

Responsive Regulation of Cross Border Assisted Reproduction

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Abstract

My question in this paper is: how might Australian regulators constructively respond to the dynamic and complex challenges posed by cross border assisted reproduction? To begin I summarise the available international scholarship and outline what little we know about Australian cross border reproductive travel. Of the three generally proposed responses to CBRC: prohibition, harm minimisation and harmonisation, I summarily reject the first approach, and instead discuss a mixture of the latter two. The paper proposes the beginnings of an immediate policy response aimed not at stopping cross border practices per se, but rather at understanding and reducing the risks associated with them, as well as flagging the pursuit of more ambitious meta-goals such as developing more equitable and accessible treatment frameworks for ART and encouraging domestic self-sufficiency in reproduction.

Introduction

In 2011 Inhorn and Gurtin noted in their ground breaking symposium on cross border reproductive care (CBRC) that ‘much of the discussion surrounding CBRC has relied upon investigative journalism on the one hand and scholarly commentary on the other’; they go on to argue that it is ‘crucial to address the empirical deficit in their field and to provide rigorous data that can illuminate questions surrounding the incidence, experience and outcomes of CBRC’.¹ In the same 2011 symposium, Hudson and colleagues published a literature review of the available research on CBRC, examining 54 articles published in preceding years. Significantly, only 15 of the papers were based upon empirical research, with the remainder comprising commentary, leading to the authors’ conclusion that CBRC is both ‘under-researched and under-theorized’.² The extent of CBRC is unknown, and likely to remain so.³ However recent years have seen a burgeoning range of qualitative ethnographic studies,

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¹ Inhorn M and Gurtin Z, “Cross-Border Reproductive Care: A Future Research Agenda” (2011) 22 *Reproductive Biomedicine Online* 665 at 665-666.

² Hudson N et al, “Cross-Border Reproductive Care: A Review of the Literature” (2011) 22 *Reproductive Biomedicine Online* 673 at 682.

³ Ethics Committee of the American Society for Reproductive Medicine, “Cross-Border Reproductive Care: a Committee Opinion” (2010) 100 *Fertility and Sterility* 645 (ASRM) at 646.

often focused upon particular destinations,⁴ national or regional groups of patients,⁵ or assisted reproductive practices (such as egg donation);⁶ accompanied by an increasingly sophisticated body of feminist socio-legal and bio-ethical analysis.⁷

The American Society for Reproductive Medicine (ASRM) has noted that the ‘gravest concern for traveling patients is the protection of their health and safety’, explaining,

In the absence of international policies and norms dictating quality control measures, patients are disadvantaged in their ability to discover and access the standard of care in any given foreign jurisdiction. Essential measures of quality such as the expertise of physicians and embryology staff, the sophistication of the screening, surgical and laboratory technology, and basic matters such as cleanliness to avoid contamination of gametes and embryos can be difficult for a visiting patient to access. Indeed, patients take some risk when they access any fertility treatment, but the risk increases as patients leave their home country where information about quality is likely more accessible.⁸

Notably in their policy statements both the ASRM and the European Society for Human Reproduction and Embryology (ESHRE) Task Force on Ethics and Law have acknowledged that CBRC brings *benefits* as well as risk, in particular for patients excluded from treatment in their home jurisdiction.⁹ The ASRM notes potential benefits to patients such as improved access to treatment, particularly if it is available earlier in life with greater likelihood of successful outcomes, decreased discrimination, and greater access to cultural comfort and/or ethnically diverse donor gametes.¹⁰

An evaluation of CBRC that is sensitive to context includes relativities of risk, and benefits, for all participants and encompasses the risks and benefits posed by alternatives to treatment, including the lack of access to treatment. Pennings, Storrow and others have noted the

⁴ See eg Inhorn M, *Cosmopolitan Conceptions: IVF Sojourns in Global Dubai* (Duke University Press, Durham, 2015); Pande A, “Transnational Commercial Surrogacy in India” (2011) 22 *Reproductive Biomedicine Online* 618; Whittaker A and Speir A, ““Cycling Overseas”: Care, Commodification, and Stratification in Cross Border Reproductive Travel” (2010) 29 *Medical Anthropology* 363; Whittaker A, “Merit and Money: The Situated Ethics of Transnational Commercial Surrogacy in Thailand” (2014) 7 *Int J Fem Approaches Bioeth* 100.

⁵ See eg Krolokke C, “A Feminist Perspective on Reproductive Travel from Denmark to Spain” (2014) 7 *Int J Fem Approaches Bioeth* 144; Rachel M, *Extractions: An Ethnography of Reproductive Tourism* (Palgrave Macmillan, Basingstoke, 2013).

⁶ See eg Krolokke C, “Have Eggs, Will Travel: The Experiences and Ethics of Global Egg Donation” (2015) 5 *Somatechnics* 12.

⁷ See in particular articles in the following Special Issues, Baylis F and Downie J, “Introduction” (2014) 7 *Int J Fem Approaches Bioeth* 1; Krolokke C, Foss K and Pant S, “Fertility Travel: The Commodification of Human Reproduction” (2012) 8 *Cultural Politics* 273.

⁸ ASRM, n 3 at 647.

⁹ See ASRM, n 3; Pennings G et al, “ESHRE Task Force on Ethics and law 15: Cross-Border Reproductive Care” (2008) 23 *Human Reproduction* 2181. See also Whittaker A, Manderson L and Cartwright E, “Patients Without Borders: Understanding Medical Travel” (2010) 29 *Medical Anthropology* 336.

¹⁰ ASRM, n 3 at 647.

‘pluralism’ and ‘safety valve’ function of CBRC in responding to restrictive and/or discriminatory legal regulation.¹¹

A nuanced Australian-specific analysis of CBRC must recognise that aspects of domestic law have, to a greater or lesser extent, acted as drivers of cross border practices. For example even though many state and federal laws were amended through the 1990s and 2000s to remove sexual orientation and marital status discrimination, many jurisdictions retain discriminatory exclusions: such as those preventing gay men from accessing regulated assisted reproductive treatment (ART) or parentage orders as part of a surrogacy arrangement in Western Australia and South Australia. There is a long history of Australian patients travelling domestically in response to legislative exclusions and such evasion has been widely accepted by clinicians and the public.¹² There are also material conditions, such as shortages of donor eggs and embryos, which act as drivers of travel. Such shortages both reduce the likelihood of successful treatment for women generally (due to delays of years in treatment) and impact with particular severity upon particular classes of women, such as those who are single, or older (who are less likely to be selected by prospective donors), and recipients who are from ethnic minorities, where donor shortages are particularly acute. For these patients, CBRC may represent the best, or only, available path to parenthood.

CBRC may also offer benefits to reproductive contributors such as surrogates and egg donors. Angela Ballantyne has recently argued that the identification of vulnerabilities and risks in cross border care should not uncritically be equated with ‘exploitation’.¹³ For reproductive contributors with mixed motivations due to financial incentives,¹⁴ including those living in poverty, some forms of (risky) reproductive labour may still represent a better option than other available avenues of (risky) productive labour.¹⁵ I stress at the outset that an acknowledgement of relativities of risk and benefits in CBRC does not entail blindness to its potential harms, nor to the possibility that risks are increasing or are exacerbated in certain contexts.

It is important to consider CBRC practices holistically. Inhorn and Gurtin note that,

¹¹ See eg Storrow R, “Assisted Reproduction on Treacherous Terrain: The Legal Hazards of Cross-Border Reproductive Travel” (2011) 22 *Reproductive Biomedicine Online* 538; Van Hoof W and Pennings G, “Extraterritoriality for Cross-Border Reproductive Care: Should States Act Against Citizens Travelling Abroad for Illegal Infertility Treatment?” (2011) 22 *Reproductive Biomedicine Online* 546.

¹² See Petersen K, Baker HWG et al, “Assisted Reproductive Technologies, Professional and Legal Restrictions in Australia” (2005) 12 *JLM* 373; Millbank J, “From Alice and Evelyn to Isabella: Exploring the Narratives and Norms of ‘New’ Surrogacy in Australia” (2012) 21 *GLR* 101.

¹³ Ballantyne A, “Exploitation in Cross-Border Reproductive Care” (2014) 7 *Int J Fem Approaches Bioeth* 75.

¹⁴ See Pennings G et al, “Socio-Demographic and Fertility-Related Characteristics and Motivations of Oocyte Donors in Eleven European Countries” (2014) 29 *Human Reproduction* 1076; Pennings G, “Central Role of Altruism in the Recruitment of Gamete Donors” (2015) 33 *Monash Bioethics Review* 78.

¹⁵ See eg Pande A, “Commercial Surrogacy in India: Manufacturing a Perfect ‘Mother-Worker’” (2010) 35 *Signs* 969; *Wombs in Labor: Transnational Commercial Surrogacy in India* (2014, New York, Columbia University Press); Rudrappa S, “India’s Reproductive Assembly Line” (2012) 11 *Contexts* 22.

Conceptualizations of CBRC should not be confined to the travel of assisted reproductive patients across borders. The movements of clinicians, donors and surrogates, and the importing and exporting of gametes, should also be regarded as variations of this phenomenon.¹⁶

I suggest that the movement of gametes disembodied from donors or patients, and the shifting and multiple border crossings of multinational providers (and their sourcing and transporting of 'bioavailable' surrogates and donors¹⁷) should not be considered as variations or additional complications but rather as entrenched or enmeshed dimensions of the modern practice of CBRC. For example, it appears that donor eggs are significantly more likely to be used in international surrogacy compared with domestic practice. The prevalence of gestational (rather than genetic) surrogacy and location of providers in developing countries means that when international surrogacy arrangements involve intended parents who are Anglo-Saxon, providers routinely partner with egg brokerage companies who 'import' egg donors from third countries such as South Africa and Ukraine as part of the treatment process.¹⁸

We are also seeing an increasing development of cross-cross border reproduction; that is where not only are patients, donors, surrogates, and gametes all crossing borders, so are clinicians and the providers who are organising or brokering the treatment process. The last ten years has seen the rise of truly transnational providers such as 'New Life', which began in Georgia but now operates out of eleven countries.¹⁹ The rise and rapid fall of permissive regimes in countries such as India and Thailand has highlighted this cross-cross border dimension, as providers and agents cross borders evasively in response to regulatory developments in 'hub' destinations – notably many Indian providers quickly set up operations in Nepal, while those in Thailand shifted to Cambodia.²⁰ These developments compound existing risks through, for example, the interplay of multiple and potentially conflicting legal and ethical regimes, the practical possibility of no common language for all participants, and the decreased likelihood of both informed consent at the time and traceable medical and identity records in the longer term.

My question in this paper is: how might Australian regulators constructively respond to the dynamic and complex challenges posed by cross border assisted reproduction? When I speak about regulation in the Australian setting I mean it in the broadest sense, encompassing the

¹⁶ Inhorn and Gurtin, n 1 at 672.

¹⁷ See Whittaker and Spier, n 4.

¹⁸ Even with advances in egg vitrification technology it appears to still be cheaper and less legally complex to transport women instead of eggs for transnational egg donation in surrogacy.

¹⁹ See *New Life Global Network*, <http://www.newlifeglobalnetwork.com/> listing branches in Georgia; Ukraine; India; South Africa; Poland; Israel; Mexico; Nepal; China; Greece; and Cambodia. The Thailand branch closed in 2015. The 'Upcoming Branches' tab mentions South Korea; Japan; Brazil; Argentina and Egypt as possible new destinations.

²⁰ The wide acceptance, but close (and discriminatory) regulation, of surrogacy in Israel, including eligibility restrictions based on religion and sexual orientation, has also generated a number of off-shore Israeli providers, for example in Ukraine and Nepal.

policy, law, practice and ethical norms set down through peer regulators ‘soft’ or ‘grey law’ and national ethical guidance,²¹ in addition to black letter regulation through state and federal legislation setting mandatory requirements or prohibitions.²² I have argued elsewhere for a facilitative mode of regulation in assisted conception, encompassing policy based upon respect for reproductive autonomy.²³ The Nuffield Council has expressed this eloquently as a ‘stewardship’ role for the State,

to *facilitate* what are seen as beneficial behaviours: to ‘provide conditions’, whether physical or social, that help and enable people in making their choices, while avoiding active intrusion in those choices unless there is very strong evidence to justify such intrusion for the benefit of others.²⁴

In my analysis I aim to centre women’s interests and needs in reproduction. Elsewhere I have summarised this approach specifically in relation to surrogacy as,

a feminist perspective that values autonomy and “resonant choice” for women in family formation and reproductive work practices. This entails a textured understanding of choice that attends to women’s experiences and respects their agency, while acknowledging that a wide range of structural factors can and do constrain it. I see a role for the State in enhancing opportunities for the exercise of such textured choice in the context of surrogacy and other forms of assisted reproduction, through maintaining minimum clinical and ethical standards of care and preventing demonstrably unsafe practices. In my view, surrogacy is not a harmful practice when a birth mother makes an informed decision to undertake surrogacy and to relinquish the baby. A baby created via surrogacy does not cease to be the baby of the surrogate mother because of genetics or contracts, but because she herself believes this to be so. Legal regimes concerning surrogacy should provide

²¹ Under the *Research Involving Human Embryos Act 2002* (Cth), s 11, embryos can only be used or developed in the course of a woman’s reproductive treatment by ART units that have been accredited by the Fertility Society of Australia’s Reproductive Technology Accreditation Committee (‘RTAC’). Consequently, all clinics that create, develop or store embryos, must comply with the RTAC *Code of Practice for Assisted Reproductive Technology Units* (revised Oct 2010) (‘RTAC Code of Practice’), <http://www.fertilitysociety.com.au/rtac/>. The RTAC Code of Practice in turn requires evidence of compliance with the National Health and Medical Research Council, *Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research* (2007) (‘NHMRC Ethical Guidelines’) — unless alternate policies have been directed by a registered ethics body affiliated to the clinic. This means that all clinics in Australia must, at a minimum, comply with the NHMRC Ethical Guidelines.

²² Four Australian states have chosen to legislate on the provision of ART in their jurisdictions: these are New South Wales, Victoria, South Australia and Western Australia: see the *Assisted Reproductive Technology Act 2007* (NSW); *Assisted Reproductive Treatment Act 2008* (Vic); *Assisted Reproductive Treatment Act 1988* (SA); *Human Reproductive Technology Act 1991* (WA). Victoria, South Australia and Western Australia also legislatively require compliance with the NHMRC Ethical Guidelines. Only WA and Victoria have stand-alone statutory authorities responsible for assisted reproduction: the WA Reproductive Technology Council and the Victorian Assisted Reproductive Treatment Authority, respectively.

²³ Millbank J, Karpin I and Stuhmcke A, “Towards Facilitative Regulation of Assisted Reproductive Treatment in Australia” (2013) 20 JLM 701 at 710; Millbank J, “Rethinking “Commercial” Surrogacy” (2014) *Journal of Bioethical Inquiry*, DOI 10.1007/s11673-014-9557-9.

²⁴ Nuffield Council on Bioethics, *Donor Conception: Ethical Aspects of Information Sharing* (2013) at [5.67].

for support and information prior to conception and allow for *consensual* relinquishment after birth.²⁵

As an extension of this approach I have argued, as has my colleague Anita Stuhmcke, that criminal prohibitions on a wide variety of commercial surrogacy practices throughout domestic law, and the extra-territorial criminalisation of paid surrogacy in place in three Australian states and territories, are ill justified and completely ineffective in making surrogacy practices safer.²⁶

Therefore, of the three generally proposed responses to CBRC: prohibition, harm minimisation and harmonisation,²⁷ I summarily reject the first approach, and instead discuss a mixture of the latter two. In this article I outline the beginnings of an immediate policy response aimed not at stopping cross border practices *per se*, but rather at understanding and reducing the risks associated with them, as well as flagging the pursuit of more ambitious meta-goals such as developing more equitable and accessible treatment frameworks for ART and encouraging domestic self-sufficiency in reproduction.²⁸

First I summarise the available international scholarship and outline what little we know about Australian cross border reproductive travel in order to frame the following sections discussing risks to beneficial practices and exploring how Australian regulation could address such risks.

I. Understanding why cross border travel is occurring

Gurtin and Inhorn note that the available scholarship identifies 10 reasons why CBRC occurs, which they concisely summarise as,

- (i) Legal, religious or ethical prohibitions [on particular ART practices such as gamete donation or embryo storage];
- (ii) denial of treatment to certain categories of persons (based on age, marital status or sexual orientation);
- (iii) high costs;
- (iv) absence of assisted reproductive technologies in resource-poor countries...;
- (v) long waiting times ...;
- (vi) safety concerns;
- (vii) low quality care and/or success

²⁵ Millbank, n 23 (citations omitted).

²⁶ Millbank, n 23; Stuhmcke A, "The Criminal Act of Commercial Surrogacy in Australia: A Call for Review" (2011) 18 JLM 601; "Extraterritoriality and Surrogacy: The Problem of State and Territory Moral Sovereignty" in Gerber P and O'Byrne K, (eds) *Surrogacy, Law and Human Rights* (Ashgate, Surrey, 2015).

²⁷ Summarised succinctly in Hudson et al, n 2 at 681-682.

²⁸ Martin D, "Medical Travel and the Sale of Human Biological Materials: Suggestions for Ethical Policy Development" (2010) 10 Global Social Policy 377; Martin D and Kane S, "National Self-Sufficiency in Reproductive Resources: An Innovative Response to Transnational Reproductive Travel" (2014) 7 Int J Fem Approaches Bioeth 10.

rates; (viii) desire or cultural understanding...; (ix) proximity to support networks ...; and (x) privacy concerns.²⁹

The ASRM distils these into four groupings: access; cost; regulation and privacy/cultural comfort.³⁰ Both the available quantitative and qualitative research from Europe and the UK suggests that there is rarely one reason for travel, with a complex interplay of ‘push’ and ‘pull’ factors.³¹ A survey of European fertility treatment providers indicated that patients had very different main reasons for travel depending on their home country, with legal restrictions a major driver for those from countries such as Italy and Germany (at times when they had strict restrictions on the use of donor gametes, and embryo storage, respectively); while waiting times and availability of donor gametes were major issues for patients coming from more liberal jurisdictions such as the UK.³²

Hudson and Culley’s interview study of 51 UK patients found that reasons included,

Shortages of donor gametes, waiting times in the UK, cost of UK treatment, dissatisfaction with UK treatment, overseas success rate, desire to combine treatment with a holiday, seeking multiple embryo transfer, more choice of donors or as a ‘last resort’. However the combinations and expressions of these reasons were highly individual and contingent.³³

At present we have extremely limited information on numbers of Australians travelling for CBRC and virtually no insight into their motivations and experiences. In terms of particular practices, there are only very loose estimates of numbers of Australians travelling abroad for surrogacy, based on inferences drawn from the rising number of applications of citizenship by descent from particular destination countries. There is no data on the numbers of Australians travelling abroad for egg donation or sex selection³⁴ and no data on the proportion of imported donated sperm utilised in ART within Australia (with incomplete information more recently on imported eggs). We know next to nothing qualitatively about these experiences,³⁵ such as how Australian patients sought information, how they made

²⁹ Gurtin Z and Inhorn M, “Introduction: Travelling For Conception and the Global Assisted Reproduction Market” (2011) 22 *Reproductive Biomedicine Online* 535 at 535.

³⁰ ASRM, n 3 at 646.

³¹ Hudson et al, n 2 at 680; Hudson N and Culley L, “Assisted Reproductive Travel: UK Patient Trajectories” (2011) 23 *Reproductive Biomedicine Online* 573 at 576.

³² Shenfield F et al, “Cross Border Reproductive Care in Six European Countries” (2010) 25 *Human Reproduction* 1361; Culley L et al, “Crossing Borders for Fertility Treatment: Motivations, Destinations and Outcomes of UK Fertility Travellers” (2011) 26 *Human Reproduction* 2373.

³³ Hudson and Culley, n 31 at 575.

³⁴ Although these are clear indications that these practices are occurring, for example with one major Australian IVF clinic establishing an off-shoot practice to provide sex selection in Thailand, with 111 patients treated there in the 20 month period from August 2011 to March 2013: Fertility Society of Australia, “New Data Reveals Growing Trend in Australian Couples Seeking Social Sex Selection in Overseas IVF Units” Press Release, 2 September 2013, on file with author.

³⁵ Although see publications arising from Stockey-Bridge’s PhD study of Australian intended parents and surrogates in India: Stockey-Bridge M, “Success and Selection: an Ethnographic Account of Australian Intending Parents Selective Boundaries While Involved in Commercial Surrogacy in India” in Wahlberg A and Gammeltoft T (eds), *Selective Reproductive Technologies*, forthcoming.

decisions about where to travel or which providers to utilise, the role of paid intermediaries and brokers, whether treatment experiences were positive in either a clinical or emotional sense, or patient's subsequent reflections on their decisions and pathways.

An important start was made by Iolanda Rodino and colleagues who published the first survey of Australians and New Zealanders seeking and undertaking CBRC in 2014. The survey of 137 respondents (105 from Australia and 32 from New Zealand) identified egg donation and surrogacy as the major practices sought, followed by sex selection,³⁶ primarily from providers in the USA, India, Thailand and South Africa.³⁷ The unavailability of treatment, long waiting lists for donor gametes and limited choice of donors were the most indicated motivations.³⁸ Only a small minority indicated that a desire to use an anonymous donor was a motivation.³⁹ The authors note the specific Australian context of widely available and heavily subsidised ART treatment as an important contextual factor in understanding why cost was not reported to be a major reason for travel.⁴⁰

A limitation of this study, common to many patient surveys in this field, is that only a minority of participants (59 or 43%) had actually undertaken CBRC at the time of their response. Among those who had travelled for treatment, a large majority agreed that their medical needs had been met (91%) and that treatment 'felt safe' (89%), but a much lower percentage (58%) reported that their emotional needs had been met.⁴¹ Only 10 participants had received any jurisdiction-specific counselling through the CBRC provider.⁴² Another finding of significance for future research was the very limited involvement of Australian medical practitioners in terms of information giving, clinical preparation or liaison.⁴³

Any Australian response to CBRC must begin with more comprehensive and detailed information on who is going where and for what, so that we can explore drivers and inducements and understand how these relate to both particular practices and specific destinations. In the subsections below I outline the limited data available concerning our state of knowledge about numbers of Australian patients travelling abroad and overseas gametes

³⁶ Rodino I et al, "Motivations and Experiences of Patients Seeking Cross-Border Reproductive Care: the Australian and New Zealand Context" (2014) 102 *Fertility and Sterility* 1422 at 1425.

³⁷ Rodino, n 36 at 1426.

³⁸ Rodino, n 36 at 1425.

³⁹ In the 'applies very much' response, 16% of respondents indicated, 'Desire to use an anonymous donor', compared to 41% who indicated 'Long donor waiting list in my home state': Rodino, n 36 at 1425.

⁴⁰ In contrast, cost is reported as a major motivation for travellers from the USA: Speier A, "Brokers, Consumers and the Internet: How North American Consumers Navigate Their Infertility Journeys" (2011) 23 *Reproductive Biomedicine Online* 592.

⁴¹ Speier, n 40.

⁴² Rodino, n 36 at 1425.

⁴³ Rodino, n 36 at 1429.

travelling into Australia, address the limitations of this data and indicate where we may be able to garner better quality information in the future.

Australians Travelling Overseas for Surrogacy

While it is not possible to know accurately how many Australians are travelling abroad to pursue surrogacy there are a number of sources of information that give a broad picture of which countries are major destinations and provide indications of both large numbers and rapid increase in uptake in the past decade. In contrast surrogacy births within Australia through regulated treatment over the past seven years have remained stable at between 6 and 20 babies per annum.⁴⁴

In 2011 a parent support group 'Australian Families Through Gestational Surrogacy' selectively surveyed IVF clinics and agencies identified by their members in India, Thailand the USA and Canada asking them to report on their records of surrogate births to Australian intended parents through their service. The figures returned by these providers showed almost a threefold increase in births to Australians in a three year period, from 99 in 2008/09 to 276 in 2010/11, with a marked increase in births to Australians utilising providers in Thailand and India and a slight decline for the USA.⁴⁵ A later larger scale survey of Australian intended parents by Everingham et al reflected these trends, finding that,

Among the 143 respondents with a current or previous compensated arrangement, the US was the most commonly used country before 2009. India fast became the destination of choice until 2012, when new visa rules restricted access to surrogacy to married heterosexual couples. A rise in popularity of Thailand since 2011 is apparent.⁴⁶

In 2013, the then Department of Immigration and Citizenship (now Department of Immigration and Border Protection) stated that it,

⁴⁴ In 2012 there were 19 births through surrogacy using Australian regulated treatment: Macaldowie A et al, *Assisted Reproductive Technology in Australia and New Zealand 2012* (UNSW, 2014) at 4. In 2010–2011, there were 16 (Macaldowie A et al, *Assisted Reproductive Technology in Australia and New Zealand 2010* (AIHW, 2012)), in 2009 there were 19 (Wang Y et al, *Assisted Reproductive Technology in Australia and New Zealand 2009* (AIHW, 2011) at 4), in 2008 there were 8 (Wang Y et al, *Assisted Reproductive Technology in Australia and New Zealand 2008* (AIHW, 2010) at 4); in 2007 there were 7 (Wang Y et al, *Assisted Reproductive Technology in Australia and New Zealand 2007* (AIHW, 2009) at 4) in 2006 there were 20 (Wang Y et al, *Assisted Reproductive Technology in Australia and New Zealand 2006* (AIHW, 2008) at 40), in 2005 there were six (Wang Y et al, *Assisted Reproductive Technology in Australia and New Zealand 2005* (AIHW, 2007) at 39). This data was not included in the reports concerning treatment in 2004 and earlier.

⁴⁵ Australian Families Through Gestational Surrogacy, *Statistics on Babies Born to Australians* (2011), <http://surrogacyaustralia.org/australian-babies-born-by-clinic>.

⁴⁶ Everingham S, Stafford-Bell M and Hammarberg K, "Australians' Use of Surrogacy" (2014) 201 Med J Aust 1 at 3.

is aware of over 420 citizenship applications by children born through surrogacy [from 2008 to 2012]. However, the number may be larger as surrogacy may not be declared, detected or manually reported in all cases.⁴⁷

In a submission to a public inquiry the same year, the Department acknowledged that numbers of citizenship applications for surrogacy births abroad had increased since 2008⁴⁸ and estimated that ‘there are now well over 100 cases per year.’⁴⁹ These numbers are likely to be a very low estimate because there is no automatic data collection for surrogacy applications. Generally a case will only be notified when the face of the documentation reveals or suggests surrogacy, for example where a birth certificate lists two male names or there are other details such as travel dates to the country of birth very close to, or after, the date of birth.⁵⁰

It is not possible to identify from citizenship data how many children were simply born to Australian citizens living or travelling abroad and how many were born through surrogacy. However inferences can be drawn from dramatic increases in the number of such applications over periods in which surrogacy providers and patients have also reported a surge in Australian participation in surrogacy in those countries.⁵¹ Similarly with the recent introduction of restrictions and bans on surrogacy in India and Thailand, respectively, inferences can be drawn based on dips in numbers of citizenship by descent applications from those destinations in the following years.

Notably while the figure for Australian citizenship accorded to children born in the USA remained stable across the period 2007/2008 to 2012/13, the figure for citizenship by descent granted to those born in India increased sharply each year during that period, such it more than tripled – from 170 to 619 per annum.⁵² I suggest that, in the absence of any other plausible explanation for such a dramatic increase, most if not all of that differential must be attributed to surrogacy births.

In July 2012 India limited access to surrogacy through the introduction of a requirement for a ‘Medical Visa (Sub class Surrogacy)’ for those utilising surrogacy. This was restricted in

⁴⁷ Department of Immigration and Citizenship (DIAC), Email Communication to the Author, in response to FOI request, 11 June 2013.

⁴⁸ For the UK, drawing only on parental orders, a similar increase is evident. In 2009 only 4% of orders concerned births overseas, while in 2011 the figure was 26%: see Crawshaw M, Blyth E and van den Akker O, “The Changing Profile of Surrogacy in the UK: Implications for National and International Policy and Practice” (2012) 34 J Soc Wel & FamL 267 at 271.

⁴⁹ DIAC, “International Surrogacy Arrangements”, *Submission to Family Law Council Surrogacy Inquiry*, June 2013 at 2.

⁵⁰ DIAC, n 49 at 5.

⁵¹ Both Australian parent reports and foreign clinic and agency reports indicated a dramatic increase in overseas surrogacy births to Australian over this period and that they were mostly occurring in India. Everingham S, “Use of Surrogacy by Australians: Implications for Policy and Law Reform” in Hayes A and Higgins D (eds) *Families, policy and the Law: Selected Essays on Contemporary Issues for Australia* (AIFS, Melbourne, 2014).

⁵² Family Law Council, *Report on Parentage and the Family Law Act* (2013) at 64. See also DIAC, *Citizenship by Descent Applications Granted to Infants by India and USA posts 2008–2011*, FOI request FA 12/03/00935, Canberra DIAC, on file with author; Department of Immigration and Border Protection, n 54.

eligibility to heterosexual married couples who had been together for 2 years.⁵³ The decline of citizenship grants to 532 in 2013/14 – the only decline in any of the available figures – likely represents the exclusion of gay couples, unmarried couples and singles from that time.⁵⁴ From the end of 2014 an administrative practice emerged of declining to issue any medical/surrogacy visas to Australian applicants from NSW, the ACT or Queensland, and later to any Australians at all.⁵⁵ One would anticipate a more dramatic decline to follow, yet applications for citizenship by descent grew again to 611 in 2014/15; suggesting that there may be a period of transition as those with babies from earlier arrangements are allowed to exit, or that there is evasion of the visa requirement. When available the 2015/16 figures should shed more light on these developments, unless the visa ban is lifted in the meantime.

The actual number of medical visas issued to Australians in the 2012-2014 period would provide a solid indication of numbers of (heterosexual married) Australians travelling to India to undertake surrogacy in that period. This would be a significant advance in augmenting the citizenship by descent data, because it would also include those who travelled and engaged in arrangements that did not result in a live birth. However the Indian High Commission and Consulates in Australia have declined requests to provide data on the number of medical visas issued.⁵⁶

The shift from India to Thailand in the early 2010s followed by the complete shut-down of commercial surrogacy in Thailand in late 2014 offers the possibility of strong inferences on the number of births attributable to surrogacy in Thailand to Australians. Applications for citizenship by descent steadily grew - from 297 in 2007/8⁵⁷ to 624 in 2013/14, peaking at 759 in 2014/15.⁵⁸ Press reports stated that 150 babies were taken back to Australia in the first half of 2015 under transitional provisions after the shut-down occurred.⁵⁹ When the 2015/16

⁵³ The circular from the Minister was dated July 2012 but it was not entirely implemented until early 2013. See Bureau of Immigration, India, <http://boi.gov.in/content/surrogacy> and Ministry of Health and Family Welfare, Press Release, 23 April 2013, <http://pib.nic.in/newsite/PrintRelease.aspx?relid=94917>.

⁵⁴ Department of Immigration and Border Protection, *All Applications for Citizenship by Descent Lodged for Applicants 18 yrs or under by Country of Birth* (Cambodia, Georgia, India, Mexico, Nepal, Russian Federation, Thailand, Ukraine, USA and Vietnam) 1 July 2012-30 June 2015, FOI request FA 15/07/01974, 21 September 2015, on file with author.

⁵⁵ See Australian High Commission India, <http://india.embassy.gov.au/ndli/surrogacy0115.html>; March S, "Indian Surrogacy: India says Australia Must Resolve Impasse Around Expecting Couples' Visa Rejections" *ABC News*, 7 November 2014, <http://www.abc.net.au/news/2014-11-07/ball-in-australias-court-on-surrogacy-visa-rejections-india/5873414>.

⁵⁶ Emails to Miranda Kaye, project researcher from: Banerjee A, Vice Consul, Consulate General of India, Sydney, 26 May 2015; Kumar M, First Secretary Canberra High Commission, 1 June 2015. The author is presently collaborating on a Right to Information request under Indian law which requires that the applicant be an Indian citizen.

⁵⁷ See also DIAC, "Applications for Citizenship by Descent Lodged for Applicants 18yrs or under, by Country of Birth (India, Thailand, Ukraine & USA), by financial year of finalisation, and office where finalised (1 July 2007 to 30 June 2012)" Canberra 2013, provided in response to FOI request, on file with author.

⁵⁸ Department of Immigration and Border Protection, n 54.

⁵⁹ Murdoch L, "Gay Couple and Thai Surrogate Mother in Custody Tug-of-war" *SMH*, 16 August 2015.

citizenship figures are known, the difference between 2014/15 should give a fair indication of the numbers of surrogacy births that occurred in preceding years.

A reported shift to destinations such as Mexico and Nepal should also be reflected in citizenship applications in 2015/16 and later years.⁶⁰ In Nepal surrogacy was only introduced there in late 2014, although it is unknown at the time of writing whether a shut-down in late 2015 will be permanent.⁶¹

Egg Importation

The unavailability of donor eggs in Australia is so well established as to be taken for granted. The FSA submission to a 2010 Senate Inquiry on donor conception reported that only 'occasionally' were egg donors recruited by clinics, with almost all donor eggs in Australia provided by women already known to the recipient or recruited by her.⁶² This is borne out by figures from Victoria, the only state to disaggregate clinic-recruited and recipient-recruited donor cycles or births. The Victorian Assisted Reproductive Treatment Authority (VARTA) reported that in the 2013/14 year there were 216 egg donors recruited by recipients, compared with a mere 6 donors recruited by clinics.⁶³

Until very recently low success rates for thawing and fertilisation of frozen eggs (as opposed to embryos) meant that egg donors were recruited simultaneously with recipient women's treatment cycles and egg banks were not viable in the same way that sperm banks have been since the 1980s. This has changed in the 2010s with advances in egg vitrification technology and the development of international providers such as the 'World Egg Bank'.⁶⁴

Victoria is also the only state in which individual application by the recipient is required for any import (or export) of a donated gamete.⁶⁵ In 2014 VARTA reported that there were 68 applications to import eggs, a major increase on the previous year attributed to the use of the 'World Egg Bank' by a major clinic operating in Victoria.⁶⁶ The same IVF provider also imports eggs into its clinic in Queensland, which does not have an approval requirement. This trend

⁶⁰ From 2012/13 to 2014/15 citizenship applications by descent have remained steady from both countries, with 26-35 per year from Mexico and less than 10 per year from Nepal: Department of Immigration and Border Protection, n 54.

⁶¹ Wilson L, "Australian Families in Limbo as Nepal Joins India and Thailand in Banning Commercial Surrogacy" *News.com.au*, 3 September 2015.

⁶² Fertility Society of Australia, Submission 106 at (unnumbered page) 9, http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/Completed_inquiries/2010-13/donorconception/submissions.

⁶³ VARTA, *Annual Report 2014* (2014) at 31. VARTA provides resources to assist intended parents in this process, see eg VARTA, *Finding an Egg Donor*, <https://www.varta.org.au/resources/brochure/finding-egg-donor>.

⁶⁴ See *The World Egg Bank*, <http://www.theworldeggbank.com/>. See also *Fairfax Egg Bank* (an offshoot of an established major US sperm bank), <http://www.fairfaxeggbank.com/>.

⁶⁵ Western Australia requires accredited clinics using imported gametes to ensure that the same information is available to them as that required for gametes obtained within the state: *Human Reproductive Technology Act Directions 2004* (WA), 6.2. See n 78.

⁶⁶ VARTA, *Annual Report 2014* (2014) at 14.

appears set to continue, as in 2014 Genea, a major IVF provider based in NSW, announced that it was also planning to import eggs using the World Egg Bank.⁶⁷

Australians Travelling Overseas for Egg Donation

As noted above, prior to developments in egg vitrification technology, it has historically been women, not eggs, crossing borders. It has been reported that Australian women routinely travel to Greece, Thailand, South Africa and Spain to receive donor eggs, with press reports estimating 500 births to Australians per year – ie roughly the same number as those born within Australian regulated treatment utilising donor eggs.⁶⁸ Such estimates are impossible to verify as there are no Australian records of treatment cycles or births to women utilising donor eggs outside Australia. A recipient woman will travel abroad on a tourist visa and if successful return to Australia pregnant: the birth is registered in Australia with her as the mother and no record of the donor in any identity register. However there are a number of self-reports from provider websites and media reports that suggest a longstanding practice of Australian engagement with egg donation services overseas.

One Australian based egg donation ‘co-ordination service’ (largely but not exclusively arranging treatment in Greece) reports 360 live births to Australians over a 14 year period.⁶⁹ International egg donation services quoted in press reports and on their own websites state that between 25⁷⁰ and 60 percent⁷¹ of their clientele are Australian, and report 20 to 40 births to Australians per year.⁷²

There are also indications that a significant proportion of international surrogacy arrangements involve the use of donor eggs. In a survey of 112 Australian intended parents, Stafford-Bell et al found that 85% had utilised donor eggs as part of the arrangement, in part reflecting that a majority of respondents were gay male couples.⁷³ However even among the heterosexual respondents, only 51% reported using their own eggs in the arrangement.⁷⁴ Yet it is easy for this aspect of international surrogacy to ‘fall off the radar’ as commentary focuses upon the surrogacy arrangement. Therefore I suggest that any exploration of Australians

⁶⁷ Arlington K, “Genea Partners with World Egg Bank to Provide Donor Eggs” *SMH*, 17 August 2014. See also smaller clinics such as *Demeter*, <http://www.demeterfertility.com/donor>.

⁶⁸ See Baker J, “Australians Fly Overseas to Find Egg Donors and Surrogate Mothers, But What Happens when the Children Grow Up?” *Daily Telegraph*, 30 September 2012. See also Cornish L, “Australians are the Leading Users of International IVF as Demand Grows for Donor Eggs” *News.com.au*, 5 April 2014; Smith A, “Older Women Turning to Europe for Affordable IVF” *SMH*, 23 March 2014.

⁶⁹ See *Donor Eggs Australia*, <http://www.donoreggsaustralia.com.au/>.

⁷⁰ See *IVF Treatment Abroad*, <http://ivftreatmentabroad.com/> quoted in Cornish stating that a quarter of their patients are Australian, with 30 Australians using the service in 2013: Cornish, n 68.

⁷¹ Baker, n 68.

⁷² See *Global Egg Donors*, <http://www.globaleggdonors.com/> reporting 420 babies born over an 11 year period and stating that around half of the clientele are Australian, also quoted in Cornish, n 68, stating ‘over 40%’ of clients are Australian.

⁷³ Stafford-Bell M, Everingham S and Hammarberg K, “Outcomes of Surrogacy Undertaken by Australians Overseas” (2014) 201 *Med J Aust* 330.

⁷⁴ Stafford-Bell et al, n 73 at 332.

undertaking egg donation abroad should address both egg donation as a sole practice and the use of egg donation in tandem with surrogacy.

Sperm Importation

In the UK the identity of gamete donors has been recorded since 2005 in a central register. Using the residential address of the donor as the basis of the category, in 2011 the Human Fertilisation and Embryology Authority (HFEA) provided a breakdown of 'UK sperm donors' and 'Overseas sperm donors' each year from 2005 to 2010. This fluctuated from 11% of overseas donors in 2005 to 24% in 2010.⁷⁵ In 2014 the HFEA published figures based only upon new donor registrations, showing that for 2010-2013, 23% of sperm donors were living overseas.⁷⁶

In Australia only Victoria and Western Australia have any degree of regulatory oversight of importation of donated gametes. Thus, despite the fact that there have been press reports of sperm importation into Australia since at least 2003⁷⁷, there are very few sources of data from which estimates can be generated.

In 2002 the Western Australian regulator, the Reproductive Technology Council (RTC) issued a circular to clinics requiring any sperm imported into WA to comply with local legislation. From that time a number of clinics indicated that they were importing and provided the RTC with a copy of their standing agreement to demonstrate compliance with WA regulations.⁷⁸ However the WA regulator does not record actual numbers of treatment cycles or births with imported gametes.

Press reports indicate that from 2005 at least two major fertility clinics in the Eastern states were importing sperm.⁷⁹ In 2009 the Reproductive Technology Accreditation Committee (RTAC) issued a technical bulletin in response to 'several' requests to clarify the legality of importing sperm from commercial providers,⁸⁰ and in 2011 updated this advice.⁸¹

⁷⁵ HFEA, *UK and Overseas Donors* (27 January 2012). Egg donors remained relatively unchanged over this period, from 4% in 2005 to 5% in 2010.

⁷⁶ HFEA, F-2014-00182 - *Numbers of UK and foreign sperm donors registering in the UK since 2010* (28 July 2014), <http://www.hfea.gov.uk/9104.html>.

⁷⁷ Radio National, *Sperm Bank Database*, 5 August 2003, <http://www.abc.net.au/radionational/programs/breakfast/sperm-bank-database/3548998>.

⁷⁸ Maureen Harris, RTC, email to the author, 4 June 2015, see n 65.

⁷⁹ Petersen F, "Gay Community Helps Ease Sperm Shortage for Aspiring Mothers" *SMH*, 8 May 2012, <http://www.smh.com.au/national/health/gay-community-helps-ease-sperm-shortage-for-aspiring-mothers-20120507-1y81e.html>. See also *Clark v Macourt* [2013] HCA 56; *Macourt v Clark* [2012] NSWCA 367 (concerning the importation of sperm into NSW in 2000 from Denmark and from 2005 from the USA).

⁸⁰ RTAC, Technical Bulletin No 2, *Obtaining Donor Sperm Outside Australia and New Zealand* (July 2009) at 1. The bulletin provides that in addition to compliance with local laws each unit should 'seek independent legal opinion that takes into account the type and amount of 'reimbursement' given to the sperm donor by the sperm bank.'

⁸¹ RTAC, Technical Bulletin No 3, *Donor Issues* (April 2011).

In 2010 the Fertility Society of Australia (FSA) submission to a Senate Inquiry into donor conception reported ‘a shortage of sperm donors in some clinics’.⁸² When one clinic indicated that ‘the majority’ of donor treatment cycles it performed utilised imported sperm the then President of the FSA, Peter Illingworth, responded in oral evidence that it was ‘not true’ that, ‘the majority of donor gamete treatment in this country is through the use of imported gametes’.⁸³ Dr Illingworth asserted that at that time, ‘Most clinics in Australia do not use sperm that has been imported from overseas’.⁸⁴ Yet by 2014 the Victorian regulator VARTA stated the contrary in its Annual Report, ‘The majority of Australian clinics are now importing donor sperm from international sperm banks’,⁸⁵ a claim later confirmed by FSA Vice-President Michael Chapman in press reports.⁸⁶

In 2014 there were just eight applications for importation of sperm into Victoria. This very low number reflects the fact that Victoria had until that time bucked the trend of shortages. This could in part be explained by the better ‘supply’ of donated gametes in Victoria due to the greater focus on community education around donation in that jurisdiction. However the lack of shortage was also due to an artificial restriction in ‘demand’ through the exclusion of single women and lesbian couples from ART treatment until the new Act commenced in 2010, and the complex process by which applications for importation had to be brought by individual recipients.⁸⁷ In acknowledgement that shortages are now occurring in Victoria, and in response to clinic requests, VARTA altered its guidelines in 2014 to allow ‘class applications’ for importation to be brought by clinics.⁸⁸

One opportunity to get a fair indication of the proportion of overseas sperm used in Australia would be to duplicate the UK approach by determining how many sperm donors on identity registers were recorded with overseas residential addresses. Such data excludes those states and territories with no central donor identity register and so would be limited to NSW (since 2010) and Western Australia (since 2004), (with Victoria also excluded because it has not imported to date). Yet these numbers would still represent a significant advance in knowledge, particularly if they could be broken down by year to give an indication of change

⁸² FSA, n 62.

⁸³ Senate Legal and Constitutional Affairs References Committee, *Donor Conception Practices in Australia: Report* (Commonwealth of Australia, Canberra 2011) at [2.93].

⁸⁴ Senate Committee, n 83. Illingworth’s own clinic, IVF-Australia, notes on its website that it now imports sperm from the USA: *IVF Australia*, <http://ivf.com.au/fertility-treatment/donor-program/require-a-sperm-donor#using-donor-sperm-from-overseas>.

⁸⁵ VARTA, n 66 at 14.

⁸⁶ Parnell S, “One in Two IVF Sperm Donors for Australian Kids is American” *The Australian*, 11 September 2015.

⁸⁷ Thus a trend in commentary and media reports to blame ‘increased demand’ from single women and lesbians as ‘the cause’ of the shortage, see: Carney J, “Australia facing ‘serious shortage of donor sperm’ as demand from single women and same-sex couples TRIPLES in just four years” *Daily Mail* (Australia), 11 November 2014, <http://www.dailymail.co.uk/news/article-2829418/Australia-facing-shortage-donor-sperm-supply-not-meeting-single-women-sex-couples-rise-demand.html>.

⁸⁸ Carney, n 87. See also O’Brien S, “Victoria Fertility Clinics Look Overseas as Sperm Donors Wane” *Herald Sun*, 10 November 2014, <http://www.heraldsun.com.au/news/victoria/victorian-fertility-clinics-look-overseas-as-sperm-donors-wane/story-fni0fit3-1227118831227>.

over time. They could also be extrapolated out to a national estimate based on the proportions of treatment cycles taking place in the relevant states. However this data is not available. Western Australia does not record the donor's address on the register and so was unable to retrieve information on local versus overseas addresses.⁸⁹ The NSW Department of Health has refused to collate and release this information on the basis that it is too time consuming.⁹⁰

II. Considering evidence of risks to beneficial practices

Analysis should not be based on assumptions that every home practice is superior to that abroad. Rather, there should be careful investigation of practices identified as risky, with attention to both likelihood of occurrence of harm and severity of potential harm.

Patients undertaking IVF overseas *may* be exposed to less safe clinical practices such as multiple embryo transfer, less rigorous genetic screening standards and less accurate record keeping. There is also the risk of less sound ethical practices: in particular less rigorous provision of, or non-availability of, counselling and other forms of information giving and support for donors/surrogates *and* recipients⁹¹ and reduced (or nil) transparency over who is paid how much and for what. However there will be considerable variation between practices in different destination countries and as between individual providers, and I caution against sweeping generalisations as to particular practices or locales as inevitably or invariably leading to 'exploitation'.

I flag two practices here- one clinical and one ethical - as examples to explore how Australian law at present exacerbates rather than reduces the risks that they pose. These are multiple embryo transfer and the use of unidentifiable donors, both of which are prevalent in CBRC across many jurisdictions. Both practices were also commonplace in Australian fertility treatment until the mid-1990s and 2000s, respectively and arguably meet the criteria that I touched on at the outset of this paper for the justification of active intrusion into reproductive choices based upon evidence of harm.

⁸⁹ Email from Maxine Strike, WA Department of Health, to the author, 2 July 2015.

⁹⁰ The Department refused an FOI application under the *Government Information (Public Access) Act 2009* (NSW) on the basis that there was no document in existence, nor a database capable of generating it; only paper files that would have to be manually sorted through. An appeal of this decision is in progress at the time of writing: Tim Jap, Notice of Decision 8 July 2015, File Ref PA/15/82.

⁹¹ Blyth E et al, "CBRC and Psycho-social Counselling: Assessing Needs and Developing an Ethical Framework for Practice" (2011) 23 *Reproductive Biomedicine Online* 642; Thorn P et al, "Cross Border Reproductive Services – Suggestions for Ethically Based Minimum Standards of Care in Europe" (2012) 33 *Journal of Psychosomatic Obstetrics and Gynaecology* 1.

In advice to the public concerning CBRC, the HFEA describes multiple pregnancy as ‘the single greatest health risk associated with fertility treatment’.⁹² Multiple pregnancy brings demonstrably increased risk of poor neonatal outcomes including heightened likelihood of morbidity, prematurity and a range of other long term adverse health effects. In Australia there are strict standards on multiple embryo transfer in regulated ART treatment, due to the strong correlation between multiple embryos transfer with multiple pregnancy and multiple birth, with the consequence that Australia now has one of the lowest multiple birth rates from IVF conception, at 6.5%.⁹³

The use of multiple embryo transfer in international commercial surrogacy and in international egg donation practices has been a cause of concern for some time.⁹⁴ CBRC is associated with greater prevalence of multiple embryo transfer and birth due to lesser commitment to single embryo transfer protocols in the practice of IVF generally in some overseas jurisdictions (such as the USA and India)⁹⁵ and because the increased pressure of time, cost and ‘success’ rates in CBRC specifically may exacerbate such trends.⁹⁶

In Stockey-Bridge’s small scale ethnographic work on Australians utilising surrogacy in India in 2011 she found that multiple embryo transfer was common. She observed contracts in at least one clinic that provided for the treating doctor to determine whether to perform selective reduction if there were more than two foetuses in a multiple pregnancy. Contracts left the decision to the intended parents to reduce from two to one foetuses in a twin pregnancy, but most were unwilling to do so when faced with this situation.⁹⁷

In a 2014 survey of Australian intended parents who had undertaken surrogacy, Stafford-Bell et al did not collect data on multiple embryo transfer or multiple births, but did ask a number of questions concerning multiple pregnancies and outcomes. That study reports that 55% of the 112 respondents who had undertaken an overseas surrogacy arrangement indicated that there was a multiple pregnancy, and among these, of the 78 who reported gestational age at

⁹² HFEA, *Considering IVF Treatment Abroad: Issues and Risks* (6 March 2014), <http://www.hfea.gov.uk/fertility-clinics-treatment-abroad.html>.

⁹³ Macaldowie et al 2014, n 44 at vii.

⁹⁴ See eg Shenfield F et al, “ESHRE’s Good Practice Guide for Cross Border Reproductive Care for Centers and Practitioners” (2011) 26 *Human Reproduction* 1625 at 1626.

⁹⁵ In 2007 data India and the USA reported only 10% of IVF cycles utilising single embryo transfer compared to 59.6% of Australian cycles: their overall IVF multiple birth rates were 26.5% and 31.4% respectively: Ishihara O et al, “International Committee for Monitoring Assisted Reproductive Technologies: World Report on Assisted Reproductive Technologies, 2007” (2015) 103 *Fertility and Sterility* 402 at 409. See also Tanderup M et al, “Reproductive Ethics in Commercial Surrogacy: Decision-Making in IVF Clinics in New Delhi, India” (2015) *Journal of Bioethical Inquiry*, advance access DOI 10.1007/s11673-015-9642-8.

⁹⁶ Although to the contrary the ASRM has argued that the lower cost of treatment abroad (compared to the cost in the USA) could actually lead to fewer embryos being transferred for Americans undertaking CBRC: ASRM, n 3 at 647. Note also that Culley et al found a multiple pregnancy rate of 19% (in their study of 51 UK patients who had undertaken CBRC) and that the rate of dual transfer of embryos was comparable to practice in the UK at that time: Culley, n 32 at 2379.

⁹⁷ Stockey-Bridge, n 35.

birth, 45% of babies were premature.⁹⁸ A further 10% reported pregnancy loss after 12 weeks gestation.⁹⁹

These slivers of information give grave cause for concern in terms of the long and short term health effects of CBRC. But it also prompts many more questions: are Australian patients actively *choosing* to undertake multiple embryo transfer because of a desire to ‘have their whole family all at once’ because of the cost pressures of CBRC, or are they going along with it because it is just ‘how it’s done’ at the destination country or clinic? In either case are they informed by treating clinicians of any of the consequent risks? ¹⁰⁰ (And in surrogacy is the surrogate also aware of these risks, and able to make a decision about them?¹⁰¹)

Shenfield et al note in the ESHRE Good Practice Guide to CBRC that, ‘Collaboration between the home practitioner and the receiving center offers the best chance of optimal care for the cross border patient’ but add that this ‘may pose a problem...where it is forbidden for doctors to give information about alternatives that are not legal in the country of residence of the patient.’¹⁰² Arguably the Australian approach impedes the involvement of local practitioners in the reduction of risk through the federal ethical prohibition on ‘facilitating’ commercial surrogacy. The NHMRC Ethical Guidelines (2007 version) provides, under the heading, ‘Do not undertake or facilitate commercial surrogacy’,

It is ethically unacceptable to undertake or facilitate surrogate pregnancy for commercial purposes. Clinics must not undertake or facilitate commercial surrogacy arrangements.¹⁰³

In this rather repetitive and circular provision there is no definition of, or guidance on, what exactly constitutes ‘facilitating’ commercial surrogacy. Numerous reports from both patients and doctors to the author indicate anxiety and confusion over this provision, such that doctors not only decline to provide diagnostic care, ‘work ups’ or preparatory clinical care in advance

⁹⁸ Stafford-Bell et al, n 73 at 331. This also brings pressure to bear on the maternity and neo-natal care resources of the providing country.

⁹⁹ With both a physical and emotional toll to the pregnant woman. Thanks to Iolanda Rodino for the reminder that issues such as pregnancy loss and post-natal depression remain overlooked in the CBRC literature.

¹⁰⁰ See in particular the findings of Tanderup et al based on interviews with doctors and surrogates in New Dehli in 2011 and 2012. Based on the doctor’s reports, of 17 clinics, in 12 the doctor made all of the decisions about embryo transfer, in four the intended parents were involved in the decision about the number of embryos to transfer, and in only one was the surrogate also involved: Tanderup M et al, “Informed Consent in Medical Decision-Making in Commercial Gestational Surrogacy: a Mixed Methods Study in New Delhi, India” (2105) 94 *Acta Obstetrica et Gynecologica Scandinavica* 465 at 469. In three clinics any decision about selective reduction was also made by the doctor alone, while 10 clinics reported this as a decision made by doctors and intended parents; only three reported this as a process that also involved the surrogate: at 469.

¹⁰¹ Tanderup et al interviewed 14 surrogates in India; none of whom knew how many embryos had been transferred or could explain the risks associated with foetal reduction or multiple pregnancy: n 100 at 468.

¹⁰² Shenfield, n 94 at 1626.

¹⁰³ NHMRC Ethical Guidelines, n 21 at 13.1.

of CBRC, but in fact refuse to discuss the topic with patients *at all*.¹⁰⁴ In their survey study of 249 Australian intended parents who were considering or in a current or past international paid surrogacy arrangement, Hammarberg et al report that less than half had sought information from Australian IVF professionals (and of those who did, around one third reported a negative reaction).¹⁰⁵ Concern about breaching a broadly worded and unclear ethical prohibition has prevented fertility experts engaging in even basic information giving to their patients, such as what is involved in safe egg stimulation and embryo transfer protocols¹⁰⁶ or the risks that departing from these protocols bring.

The 2015 public consultation draft for the NHMRC guidelines¹⁰⁷ continues the prohibition on providing or assisting with IVF as part of a paid surrogacy arrangement as follows,

Clinics and clinicians must not practice, promote or recommend commercial surrogacy, nor enter into contractual arrangements with commercial surrogacy providers.¹⁰⁸

If adopted, these guidelines offer improved clarity on the role of information giving, as the draft provides,

Where an individual or a couple has made an autonomous decision to enter into a surrogacy arrangement at a clinic overseas (commercial or otherwise), the Australian clinician's ethical obligation to provide appropriate advice and health care to his/her patient/s remains. The Australian clinician should provide advice regarding any concerns about the standard of care in overseas clinics, or acknowledge where the standard of care is unknown.¹⁰⁹

However I suggest that this provision could, and should, go much further in terms of allowing or indeed encouraging local fertility professionals to provide both information and care that is directed towards risk reduction.

¹⁰⁴ For example comments from fertility professionals to the author at presentations in 2013 and 2014, respectively. A number of patient interviewees in our current study also remarked upon this experience. In contrast a number of interviewees in our current study reported support and medical assistance from their GP, such as blood tests and semen tests. GPs are arguably not bound by the NHMRC Guidelines.

¹⁰⁵ Hammarberg K et al, "Intended Parents' Motivations and Information and Support Needs When Seeking Extraterritorial Compensated Surrogacy" (2015) Reproductive Medicine Online, forthcoming.

¹⁰⁶ See Shenfield et al, n 94 at 1626.

¹⁰⁷ The Guidelines are under review at the time of writing (October 2015). See http://consultations.nhmrc.gov.au/public_consultations/assisted-reproductive-tech for the Review documents and discussion draft.

¹⁰⁸ NHMRC, Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research, *Public Consultation Draft* (2015), http://consultations.nhmrc.gov.au/public_consultations/assisted-reproductive-tech at cl 8.7.1. Note that the original consultation document had asked, 'In view of developments in other countries, should there be compensation, more than expenses, for gestational mothers congruent with the reproductive effort contributed?', NHMRC, Ethical Guidelines for the Clinical Practice of ART – Part B of the Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research 2007 (2014), Q57.

¹⁰⁹ NHMRC *Public Consultation Draft*, n 108 at cl 8.7.2.

The use of unidentifiable donors in CBRC is also problematic although the impact upon offspring health and wellbeing may be less immediately apparent. Not all donor-conceived individuals desire access to information about their donor or see a genetic link as significant to their self-concept or family relationships. But past practice in Australia and elsewhere of donor anonymity has shown that for those offspring and families who do desire information and are denied it, the imposition of secrecy by clinics and state agencies has been experienced as a real and lasting harm.¹¹⁰ Current research into offspring views and needs clearly supports providing a permanent record of donor identity.¹¹¹ One survey of young donor conceived adults in the USA found that, whether they intended to access it or not, most believed that access to information was an essential right; that is, it was *their* information and their choice to make whether and how to utilise it.¹¹²

There has been some confusion in the discussion of the role of donor anonymity in CBRC, with some researchers assuming that anonymity is *sought* by patients just because it is commonly practiced in the jurisdiction to which they are travelling.¹¹³ Moreover there are conflicting assumptions about the role of donor identification, with some suggesting that patients are actively choosing CBRC in order to avoid domestic donor identity registers while others argue that the introduction of donor registers produced donor shortages which have driven CBRC. Much of this debate is speculative, with little known about the actual motivations of donors and patients, particularly in the Australian context.

It is hard to know what proportion of CBRC involves gametes from donors who are anonymous, that is, donors who are not now, and never will be, identifiable. (As opposed to 'unknown' donors who may be identifiable in the future, ie their information will be released when offspring reach majority and request it). In the USA the use of anonymous donors remains common, but many egg and sperm banks also include the option of an unknown but

¹¹⁰ See eg Jadva V et al, "The Experiences of Adolescents and Adults Conceived by Sperm Donation: Comparisons by Age of Disclosure and Family Type" (2009) 24 Human Reproduction 1909; Nuffield Council on Bioethics, *Donor Conception: Ethical Aspects of Information Sharing* (Nuffield Council, London, 2013).

¹¹¹ For an overview see Blyth E et al, "Donor Conceived People's Views and Experiences of their Genetic Origins: A Critical Analysis of the Research Evidence" (2012) 19 JLM 769. For a thoughtful analysis see Freeman T, "Gamete Donation, Information Sharing and the Best Interests of the Child: An Overview of the Psychosocial Evidence" (2015) 33 Monash Bioethics Review 45.

¹¹² Mahlstedt P, LaBounty K and Kennedy W, "The Views of Adult Offspring of Sperm Donation: Essential Feedback for the Development of Ethical Guidelines Within the Practice of Assisted Reproductive Technology in the United States" (2010) 93 Fertility and Sterility 2236. See also Rodino I et al, "Donor Information Considered Important to Donors, Recipients and Offspring: An Australian Perspective" (2011) 22 Reproductive BioMedicine Online 303, considering a variety of biographic information in addition to identity. Of 23 donor conceived offspring the donor's name was ranked as the most important piece of information by 61% of them.

¹¹³ See eg Hughes E and DeJean D, "Cross-Border Fertility Services in North America: a Survey of Canadian and American Providers" (2010) 94 Fertility and Sterility e16, which found that Canadians who travelled to the USA did so mainly to access 'anonymous donor-oocytes'. In fact neither Canada nor the USA has mandatory donor identification, and the study survey only utilised the categories of 'anonymous' and 'known' donation, such that it did not distinguish identity-release donors from those who are anonymous. That study has been reported elsewhere as evidence of a desire of patients to seek anonymous donation: eg ASRM, n 3 at 646.

identifiable donor, often referred to as an ‘identity release’ donor.¹¹⁴ In India draft legislation mandates the anonymity of donors, and this appears to reflect widespread contemporary practice.¹¹⁵ In Spain and Greece the anonymity of donors has been mandated by law since 1988 and 2002 respectively.¹¹⁶ In South Africa the regulations contemplate both known and unknown donation, and there is a central register of donor identity, but no provision for identity release as yet.¹¹⁷

The point I wish to make here is that just because Australian patients are seeking gametes in jurisdictions in which anonymity is practiced it does not mean we should assume that Australians are *seeking* anonymity. Rather, they could simply be seeking gametes in the only available places and subjecting themselves – deliberately, unthinkingly, or reluctantly - to the prevailing rules of those places. Initial research on Australian experiences suggest that intended parents are concerned about access to information and may *not* be actively seeking anonymity.

In Rodino et al’s survey study of 137 Australian and New Zealanders seeking or having undertaken CBRC published in 2014 only 16.4% of respondents indicated that they were motivated by a desire to use an anonymous donor: this was the lowest percentage response to any of the motivation factor prompts, and is on par with international data.¹¹⁸ In their analysis of open text responses the authors note that the expression of preference for an anonymous donor was not common, and that ‘having access to available donor identifying information was deemed important particularly in the context of adjustment to life after CBRC’.¹¹⁹ In Stafford-Bell et al’s survey study of Australian intended parents undertaking surrogacy, 85% of respondents had also utilised egg donation. These 112 respondents were asked whether they were most comfortable with an anonymous or identity release donor; most (71%) reported that they were most comfortable with an identity-release donor. Interestingly an even higher proportion (87%) reported that they believed using an identity

¹¹⁴ See eg one survey of policies of 219 fertility clinics, 100 egg donation agencies and 30 sperm banks in the USA, finding that 50% of the sperm banks included a formalised identity release option, whereas egg donation agencies tended to allow an individualised negotiation between donor and recipient on identification and contact (26.7%) with only 5.9% of egg agencies having a formalised identity release policy: Johnson K, “Fertility Clinic, Egg Donation Agency, and Sperm Bank Policies” (2011) 96 *Fertility and Sterility* 877 at 878; see also for more detailed discussion Johnson K, “Making Families: Organizational Boundary Work in US Egg and Sperm Donation” (2013) 99 *Social Science and Medicine* 64.

¹¹⁵ Assisted Reproductive Technologies (Regulation) Bill 2010 (India) cl 33, <http://www.icmr.nic.in/icmrnews/art/art.htm>.

¹¹⁶ *Act about Assisted Human Reproduction Techniques*, Spanish Law 35/1988 and 14/2006; *Medically Assisted Human Reproduction*, Greek Law 3089/2002 and *Medical Assisted Reproduction*, Greek Law 3305/2005. See generally, International Federation of Fertility Societies, *IFFS Surveillance 2013*, Chapter 9 http://c.ymcdn.com/sites/www.iffs-reproduction.org/resource/resmgr/iffs_surveillance_09-19-13.pdf.

¹¹⁷ *National Health Act 61 of 2003*, Regulations Relating to Artificial Fertilisation of Persons R175 of 2012, Reg 7, 8.

¹¹⁸ See Shenfield et al, n 32 at 1363 reporting that overall 17.9% of respondent patients indicated a wish for anonymous donation as a reason for travel. See also Culley et al, n 32 at 2379 indicating that only 10% of their 51 participants expressed this desire.

¹¹⁹ Shenfield et al, n 32 at 1427.

release donor was in the best interests of their child.¹²⁰ Yet of those who had undertaken treatment abroad with donor eggs, most did so in India, where anonymity is practiced.¹²¹ These findings strongly suggest that, while desiring identifying information and believing it to be beneficial to their child, Australian parents are engaging in practices that will render this highly unlikely or impossible. Follow up studies exploring the experiences of CBRC families are needed to explore what impact this mismatch will have in the future lives of parents and children.

I suggest that the Australian ethical and legal frameworks currently in place may impede beneficial practice in this area as well. Most Australians undertaking CBRC have not received counselling in Australia and so may have not considered these issues until post-conception. As noted earlier ethical prohibitions on ‘facilitating’ commercial surrogacy act as a bar not only to shared-care clinical regimes but to a wide variety of information giving practices. In addition federal legislative prohibitions on offering or receiving ‘valuable consideration’ for the supply of human eggs or sperm carry penalties of up to 15 years imprisonment.¹²² Such provisions may act as a disincentive to parents seeking domestic assistance such as counselling, disclosing the use of donor gametes abroad to medical or other professionals, and to both parents and donors from availing themselves of domestic voluntary identity registers.

III. Reducing risk and facilitating beneficial practice

A key element of responsive regulation must be to ask how the home system can be more responsive and inclusive to ensure harm minimisation. This is not to say that every practice that is sought abroad should be promoted or every prohibited practice domestically should be allowed. A considered approach to domestic rules and practices should be undertaken drawing on the available evidence and, when necessary, generating more.

In the UK, the HFEA has undertaken a number of inquiries into the donation process.¹²³ In 2010 the HFEA noted evidence that many Britons were undertaking CBRC as a result of long waiting times for donated gametes. In response they undertook a public consultation and reviewed a number of aspects of donation that could broadly be characterised as related to ‘supply’: compensation of donors; numerical limits on families formed through a single donor; donations between family members; and what restrictions donors may place on their

¹²⁰ Stafford-Bell et al, n 73 at 331.

¹²¹ Of the 95 respondents reporting treatment abroad utilising donor eggs, 58 were in India, 31 in the USA and Canada and 6 in Thailand: Stafford-Bell et al, n 73 at 332.

¹²² *Prohibition of Human Cloning for Reproduction Act 2002* (Cth), s 21.

¹²³ For example HFEA, *2005/6 Sperm, Egg and Embryo Donation Review*, <http://www.hfea.gov.uk/534.html>.

donations.¹²⁴ As a result of this detailed inquiry¹²⁵ the HFEA ultimately recommended that family limits remain unchanged (at 10 families per donor) but that changes be made instead to processes in order to better utilise donor supplies. The review led to the introduction of flat amounts of recompense for donors that reflected the differential impact of donation for women and men (GBP 750 per cycle for egg donation and GBP 35 per visit for sperm donation) as the expense model of reimbursement was found to be both unwieldy and inequitable.

Since 1998 there has also been an independent charitable body, the National Gamete Donation Trust, which exists to promote awareness of donation.¹²⁶ In 2010 the trust commissioned research into donor experiences and in 2012 published a report on 'donor satisfaction' which made a number of recommendations for improved donor recruitment and communication in order to facilitate donation.¹²⁷

Australian regulators could do much more to support and strengthen the principle of solidarity in assisted reproduction through improved information and support for donors, recipients and offspring. This could include, but is not limited to:

- research into donor needs and experiences;
- improved information about, and accessibility, of donor registers;
- a State role in donor recruitment;
- consideration of 'egg sharing' regimes such as those in operation in the UK.

Regulators could also reconsider whether the 'altruistic' model in legal and ethical rules in Australia which prohibit certain kinds of payment, advertising and intermediaries has actually been successful in achieving the purported goals of solidarity and informed consent. I suggest:

- examination of risk/burden compensation measures or labour based wage models for reproductive contributors,¹²⁸ (as opposed to the current 'reasonable expenses');
- consideration of carefully regulated specialist professional intermediaries or 'brokers' in particular in egg donation and surrogacy.¹²⁹

None of these measures provide a 'magic bullet' that will necessarily lead to a matching of reproductive donation with patient needs. Moreover improved domestic access, through the development of 'regulated markets' or more avowedly uncompensated 'reproductive self-

¹²⁴ See HFEA, *Donating Sperm and Eggs, Have Your Say* (HFEA, London 2011), <http://www.hfea.gov.uk/5605.html>.

¹²⁵ See HFEA, "Donation Review Annexes", 13 July 2011, 192-4, ('HFEA Donation Review Annexes'), <http://www.hfea.gov.uk/6516.html>.

¹²⁶ *National Gamete Donation Trust*, <http://www.ngdt.co.uk/>.

¹²⁷ Machin L, "Egg, Sperm and Potential Donors Satisfaction Survey" (Final Report 2012), <http://www.ngdt.co.uk/wp-content/uploads/2015/07/Donor-Satisfaction-Research-Report.pdf>.

¹²⁸ For an excellent recent analysis see Crozier G et al, "At the Intersections of Emotional and Biological Labor: Understanding Transnational Commercial Surrogacy as Social Reproduction" (2014) 7 *Int J Fem Approaches Bioeth* 45.

¹²⁹ See Millbank, n 23. But see Martin and Kane's critique of the possible failings of 'regulated markets', n 28 at 22-24.

sufficiency', is not desirable if it occurs at the cost of safe practices or informed consent.¹³⁰ Rather I suggest that all of these issues are worth exploring as part of the complex and shifting social picture of assisted reproduction in which there is no single 'answer'. Most of these questions have not been answered, indeed most have not even been asked yet, in the Australian context. Inquiry has been hampered in part by state divisions but more pervasively by lack of resources and commitment to facilitative regulation. Infertility is still not yet acknowledged as an important issue of public health.¹³¹

Broader longer term goals could include examining how and why neighbouring regimes are out of synch with Australian regulation, what can be learnt from each other and what minimum standards of clinical and ethical care are – or could be - common to all.¹³² As part of this process there should be some commitment to shared care across borders in order to improve safety, and of developed countries not to drain the scarcer health resources of their less wealthy neighbours.¹³³

Conclusion

At present Australian engagement in cross border assisted reproduction remains largely an evidence vacuum, plagued by 'overly simplistic and extreme caricatures'.¹³⁴ In the absence of actual research data, it is easy to characterise patients as 'tourists' seeking cheaper costs or greater availability of 'products' such as commercial surrogacy. Conversely those who travel may be seen, or characterise themselves, as 'forced' offshore by restrictive or discriminatory local laws. Such evasion may perversely reinforce the status quo, by relieving participants from any responsibility for changing restrictive conditions in the home country.¹³⁵ Nor is such fly-in-fly-out utilisation of services likely to lead to improved conditions for local patients or reproductive contributors in the receiving country.

The lack of detailed empirical evidence about CBRC practices undertaken by Australians is profound. Examination of these data gaps and the process of research into them must be the highest priority, to understand the 'push' and 'pull' factors at play for particular groups of patients, concerning all kinds of ART practices, and how these play out in different destination cities and countries.

¹³⁰ See Baylis F and Downie J, "Achieving National Self-Sufficiency in Human Eggs for Third-Party Reproduction in Canada" (2014) 7 Int J Fem Approaches Bioeth 164.

¹³¹ Martin and Kane, n 28 at 31.

¹³² Shenfield et al, n 94; Shenfield F, "Implementing a Good Practice Guide for CBRC" (2011) 23 Reproductive Biomedicine Online 657.

¹³³ Whittaker A, "Cross-border Assisted Reproduction Care in Asia: Implications for Access, Equity and Regulations" (2011) 19 Reproductive Health Matters 107.

¹³⁴ Gurtin and Inhorn, n 29 at 537.

¹³⁵ See Storrow R, "The Pluralism Problem in Cross-Border Reproductive Care" (2010) 25 Human Reproduction 2939.

On a global scale, Inhorn and Gurtin highlight lack of knowledge about:

- the activities of brokers and organisation of brokers and other middle agents;
- longer term outcomes and implications for families and in particular children;
- implications for follow-up health care in the home country; and
- travel of gametes, clinicians and donors.¹³⁶

Once there is a sufficient evidence base, careful use of this evidence must include particular attention to the experience of end users and their individualised meanings of family and kinship.

The goal of Australian regulators should be informed decision-making¹³⁷ and resonant choice for all participants in assisted reproduction through the promotion of beneficial practices and protection from harm. While short terms goals are likely to be identifying and reducing the most risky clinical and ethical practices, such as multiple embryo transfer and donor anonymity, regulators, and practitioners, should also address broader structural issues such as establishing equity of access to ART, parity of treatment across borders and consideration of the goal of national self-sufficiency in reproduction.

¹³⁶ Inhorn and Gurtin, n 1 at 666; see also Hudson et al, n 2 at 683.

¹³⁷ Informed choice was also a strong theme in Culley L et al, ““What Are you Going to Do, Confiscate Their Passports?” Professional Perspectives on Cross-Border Reproductive Travel” (2013) 31 Journal of Reproductive and Infant Psychology 46.