William Pancoast discussed with a class of medical students a married couple who wished to conceive a child; although the wife had no apparent pathology, her husband was azoospermic. A means of resolving the couple's dilemma by obtaining the services of a 'hired man' to impregnate the woman was proposed. Pancoast took a sperm sample from the 'best looking student in the class' and inseminated the woman while she was anaesthetized and without either her knowledge or consent. Although the husband was told of his wife's impregnation, she was never informed. The story remained a secret until 1909 when it was recounted in a medical journal by one of the students, Addison Hard, who reported that he had 'shake[en] the hand of the young man' who had been conceived as a result of the insemination, raising speculation that Hard himself had been that 'best looking student'(Daniels 1998; Gregoire and Mayer 1965). However, response to the controversial nature of this 'unorthodox medical procedure led to the reinforcement of a perceived need for discretion, particularly in those circumstances in which physicians resorted to an anonymous semen provider' (Novaes 1998, p. 110).

While DI continued to be practised on an increasing scale throughout the twentieth century, it was not until the 1980s that other forms of third party assisted conception became available. Holder (1988) reports that the first publicly recorded (genetic) surrogacy birth in modern times occurred in 1980, while the first successful use of gestational surrogacy was reported in 1985 (Utian *et al.*) culminating in a successful birth in April 1986 (Chargot and Flanigan). Since 1981, when the first baby in the US was born as a result of *in vitro* fertilization (IVF), the use of IVF and related procedures has continued to rise (Centers for Disease Control and Prevention 1999).

Access to assisted conception services

From the consumer's viewpoint, the greatest barrier to services has been economic. The median cost of an IVF cycle in 2001 was estimated at US$9226– excluding the cost of medication which can cost another US$2000– US$4000. Intra cytoplasmic sperm injection (ICSI) adds another US$2000, and use of an egg donor another US$5000 (Katz, Nachtigall and Showstock 2002).

Unlike some other countries, assisted conception in the US is not covered under a national health insurance programme, and all such services are provided on a fee-paying basis. Many American employers ensure health cover for their employees by means of health care insurance and other individuals may pay into personal insurance schemes. However, whether or not such coverage includes assisted conception services varies, so the highly technological, expensive procedures are only available to people with sufficient financial resources to pay for their treatment, i. e. primarily married, older, Caucasian, upper income patients (Katz *et al.* 2002). The costs mean that assisted conception is not an option for many – if not most – people who would wish to access such provision (VanVoorhis *et al.* 1987).

Mandated coverage for assisted conception remains controversial. The high cost of services (especially IVF) has given rise to programmes offering various financial options, the most controversial of which is the 'shared risk' plan under which the patient pays initially higher fees, with a 'warranty' of a refund if pregnancy is not achieved, and the programme keeping all fees if pregnancy does occur. The Ethics Committee of the professional body, the

American Society for Reproductive Medicine (ASRM), notes the potential risk of patient exploitation and concludes:

> great care is needed in their implementation to ensure that patients are fully aware of the advantages and disadvantages of shared risk programs, including the likelihood of success, the costs that are not covered, and the incentives that providers offering this plan have to take risks to assure success. (American Society for Reproductive Medicine 1998)

One of the sharper differences between practice in the US and that in other industrialized countries has been the relative absence of access criteria. While the ethics of providing services to women with no medically diagnosed impairment e.g. single women or postmenopausal women have been debated, there are no professional or legal regulations restricting access to such groups. Thus each provider can make their own decision. While historically DI was available only for married women, since the 1970s a growing number of single and lesbian women have sought to conceive through DI and their use of DI appears to have gained greater acceptance. According to published research, 9.5 per cent of doctors reported in 1979 that they would provide DI for unmarried women and by 1990 this figure was up to 35 per cent (Wendland, Byrn and Hill 1996), while there is no consensus about use of donor eggs for postmenopausal women.

Regulation of assisted conception practice

In the US, resolution of the legal ethical issues has been dealt with by courts on a case-by-case basis, through the interpretation of existing legislation and, less frequently, by enactment of new state and federal legislation. A variety of governmental and non-governmental bodies have issued papers, declarations, guidelines, standards and recommendations concerning both assisted conception in general and third party assisted conception in particular. Approximately two-thirds of states have legislation on DI and five have legislation on egg donation; these statutes existing primarily to ensure legal parentage for the recipients. In addition, the Uniform Parentage Act proposed by the American Law Institute defines the donor–recipient relationship in assisted conception, guarantees donor anonymity and establishes donors' rights and obligations; this act has been adopted by 19 states.

Various reasons for the absence of state and federal legislation have been advanced. Havins and Dalessio (1999) cite the speed at which technologies develop and the difficulty for legislation to keep pace with technological developments; the 'entrepreneurial spirit' of American medicine (i.e. assertions of independence from government control) and the emphasis on the primacy of the individual and personal autonomy in American culture; historical distrust of government that some believe is central to American identity (Wills 1999) and the absence of a health care payment system. Stenger (1995) has also commented on the pervasive and divisive debate in the US on abortion and its association with aspects of reproductive technology and assisted conception procedures.

The absence of federal legislation, and the fact that some states have introduced legislation while most have not, has led to a patchwork of variable regulatory procedures and inter-state differences. It is beyond the scope of this chapter to consider in detail these regulatory differences for the entire country; nevertheless broad trends will be discussed.

In 1992 the federal government passed the Fertility Clinic Success Rate and Certification Act, requiring clinic-specific reporting of IVF cycles and outcomes. ASRM has worked closely with the National Center for Disease Control (CDC) since 1995 to produce annual reports that contain details of annual pregnancy and birth outcomes resulting from 'all fertility treatments in which both eggs and sperm are handled', i.e. IVF, ICSI, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT), provided by centres and individual physicians listed by the Society for Assisted Reproductive Technology (National Center for Disease Control 2002). Crucially for the purposes of this discussion, these outcome data do not include DI, so the official statistics do not reveal the full incidence of third party assisted conception in the US. The latest report includes outcome data for services provided in 2000 from 383 centres nationwide (National Center for Disease Control 2002) which the CDC believes is a near-complete record of all centres providing such services nationwide. Eighty-seven per cent of centres offered donor egg procedures, 54 per cent offered donor embryo procedures and 65 per cent offered 'gestational carrier' (gestational surrogacy) procedures. Eighty-four per cent provided a service to single women. Of the recorded 99,639 treatment cycles performed during 2000, 10,389 (10 per cent) involved donated eggs or embryos and 1210 (1 per cent) involved a gestational surrogacy arrangement. There were, in total, 25,228 births (i.e. deliveries of one or more living babies) and 35,025 babies. Further key data relating to donor procedures indicate that older women are more likely than younger women to undergo donor egg procedures: few women under the age of 39 undergo donor egg procedures, while among women aged over 46, more than 70 per cent of treatment cycles used donor eggs.

In January 2003 a new rule issued by the federal Food and Drug Administration (FDA) came into force, requiring all 'manufacturers' of human cells, tissues and cellular and tissue-based products to register with the FDA and to provide a list of products 'manufactured' (66 Fed Reg. 5447 (19 January 2001)). The FDA indicated that this rule would apply to establishments engaged in egg donation, retrieval, semen processing and IVF, since it defined 'manufacture' to include tissue recovery, processing, storage, labelling, packaging, distribution activities and tissue donor screening and testing (i.e. for communicable disease agents) (Genetics and Public Policy Centre 2002).

In the absence of requirements to record DI outcomes no-one knows exactly how many DI-conceived individuals exist in the US and 'best-guess' estimates suggest that between 30,000 and 80,000 donor-conceived children are born annually (Ford 2000). Similarly, there are no requirements to record the number of children born as a result of genetic surrogacy arrangements. According to Hanafin (1999) the first contractual surrogacy case occurred in the US in 1977 and by 1997 there had been 6000 births to surrogate mothers.

Egg donation was practised initially in a few academic settings in the 1980s and limited in its application primarily to women with premature ovarian failure. With the advent of embryo freezing techniques and vaginal aspiration of eggs, egg donation has become a standard part of assisted conception services (Sauer 1997a). Starting with 122 egg donor births in 1990 (Benward 1994) there were 3491 births in 2000 (National Center for Disease Control 2002). Ten and a half per cent of all IVF cycles involve embryo transfer with donor eggs. While anonymous egg donation is the norm, many programmes now recruit known donors.

Remuneration of gamete donors

In contrast to most other countries where donor conception is practised, the US has promoted a model of donor remuneration. This distinction is not unique to gamete donation, since blood and plasma donors are also remunerated, and the linkage between paying blood donors and paying gamete donors has been noted in contemporary debates (see, for example, Sauer 1997b). In the case of DI, the origins of donor payment appear to be lost in the shrouds of history:

> In the USA, men have always been paid to provide gametes. A lucrative industry has been built around sperm banking and has existed for decades, largely unquestioned. (Sauer 1997b, p.1844)

Currently, the ASRM notes:

> payment to donors varies from area to area, but should not be such that the monetary incentive is the primary motivation in donating sperm. However, the donor may be compensated for his time and expenses. (ASRM 2002, p.S5)

The origins of payment to egg donors, on the other hand, have been pinpointed with a greater measure of accuracy. Sauer (1997c) claims that this originally arose from a 'research' trial in California in 1984 in which women were remunerated $250 for undergoing uterine lavage.

While remuneration in sperm donation has generally been taken for granted, the requirements of egg donation have presented additional ethical concerns. Since clinical experience indicates that, to a large extent, successful outcomes of egg donation are more closely linked to the age of the donor than to the recipient (Toner, Grainger and Frasier 2002), there are obvious advantages in recruiting 'young' donors. In addition, the requirements of egg donation, involving intrusive and demanding pharmacological and surgical regimens and potential health and psychological risks, mean that recruitment of altruistic donors is incapable of keeping up with potential demand. Egg sharing is not widely available, especially as large egg donation programmes are able to recruit paid donors. Reasons given for this include: patient preference for cryopreservation, the possibility of compromised fertility and potentially adverse psychological consequences for the donor (Moomjy *et al.* 2000).

Advocates of donor remuneration have suggested that without a scheme of remuneration, the resultant shortage of donors could mean that some people may simply not get a service; services will be subjected to long waiting lists; some people may seek unregulated services, possibly in other countries that may have fewer safeguards, thus placing themselves and any child at risk; and that service quality may be impaired by compromised matches (Sauer 1997b, 1997c).

While the issues of commercialization and exploitation are not unique to gamete donation and have plagued adoption practice for some time as well, it is important to note that there has grown up a considerable market in egg donation and increasingly lucrative levels of reimbursement to donors (although whether these adequately reflect the level of risk – and how monetary value can be put on such risk – is a moot point). In any event, the reimbursement of egg donors is generally supported within the US on the grounds of the complexity of the process (Lindheim, Frumovitz and Sauer 1998); the effort expended by the donor (American Society for Reproductive Medicine 2000); the risk to the donor (American Fertility Society 1993; American Society for Reproductive Medicine 2000; Lindheim *et al.* 1998); the inconvenience (American Fertility Society 1993), discomfort (American Fertility Society 1993) and pain (American Society for Reproductive Medicine 2000) experienced by the donor; and the donor's time (American Fertility Society 1993; American Society for Reproductive Medicine 2000; Lindheim *et al.* 1998). This is not, however, to advocate a 'free-for-all' market in egg procurement. Payment should not discriminate against lower income women (American Society for Reproductive Medicine 2000). Neither should it be a primary reason for donation (American Fertility Society 1993), nor coercive or exploitative (American Society for Reproductive Medicine 2000). In 1998, Klock proposed a price limit on non-coercive remuneration for egg donors, suggesting that 'amounts above $3000 may be viewed as coercive'. The ASRM notes:

> Monetary compensation of the donor should reflect the time, inconvenience and physical and emotional demands and risks associated with oocyte donation and should be at a level that minimizes the possibility of undue inducement of donors and the suggestion that the payment is for the oocytes themselves. (American Society for Reproductive Medicine 2002 p.S8)

Increasing demand for eggs, though, coinciding with extrinsic factors, such as students experiencing large loan debts (Shanley 2001), means that university and college students – many of whom will not have had prior experience of either pregnancy or childbirth – are now routinely targeted by agencies offering differential levels of remuneration dependent on particular physical, intellectual and racial characteristics.

While the implications of remuneration for donors have been debated, interest in the potential implications for people born following remunerated donor conception has been virtually non-existent. Suzanne Rubin, one of the first donor-conceived individuals to make public her thoughts about her conception, expresses her concern about the 'commodification' of donor conception:

> How do I reconcile my sense of integrity with knowing that my father sold what was the essence of my life for $25 to a total stranger… What kind of man sells himself and his child so cheaply and so easily? (Rubin 1983, p.214)

While Rubin's question may invite the rejoinder that donors should simply charge, or be paid, more and, by extension, that particularly desirable attributes should command a greater price, Shanley (2001) challenges the concept of differential pricing of gametes since this may impact invidiously on children. They may bear a lifelong burden of wondering what they 'cost' compared to other children and spend the rest of their lives demonstrating that they were worth the price their parents paid for them.

Surrogacy arrangements

It is difficult to obtain an accurate picture of the practice of surrogacy in the US, since instances of gestational surrogacy only are formally reported. Gestational surrogacy accounted for 1.2 per cent (1210) of all IVF cycles in 2000 (National Center for Disease Control and Prevention 2002). When outcomes for 'gestational carrier' and 'non-gestational carrier' procedures are compared, for all forms of procedure reported, cycles involving a 'gestational carrier' had higher success rates than cycles that did not. Fewer than half of reporting clinics perform gestational carrier cycles (166) and two-thirds of those were performed by just 34 clinics located in ten states. In other words, 8 percent of the clinics perform the majority of the cycles. It would appear that surrogacy arrangements represent a small percentage of assisted conception services, and that many clinics either do not perform gestational surrogacy or to do so only in small numbers. Over half of the centres providing gestational surrogacy (18) were located in a single state, California. This in part reflects the relatively favourable legal environment for surrogacy in California.

According to Hamilton (2003), the number of gestational surrogacy cases has doubled since 1997 and accounts for 95 per cent of all surrogacy situations. Estimates of the total cost of surrogacy range up to US$65,000 which includes the IVF cycle, medical bills and US$20,000–US$25,000 in payment to the surrogate mother; the remainder covers other medical, legal and agency fees.

While, as previously indicated, surrogacy is permitted within the US, there are widespread inter-state differences. ASRM (1994) considers that the major issue posed by surrogacy is 'not so much the morality of an innovative reproductive technology as to the possible exploitation of women' (p.70S) and has expressed specific concerns about the potential exploitation of surrogate mothers and couples by professionals acting as brokers (p.68S).

In contrast to other forms of third party assisted conception, nearly half of the states have legislation relating to surrogacy. Some states specifically criminalize participation in a surrogacy arrangement and/or brokering activities; some states expressly permit commercial surrogacy; some states expressly permit altruistic surrogacy only, and others permit the payment of liberally-defined expenses (while proscribing overt payment to surrogate mothers).

In states where commercial surrogacy is permitted, some IVF programmes recruit their own surrogates. More commonly, in California for example, agencies that are independent of assisted conception units advertise for, recruit and undertake psychosocial screening of surrogates. There is also an increasing number of couples and surrogates advertising on the internet who meet each other, without the benefit of the involvement of either an agency or IVF clinic.

While, for the most part, surrogacy arrangements appear to proceed as planned, with the surrogate mother relinquishing the child to the commissioning parents, there have been some (usually highly publicized) instances where initial agreements have not been kept – and surrogacy remains controversial (see, for example, Bartels *et al.* 1990; Ragoné, 1994).

There has been very little research on surrogacy arrangements in the US (as is also the case in other countries). Much of what has been undertaken has concerned itself with the assessment and motivation of surrogate mothers involved with commercial agencies (Fischer and Gillman 1991; Franks 1981; Hanafin 1987; Macphee and Forest 1990; Parker 1983). In contrast, there has been limited research on the experiences of surrogacy arrangements for commissioning parents or on children born as a result of surrogacy arrangements (for an exception see Serafini 2001 – although this evaluation is restricted to medical and physical health outcomes only). There have been a few follow-up up studies of surrogate mothers that have found that generally they do not regret their involvement in surrogacy. One study indicated that the relationship with the intended parents was a critical factor in long-term satisfaction (Hanafin 1999).

Embryo 'adoption'

Widespread publicity given to the theft of embryos from the internationally-renowned Center for Reproductive Health in California (see Heisel 2001) highlighted the existence of large numbers of cryopreserved embryos that were no longer required by the people who had placed them in storage or where contact with these people had been lost. Embryo donation is offered by a majority of IVF programmes although it appears that only a minority of programmes have actually performed embryo donation cycles. Only 28 per cent of programmes required donating couples to have a psychological consultation with a mental health professional (Kingsberg, Applegarth and Janata 2000).

The fact that the terms embryo 'donation' (as used in many other countries) and embryo 'adoption' are used interchangeably in the US, serves to underline the controversial nature of embryo donation currently, with the Bush administration supportive of pressure to assign to the embryo the status of personhood. In July 2002 a Federal Funding Initiative (Federal Register 2002) was announced, allocating nearly US$1 million funding 'for public awareness campaigns on embryo *adoption*' (emphasis added) and two states (Massachusetts and New Jersey) have drafted 'embryo adoption' legislation:

> Abortion rights advocates worry that the program lays the legal groundwork for considering embryos human beings with full legal rights. Using the term 'adoption' rather than 'donation' makes it appear that the program views embryos as children, said Kate Michelman, president of the National Abortion and Reproductive Rights Action League. (Meckler 2002)

In the same article, Meckler notes that Nightlight Christian Adoptions plans to apply for one of the grants. Its embryo programme, called Snowflakes, has produced 18 babies, with five women pregnant now:

> Officials there are thrilled by the opportunity to promote their philosophy with federal dollars. 'I believe every embryo is a child that deserves a chance to be born,' said JoAnn Eiman, a spokeswoman for Snowflakes. 'This is more than mere tissue. They need an option they haven't had in the past'. (Meckler 2002)

On the other hand, RESOLVE (the major infertility patient support group in the US) and others have sought to make a distinction between embryo donation and adoption and for embryo donation to be treated in the same way as gamete donation.

Donor information

While several countries since the 1980s have debated and/or created donor registries, until recently relatively little attention was given to this issue in the US and there is no federal legislation mandating the recording of donor information (Benward 1998). Although ASRM has no stated position on the creation of a registry, it has recommended that:

> [i]t is highly desirable to maintain permanent confidential records of donors, including a genetic workup and other non-identifying information, and to make the anonymous record available on request to the recipient and/or any resulting offspring. (American Fertility Society 1993)

In 1994, the Ethics Committee of ASRM stated there was '…an ethical obligation…to retain some means for recontacting donors and providing medical follow-up' (ASRM 1994, p.15S), and in 2002 ASRM recommended that '[a] mechanism must exist to maintain [embryo donation] records as a future medical resource for any offspring produced' (ASRM 2002 p. S10). Recent research indicates that the majority of clinics plan to keep their donor records permanently and that the majority of practitioners responding felt that legislative mandate of this was appropriate (Braverman, Benward and Scheib 2002).

The driving force behind the collation of donor information has come from a growing number of private for-profit organizations offering donor or surrogacy services and as sperm banks have become the preferred source of donor sperm, rather than doctors recruiting their own donors; therefore more detailed records have been kept (Benward 1998). Such organizations provide potential recipients with donor profiles, including baby photos, written pen-portraits, audio and video interviews – and information available from the internet (see, for example, California Cryobank Inc undated; Center for Surrogate Parenting and Egg Donation for egg donation; Xytex Corporation 2000 for DI). Alongside this general development, an increasing number of programmes are recruiting identifiable donors. While much of the drive for pretreatment donor information has come from recipients of donated gametes and embryos, the recruitment of identifiable donors is focused on the interests of donor-conceived people. It is they, and not their parents, who will be able to obtain details of the donor's identity. Pioneers in this area have been the Sperm Bank of California (Raboy 1993; Scheib, Riordan and Rubin 2003; Scheib, Riordan and Shaver 2000), California Cryobank (California Cryobank Inc undated) and Xytex Corporation (Xytex Corporation 2000). However, different models of identifiable donors have been developed. The Sperm Bank of California, for example, specifically requests donors at the time of donation to indicate their willingness to be identified to any offspring once he or she reaches 18. California Cryobank operates an 'openness policy' based on a presumption that neither a donor nor a recipient of donor sperm should be asked at the point of donation or insemination whether to commit to a decision about disclosure to any child. Rather, 'when a child is age 18 or older, if he or she request additional information about the genetic father, we will make all reasonable efforts to supply that information' (California Cryobank Inc undated, p.6). The difference between the two models, of course, is that the Sperm Bank of California system offers a greater likelihood that a donor-conceived adult wishing to learn the identity of his or her donor will be able to do so. Recently, other sperm banks have begun to use donors whose identity will be available to the offspring at age 18 (Xytex; New England Cryogenic Center). While most donor egg programmes practise anonymous donation, independent egg donor recruitment agencies will facilitate contact between donor and recipient when this has been mutually agreed (see, for example, Center for Surrogate Parenting and Egg Donation).

Research on the intentions of recipients of donor gametes towards disclosure indicates that where more information is generally available about either anonymous or identifiable donors and where programme policy encourages openness, recipients are more likely to disclose or indicate an intention to disclose to their child the nature of his or conception. Klock, Jacob and Maier (1996) and Nachtigall *et al.* (1998) give figures ranging between 20 and 30 per cent (with a further 10 to 15 per cent remaining undecided), while Braverman and Corson (1995) found that 72 per cent of female DI recipients favoured disclosure. As has been found elsewhere (see, for example, Brewaeys *et al.* 1993) lesbians and single women are more likely to disclose recourse to donor conception than heterosexual recipients (Jacob, Klock and Maier 1999; Klock *et al.* 1996; Leiblum, Palmer and Spector 1995; Scheib *et al.* 2003; Wendland, Byrn and Hill 1996). However, heterosexual DI recipients at the Sperm Bank of California appear much more likely to disclose than heterosexual DI recipients in other studies (Nachtigall *et al.* 1998; Scheib *et al.* 2000; Scheib *et al.* 2003).

The Sperm Bank of California's policy is perceived as an instrumental factor in promoting disclosure: 'The identity-release program probably encourages parents to be open about DI since they will be able to offer their children the option of more access to information about the donor' (Scheib 2002).

In the absence of any registry for past donations, a nationwide Sibling Registry of children conceived following anonymous sperm, egg or embryo donation, has been established by a self-help group, Single Mothers by Choice (undated), after several mothers in SMC coincidentally learned that they had used the same donor and that their children were half-siblings. This registry is open to any parent and donor-conceived person aged over 18 to enable them to locate other children conceived with the same donor using the name of the clinic at which donations were made and donor ID numbers. It is reported that approximately 10 per cent of those who have registered have found a match.

Mental health professionals and professional body guidance

From their beginnings in IVF clinics counselling pretreatment patients, the role and responsibilities of the mental health professional have grown. There appears to be general recognition of the importance of incorporating mental health counsellors into assisted conception practice and of counselling patients and donors about the psychosocial implications of assisted conception and gamete donation. Mental health counselling, in part because of the absence of a central legislative body, is not required and the existence of psychosocial services is not part of the accreditation review process for assisted conception units. Mental health professionals, however, have been welcomed into the ASRM where they participate in the influential Ethics Committee and the SART (Society for Assisted Reproduction, which represents all IVF clinics) Education Committee, as well as having their own special interest group which provides symposia papers and cross-disciplinary seminars at the annual ASRM meeting.

Additionally, ASRM has produced several statements regarding third party assisted conception – including on ethical issues – dealing with sperm donation (American Society for Reproductive Medicine 1994, 2002); egg donation (American Society for Reproductive Medicine 1994, 2000, 2002); egg donation to postmenopausal women (American Society for Reproductive Medicine 1997); psychological assessment of gamete donors and recipients (American Society for Reproductive Medicine 2002); embryo donation (American Society for Reproductive Medicine 1994); psychological guidelines for embryo donation (American Society for Reproductive Medicine 2002); surrogacy arrangements (American Society for Reproductive Medicine 1994); posthumous conception (American Society for Reproductive Medicine 1997) and use of foetal tissue (American Society for Reproductive Medicine 1997). It should be noted that these are seen as a model of good practice for ASRM members rather than obligatory codes of practice with sanctions for non-compliance.

ASRM accepts the use of DI for a range of male factors and for women without a male partner (American Society for Reproductive Medicine 2002 p.S2) and recommends a limit of ten offspring per donor (American Society for Reproductive Medicine 1994). Donor screening is mandated and psychological evaluation and counselling by a qualified mental health professional are recommended. Psychological consultation should be required for individuals in whom there appear to be factors that warrant further evaluation (American Society for Reproductive Medicine 2002).

In the case of 'directed donation' (i.e. non-anonymous or known), psychological evaluation and counselling are strongly recommended for the donor and any partner, and well to the recipient(s). Issues such as the potential impact of the relationship between the donor and the recipient(s) should be explored. Psychological assessment should also address the potential psychological risks and evaluate for evidence of emotional or financial coercion. It is also important to ascertain the donor's knowledge and understanding of the degree of intended disclosure and any plans for future contact. (American Society for Reproductive Medicine 2002 p.S3). Many assisted conception centres advertise comprehensive donor evaluation procedures; for instance, California Cryobank Inc (undated) emphasizes in promotional material that only 5 per cent of the donors applying to its programme are accepted. While donor anonymity in sperm donation is accepted as the general rule, ASRM accepts the principle of mutually-agreed 'directed donation' (American Society for Reproductive Medicine 2002, p.S3). For egg donation ASRM accepts the use of known donors in the light of 'pragmatic considerations such as the difficulty in recruiting suitable donors' (American Society for Reproductive Medicine 2002, p.S7). Where known donation is contemplated 'the potential impact of the relationship between donor and recipient should be explored' (American Society for Reproductive Medicine

2002, p.S7). Where egg donation within kin and friendship networks is contemplated, ASRM notes the risk of 'overt or covert undue pressure to provide a donation because of familial or societal relationship' (American Society for Reproductive Medicine 1994, p.47S). Recipients of donor gametes should receive counselling about the psychological implications (American Society for Reproductive Medicine 2002, p.S11) and psychological counselling should be offered to the recipient by the physician and should 'require psychological consultation for couples in whom factors appear to warrant further evaluation' (American Society for Reproductive Medicine 2002, p.S3). ASRM discourages, although does not prohibit, the provision of egg donation to postmenopausal women. It considers that: 'Infertility should remain the natural characteristic of menopause. Because of this and the physical and psychological risks involved, post-menopausal pregnancy should be discouraged' (1997, p.3S). Where it is contemplated 'prospective parents and their treating physicians must carefully consider the specifics of each case before using oocyte donation, including the woman's health, medical and genetic risks, and the provisions for child-rearing.' (American Society for Reproductive Medicine 1997, p.3S). ASRM recognizes that, technically, posthumous reproduction is little different to routine cryopreservation and insemination, although 'the social issues are complex' (American Society for Reproductive Medicine 1997, p.3S). If posthumous reproduction is contemplated, practitioners must ensure full disclosure to all parties to ascertain that all appropriate consents are obtained and to ensure adequate screening and counselling (American Society for Reproductive Medicine 1997, p.3S). ASRM has taken a stronger line with the use of foetal tissue, noting that there are a variety of ethical and psychosocial concerns about its use in assisted conception. Given an 'absence of a current compelling need for fetal ooctyes...use of fetal oocytes for oocyte donation should not be pursued' (American Society for Reproductive Medicine 1997, p.3S).

Conclusion

By virtue of its size and wealth, the US will continue to be at the forefront of technological developments in assisted conception, an impact that will be felt beyond its geographical boundaries. In aspects of third party assisted conception, too, it will continue to influence debates internationally, notably concerning the remuneration of donors and overseas recruitment of donors (see, for example, Blyth and Haase in this volume), the status of the embryo and embryo donation.

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Summary and Conclusions

Ruth Landau and Eric Blyth

Many forms of donor-assisted conception and genetic surrogacy derive from comparatively recent advances in biotechnology. By their very nature these advances open up new options for humankind, while at the same time challenging our thinking about family, one of the most fundamental institutions of society. Family and marriage are perceived as the basic mechanisms for the care of and socialization of future generations, and their centrality has been widely documented in anthropological studies. In the past, the identity of a child's father may have been questionable. However, until the advent of the new reproductive technologies, particularly *in vitro* fertilization (IVF), there were no doubts about the identity of the mother. Nowadays, biotechnology enables genetic, biological, social and legal parentage to be shared by a number of individuals and a variety of new family forms are acquiring more legitimacy.

Consequently, one might assume that third party assisted conception would be approved by society as the ultimate means of forming a family for those individuals and couples with no other alternative due to infertility, or because this means is their preferred choice. The chapters of this volume, representing a variety of societies from all five continents, demonstrate clearly that this is not the case. Third party assisted conception generally, and particularly some of the techniques it offers, are received quite differently in different countries. As would be expected, the values of family, marriage and the child's well-being emerge as the most important core values in all the societies described in this book. However, these values are quite diversely reflected in the legislation and regulation of third party assisted conception. In each country, the debate on issues pertaining to the various means of third party assisted conception focuses on factors historically central to that society.

By definition, 'third party' assisted conception involves individuals other than the potential mother or parents in the process of fertilization or pregnancy. In all donor procedures, as well as in the case of gestational surrogacy, where the child will be brought up by two intended parents, at least one of these is genetically unrelated to the child thus conceived. In most cases of donor conception the donors were unknown to the potential parents before the medical intervention and their identity frequently remains secret and inaccessible after the child's birth.

The importance attached to the right to know one's genetic origins is an appropriate example for demonstrating how the basic values of a society, its historical roots, economic situation and geo-political situation may lead to different approaches and policies concerning third party assisted conception, as reflected in the various chapters in this book. For example, in New Zealand, due to the relatively small population and because of a political treaty with the indigenous Maori made in 1840, the need for protecting the means by which individuals establish descent from their ancestors has resulted in a policy favouring unconstrained access to information identifying the genetic parents of children born as a result of fertility treatments. In Hong Kong, however, the same strong belief in intergenerational family and blood ties rooted in traditional Chinese culture results in extremely low acceptance of any form of third party assisted conception. Similarly, Argentina and Poland have relatively low incidence of third party assisted conception due to the strong impact of the Roman Catholic Church, which regards all methods of assisted conception as immoral, and thus there is little debate on the right to know one's genetic origins. In Germany, on the other hand, the shadows of recent history influence the current policy that bans all forms of third party assisted conception, except artificial donor insemination (DI), which is also shrouded in secrecy. In contrast, in Israel, despite its pro-natal policy and record high rate of assisted conception births, there is no public debate on the issue of an individual's right to information about their genetic origins and no mechanisms assure the availability of such information.

The countries reviewed in this volume can be divided into either permissive or restrictive in their approaches toward third party assisted conception. The more permissive countries tend to be so regarding most assisted conception procedures, whereas countries with a less permissive approach tend to be more restrictive with regard to most of the techniques in fertility treatment. Donor insemination is the most prevalent method of third party assisted conception, while surrogacy and posthumous conception are the most controversial. An important exception is South Africa, which – due to a variety of pressing health issues such as HIV/AIDS, malnutrition, teenage pregnancy, rape, violence and child abuse – does not view infertility in general, and third party assisted conception in particular, as a priority at all. It seems likely that many other developing countries may perceive third party assisted conception as a luxury restricted to the rich; their leaders instead facing issues of overpopulation and poverty.

The themes dealt with in this book focus on the issues of availability and accessibility of third party assisted conception procedures; donor anonymity and secrecy versus openness about genetic origins of offspring; commercialization of genetic material and reproductive tourism; and counselling. The information included in this book reflects the situation as it was mid-2003.

Availability and accessibility of third party assisted conception treatments

While the chapters on Australia and New Zealand emphasize the pioneering practices and polices promoting disclosure of the offspring's genetic origins, they also implicitly reveal that DI, IVF utilizing sperm donation and/or egg donation are generally available in both countries. Altruistic surrogacy is currently also available in both New Zealand and in some Australian states, although it is not permitted on a commercial basis. Where evidence is available, this shows a reduction in demand for sperm donors during the last decade.

The Finnish national health care system funds fertility treatments, including those that involve third parties, resulting in fertility services being relatively very accessibile. Yet, waiting lists are common and there are limits of age – below 40 years for women – and on single and lesbian women, as well as a limit of a maximum five IVF cycles per couple.

In the absence of public policy and regulation, the different forms of third party assisted conception are not prohibited in Canada. However, both limited funding by the federal government and the Provinces and Canada's vast geographic size create a barrier to the accessibility of fertility services. In Ontario IVF is funded by the government, but only up to three complete treatment cycles, and this only for women with a diagnosis of complete tubal blockage. While funding for IVF is very limited, the Ontario government is ready to fund DI. That is, government funding policies may actually encourage couples with male infertility to forgo attempting to achieve a child related genetically to both parents (with IVF and intra cytoplasmic sperm injection (ICSI)). Similarly, due to the extensive screening requirements for donor semen in Canada, Canadian clinics have increased their reliance on commercial American sperm banks and have limited recruitment of Canadian sperm donors.

Egg donation and surrogacy arrangements are completely prohibited in Germany as is DI for single and lesbian women. The German health care system reimburses assisted conception only when a married couple uses their own gametes. Hong Kong follows a similar approach toward third party assisted conception. Interestingly, though, while third party assisted conception is allowed only for married couples, singles are permitted to donate gametes or enter surrogacy arrangements, even though commercial surrogacy is prohibited. In Singapore, surrogacy, egg donation and postmenopausal pregnancy are not permitted. Assisted conception services are to be provided only to married infertile couples and each woman may undergo only a maximum of ten IVF cycles. Singapore has a unique system of recruiting sperm donors based on altruistic volunteers instead of commercial sperm banks. Childless couples are requested to ask men to donate sperm to be used by another couple not known to the exchange donor. Consequently, the number of sperm donations is equal to the number of needed donations and since each sperm donor probably donates only once in his lifetime, the risk of incest is very low.

In South Africa, as already noted, infertility is not seen as a priority area and the government does not fund fertility treatment. Although singles and couples in same sex relationships are not formally given access to fertility treatments, in practice patients are not requested to show marriage licenses. In Poland, the role of the Church in the lives of the Polish population and the economic situation of the country seem to result in a more restrictive approach. In Argentina, the strong impact of the Roman Catholic Church and the fact that Argentine law does not recognize infertility as a disease explain its lack of financial coverage for assisted reproduction-related procedures.

The law in the UK permits the provision of a wide range of assisted conception services, including sperm, egg and embryo donation, and both genetic and gestational surrogacy. These services are offered both by the publicly funded health care system and privately. Nevertheless, the national health system operates a rationing policy that varies from one region to another, thus creating inequality in accessibility to third party assisted conception services. In the US, all forms of third party assisted conception are generally available, although there is inequality of access due to the severe constraints stemming from the dictates of the free market economy.

In contrast to a number of countries examined here, in Israel all strata of the population, including all women up to the age of 51, have unlimited access to third party assisted conception services using their own or donated eggs. All forms of fertility services are fully funded by the public health care system up to the birth of two living children. Accessibility to third party assisted conception is mainly limited by the supply of egg donations.

In summary, the international perspectives presented in this book show that a country's prevalent belief systems determine whether parenthood may be achieved as a result of authentic free choice, external constraints or perhaps social pressure. While accessibility to third party assisted conception services for individuals of different marital status, age or sexual preference is apparently more liberal in some countries than in others, and access to some of the methods of third party assisted conception may be more restrictive than in others; even in the most liberal country, such as the US, the potential parent's financial situation emerges as the major barrier to the desired parenthood.

Donor anonymity and secrecy versus openness concerning the genetic origins of the offspring – current situation

In third party assisted conception, the conceived child is the one who ultimately faces the consequences of the circumstances of her or his conception and birth. While this is true for all children, still we believe that there are some basic differences when a child is naturally conceived and when (s)he is carefully planned and conceived with the assistance of the medical profession and other individuals, who either donated genetic material or were involved in the process of surrogacy. All countries surveyed in the analysis here apparently attach considerable importance to the well-being of children resulting from assisted conception. Yet, the legislation and regulations in each country are different.

The Family Law Council of Australia addressed this issue as early as 1985 (see Szoke in this volume):

> Given that the major purpose of reproductive technology is to create a child who would not otherwise have been conceived, and that a substantial allocation of public resources is required to enable this, it seems clear that the community has a particular responsibility to promote and protect the interests, needs and welfare of that child when born. (Family Law Council, 1985, p.11)

The question as to whether children born as a result of the successful use of donor gametes should have access to information about their origin was already perceived as paramount in 1984 in the state of Victoria in Australia. Legislation in this year required that a central register be established to give information about persons born following third party assisted conception. This has become one of the most comprehensive statutory protections of the interests of donor offspring in the world. The revised statute from 1995 provides offspring with the right to access identifying information, if they so choose, at the age of 18 years. While South and Western Australia are following Victoria's example, the other Australian states have not yet made specific statutory protections. Most remarkable is the establishment in Victoria, and now Western Australia and the UK also, of a voluntary contact register enabling both donors and offspring to leave messages and stipulate conditions under which personal information can be released. Although we do not yet know the likelihood of parents in Australia disclosing birth origins to their children, it is noteworthy that men who donated sperm three decades ago are now applying to the register in Victoria.

In New Zealand too, children's rights and needs have always been central in any consideration of new assisted conception procedures, with the debate not just focusing on the infertile couple or individual. The legislation proposed for dealing with this issue reflects the positive approach toward openness regarding one's genetic origins. A recently proposed Bill stipulates the establishment of a national register of information for those involved in third party assisted conception with provisions ensuring access to this information. In recent years, because most clinics in New Zealand have only recruited donors prepared to be identified, many offspring will indeed have access to information on their genetic background via the clinics. Where donors are recruited personally by infertile individuals and couples, the issue of secrecy and anonymity is irrelevant.

According to UK law, the UK Human Fertilisation and Embryology Authority is required to maintain a record of all licensed treatments, including a register of details of the gamete donors, the recipients and the resulting children. The 1990 Human Fertilisation and Embryology Act governing the information collected by the authority still generally preserves the anonymity of the gamete donor. Yet it does provide for a donor-conceived individual to receive some non-identifying information about the donor. Moreover, the Act also permits individuals intending to marry to ascertain whether the register provides any evidence of a genetic relationship to their intended spouses. A key issue under current consideration in the UK is whether to require future donors to be potentially identifiable, whether anonymity will be preserved or whether to establish a 'double-track' scheme which would allow donors to choose whether to be identifiable or remain anonymous.

Despite its remarkably low rate of third party assisted conception, mostly DI, Hong Kong has a national register similar in many respects to that of the UK, where a person can inquire about the possibility of being genetically related to their proposed partner. The idea of establishing this type of national register has also been considered in Finland and Canada. The latest Bill introduced by the Canadian government postulates that donors be given the option of remaining anonymous and that offspring have access to non-identifying genetic information. However, as most donor sperm now used in Canada comes from the US, tracing donors could still remain difficult.

In Germany, family building by DI, the only method of third party assisted conception legalized in the country, has only been recently acknowledged. Although secrecy is perceived as pathologizing third party assisted conception, current medical practices enable destruction of records on semen donors and recipients after a period of ten years.

Argentina, Israel, Poland, Singapore and South Africa still adhere to secrecy concerning the genetic origins of offspring and anonymity of donors. The Latin culture of Argentina, with its emphasis on male strength, perceives infertility as very shameful for men. Consequently, although the psychological community would prefer disclosure of information, and the medical community is divided on the issue of secrecy, there has been no legislation and the medical centres are left with the sole responsibility of keeping any records. Israel practises full anonymity and secrecy. The recently proposed Bill on egg donations does suggest some access to non-identifying information about donors even though the egg donor is to remain anonymous. However, the Bill recommends establishing a register which would protect information on the genetic origins of the offspring to prevent marriage between genetic siblings. Adults over the age of 18 will be allowed access to the register and to determine whether they were born from egg donations. In Poland, donor anonymity and the secrecy of the procedure are viewed as instrumental for securing the stability of a family created by DI. In Singapore, each medical centre is required to keep its own register of children conceived and delivered, but no access to information on gamete donors is provided for the children. In contrast, a central, legally sanctioned donor registry does exist in South Africa, where the details of gamete donors and the recipients have to be sent to the Director General of Health on a yearly basis. This information is not publicly revealed, and secrecy and anonymity surround third party assisted conception.

The US has not enacted any specific federal or state laws concerning the genetic origins of children born as a result of third party assisted conception and all of these procedures are managed privately. Consequently, there is no one national register that collects information on gamete donors and recipients. In the absence of legislation or regulations, the management of offspring access to information on genetic origins is dependent on the specific agencies' guidelines and their compliance with them. Yet, according to the overview of the US in this volume, given the fact that the US is a litigious society and that more importance is being attached to genes, the general approach in the country is now more in favour of openness and of providing more complete information to the offspring.

Commercialization of genetic material and reproductive tourism

In most of the countries surveyed in this book, with the exception of the US, commercialization of genetic material and surrogacy is officially prohibited but gamete donors usually receive some compensation for their donation. In addition, differences between countries in services connected with third party assisted conception invite and may even encourage reproductive tourism. For example, the chapter on Australia reports that, although commercial surrogacy has no basis in any Australian jurisdiction, infertile Australian couples have utilized the services of an American surrogacy agency, paying commercial rates of about US$55,000. In Finland, commercialization is not dominant due to the public funding of third party assisted conception treatments for the majority of applicants. However, the absence of comprehensive legislation has led to an influx of reproductive tourists, particularly from other Nordic countries. At the same time, Finnish private IVF clinics have been established in Russia, in Portugal and in Spain.

Similarly, it is not surprising that Canadians increasingly find the US more attractive, considering Canada's geographical location and its lack of public policy, regulation and public funding for third party assisted conception. The Canadian government's stated intention to eliminate commercialization in gamete donations and surrogacy is thus apparently belated – commodification is already a common practice. The same contradictions are seen within the law. While the recent Standing Committee on Health expressed the view that commercial surrogacy treats children as objects and the reproductive capacity of women as an economic activity, the latest Bill introduced by the Canadian government stipulates that donors and surrogate mothers continue to be allowed to receive expenses.

Commercialization of genetic material and surrogacy is seen as improper in Hong Kong, which prohibits not only commercial advertisements relating to surrogacy arrangements, but also any commercialization of genetic material. Commercialism or the buying and selling of human gametes is also prohibited in South Africa, where sperm donors are mainly medical, dental, veterinary and agricultural students, and egg donors are usually family and friends of infertility patients. In Argentina most of the IVF centres also accept egg donations from friends and family. As already mentioned, there are no commercial sperm banks in Singapore.

In the UK, while the stated approach objects to payment 'in principle' for gamete donations, regulations permit limited payment to donors in addition to reimbursement of expenses. With regard to surrogacy, although payment is restricted to 'reasonable' expenses, in practice there is a commercial market between commissioning parents and surrogate mothers. The situation is quite similar in Israel where, despite objection to payment, sperm donors are paid a small sum, and the basic 'compensation' for a surrogacy is about US$25,000. The US shows the most extreme commercialization of third party assisted conception – advertisements for gamete donations from individuals with high IQ, beauty and other preferred qualities, as well as ads for surrogacy agencies, are freely published and high fees are offered.

The comparative analysis of the countries examined in this volume reveals considerable differences in their perception of human genetic material, particularly of human gametes and surrogacy. The less restrictive and intrusive the state's legislation regarding third party assisted conception, the greater is the issue of commercialization of human genetic material. Countries that explicitly prohibit surrogacy and egg donation do not develop a market for the involvement of surrogate mothers and egg donors. A further problem is that in countries with no legislation (and limitations) in this area, such as Argentina or the US, patients, donors, physicians and other professionals may find themselves defenceless when something goes wrong. In countries permitting extensive commercialization, the issue arises of the status of women offering themselves on the marketplace of the industry of human reproduction services, and also of the intrinsic value of a person created by such means.

Counselling

Apart from DI, all third party assisted conception techniques involve lengthy, intrusive and painful procedures for the woman, as well as many difficult decisions before, during and after the process of the medical intervention both for her and her partner. Although the gamete donor or the surrogate mother may not anticipate the long-term consequences of their decision when they agree to be part of the process, they may need counselling at some time later. This is perhaps why psychosocial counselling is either mandatory or at least recommended in countries that are more permissive towards third party assisted conception, and particularly where explicit legislation is in effect. In Australia, for example, the appropriate legislation requires that donors and recipient parents receive adequate information and be counselled on both the treatment itself and the physical and psychological consequences for all concerned. In the case of surrogacy, both partners to the agreement, the surrogate mother and the commissioning parents, are required to receive assessment and counselling in addition to that concerning the IVF treatment. In the UK, although counselling must only be made available, in practice some clinics impose mandatory counselling under some circumstances, most often in relation to forms of third party assisted conception.

The laws of New Zealand and Israel require assessment and psychosocial counselling for those involved in surrogacy agreements. The more specific focus on the need for counselling for those involved in surrogacy agreements raises the question of whether the aim of counselling is to dissuade potential parents from this involvement or, on the contrary, to ensure that the relationship between the parties will end as planned with the surrogate mother indeed handing over the child to the commissioning parents.

In Canada and Finland, the relevant commissions or authorities have in principle acknowledged the importance of counselling in third party assisted conception and have included a recommendation for mandatory counselling. In Singapore, counselling on the possible consequences of third party assisted conception is limited to the medical treatment itself, particularly its costs and risks. In countries with a more restrictive approach to third party assisted conception, where there are few such treatments, counselling is still in its early stages. It is important to note that many patients forgo psychosocial counselling despite its apparent importance, perhaps due to their overwhelming involvement in the medical fertility treatments.

Closing remarks

Third party assisted conception, both the medical treatment and its short- and long-term consequences for all the individuals involved, is not and should not be perceived as simply another means of family planning. Since it really has a life-long impact, and may even affect following generations, it should be deeply and seriously reflected upon.

In 1991 Knoppers and LeBris reported on a survey of government, and government-initiated, reports on assisted conception around the world. They identified twelve areas on which there seemed to be a general consensus and six areas on which there was little consensus. Among the latter, four were associated with third party assisted conception. Two of these – the eventual access by the donor-conceived individuals to information on their donor and the type of donor information that may be made available, and the keeping of registers – remain highly contentious, as indicated by the contributors to this book.

We hope that this book, which provides an account of the development of services and policies in 13 very different countries, will contribute to the continuing discussion of issues surrounding third party assisted conception and aid comprehension both of their complexity and the ways in which different communities are attempting to resolve the problems emerging from them.

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