



Victorian
Law Reform
Commission



PRODUCTIVE
& ADOPTION

ASSISTED REPRODUCTIVE TECHNOLOGY & ADOPTION

Final Report

The Victorian Law Reform Commission was established under the *Victorian Law Reform Commission Act 2000* as a central agency for developing law reform in Victoria.

This report reflects the law as at February 2007.

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The publications of the Victorian Law Reform Commission follow the Melbourne University Law Review Association Inc, *Australian Guide to Legal Citations* (2nd ed, 2002).

GH2 Design 0409 380 199.

Photo of family (page 23 and others)
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Victorian Law Reform Commission.

Assisted reproductive technology & adoption:
final report.

Bibliography.

Includes index.

ISBN 9780975846537 (pbk.)

1. Reproductive technology - Law and legislation - Victoria.
2. Adoption - Law and legislation - Victoria.
3. Law reform - Victoria. I. Title.

344.94504196

Victorian Government Printer

No 10 Session 2006-07



Victorian
Law Reform
Commission

ASSISTED REPRODUCTIVE TECHNOLOGY & ADOPTION

Final Report

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Abbreviations

ACT	Australian Capital Territory
AHEC	Australian Health Ethics Committee
ART	assisted reproductive technology
CP	consultation paper
Cth	Commonwealth
FSA	Fertility Society of Australia
GIFT	gamete intra-fallopian transfer
HFEA	Human Fertilisation and Embryology Authority
ICSI	intracytoplasmic sperm injection
ITA	Infertility Treatment Authority
IVF	in-vitro fertilisation
J	Justice
n	footnote
NHMRC	National Health and Medical Research Council
NSW	New South Wales
PGD	preimplantation genetic diagnosis
PP	position paper
pt	part
RTAC	Reproductive Technology Accreditation Committee
s	section (ss plural)
UK	United Kingdom
US	United States

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Preface

This is the Victorian Law Reform Commission's final report on assisted reproductive technology (ART) and adoption. There have been significant developments in technology since the current legislation covering ART was introduced in Victoria, as well as changes in community attitudes to the use of ART. The need for a review of existing arrangements for accessing ART in Victoria was further highlighted by recent case law which found some aspects of the legislation to be unlawful or ineffective.

The commission was asked to examine the eligibility criteria for access to assisted reproductive technology and to consider whether it should be expanded. Many parties are affected by the use of ART, including the child conceived, those who will parent that child, and gamete donors and their partners. There are also wider social and policy considerations which need to be addressed. In producing this report and in framing its recommendations. The commission used the best interests of the child as its primary consideration and unifying rationale. This focus on the interests of the child was widely supported in commission consultations and was common ground among many stakeholders, including many who held opposing views on other aspects of the inquiry.

The issues raised by the reference generated considerable community interest and the commission received over 1000 written submissions from a broad range of interested groups and individuals. The commission also held roundtable consultations and other events to gather views and information. The contribution of all those who participated was invaluable to the commission's work.

I record the commission's gratitude to the Advisory Committee, who participated in our consultation sessions, and provided specialist advice in accordance with their areas of expertise: Professor Gordon Baker, Department of Obstetrics and Gynaecology, University of Melbourne, Research and Quality Assurance Director for Melbourne IVF and Director of Clinical Research, Reproductive Biology Unit, Royal Women's Hospital; Dr Chris Bayly, Associate Director, Women's Services, Royal Women's Hospital; Justice Sally Brown, Family Court of Australia; David Edney, partner, CE Family Lawyers; Dr Lynn Gillam, Centre for Health and Society, University of Melbourne; Dr Ruth McNair, General Practitioner and Senior Lecturer, Department of General Practice, University of Melbourne; Moira Rayner, lawyer and children's rights advocate; Dr Helen Szoke, CEO, Victorian Equal Opportunity and Human Rights Commission and formerly CEO, Infertility Treatment Authority; and Associate Professor Kristen Walker, Law School, University of Melbourne.

I would also like to acknowledge the assistance provided by members and staff of the Infertility Treatment Authority: Louise Johnson (CEO), Jock Findlay (Chairperson), Helen Szoke (former CEO), Lexi Neame (former Research and Policy Officer), Michael Gorton (member) and Helen Kane (Manager, Donor Register Services).

The production of this report and the inquiry process has been a large and complex undertaking. I gratefully acknowledge the outstanding work done by the principal authors of the report, Mary Polis, who was also team leader for the project, and Prue Elletson, research and policy officer. Their research, writing and analytical skills were invaluable.

I thank the commissioners who worked directly on this reference: Judge Felicity Hampel who acted as chair of the division, Professor Sam Ricketson and Paris Aristotle. Their commitment to the project and preparedness to give their time, despite all being part-time commissioners, is greatly appreciated. Our past Chairperson (now Justice) Marcia Neave undertook considerable work on the reference before her departure, and guided the consultation process and development of interim recommendations. I also thank past Commissioner Judith Peirce and CEO Padma Raman for their contribution to this reference.

Many other people assisted in the preparation of this report and I thank the editor of the report Trish Luker, Alison Hetherington for editorial assistance, Kath Harper for the proofreading and indexing, and Kat Brazenor for assisting with footnotes. Kathy Karlevski and Failelei Siatua provided crucial administrative backup for production and distribution of the report.

Previous staff of the commission who conducted research and worked on other publications in this reference from which we have drawn in compiling this report were Kate Foord and Sonia Magri, former Research and Policy Officers. Interns Louise Parrott, Natasha Stojanovich and Amelia Ie also provided research assistance.

Acting Chairperson and Part-time Commissioner

Iain Ross Commission

Terms of Reference

1. The Victorian Law Reform Commission is to enquire into and report on the desirability and feasibility of changes to the *Infertility Treatment Act 1995* and the *Adoption Act 1984* to expand eligibility criteria in respect of all or any forms of assisted reproduction and adoption; and make recommendations for any consequential amendments which should be made to the:
 - Status of Children Act 1974*
 - Births, Deaths and Marriages Registration Act 1996*
 - Human Tissue Act 1982*
 - Equal Opportunity Act 1995*and any other relevant Victorian legislation.
2. In making its enquiry and report, the commission should take into account, to the extent it decides is necessary or desirable:
 - (i) social, ethical and legal issues related to assisted reproduction and adoption, with particular regard to the rights and best interests of children;
 - (ii) the public interest and the interests of parents, single people and people in same-sex relationships, infertile people and donors of gametes;
 - (iii) the nature of, and issues raised by, arrangements and agreements relating to methods of conception other than sexual intercourse and other assisted reproduction in places licensed under the *Infertility Treatment Act 1995* ('the Act');
 - (iv) the penalties applicable to persons, including medical and other personnel, involved in the provision of assisted reproduction (whether through a licensed clinic or otherwise); and
 - (v) the laws relating to eligibility criteria for assisted reproduction and adoption and other related matters which apply in other states or countries and any evidence on the impact of such laws on the rights and best interests of children and the interests of parents, single people, people in same-sex relationships, infertile people and donors of gametes.
3. In addition, the commission should consider whether changes should be made to the Act to reflect rapidly changing technology in the area of assisted reproduction.
4. The commission is also requested to consider the meaning and efficacy of sections 8, 20 and 59 in relation to altruistic surrogacy, and clarification of the legal status of any child born of such an arrangement.

On making its report the commission should consider the relationship between changes to Victorian legislation and any relevant Commonwealth legislation including the *Family Law Act 1975* and the *Sex Discrimination Act 1984* as well as any international conventions and instruments to which Australia is a signatory.

Executive Summary

Victoria's regulation of assisted reproductive technology (ART) has failed to keep pace with the emergence of new families and developments in reproductive technology. In this report the Victorian Law Reform Commission makes a series of recommendations designed to meet the needs of all children born through ART, and to provide a robust framework capable of accommodating future social and technological change.

The law plays an important role in defining and recognising families and relationships between partners, parents and children. Over time, the law has developed to reflect changes in family structures and community attitudes to different types of relationships.

In Victoria the law establishes many powers and responsibilities parents have in respect of their children. The law also plays a role in sanctioning the formation of families through ART and adoption.

Currently in Victoria the law neglects several family types, either by excluding certain categories of people from accessing ART services to enable them to have children or by failing to recognise the relationships existing within certain families.

In this report we examine how the limitations of the current law affect families in Victoria and make recommendations for a more inclusive approach designed to protect the best interests of all Victorian children, regardless of how they are conceived or their family structure.

A FLEXIBLE REGULATORY REGIME

Assisted reproductive technology facilitates the conception of children in circumstances which not long ago were unimaginable. For example a person or couple may commission a woman to act as a surrogate mother using sperm and eggs donated by third parties. Parents are able to select embryos for implantation that are unaffected by a genetic disease or condition which they would otherwise be at risk of transmitting. Conception can take place years after the death of one of a child's parents. In the future, advances in medical science and technology will facilitate the conception and birth of children in ways which we can only speculate about at present.

Some people in the community regard these advances as positive developments for human reproduction and autonomy. Some are opposed to all forms of interference or assistance in the process of conception. Others do not oppose ART, but are cautious about the implications of new treatments and technologies for individuals and for society in general. As some forms of ART become more widely used community attitudes to them change.

Rapid technological change and diversity of community opinion present challenges for governments seeking to monitor and control the provision of ART services. Detailed prescriptive regulation can quickly become out of date and therefore ineffective. It also lacks the capacity to respond to new developments in treatment or to cater to diverse, novel or unexpected circumstances. In many respects the *Infertility Treatment Act 1995* suffers from these limitations.

The commission has made a series of recommendations aimed at promoting more flexibility in the regulation of ART. The legislation should set down guiding principles which reflect broad community expectations, and should establish processes to facilitate access to ART. There should be sufficient flexibility and scope for discretion to ensure that the legislative framework can endure developments in technology. It should also be able to keep up with research about the impact of ART on participants, in particular the children who are born as a result. We have proposed that new or complex decisions about the provision of ART services be devolved to interdisciplinary decision-making bodies that have the necessary expertise and skill to respond to the features of individual cases and the implications of new developments in treatment.

BEST INTERESTS OF CHILDREN

There is general consensus that in all decisions to be made about ART, the best interests of the child to be born should be the paramount consideration. The law currently assumes that limiting treatment to women in heterosexual relationships serves to protect the best interests of children born through ART. The commission has reviewed the available research about outcomes for children born as a result of ART into a range of family types and is satisfied that parents' sexuality or marital status are not key determinants of children's best interests. Rather, it is the quality of relationships and processes within families that determine outcomes for children.

Currently doctors and counsellors are not given any guidance about how to deal with cases where they are concerned that a future child may be at risk of harm. Decisions about whether to provide treatment in such cases are made privately and are not transparent. As a result, decisions about access to treatment may be made unfairly, inconsistently or without reference to expert opinion.

We firmly believe the assessment of the best interests of children should be based on objective and verifiable risk factors. People convicted of sexual or violent offences or who have previously had a child removed from their care should not be able to receive treatment unless an independent review panel is satisfied a future child would not be at risk of harm. If a doctor or counsellor is concerned that a prospective child might be at risk of harm for other reasons, the decision about whether to proceed with treatment should be made by an expert clinical ethics committee.

A MORE INCLUSIVE APPROACH

The Infertility Treatment Act 1995 states that before a woman can receive treatment, a doctor must be satisfied that she is unlikely to become pregnant, or is at risk of transmitting a genetic disease to a child, other than by a treatment procedure. It also states that she must be married or in a de facto relationship with a man in order to be eligible for treatment. This latter requirement is no longer valid, as a result of the Federal Court's decision in *McBain v State of Victoria*, which found it was inconsistent with the federal *Sex Discrimination Act 1984*.

Excluding women from treatment because they are single or in a same-sex relationship is therefore no longer tenable following the *McBain* decision. The Infertility Treatment Act has not been amended to reflect this, but should be. The marital status requirement is also contrary to the principles of equality of treatment espoused in Victoria's new *Charter of Human Rights and Responsibilities*.

The requirement that a woman be 'unlikely to become pregnant' is currently applied inconsistently. If a woman has a male partner, her inability to become pregnant may be the result of any number of factors, including her partner's infertility or an unidentifiable cause. If she does not have a male partner, she must be 'clinically infertile' to be eligible for treatment. This means that single and lesbian women can access treatment if they have a medical condition which would prevent them from becoming pregnant. Single and lesbian women without such a condition are ineligible for treatment.

It is clear that excluding certain categories of women from treatment does not prevent them from having children. Many women who are ineligible for treatment in clinics make private arrangements to self-inseminate with sperm from donors who may or may not be known to them. In our view, this exposes women and children to unacceptable health risks, as there is no guarantee the donor will be screened for communicable or heritable genetic diseases. If the woman, her partner (if any) and the donor have not adequately explored their respective roles in relation to the child, the potential for future conflict escalates.

Other women choose to travel interstate or overseas to places where the law does not prevent them from undergoing treatment in a clinic. This puts women to significant expense and inconvenience for no valid reason. Moreover, it may mean that their children have no right to access information about their donors, if that jurisdiction continues to permit anonymous donations.

Restrictions in the legislation also prevent people from pursuing surrogacy arrangements in Victoria. Altruistic surrogacy is legal, but potential surrogates must be infertile in order to be eligible for treatment in a clinic. As a result, people who are unable to carry a pregnancy themselves seek assistance from interstate and overseas service providers to enable them to have children with the help of a surrogate mother. Again, this may increase the potential for negative outcomes for all involved, including the child.

A more inclusive approach to provision of ART services in Victoria would ensure more families have access to the safeguards offered through the licensed clinic system such as medical checks, mandatory counselling and registration of donor information. To achieve this, the commission recommends that the requirement that a woman be unlikely to become pregnant be interpreted broadly, to encompass the many reasons women seek assistance to conceive, including when they do not have male partners.

Similarly, the commission recommends that if women choose to self-inseminate using sperm from a known donor, they should be able to avail themselves of the screening, storage and counselling services offered by clinics, in order to minimise any of the risks associated with conceiving outside the clinic system.

Recognising that a person's sexual orientation is not in itself considered to be an indicator of risk of harm to children, the commission also recommends that people in same-sex relationships be eligible to apply to adopt children. It is in the best interests of this vulnerable group of children that the widest possible field of potential adoptive parents be available. Selection of adoptive parents would remain subject to the rigorous and extensive approval process that currently applies under the *Adoption Act 1984*.

RECOGNISING PARENTS

Parents are responsible for the welfare of their children. The law imposes an extensive range of obligations on parents to ensure their children are cared for, provided for financially, receive an education and are protected from harm. The law also ensures children have rights to their parents' deceased estates. Parents are empowered to make decisions and take actions necessary to fulfil their obligations to look after their children.

Currently in Victoria, some children are cared for by people who are not legally recognised as their parents. As a consequence, these children lack many of the rights and protections afforded to all other children.

The commission strongly believes all children should have the same protection of the law, regardless of their family structure. We therefore recommend that when children are born to lesbian couples, non-birth mothers should have the same powers and responsibilities in respect of the child as all other parents. Legal recognition of non-birth mothers should be achieved in the same way as for non-biological parents of donor-conceived children born to heterosexual couples: by way of automatic statutory presumption. Non-birth mothers should be registered as parents on their children's birth certificates.

Executive Summary

When children are born as a result of surrogacy arrangements, the people who have commissioned the surrogacy and who care for the child should have the same powers and responsibilities in respect of the child as all other parents. However recognition of their parental status should be subject to court supervision, to ensure the surrogate mother consents to the arrangement and it is in the best interests of the child.

Some donor-conceived children know their donors, others do not. Donors rarely play a primary parental role in the child's life. The law should clarify that a donor is not a legal parent of a child conceived using his or her gametes, regardless of the type of family into which the child is born. This does not mean that donors cannot or should not be part of the child's life. As with all relationships, this is a matter to be negotiated, planned and discussed in each family before the child is born and as he or she grows up. Arrangements providing for a parental role for donors can be formalised with parenting orders from the Family Court, which are flexible enough to reflect the needs of individual families.

COUNSELLING AND EDUCATION

Having children through ART, and in particular through donor treatment procedures, involves consideration of a range of issues. Counselling and provision of information assist people to understand the medical and psychological implications of treatment and are important avenues for exploring how to protect the best interests and meet the particular needs of any child to be born.

Donor-conceived people deserve to know about their genetic origins, just as adopted people deserve to know they are adopted and to have access to information about their birth parents. Victorian law recognises the right of donor-conceived people to be able to discover the identity of their donors. However, many donor-conceived people are unaware of the circumstances of their conception because their parents do not disclose their donor status to them. Secrecy about a child's genetic origins, once revealed, can cause feelings of betrayal, mistrust and grief within the family.

More can be done to encourage parents to tell their children about their genetic origins. Even if parents want to be open with their children, sometimes they do not feel confident about how or when to tell them they are donor-conceived. The Infertility Treatment Authority has already undertaken important work in this area, and new and emerging ways to equip parents to tell their children should continue to be investigated and supported. The commission also recommends some changes be instituted to Victoria's system for collecting, managing and releasing information kept on donor registers in order to enhance the rights of donor-conceived children to access information about their donors.

Counselling is also crucial for people planning to have children with the assistance of known donors and/or surrogate mothers. Providing a forum for all participants to explore the roles they will each play in the child's life can help to minimise or avoid conflict in the future. Specialist counselling services should be available for all people involved in the conception of a child through ART, whether or not they choose to use the services of a clinic. They should also be available both before and after the birth of the child.

Recommendations

ELIGIBILITY FOR TREATMENT

GUIDING PRINCIPLES

1. The Infertility Treatment Act should set out the following principles to guide the administration of the Act and the carrying out of activities regulated by the Act:
 - The welfare and interests of children to be born as a result of the use of assisted reproductive technology are paramount.
 - At no time should the use of reproductive technology be for the purpose of exploiting (in trade or otherwise) either the reproductive capabilities of men and women or the children born as a result of the use of such technology.
 - All children born as a result of the use of donated gametes have a right to information about their genetic parents.
 - The health and wellbeing of people undergoing assisted reproductive treatment procedures must be protected at all times.
 - People seeking to undergo assisted reproductive treatment procedures must not be discriminated against on the basis of their sexual orientation, marital status, race or religion.

CLINICAL ETHICS COMMITTEES

2. It should be a condition of licence that each licensed clinic establish a clinical ethics committee for the purpose of considering cases where there is a concern that a prospective child will be at risk of abuse or neglect.
3. If, before a woman undergoes treatment, a doctor or counsellor believes that any child that might be born as a result of a treatment procedure may be at risk of abuse or neglect, the doctor should seek advice about whether or not to proceed with treatment from the clinical ethics committee operating within the licensed clinic.
4. Clinical ethics committees should be empowered to make decisions about whether treatment should be provided to a person or couple where there is a concern that a prospective child will be at risk of abuse or neglect.
5. Clinical ethics committees should include a child development expert, a psychologist or psychiatrist with expertise in prediction of risk of harm to children and a doctor with experience in assisted reproductive technology.
6. Clinical ethics committees should develop their own procedural guidelines and processes, and should have regard to the guiding principles of the Infertility Treatment Act.
7. Clinical ethics committees should be able to convene quickly to ensure cases are dealt with expeditiously.
8. Clinical ethics committees should be provided with training and support.
9. The Infertility Treatment Authority should review the operation of clinical ethics committees after five years.

10. Where a clinical ethics committee decides that a person or couple should not be treated:
 - (a) the person or couple may apply to the Infertility Treatment Authority review panel to have the decision reviewed
 - (b) a clinic must not treat that person or couple unless the committee's decision is reviewed by the Infertility Treatment Authority review panel and the panel decides that there is no barrier to treatment or decides that subject to compliance with certain conditions, there is no barrier to treatment.
11. Where a clinical ethics committee decides that there is no barrier to a person or couple being treated, a clinician should not be compelled to provide treatment.

PRESUMPTIONS AGAINST TREATMENT

12. A licensee should not treat a person without the approval of the Infertility Treatment Authority review panel if the licensee is aware that the person seeking treatment and/or his/her spouse or partner (if any):
 - (a) has had charges proven against them for a sexual offence as defined in clause 1 of Schedule 2 to the *Sentencing Act 1991* or
 - (b) has been convicted of a violent offence as defined in clause 2, Schedule 1 to the *Sentencing Act 1991* or
 - (c) has had a child protection order (but not an interim order) made in respect of one or more children in their care under a child welfare law of Victoria or any equivalent law of the Commonwealth, or any place outside Victoria (whether or not in Australia).
13. In order to determine whether a presumption against treatment applies, clinics should require people seeking treatment to make a statutory declaration as to the existence or otherwise of facts or circumstances giving rise to a presumption against treatment.

REVIEW PANEL

14. A review panel should be established to decide whether or not a person or couple is eligible for treatment where:
 - one of the presumptions against treatment in Recommendation 12 applies or
 - a person or couple seeks review of a clinical ethics committee recommendation that they not be treated because of a concern about the health and wellbeing of any child that might be born as a result of a treatment procedure or
 - a person or couple seeking treatment does not satisfy the requirements in recommendation 28.
15. A person whose case is being heard by the review panel shall have:
 - the right to be heard
 - the right to be represented by a lawyer
 - the right to call evidence.
16. The review panel should otherwise determine its own processes and procedures.

Recommendations

17. In making its decisions the review panel should have regard to the guiding principles of the Infertility Treatment Act.
18. If the review panel decides that a person or couple should not be treated, a clinic must not treat that person or couple.
19. If the review panel decides that a person should not be treated unless he or she (or a partner) meets certain conditions, a clinic must not treat that person (or couple) until those conditions have been met.
20. Where the review panel decides there is no barrier to treatment, or there is no barrier to treatment once certain conditions have been met, the decision of the panel must be conveyed to all licensed clinics in Victoria and to the person (or couple) seeking treatment. In such circumstances a clinic will not be compelled to treat the person (or couple).
21. The review panel should comprise five members, including:
 - a lawyer with experience in the conduct of hearings and knowledge of relevant areas of law, to sit as chair of the panel
 - a person with expertise in child development and welfare and the prediction of risk of harm to children
 - a person with expertise in the clinical medical practice of assisted reproductive technology
 - a psychologist or psychiatrist with expertise in families
 - a person with knowledge of the ethics of clinical medical practice.
22. The review panel should be able to seek expert advice about the case before it from people:
 - with understanding of the concerns of people with ongoing disability or illness
 - with expertise in the rehabilitation of people who have committed sexual offences and/or offences involving violence.
23. There should be a gender balance in the membership of the review panel.
24. Members of the review panel should receive training about the conduct of hearings and the principles of natural justice and procedural fairness.
25. Decisions of the review panel should be reviewable by the Supreme Court of Victoria in accordance with the *Administrative Law Act 1978*.

MARITAL STATUS

26. The requirement that a woman who undergoes an assisted reproduction treatment procedure be 'married and living with her husband on a genuine domestic basis', or 'living with a man in a de facto relationship' should be removed.
27. The Infertility Treatment Act should otherwise be amended to recognise that some people to whom the Act applies will be married or in heterosexual de facto relationships, some will be in same-sex relationships and others will not have partners.

UNLIKELY TO BECOME PREGNANT

28. Before a woman undergoes an assisted reproductive treatment procedure a doctor must be satisfied that the woman is:
 - (a) in the circumstances in which she finds herself, unlikely to become pregnant other than by a treatment procedure or
 - (b) unlikely to be able to carry a pregnancy or give birth to a child without a treatment procedure or
 - (c) at risk of transmitting a genetic abnormality or a disease to a person born as a result of a pregnancy conceived other than by a treatment procedure (including where the woman's partner is the carrier of the genetic abnormality or disease which is likely to be passed on to a child conceived other than by a treatment procedure).

For the purpose of (a), the doctor may be satisfied that a woman is unlikely to become pregnant other than by a treatment procedure if she does not have a male partner.

For the purpose of (c), the doctor must seek advice from another doctor who has specialist qualifications in human genetics or infectious diseases.

29. Where a woman does not satisfy these requirements she may apply to the review panel, which may authorise the clinic to provide the treatment procedure.
30. In deciding such applications, the review panel should have regard to:
 - the guiding principles of the Act
 - whether the treatment being sought is for a therapeutic goal and is consistent with the best interests of the child to be born.

ELIGIBILITY FOR DONATED GAMETES

31. In circumstances where donated gametes are not available, treatment with donated embryos should be permitted even where one partner in a couple has viable gametes.

NEW DEVELOPMENTS IN TREATMENT

32. An ethics committee should be established to consider the ethical implications of new developments in treatment or new applications of existing techniques.
33. The Infertility Treatment Authority should provide administrative support to the ethics committee and should be responsible for convening the committee.
34. Where the Infertility Treatment Authority becomes aware of a new development in treatment, or a new application of an existing technique, the matter must first be considered by the ethics committee before it permits clinics to make those treatments available pursuant to the Authority's conditions for licence.
35. Where an approved doctor, scientist or counsellor considers that a new development in treatment or a new use of treatment raises ethical concerns, the matter must be referred to the ITA's ethics committee for advice.

36. In reaching a decision about whether clinics should be able to make the new development in treatment available, the ethics committee:
 - must have regard to the guiding principles of the Act
 - may choose to undertake public consultation.
37. The Infertility Treatment Authority should act on the advice of the ethics committee when making decisions about applications and conditions for licence.
38. The ethics committee should comprise five members appointed by the Minister, including:
 - a representative from the Fertility Society of Australia
 - a senior clinician not involved in assisted reproductive technology, with experience in research
 - an ethicist
 - a person with expertise in public health policy and research, including the broad social determinants of health
 - a person with expertise in child development and families.
39. The committee should be able to consult with experts in particular areas, for example a person with knowledge of and expertise in disability policy, as the need arises.

NAME OF ACT AND AUTHORITY

40. The Infertility Treatment Act should be renamed the Assisted Reproductive Technology Act.
41. The Infertility Treatment Authority should be renamed the Assisted Reproductive Technology Authority.

SELF-INSEMINATION

42. Clinics should continue to be permitted to screen and store sperm for use by women who wish to self-inseminate with sperm from known donors.
43. The Infertility Treatment Authority should develop information resources for people who use self-insemination to conceive. Such resources should:
 - include information about the implications of donor conception for parents and children
 - refer people to available support services including counsellors, doctors and lawyers
 - be made available for distribution by the Registry of Births, Deaths and Marriages, obstetricians and gynaecologists, and gay and lesbian health services and resource centres.
44. The Infertility Treatment Authority should be empowered to accredit non-clinic-based counsellors who have received specialist training in relation to donor conception and same-sex parented families. Training should cover same-sex parenting, family arrangements, health issues, legal implications, disclosure of donor information, and children's outcomes.

45. Counselling should:
 - be available to all women who are contemplating or engaged in conception through assisted reproduction, irrespective of whether they are undergoing treatment in a clinic or not
 - be available before conception and throughout the process as required
 - discuss options, clarify rights and responsibilities of all parties and ensure informed consent
 - be affordable
 - be provided by trained and accredited counsellors working both inside and outside the clinic system.
46. It should not be an offence for a woman to carry out self-insemination, nor an offence for her spouse, domestic partner (if any) or friend to assist her to carry out self-insemination.
47. No person should be permitted to carry out assisted insemination as a service unless he or she is licensed to do so.

DONATION OF GAMETES

48. The questions asked of donors in the tissue donation statement should relate directly to identifiable risk factors, and should be no more intrusive of the donor's privacy than is necessary to be able to identify those factors. The form of the declaration should be reviewed periodically to ensure it is consistent with current medical knowledge.
49. Clinics should inform potential donors about the use of information given in answers to questions in the tissue donation statement.
50. The time period for which sperm should be quarantined before it can be used in a treatment procedure should be prescribed by the Infertility Treatment Authority, rather than by legislation. The period should reflect current medical knowledge about risk factors, and should be reviewed periodically.
51. Donors should not be permitted to specify the qualities or characteristics of the unknown recipients of their donated gametes and embryos.

POSTHUMOUS USE

CONSENT

52. If, and only if, a person has expressly consented to the posthumous use of their gametes (or embryos formed with the gametes) by their partner, should a clinic able to use those gametes or embryos in a treatment procedure in accordance with any conditions stipulated by the deceased (unless those conditions are contrary to law).
53. It should not be possible to use donated gametes in a treatment procedure if a clinic is aware that the donor has died.

Recommendations

APPLICATIONS

54. Each application to use the gametes or embryos of a deceased person should be considered by the clinical ethics committee within the licensed clinic to assess the possible impact on any child to be born, with particular regard to any research findings on outcomes for children conceived after the death of one parent. The assessment process should take account of the sensitive nature of the application.

COUNSELLING

55. If a person intends to use the gametes or embryos of his or her deceased partner in a treatment procedure, the person must receive appropriate counselling before the treatment procedure is carried out. Counselling must address the grieving process and its impact on conception, and in particular the appropriate period of time which should elapse between the deceased's death and attempts at conception.
56. Where a person is seeking treatment using the gametes or embryos of a person who has died, the counselling and information provisions in the Act should not apply in respect of the deceased person.
57. The Infertility Treatment Authority should monitor any available research on the effects on children born as a result of posthumous use of gametes and embryos.

RETRIEVAL

58. A medical practitioner should be able to remove gametes from a living person where that person has expressly consented to such removal, but not in any other circumstances.
59. A medical practitioner should be able to remove gametes from a person who is dead if the deceased person expressly consented to posthumous retrieval and to their use by the surviving partner to create a child.
60. Where express consent to retrieval of gametes after death exists but cannot be located, the spouse or next-of-kin should be required to make a statutory declaration that written consent exists before a medical practitioner can retrieve the gametes. The written document must be produced before the gametes can be used in a treatment procedure.

NOTIFICATION OF WISHES

61. Clinics should ensure that people's wishes about posthumous use of their gametes and embryos are recorded.
62. Clinics should contact all people whose gametes and embryos are already in storage to ascertain their wishes with respect to posthumous use.
63. Donors should be counselled about the limits on posthumous use of gametes and must be advised to make arrangements for the clinic to be notified if they die.

EXPORT

64. In making decisions about whether approval should be given to export gametes or embryos outside Victoria, the Infertility Treatment Authority should be required to take into account whether the gametes or embryos will be used in a manner which is consistent with Victorian law.

STATUS OF CHILD AND DECEASED

65. Where a woman gives birth to a child conceived with gametes contributed by her deceased partner, the child should be regarded as the child of the deceased for the purpose of birth registration, but not for any other purpose under Victorian law (in particular the laws of succession).
66. Where a couple in a treatment program is contemplating posthumous use of gametes or embryos, they should be counselled to seek legal advice about making provision for any posthumously conceived child in their wills.

ADOPTION

67. The *Adoption Act 1984* should be amended to allow the County Court to make adoption orders in favour of same-sex couples.
68. The same-sex partner of the parent of a child should be able to apply to adopt the child in accordance with the same criteria that apply to opposite-sex partners.
69. The Department of Human Services should review the *Adoption and Permanent Care Procedures Manual* to accommodate applications by same-sex couples.
70. Adoption agency staff should receive training to provide education about parenting by same-sex couples.
71. The *Adoption Act 1984* should be amended to allow the County Court to make an adoption order in favour of a single person in accordance with the same criteria that apply to couples.

RECOGNITION OF NON-BIRTH MOTHERS

72. The law should recognise a birth mother's female partner (non-birth mother) as a parent of the child.
73. A non-birth mother should be presumed for all purposes to be a parent of the child where:
 - she is the domestic partner of the mother of the child
 - she consented to the treatment procedure by which the mother conceived the child at the time the procedure was carried out.
74. The existence of a non-birth mother's consent at the relevant time should be presumed, but able to be rebutted. The presumption of parentage should otherwise be conclusive.
75. The presumption of parentage should apply in respect of children born both before and after the introduction of the presumption. However, it should not affect any property rights or interests which existed prior to the introduction of the presumption.

76. The Supreme Court should be empowered to make declarations of parentage in relation to donor-conceived children to whom presumptions of parentage apply.
77. Consequential amendments should be made to the *Births, Deaths and Marriages Registration Act 1996* and, where appropriate, to all other Victorian legislation which contains provisions relating to parent-child relationships, to recognise that a child may have two parents of the same sex.
78. The Attorney-General should work with the Standing Committee of Attorneys-General and Family Law Council to seek reform of the *Family Law Act 1975* to ensure that non-birth mothers are recognised as parents for the purposes of that Act and *Child Support (Assessment) Act 1989*.

STATUS OF DONORS

79. Where a woman becomes pregnant as the result of a treatment procedure using donor sperm (whether carried out in a licensed clinic or not), the man who donated the sperm should be presumed for all purposes not to be the father of any child born as a result of the pregnancy.
80. Where a woman becomes pregnant as the result of a fertilisation procedure using a donated egg, she should be conclusively presumed to be the mother of any child born as a result of the pregnancy. The woman who donated the egg should be presumed for all purposes not to be the mother of any child born as a result of the pregnancy.

BIRTH REGISTRATION

81. Where a woman is presumed to be a parent of a child she should be entitled to be registered on the register of births.
82. The Registry of Births, Deaths and Marriages should produce revised birth registration forms and birth certificates giving people the choice of the terms 'mother', 'father' and 'parent'. Parents should be provided with information explaining these options.
83. Where a woman is presumed to be a parent of a child as a result of the retrospective application of the presumption in Recommendation 75, and wishes to have her name recorded on the child's birth certificate, she should be able to apply to amend the child's birth certificate to name her as a parent.
 - If the birth certificate lists only one parent, the application should be made by the child's mother and non-birth mother and should be accompanied by a statutory declaration verifying that the non-birth mother consented to the procedure by which the child was conceived.
 - If the birth certificate already includes the name of the donor as the child's father, a court order should be required before the births register can be amended.
84. The staff of the Registry of Births, Deaths and Marriages should receive training on these changes.

ACCESS TO INFORMATION

DISCLOSURE OF DONOR STATUS

85. Parents who have children born through the use of donated gametes should be provided with access to ongoing counselling and support and resources to enable them to inform their children about their genetic origins. New and emerging ways of encouraging and equipping parents to tell their children should be investigated by the Infertility Treatment Authority, counsellors and clinicians.

DONOR ACCESS TO INFORMATION

86. Donors should not be able to apply for identifying information about children conceived using their gametes.
87. Donors should be able to register with the Infertility Treatment Authority their wishes for identifying information about, or contact with, any children conceived using their gametes, in the event that a child initiates an inquiry.
88. Donors should be encouraged to advise the Infertility Treatment Authority if, after the donation has been made, they become aware of a genetic illness or condition which may have been transmitted to any person conceived using their gametes.
89. If the Infertility Treatment Authority receives a medical report containing such information, it should pass the information on to the parents of the donor-conceived child, if under 18. If 18 or over, the information should be provided directly to the donor-conceived person.
90. When passing on the information to the donor-conceived person, the Infertility Treatment Authority should offer him or her information and counselling about the significance of the information.
91. If a clinic becomes aware of relevant genetic information about donors, it should pass that information on to the Infertility Treatment Authority.
92. People who have already donated gametes which have been used in the conception of a child should have a window period of 12 months in which to make an application under existing provisions for information about people conceived with their gametes. After this time period, all donors should be subject to the new procedures, regardless of the date on which they made their donation.

CHILDREN CONCEIVED OUTSIDE THE CLINIC SYSTEM

93. Women who conceive children by self-inseminating with sperm from known donors should be encouraged to register the donors' names on donor registers.
94. If the Registry of Births, Deaths and Marriages is aware that a child whose birth is being registered is donor-conceived, it should encourage the parents of the child to register the name of the donor with the Infertility Treatment Authority, if they have not already done so.

Recommendations

CHILDREN'S ACCESS TO INFORMATION

95. Donor-conceived children under the age of 18 should be able to apply for information identifying donors, but access to the information should only be granted if an accredited counsellor is of the opinion that the child has sufficient maturity to be able to understand the nature of the information.
96. If a donor-conceived child applies for information identifying the donor before he or she is 18 years old, that information should be able to be released to the child without the consent of the donor.

RETROSPECTIVE ACCESS TO INFORMATION

97. If a person conceived with gametes donated prior to 1 January 1998 wishes to obtain identifying information about the donor and the donor has not registered his or her wishes on a voluntary register:
 - The donor-conceived person should contact the agency managing the registers to request that it facilitate an approach to the donor.
 - The agency managing the registers should contact the clinic where the person's mother received treatment (if it can be identified) and ask the clinic to forward a letter from the Infertility Treatment Authority to the donor.
 - The letter from the agency managing the registers to the donor should explain the donor's options in respect of providing identifying information to the person conceived with his or her gametes, and should draw attention to the availability of counselling to explore those options further.

DONOR REGISTERS

98. A service, independent of the Infertility Treatment Authority and connected to the Registry of Births, Deaths and Marriages—similar to the Adoption Information Service—should be established to manage donor registers. Donor registers should be transferred from the Infertility Treatment Authority to this new agency.

ELIGIBILITY FOR SURROGACY

ELIGIBILITY

99. If a person or couple wishes to commission a woman to carry a child on their behalf, a doctor must be satisfied that:
 - they are in the circumstances in which they find themselves, unlikely to become pregnant, be able to carry a pregnancy or give birth or
 - a commissioning woman is likely to place her life or health, or that of the baby, at risk if she becomes pregnant, carries a pregnancy or gives birth.

100. If, before a person or couple commission a woman to carry a child on their behalf, a doctor or counsellor believes that any child that might be born as a result of the arrangement may be at risk of abuse or neglect, he or she should seek advice about whether or not to proceed with treatment from the clinical ethics committee operating within the licensed clinic.
101. Where a clinical ethics committee decides that a person or couple should not be able to commission a surrogacy, or the surrogate mother and her partner (if any) should not be able to participate in a surrogacy arrangement:
 - (a) the person concerned may apply to the Infertility Treatment Authority review panel to have the decision reviewed
 - (b) a clinic must not take any steps in relation to the surrogacy unless the committee's decision is reviewed by the Infertility Treatment Authority review panel and the panel decides that there is no barrier to treatment or that, subject to compliance with certain conditions, there is no barrier to treatment.
102. A licensed clinic should not assist in a surrogacy arrangement without the approval of the Infertility Treatment Authority review panel where the person or couple commissioning the surrogacy, or the surrogate mother and/or her partner (if any):
 - (a) has had charges proven against him or her for a sexual offence as defined in clause 1 of Schedule 2 to the *Sentencing Act 1991* or
 - (b) has been convicted of a violent offence as defined in clause 2, Schedule 1 to the *Sentencing Act 1991* or
 - (c) has had a child protection order (but not an interim order) made in respect of one or more children in their care under a child welfare law of Victoria, any equivalent law of the Commonwealth or any place outside Victoria (whether or not in Australia).
103. A person or couple should be able to commission a surrogacy arrangement regardless of relationship or marital status or sexual orientation.

COUNSELLING AND LEGAL ADVICE

104. Before entering into a surrogacy arrangement the person or couple commissioning the surrogacy and the woman intending to act as the surrogate mother and her partner (if any) should receive:
 - counselling about the social and psychological implications of entering into the arrangement
 - advice and information about the legal consequences of entering into a surrogacy arrangement.

105. The regulations should specify the following matters to be addressed during counselling:

- the implications of surrogacy for relationships between members of a commissioning couple and between the surrogate mother and any partner
- the implications of surrogacy for the relationship between commissioning parent(s) and the surrogate mother
- the implications of surrogacy for any existing children of the surrogate mother and/or the commissioning parent(s)
- the possibility of medical complications
- the possibility that any of the parties may change their mind
- refusal of the surrogate mother to relinquish the child
- refusal of the commissioning parent(s) to accept the child
- the motivation and attitudes of the surrogate mother
- attitudes of all parties towards the conduct of the pregnancy
- attitudes of the commissioning parent(s) to the possibility that the child may have a disability
- attitudes of all parties to investigation of a genetic abnormality, the possibility of termination of pregnancy or other complications
- a process for the resolution of disputes
- the commissioning parent(s)' intentions for custody of the child, if one of them should die
- possible grief reactions on the part of the surrogate mother and/or her partner
- ways of telling the child about the surrogacy
- attitudes to an ongoing relationship between the surrogate mother and the child
- access to support networks.

106. The Infertility Treatment Authority should develop guidelines about the application of these regulations, in consultation with clinics, and should evaluate and monitor their effectiveness over time.

107. If the counsellor considers it appropriate, independent psychological testing (in accordance with accepted professional standards) or a home study should be permitted.

APPROVAL

108. In each surrogacy arrangement, the clinical ethics committee at the licensed clinic where treatment is proposed to be carried out must decide whether treatment can proceed.

109. In making a decision about whether the surrogacy can proceed, the clinical ethics committee must be satisfied that the parties:

- are aware of and understand the personal and legal consequences of the surrogacy arrangement
- are prepared for the consequences of the arrangement if it does not proceed in accordance with the parties' original intentions
- are able to make informed decisions about proceeding with the arrangement.

110. The clinical ethics committee's decision should be based on a report from a counsellor and an acknowledgement from the parties that they have received all the required and relevant information and advice.

111. A decision made by the clinical ethics committee about whether the surrogacy can proceed should be reviewable by a review panel.

SURROGATE MOTHERS

112. A woman intending to act as a surrogate mother should not be subject to the requirement that she is unlikely to become pregnant other than by a treatment procedure.

113. Apart from the above recommendation, a woman intending to act as a surrogate mother should be subject to the same criteria that apply to all women undergoing assisted reproductive technology services.

114. A woman intending to act as a surrogate mother should be at least 25 years old.

115. In assessing whether a woman is able to give informed consent to act as a surrogate mother, consideration should be given to whether she has already experienced pregnancy and childbirth, however, this should not be a prerequisite.

GENETIC CONNECTION

116. Partial surrogacy should be permitted. That is, it should be possible for the surrogate mother's egg to be used in the conception of the child.

117. If the surrogate mother's egg is used in the conception of the child, counselling must address the implications of this for:

- the relinquishment of the child
- the relationship between the surrogate mother and the child once it is born.

The clinical ethics committee should confirm these matters have been the subject of counselling.

118. A genetic connection between the child and the commissioning parent(s) is to be preferred, but people should not be excluded from commissioning a surrogacy arrangement if they are unable to contribute their own gametes.

Recommendations

SURROGACY EXPENSES

119. A woman must not receive any material benefit or advantage as the result of an arrangement to act as a surrogate mother.
120. Consistent with the principle that a woman should not receive any material benefit or advantage for acting as a surrogate mother, reimbursement of prescribed payments actually incurred should be permitted.
121. Prescribed payments should be limited to:
 - any reasonable medical expenses associated with the pregnancy which are not otherwise provided for through Medicare, private health insurance or any other benefit
 - in the absence of any entitlement to paid maternity or other leave, lost earnings up to a maximum period of two months
 - any additional lost earnings or medical expenses incurred as a result of special circumstances arising during pregnancy or immediately after birth, for example, where the surrogate mother has been advised by her doctor that she should stop working earlier than anticipated
 - any reasonable legal expenses associated with the surrogacy arrangement.
122. Surrogacy agreements should continue to be void. However, where parties to a surrogacy arrangement have agreed to the reimbursement of prescribed payments, that part of the agreement should be enforceable.

SURROGACY AND PARENTAGE

LEGAL PROCESS

123. The *Status of Children Act 1974* should be amended to empower the County Court to make substitute parentage orders in favour of a person or couple who have commissioned a surrogacy arrangement (the applicant(s)), subject to the conditions that:
 - the court is satisfied that the order would be in the best interests of the child
 - the application was made no earlier than 28 days and no later than six months after the birth of the child
 - at the time of the application, the child's home is with the applicant(s)
 - the applicants have met the eligibility criteria for entering into a surrogacy arrangement
 - the surrogate mother and/or her partner (if she has one) has not received any material advantage from the arrangement save for reimbursement of expenses permitted by the legislation
 - the surrogate mother freely consents to the making of the order.

124. In deciding whether to make a substitute parentage order, the court should also take into consideration whether the surrogate's partner (if she has one) consents to the making of the order.
125. If the application is made by a person whose partner consented to the arrangement before the child was conceived but has not consented to the application for a substitute parentage order, there should be a presumption that that person will also become a legal parent of the child.
126. A substitute parentage order should have the same status and effect as an adoption order made under the *Adoption Act 1984*.

COMPLETED SURROGACY ARRANGEMENTS

127. The court should have discretion to make substitute parentage orders in favour of people who have already had children through surrogacy. In exercising its discretion, the court should be satisfied that:
 - the order would be in the best interests of the child
 - the child's home is with the applicants
 - the applicants have to the extent possible met the eligibility criteria for entering into a surrogacy arrangement
 - the surrogate mother and/or her partner (if she has one) has not received any material advantage from the arrangement, save for reimbursement of expenses permitted by the legislation
 - the surrogate mother freely consents to the making of the order.

BIRTH CERTIFICATES

128. Once a substitute parentage order has been made, the birth register should be amended to record the commissioning parent(s) as the parents of the child and a new birth certificate should be issued.

PROVIDING INFORMATION

129. The central register maintained under the *Infertility Treatment Act 1995* should be expanded to allow identifying information about a surrogate mother and commissioning parent(s) to be registered and released to the child in the same way as information about donors is registered and released.
130. The commissioning parent(s) and the surrogate mother should be counselled about the importance of informing children of their genetic origins and the circumstances of their birth. They should be provided with ongoing counselling and support to enable them to inform children about their origins.

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Chapter 1

Introduction

The provision of and access to assisted reproductive technology in Victoria is governed by the *Infertility Treatment Act 1995* and adoption is regulated by the *Adoption Act 1984*. Initially, the law restricted access to reproductive services to women who were married and living with their husbands; similarly, only married couples could adopt children. In 1997 access to reproductive technology and adoption was extended to people in heterosexual de facto relationships.¹ The following year, the Equal Opportunity Commission of Victoria produced a report on same sex relationships and the law in which it called for more consideration and consultation on the issues surrounding extension of adoption and reproductive technology to people in same sex relationships.²

In 2002, the Attorney-General, the Honourable Rob Hulls, asked the Victorian Law Reform Commission (the commission) to conduct an inquiry and report on the laws that govern the use of assisted reproduction in Victoria and in particular the desirability and feasibility of expanding the eligibility criteria for access to assisted reproduction and adoption.³

WHAT IS ASSISTED REPRODUCTION?

Assisted reproduction refers to procedures that are used to help a person to conceive a child when conception through heterosexual intercourse is impossible or difficult, or carries a risk that a disease or genetic abnormality may be transmitted to the child. Some people provide their own sperm and eggs for the procedure; other people may need to use donated sperm and/or eggs (referred to as gametes). The need to use donated gametes arises when there are difficulties conceiving, when a person carries a disease or genetic abnormality and when women without male partners want to have children. Donors may be known to the recipients or anonymous.

Assisted reproduction may include the use of one or more of the following procedures:

- insemination with donor sperm (sometimes referred to as artificial or assisted insemination)
- gamete intra-fallopian transfer (GIFT)
- intracytoplasmic sperm injection (ICSI)
- in-vitro fertilisation (IVF)

We briefly explain each of these terms below.

INSEMINATION

A woman may be assisted to conceive if semen is placed in her vagina (birth canal), cervix (the opening to her uterus) or directly into her uterus. We call this assisted insemination. Vaginal insemination does not necessarily require medical assistance. If a woman has access to fresh semen she can perform vaginal insemination herself by injecting semen (usually fresh) into the vagina, usually using a plastic syringe. We call this self-insemination. Intrauterine insemination does require medical assistance as it involves the placement of sperm into the womb using a fine catheter.⁴

GIFT, ICSI AND IVF

Gamete intra-fallopian transfer (GIFT) is a medical procedure developed to treat infertility. Eggs are collected from a woman's ovaries and are then placed together with sperm (which has been collected and washed) directly into the woman's fallopian tube using a fine sterile plastic tube.⁵

Intracytoplasmic sperm injection (ICSI) is the direct injection of a single sperm into the substance (cytoplasm) of the egg. The microinjection procedure is most commonly used for severe forms of male infertility or after a cycle with poor fertilisation.⁶

In-vitro fertilisation (IVF) is the procedure by which a woman's egg and a man's sperm are mixed in a laboratory. It involves mixing the egg with thousands of sperm and allowing the process of fertilisation to take place over a number of hours in a culture dish. Provided fertilisation occurs in the laboratory and the resultant embryos look normal, the embryos are transferred into the uterus of the woman.⁷

OTHER PROCEDURES

If a woman requires treatment other than insemination in order to conceive, this treatment is likely to involve a 'stimulation cycle'. This includes the administration of drugs (either by the clinic or by the woman herself) designed to encourage the development of multiple eggs in the woman's ovaries. If one or more eggs do develop, these will be surgically removed (this is referred to as egg pick-up). After this procedure, the woman may remain in theatre and be given a general anaesthetic while a fine tube is loaded with a volume of sperm, the eggs and another volume of sperm. The contents of this tube are then transferred into the woman's fallopian tube through a GIFT process. Some types of GIFT procedure do not require general anaesthetic.

Alternatively (and also if there are remaining eggs from the GIFT procedure) the eggs will be fertilised in a laboratory. This may be done by the conventional IVF method. Alternatively, if this technique is unlikely to result in fertilisation (because the number of sperm available is insufficient or because there is reason to believe that the sperm will be unable to penetrate the egg), the technique of ICSI is usually applied. If fertilisation is successful, the embryo or embryos will be transferred to the woman's uterus two to three days after egg pick-up. No anaesthetic is required. Further medication may be prescribed after embryo transfer.

If there are more than one or two embryos, the remainder will be frozen after the fresh embryo transfer.⁸ If a woman does not achieve a pregnancy on this first cycle, a subsequent attempt may be made by thawing the embryos at the appropriate time in her cycle and transferring them to her uterus by the same process as the transfer of a fresh embryo.

PREIMPLANTATION GENETIC DIAGNOSIS

Preimplantation genetic diagnosis (PGD) is a process where embryos are examined to determine if they are affected by a particular disease or disorder. It is used by parents who wish to avoid passing a serious genetic disease to their children. The process of gene testing by PGD means that the sex of an embryo can be determined before it is transferred to a woman's body.

SURROGACY

Surrogacy involves a woman who agrees to become pregnant and give birth to a baby which she then permanently surrenders to another person or couple who will be the child's parent or parents. Surrogacy arrangements may involve the use of forms of ART, for example an embryo may be formed in a laboratory and then transferred to the surrogate's uterus. In such cases the embryo may be created with the commissioning mother's or donated eggs and fertilised with the commissioning father's or donated sperm, or using the surrogate mother's own eggs fertilised with the commissioning father's or donated sperm.

ADOPTION

Adoption is relatively rare in Australia. Birth parents are generally encouraged to explore alternatives to adoption such as permanent care arrangements, which preserve their legal relationship with the child. However, in situations where this is not feasible, adoption does occur. The primary purpose of adoption is to provide a stable family for a child in need, rather than to meet the need or desire of an adult for a child.

Infant adoption involves the birth parent or parents of a child relinquishing responsibility for that child to another individual or couple. Step-parent adoption is the adoption of the child by a heterosexual partner of one of the child's birth parents. Step-parent adoption extinguishes the legal relationship between the child and one of his or her birth parents, but not the other. Relative adoption is the adoption of the child by a grandparent, brother, sister, uncle or aunt.

WHAT THE REFERENCE COVERS

The commission was asked to report on the laws that govern the use of assisted reproduction in Victoria and in particular the desirability and feasibility of expanding the eligibility criteria for access to assisted reproduction and adoption. As part of the reference, the commission has also considered the laws that govern family relationships that arise as a consequence of assisted reproduction.

The reference involves consideration of possible amendments to the following Victorian legislation:

- *Fertility Treatment Act 1995*
- *Adoption Act 1984*
- *Status of Children Act 1974*
- *Births, Deaths and Marriages Registration Act 1996*
- *Human Tissue Act 1982*
- *Equal Opportunity Act 1995*

and any other relevant Victorian legislation.

In conducting our research, the commission has been asked to take into account:

- the social, ethical and legal issues related to assisted reproduction and adoption, with particular regard to the rights and best interests of children
- the public interest and the interests of parents, single people, people in same-sex relationships, infertile people and donors of gametes

1 *The Disability Services and Other Acts (Amendment) Act 1997* amended the *Adoption Act 1984* and the *Infertility Treatment (Amendment) Act 1997* amended the *Infertility Treatment Act 1995*. A de facto relationship is defined as the relationship of a man and a woman who are living together as husband and wife on a genuine domestic basis, although not married.

2 Equal Opportunity Commission Victoria, *Same Sex Relationships and the Law* (1998), 29.

3 The full terms of reference are set out on page 5.

4 Monash IVF, *Guide to Getting Started* (2003) 28.

5 *Ibid* 27.

6 *Ibid* 28.

7 *Ibid*.

8 This process of deep-freezing embryos which have not been transferred to the body of a woman is known as embryo cryopreservation.

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- the nature of and issues raised by arrangements and agreements relating to methods of conception other than sexual intercourse and other assisted reproduction in places licensed under the *Infertility Treatment Act 1995*
- the penalties applicable to persons, including medical and other personnel, involved in the provision of assisted reproduction (whether through a licensed clinic or otherwise)
- the laws relating to eligibility criteria for assisted reproduction and adoption and other related matters which apply in other states or countries and any evidence on the impact of such laws on the rights and best interests of children and the interests of parents, single people, people in same-sex relationships, infertile people and donors of gametes.

The commission was also asked to consider whether amendments should be made to reflect rapidly changing technology in the area of assisted reproduction.

Our terms of reference in relation to surrogacy are limited. The commission was requested to specifically consider how certain provisions of the *Infertility Treatment Act* apply to the practice of altruistic surrogacy and to make recommendations for clarification of the legal status of any child born of such an arrangement.

The commission was asked to consider the relationship between changes to Victorian legislation and any relevant Commonwealth legislation including the *Family Law Act 1975* and the *Sex Discrimination Act 1984* as well as any international conventions and instruments to which Australia is a signatory.

WHAT IS NOT UNDER REVIEW?

The commission has been asked to enquire into and report on the desirability and feasibility of expanding the eligibility criteria for access to assisted reproduction. We have not been asked to address the question of whether such services should be available in the first place.

There are a number of issues covered by the *Infertility Treatment Act* which the commission has not been asked to examine:

- human cloning, which is prohibited under the *Infertility Treatment Act* under Part 4A, Division 1
- human embryo research, which is regulated by the *Infertility Treatment Act* under Part 3, Divisions 1 and 2
- the system for licensing clinics which provide treatment procedures or research (*Infertility Treatment Act*, Part 8)

Our terms of reference in relation to adoption are also limited. The commission has been asked to make recommendations in relation to eligibility for adoption. We have not been asked to examine the overall regulation of adoption, the process for approval of adoption applications or regulation of access to adoption information.

OUR PROCESS

The commission's research process for the project leading to this final report has been conducted over four years. We have engaged in detailed research, written and produced publications, held consultations and roundtables and received a great many submissions.

PUBLICATIONS

In December 2003 the commission published a Consultation Paper in which we sought feedback on whether the criteria for access to assisted reproductive technology and adoption should be changed in Victoria.⁹ In this publication, we provided an overview of the current regulatory framework and highlighted the effects of restrictions on access to ART services. The consultation paper presented a series of questions and possible options for reform in relation to the three key areas covered in the reference: access to services, family relationships and surrogacy.

The commission published three Occasional Papers during 2004, each of which provided detailed analysis and commentary by experts working in the field.¹⁰ Dr Ruth McNair of the Department of General Practice, University of Melbourne, provided the results of her research into outcomes for children born of ART in a diverse range of families. Adjunct Professor John Seymour and Sonia Magri provided a comparative legislative review of assisted reproductive technology (ART), surrogacy and legal parentage in Australia, Canada, the United Kingdom and the United States. John Tobin from the Law School at the University of Melbourne provided an account of the *Convention on the Rights of the Child* and its application to the principle of the rights and best interests of children conceived through assisted reproduction.

During 2005, we published three Position Papers which set out the commission's preliminary views on the three areas of access, parentage and surrogacy. Each Position Paper included a discussion of the relevant issues, a summary of findings and arguments and draft interim recommendations. *Position Paper One: Access* covered the issues associated with access and eligibility, self-insemination, directed donations and posthumous use of gametes. *Position Paper Two: Parentage* included interim recommendations on status of non-birth mothers, status of donors, access to information and adoption. *Position Paper Three: Surrogacy* presented proposals for regulation of eligibility, payment, parentage and access to information in relation to altruistic surrogacy. The commission invited comments on the recommendations and responses to questions about the practical operation of the proposals.

CONSULTATIONS

Consultations were first held throughout 2004.¹¹ Approximately 60 stakeholders attended a session to discuss access to ART and adoption in the creation of new families. A public forum held to launch the three Occasional Papers was advertised widely and attended by approximately 150 stakeholders and members of the public. People with relevant expertise in medicine, law and social sciences were invited to participate in a series of roundtable discussions on the key areas of access to services, recognition of family relationships, surrogacy and technological change.¹² During this year, the commission also attended 14 meetings and forums with experts, community groups, service providers and statutory authorities to discuss specific aspects of the project and general progress on the reference.

A further 14 meetings and forums were attended during 2005 in which the commission briefed community groups, agencies and experts on the proposals presented in the Position Papers.

During 2006, further consultations were held to discuss the commission's interim recommendations, including another series of roundtable discussions and meetings.

SUBMISSIONS

There has been strong public interest in the commission's work on this project, attracting the involvement of people with a wide range of perspectives on the issues associated with assisted reproductive technology and adoption. The majority of submissions have been received from individuals. The commission received 255 submissions in response to the consultation paper.¹³ Submissions referred to issues of access and eligibility, whether it was justifiable for decisions about access to treatment to be based on marital status or sexual orientation, gamete donation and the posthumous use of gametes. Many submissions expressed concern about the lack of clear legal rules to determine the parentage of children conceived through assisted reproduction and supported the right of children to have access to information about their genetic heritage; many also focused on issues relevant to surrogacy.

The commission received a further 351 submissions in response to the commission's draft interim recommendations in Position Paper One; Position Paper Two attracted 352 submissions and 60 submissions were made to Position Paper Three.¹⁴

RESEARCH

There is significant research interest in the field of assisted reproduction and changing family formations and a growing amount of literature relevant to the issues raised in this project. Members of the research team have engaged in thorough analysis of published research, identifying, collecting and reading literature since the beginning of the project. We have established and maintained a library of over 450 books and articles drawn from the fields of medicine, law and social sciences and have kept up-to-date with developments in the field.

GUIDING PRINCIPLE

The commission has drawn on the internationally recognised principle of the best interests of the child to guide the development of our recommendations in relation to ART and adoption. This principle is clearly articulated in the international *Convention on the Rights of the Child*, to which Australia is a signatory.¹⁵ The principle is reflected in ART, child welfare and care and protection legislation in Victoria, South Australia, Western Australia, the United Kingdom and Canada.¹⁶

9 Consultation Paper, *Assisted Reproductive Technology & Adoption: Should the Current Eligibility Criteria in Victoria be Changed?* (2003), available from our website <www.lawreform.vic.gov.au>.

10 All occasional papers are available from our website <www.lawreform.vic.gov.au>.

11 A list of all consultations held throughout the reference is included in Appendix 3.

12 Details of roundtables are included in Appendix 3.

13 A list of submissions in response to the Consultation Paper is included in Appendix 2.

14 Lists of submissions in response to the three Position Papers are included in Appendix 2.

15 United Nations, *Convention on the Rights of the Child*, UN GAOR, 44th sess, UN Doc A/44/736 (1990) art 3(1).

16 The principle is variously expressed as 'welfare', 'welfare and interests', 'best interests' or 'health and wellbeing' of the child or person to be born.



Chapter 1

Introduction

ABOUT THIS REPORT

This report is divided into four sections. In this first section, we provide information about the social context in which the issues relevant to ART and adoption arise and an overview of the current regulatory framework in Victoria.

The second section of the report (Chapters 4–10) covers issues associated with access to treatment, including eligibility, self-insemination, sex selection, gamete and embryo donation, posthumous use and adoption.

In the third section (Chapters 11–15) we discuss family relationships, including legal parentage, recognising non-birth mothers, status of donors, birth registration and access to information.

In the final section (Chapters 16–19) we discuss surrogacy, including eligibility, payment of expenses and determining legal parentage.

Recommendations are included in the chapters alongside the relevant discussion and a consolidated list of all recommendations can be found at the beginning of the report.

The appendices include tables of research findings from empirical studies which are relevant to the project. There is also a comprehensive list of all submissions, consultations and roundtables conducted by the commission. We have provided a bibliography and index.