



Victorian
Law Reform
Commission



ASSISTED REPRODUCTIVE TECHNOLOGY & ADOPTION

Final Report

Published by the Victorian Law Reform Commission.

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).

Designed by GH2 Design 0409 380 199.

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National Library of Australia

Cataloguing-in-Publication

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

Ordered to be printed

Victorian Government Printer

No 10 Session 2006-07



Victorian
Law Reform
Commission

ASSISTED REPRODUCTIVE TECHNOLOGY & ADOPTION

Final Report

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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.



Iain Ross AO

Acting Chairperson and Part-time Commissioner
Victorian Law Reform 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 1995* 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 reproductive 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 Infertility Treatment Authority'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 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 the *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 the person is 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
 - the 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 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, 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 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.

Chapter 1 Introduction



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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:

- *Infertility 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.

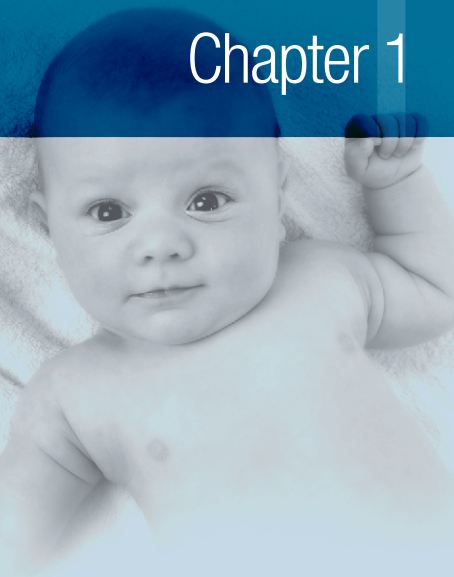
4 Monash IVF, *Guide to Getting Started* (2003) 28.

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.



- 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.

Chapter 2 Social Context

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Chapter 2

Social Context



‘While some people will regard some contemporary family changes and diversity as evidence of family decline, others will see these trends as evidence of the resilience of families as they seek to adapt to a changing world.’

In this reference the commission has considered whether eligibility criteria for all forms of assisted reproduction and adoption should be expanded, and if so, whether accompanying changes should be made to related areas of the law. In conducting the review, we were asked to have particular regard to the best interests of children, and to take account of the public interest, the interests of parents, single people and people in same-sex relationships, infertile people and donors of gametes.

The matters under review raise fundamental questions about what constitutes a family and a desirable environment in which to raise children. Submissions to the Consultation Paper and the three Position Papers expressed strong support for the guiding principle that the health and welfare of children should be given priority in decisions about the use of reproductive technology. As would be expected, submissions contained a broad range of views about how the law could best protect the health and welfare of children. Some submissions argued that the interests of children could only be protected by limiting access to assisted reproduction and adoption to married couples. Other submissions argued that eligibility requirements based on marital status are not an effective way of safeguarding the health and welfare of children and are also inconsistent with the principle of non-discrimination.

In considering reforms to the laws governing assisted reproduction, adoption and the status of children, the commission has taken account of the social context in which the legislation operates. The commission is committed to ensuring that our recommendations are based on evidence rather than on ideology or prejudice.

In this chapter we discuss the social context of our reference, including:

- the changes which have occurred in family structures in Australia over the past 30 years and community attitudes to different types of families
- the growth in the use of assisted reproductive technology (ART) which has occurred over the past decade and the increasing numbers of children being born as a result of this treatment
- changing community attitudes to the use of ART, including its use by couples in de facto relationships, same-sex couples and single women
- research about the health and welfare of children born as a result of different forms of ART and/or into diverse family types
- implications of social change for the law.

CHANGING FAMILY STRUCTURES

Over the past three decades there have been substantial changes in the structure of Australian families. Changes include a growth in the proportion of single parent families and blended families, and increases in the number of people living in same-sex relationships. A significant number of children are born to single mothers, or spend part of their childhood living with a single parent (most frequently their mother). If they live with a father and a mother these parents may or may not be married. Many children spend some of their childhood living in a family where they are not genetically related to the person living with or married to their parent. Although only a small percentage of couples report that they are living in gay or lesbian relationships, approximately one in five lesbian couples have children living with them.

While many are concerned about the social effects of these trends, it is important to recognise that families ‘come in many shapes and sizes—they always have and always will.’¹ Professor David de Vaus has analysed Australian Bureau of Statistics and census data to track changes in the nature of families which have occurred in Australia since 1976. He has commented that:

While some people will regard some contemporary family changes and diversity as evidence of family decline, others will see these trends as evidence of the resilience of families as they seek to adapt to a changing world... Inevitably as social and economic structures change, so too will families. Although some people may decry this, it is critical that families do change. For were they to remain unresponsive to broad social influences then families would end up playing an increasingly marginal role in people’s lives, and in helping them live in an increasingly complex world. ... Rather than simply following an agreed and well-established script for ‘doing family’, individuals increasingly have to work out how they will form and develop their own family biography.²

SINGLE PARENT FAMILIES

De Vaus' analysis found that although most children under 15 lived with two parents,³ between 1976 and 2001 there was a significant increase in the number of single parent families with dependent children and in the number of couples who do not have children. These changes mean that traditional 'nuclear families' are now a smaller proportion of all families. The growth in single parent families is largely due to an increase in the rate of relationship breakdown. More than a quarter of children born between 1976 and 1983 had spent some time living in a single parent family by the time they were 18.⁴ De Vaus found that 11.6% of children born in 2000 were born to women not living with a partner and a further 1.4% of children were born to women who were widowed, separated or divorced.⁵ Recent figures compiled by the Australian Bureau of Statistics indicate that 17.9% of Victorian children live in one parent families (15.1% with single mothers and 2.8% with single fathers).⁶

Other changes include an increase in the proportion of heterosexual couples who live together before getting married, or who do not marry at all. In 2001, 12.4% of heterosexual couples reported that they were cohabiting, compared with 5.7% of couples in 1986.⁷

BLENDED AND STEP-FAMILIES

Significant numbers of Australian children live in blended or step-families, where one of the parents is not genetically related to them. Blended families comprise a couple, at least one child of the couple and at least one child who is a stepchild of one member of the couple. Step-families comprise a couple and at least one child who is the stepchild of one member of the couple, but do not include a child of the couple. In the past, blended and step-families often came into existence after a married person died and his or her spouse remarried. Today they are more likely to be the result of relationship breakdown.⁸

It has been estimated that step-families and blended families make up 9.9% of all couple-based families with children under 18.⁹ In Victoria 6.9% of children live in blended and step-families.¹⁰

SAME-SEX PARENT FAMILIES

It is more difficult to obtain accurate figures on the proportion of couples living in same-sex relationships. In the 2001 Australian census just under half of one per cent of couples reported they were living in a same-sex relationship: 0.26% were male same-sex couples and 0.21% were lesbian couples.¹¹ In Canada, a similar proportion (0.5%) identified themselves as same-sex couples, and in the USA it is estimated that one per cent of all couples sharing a household were same-sex.¹²

Census data almost certainly underestimate the proportion of couples living in same-sex relationships. People may not report they are living in such relationships, because they fear discrimination or because they do not realise that same-sex relationships are now counted as couples in the census.¹³ The Australian Study of Health and Relationships conducted in 2000–01 asked more direct questions about respondents' living arrangements, and revealed that around 2.2% of all couples living in the same household were same-sex couples.¹⁴ Of these, 1.3% were male couples and 0.9% were female couples.¹⁵ Same-sex couples tend to be concentrated in the younger age groups, when the issue of having children is most likely to arise.¹⁶

Census data show that nearly 17% of lesbian couples and nearly 4% of gay male couples have a child living with them.¹⁷ Similarly, in a survey of 403 women and 240 men conducted by the Victorian Gay and Lesbian Rights Lobby in early 2005, 18.6% of respondents had children.¹⁸ Sixty three per cent of these parents lived full-time with their children.¹⁹

Research shows that there are different ways in which lesbians and gay men form families. The majority of children living with gay and lesbian parents are children born into a previous heterosexual relationship.²⁰ However, recent Victorian research suggests that a significant proportion of lesbians and gay men are planning to have children in the future.²¹ Some lesbian and gay couples are foster carers.²² The commission received a large number of submissions from lesbian and gay couples who have or are planning to have children.

- 1 David de Vaus, *Diversity and Change in Australian Families: Statistical Profiles* (2004) xv. For discussion of historical changes in families see Michael Gilding, 'Changing Families in Australia 1901–2001' (2001) 60 *Family Matters* 6.
- 2 De Vaus (2004), above n 1, xv.
- 3 *Ibid* 9.
- 4 The statistic is 26.8%: *ibid* 7.
- 5 *Ibid* 202.
- 6 Department of Human Services, *The State of Victoria's Children Report 2006* (2006), Table 1.7, 29.
- 7 De Vaus (2004), above n 1, 115.
- 8 *Ibid* 60.
- 9 *Ibid* 60.
- 10 Department of Human Services (2006), above n 6, Table 1.7, 29.
- 11 De Vaus (2004), above n 1, 82.
- 12 *Ibid*.
- 13 Australian Bureau of Statistics, *Marriages and Divorces Australia 2002*, Catalogue No 3310.0.
- 14 De Vaus (2004), above n 1, 83.
- 15 *Ibid*.
- 16 *Ibid* Table 7.1.
- 17 *Ibid* 84, Table 7.2. See also Sarah Wise, *Family Structure, Child Outcomes and Environmental Mediators, An Overview of the Development in Diverse Families Study* (2003), 3. Similar trends apply in both the United States and Canada. Census data in these countries indicate that 22% of lesbian-headed households in the United States and 15% of lesbian couples in Canada have children under 18 living in them. A smaller proportion of gay-headed households (6% of gay-headed households in the United States and 15% of gay couple households in Canada) had a child under 18 living with them: see de Vaus (2004), above n 1, 84.
- 18 Ruth McNair and Nikos Thomacos, *Not Yet Equal: Report on the VGLRL Same Sex Relationships Survey 2005* (2005), 41–2, Figure 11. In an earlier study of 670 people from the gay and lesbian community, 21% had children: Victorian Gay and Lesbian Rights Lobby, *Everyday Experiments, Report of a Survey into Same-Sex Domestic Partnerships in Victoria* (2001), 13.
- 19 McNair and Thomacos (2005), above n 18, 42–3 and Figure 12. A further 14.3% lived with their children part-time and 11.5% lived with their children only at weekends or during holidays.
- 20 de Vaus (2004), above n 1, 84.
- 21 McNair and Thomacos (2005), above n 18, 41–2. In the 2005 survey, 135 of the 652 respondents (20.9%) were planning to have children. A higher proportion (41%) of respondents in the 2001 survey wanted to have children.
- 22 Ruth McNair et al, 'Lesbian Parenting: Issues, Strengths and Challenges' (2002) 63 *Family Matters* 40.



It is difficult to determine the number of lesbian parents who have children conceived through donor insemination or other forms of ART. Although single women and women in lesbian relationships are eligible for clinic treatment in Victoria only if they are 'clinically infertile', women who are not eligible sometimes use self-insemination to become pregnant or travel interstate where they have access to donor insemination and other forms of treatment. We also spoke to some gay men who have children born as a result of surrogacy arrangements made overseas or were planning to have children in this way in the future.

CHANGING ATTITUDES TO FAMILIES

The Research School of Social Sciences at the Australian National University coordinates the Australian Survey of Social Attitudes²³ which is intended to provide information on 'what ordinary Australians feel about the major social, economic and political issues of the day.'²⁴ One area covered in the survey concerns attitudes to family structures. Respondents are asked to comment on whether they believe particular types of living arrangements constitute families. The results of the survey indicate that social attitudes now reflect acceptance of a broader range of families than was the case in the past. In turn, changes in social attitudes may influence the living arrangements which people make and their willingness to report that they are living in non-traditional family types.

The survey indicates that the presence or absence of children is an important factor in attitudes about whether a particular type of living arrangement creates a family. Seventy nine per cent of respondents (77% of men and 82% of women) said that unmarried couples with children constitute families. Interestingly, marriage was regarded as a less important determinant of a family relationship than the presence of children—63% of respondents said that they thought that a married couple without children was a family.²⁵

A similar pattern applies in the case of single parents and children. Seventy four per cent of respondents (69% of men and 78% of women) agreed that single parents with children are families. Forty two per cent of respondents thought that single parents could bring up a child as well as a couple.²⁶

A lower but still significant proportion of respondents (42%) said that same-sex couples with children are families (50% of women, 34% of men).²⁷

A number of factors influence attitudes to families. This research indicates that women are more likely than men to see living arrangements involving children as families. Attitudes to families are also influenced by the respondent's age, level of education and whether they regularly attend religious services. More than half of the respondents under 49 (65% of people aged 18–34 and 56% of people aged 35–49) think that same-sex couples with children are families. Just over a third of respondents said that the law should recognise same-sex couples, with support higher among younger people (49% of people aged 18–34) and women of all ages (40%).²⁸

The commission received some submissions which opposed changes to eligibility requirements and argued that children with same-sex parents would inevitably experience stigma and discrimination. (We discuss research which suggests that this may be the case below.) However there is also evidence that social attitudes to homosexuality are changing. A survey of 24,718 people over the age of 14 conducted by Roy Morgan Research asked whether respondents believed that 'homosexuality was immoral'. Sixty five per cent of respondents disagreed with this proposition, although there were regional variations in attitudes and differences related to age, gender, level of education and religious affiliation. Overall, 43% of men and 27% of women thought that 'homosexuality was immoral'. People living in Victoria were the least likely to agree with this statement.²⁹

The commission received submissions from a number of Christian church-affiliated organisations that argued that it was wrong for children to be brought up outside a traditional heterosexual family, especially by parents in same-sex relationships.³⁰ Significantly, the Roy Morgan survey suggests that people with religious affiliations do not always share these concerns, although there are differences between the various religious groups. Sixty six per cent of Catholics said that they did not agree that 'homosexuality is immoral', compared with 32% of Baptists and 38% of evangelical Christians.³¹ The survey included a 'non-Christian' category in which 55% of respondents said that they did not agree that homosexuality is immoral. Around 37% of all respondents thought that gay couples should be able to adopt children. The proportion was higher (56%) among those who did not believe homosexuality was immoral.³²

Since 2000 Anglicare Australia, a nationwide network of locally-based Anglican organisations involved in the provision of family support services, has published an annual report on the state of the family. The 2005 report explored the diverse family types discussed above and referred to the following definition of family:

*a family is any combination of two or more people living in a domestic household comprising a minimum of two adults, or one adult and one child. ... Any definition should also include reference to permanency and commitment, especially where the care of children is involved.*³³

Noting the changes in family structures which have occurred in Australia and overseas, the Anglicare report said that:

*While it is clear that we should continue to support notions of 'traditional family' values which uphold the necessity of one or more responsible adults caring for one or more protected children, we are now living in a changing environment where such responsibility and protection is sometimes provided by those not necessarily bound by blood or kin. There are also increasing numbers of households not based on the protection of children which still demonstrate the characteristics of responsibility, nurture and support.*³⁴

23 This survey takes the form of a mailed questionnaire sent out to 10,000 Australians every two years. The 2003 survey was distributed to a stratified sample of 11,380 people aged 18 or over selected from the electoral roll: Shaun Wilson et al (eds), *Australian Social Attitudes: The First Report* (2005) 6.

24 Ibid vii.

25 Ibid 14–15.

26 Ibid 17.

27 Ibid 19.

28 Ibid 14, 18, 19.

29 Michael Flood and Clive Hamilton, *Mapping Homophobia in Australia* (2005), 1–2.

30 Submissions were received from the Australian Christian Lobby (PP1 134), Catholic Women's League (CP 169, PP1 48), Presbyterian Church and Nation Committee (CP 87, PP1 263), Salt Shakers (CP 127), Caroline Chisholm Centre for Health Ethics (CP 145, PP1 222) and Knights of the Southern Cross (CP 318).

31 Flood and Hamilton (2005), above n 29, 13–14.

32 Ibid 5.

33 Sue Leppert (ed), *State of the Family 2005* (2005), 3–4.

34 Ibid.



ASSISTED REPRODUCTIVE TREATMENTS

In this report, we make recommendations for changes in the law in relation to access to ART and adoption, and in relation to surrogacy arrangements. Assisted reproductive technology is playing an increasing role in the way that Australian families are formed. Demand for and use of ART has escalated since the first Australian child conceived through IVF was born in 1980.³⁵ If implemented, the recommendations made in this report are likely to result in more people seeking access to ART in the future.

INCREASING USE

Donor insemination has been occurring in Victoria for at least the last 50 years. Before enactment of the *Infertility (Medical Procedures) Act 1984* there was no legislation which regulated infertility treatment or required records to be kept of donors. The actual numbers of women who were treated and children who were conceived through use of donated sperm will therefore never be known.

The number of people who use IVF or other forms of infertility treatment has steadily increased over the past decade. In 2000 almost 2% of all births in Australia and New Zealand were a result of assisted conception treatments.³⁶ In Australia and New Zealand in 2004 the number of treatment cycles commenced (41,904)³⁷ was more than double the number commenced in 1993 (16,999).³⁸ Over the same period there has been an almost threefold increase in pregnancies and deliveries as a result of assisted conception treatments.³⁹

The success rates of ART vary according to the cause of infertility and the type of treatment received. In 2004, 20.1% of fresh non-donor treatment cycles in Australia and New Zealand resulted in the birth of at least one living baby.⁴⁰ The success rate for cycles in which a non-donor frozen embryo was thawed was 15.6%.⁴¹ The success rate for treatment cycles using fresh or frozen donor oocytes or embryos was 18.9%.⁴² Success rates of donor insemination are measured as a percentage of live deliveries per cycle started. In 2004 there were 3170 procedures using donated semen. Of these, 307 (9.7%) resulted in the delivery of at least one living baby.⁴³

The same patterns of increased use of assisted reproduction treatments recorded Australia-wide are apparent in Victoria. In its first annual report, the Victorian Infertility Treatment Authority (ITA) reported that in 1998, 4,274 couples received

one or more of the following treatments: donor insemination, GIFT, IVF or removal of frozen embryos from storage for the purposes of implantation (thaw cycle). Seven hundred and fifty six babies were born in that year from these forms of treatment.⁴⁴ In the 2004 calendar year 7870 women underwent ART procedures, and 2032 babies were born in that year.⁴⁵

The increasing use of ART is also reflected, in part, in the increase in government expenditure for ART services under Medicare and the Pharmaceutical Benefits Scheme.⁴⁶ In 2005, 27,663 patients accessed services provided under Medicare, compared with 19,678 in 2000.⁴⁷ In 2005 the Federal Government spent \$156.1 million on ART services, an increase from \$66.3 million in 2000,⁴⁸ although there are a number of possible explanations, apart from an increase in the number of patients accessing services, for this increase in expenditure.⁴⁹

DONATED GAMETES AND EMBRYOS

The majority of babies born through ART are not conceived from donated gametes or embryos. In 2004 across Australia and New Zealand 93.6% of ART treatment procedures used patients' own gametes or embryos. Donor sperm, oocytes or embryos were used in the remaining 6.4% of treatment cycles.⁵⁰ In Victoria in 2005, 597 women were treated using donated eggs, embryos or sperm and 84 babies were recorded as born from procedures using donated gametes and embryos, with 110 ongoing pregnancies at the time of reporting.⁵¹

In Victoria since July 1988 the births of children conceived through use of donated gametes or embryos have been recorded in registers kept by the Infertility Treatment Authority.⁵² As at 31 December 2006, 3533 births had been registered on the central registers.⁵³ These figures do not include children who were born as the result of a woman inseminating herself with semen from a donor outside the clinic system.

The use of donated sperm may decrease as technology develops. Intracytoplasmic sperm injection (ICSI) enables heterosexual couples to use the male partner's sperm in situations where conception would previously have only been possible by using donated semen. Use of ICSI has increased almost fourfold since 1994 and is now more common than IVF treatment.⁵⁴ This may reduce the number of children born to women in heterosexual relationships who are not genetically related to the men who is their social fathers.

However, women without male partners who want to have children will continue to need donated sperm. If the government implements our recommendation that restrictions on eligibility of lesbian and single women for clinic treatment be removed, some of these women will be treated in Victorian clinics through use of donated sperm.

COMMUNITY ATTITUDES

The recommendations in this report reflect the deliberations of the commission and are not based simply on public opinion about particular issues. However it is relevant to note that the increase in the number of people seeking infertility treatment has been accompanied by increased community acceptance of the technology. This acceptance is reflected both in the attitudes which people express about using the technology themselves and in their views about its use by others.

In a survey about the use of IVF undertaken by the Australian Institute of Family Studies, 42% of respondents said they would use IVF if they encountered difficulties having children and a further 13–18% of men and women said they might do so. Childless respondents who said they 'definitely' wanted children were even more likely to say they would use IVF; 69% of men in their thirties and 47% of men in their twenties said they would do so, compared with 52% of women in their thirties and 66% of women in their twenties.⁵⁵

Since July 1981 Roy Morgan Research has regularly polled attitudes to IVF and other related issues.⁵⁶ In the most recent survey, conducted in June 2006, 88% of respondents supported use of IVF to assist infertile married couples, compared with 77% who approved use of the technology in 1981.⁵⁷

Attitudes about who should be able to access ART are also changing. In 1993 only 18% of respondents approved of the use of donor sperm to help single women conceive. By the October 2000 survey 38% of respondents approved, 8% were undecided and 54% disapproved. A similar change in attitude is apparent in attitudes to use of donor sperm by lesbian women. Approval for this increased from 7% of respondents in 1993 to 31% in 2000, with 10% undecided and 50% disapproving.⁵⁸ As we noted above, a relatively high proportion of the community now regards same-sex partners and their children as families. In the future this more expansive concept of family is likely to contribute to greater community acceptance of use of assisted reproductive treatment by single people and same-sex couples.

- 35 The first child conceived through IVF in the world was Louise Brown, born in the United Kingdom in 1978. The first Australian-born child conceived through IVF was Candice Reed, born on 23 June 1980. Gab Kovacs, 'Setting the Scene—What We Have and What We Know?' (Paper presented at the The Missing Link: Private Rights and Public Interest in Donor Treatment Procedures, Melbourne, 29 October 2003), 29.
- 36 Jishan Dean and Elizabeth Sullivan, *Assisted Conception Australia and New Zealand 2000 and 2001* (2003), 1.
- 37 Yueping Alex Wang et al, *Assisted Reproduction Technology in Australia and New Zealand 2004* (2006), 41, Table 34.
- 38 Joanne Bryant et al, *Assisted Reproductive Technology in Australia and New Zealand 2002* (2004) 36, Table R1; Anne-Marie Waters et al, *Assisted Reproductive Technology in Australia and New Zealand 2003* (2006), 30, Table R1. Note however that from 2002 the definition of treatment cycles was broadened to include cancelled ART cycles, unsuccessful oocyte pick-ups and embryo thaws and intrauterine insemination using donor sperm: see note to Table R1.
- 39 In 2004 there were 6,792 ART treatment cycles in Australia and New Zealand that resulted in a live delivery, compared to 2,515 in 1995: see Wang et al (2006), above n 37, 45, Figure 16.
- 40 Ibid 15, Fig 4.
- 41 Ibid 21, Fig 7.
- 42 Ibid 26, Fig 10.
- 43 Ibid 39.
- 44 Infertility Treatment Authority, *Annual Report 1999* (1999), 21, Table 1. There were also 413 ongoing pregnancies. Note that the ITA recommends that caution be exercised when interpreting and comparing data reported in its annual reports due to different reporting dates and treatment policies: Infertility Treatment Authority, *Annual Report 2006* (2006) 18.
- 45 Infertility Treatment Authority (2006), above n 44, 20.
- 46 Assisted Reproductive Technologies Review Committee, *Report of the Independent Review of Assisted Reproductive Technologies* (February 2006), 43–8.
- 47 Ibid Table 5, 47.
- 48 Ibid Table 4, 47.
- 49 The Committee surmised 'much of the increase in expenditure must be due mainly to some combination of an increase in total charges and transfer of out-of-pocket gaps to MBS [Medicare Benefits Schedule] items numbers, as well as lesser factors such as service growth, indexation and the introduction of new technologies': ibid, 48.
- 50 Wang et al (2006), above n 37, 7 Table 1.
- 51 Infertility Treatment Authority (2006), above n 44, 24, Table 4.1.
- 52 Births resulting from donations made between 1 July 1988 and 1 January 1998 are recorded in the 1984 central register. Births from donations made after that date are recorded on the 1995 central register. These are maintained separately because different rules govern access to identifying information on each register. There are also two voluntary registers on which donors, children and families can place information voluntarily. The operation of the registers is explained in Chapter 15.
- 53 Information provided by Infertility Treatment Authority, 20 February 2007.
- 54 Waters et al (2006), above n 38, 6.
- 55 Ruth Weston and Lixia Qu, 'Beliefs About IVF as a Personal Fallback Option' (2005) 71 *Family Matters* 40.
- 56 See Roy Morgan Research, Morgan Polls <www.roymorgan.com/news/polls/polls.cfm> at 28 February 2007.
- 57 Roy Morgan Research, *Large Majority of Australians Approve Extraction of Stem Cells from Human Embryos for Medical Research*, Finding No. 4036 (21 June 2006).
- 58 Gabor Kovacs et al, 'Community Attitudes to Assisted Reproductive Technology: A 20-Year Trend' (2003) 179(10) *Medical Journal of Australia* 536.



‘What children need in parents are people who are nurturing, who provide adequate, sustained care. Whether that care is provided by a single person, a woman and a man, two men or two women is irrelevant.’

WELFARE OF CHILDREN

In the course of this reference, the commission heard divergent views about how ART affects the welfare of children born. We received a number of submissions which argued that the health and wellbeing of children could best be protected by restricting eligibility for assisted reproductive treatment to married heterosexual couples. For example, Endeavour Forum objected to:

the deliberate manufacture of children through ART for single and homosexual individuals. Children need both a father and a mother, not two mothers or two fathers.⁵⁹

Other submissions argued that children could thrive in many different types of families, provided they received adequate love and support, for example:

My beliefs around parenting and what makes a positive parent are actually about particular skills, virtues and abilities. The gender and sexuality of the parents is not relevant. What children need in parents are people who are nurturing, who provide adequate, sustained care. Whether that care is provided by a single person, a woman and a man, two men or two women is irrelevant.⁶⁰

In conducting research and considering the matters under review, the commission examined a large body of social science research about how different family structures affect children’s health and psychological adjustment.⁶¹

In 2004 the commission published a literature review of studies focusing on outcomes for children born of ART in diverse family formations written by Dr Ruth McNair.⁶² In her analysis, McNair draws upon a framework for measuring child health and wellbeing developed by the Australian Institute of Health and Welfare (AIHW). The AIHW framework relies on three interrelated factors: family structure and function, factors relating to the child, and socio-cultural factors external to the family.⁶³ McNair discusses the research in relation to each of these issues for children born as the result of ART or surrogacy. She examines the health and psychological outcomes experienced by these children, concluding that there is sound evidence that children born into families with non-biological parents or same-sex parents do at least as well as other children.

In addition to drawing on the research identified by McNair, we have also examined a number of other studies, which we discuss below.

HEALTH OUTCOMES

Research indicates there are some differences in health outcomes between children conceived through ART and children who are conceived conventionally. Across Australia and New Zealand a higher proportion of twins and triplets are being born to women who conceive through assisted reproduction than to women who conceive without assistance.⁶⁴ Children conceived by ART are more likely to be stillborn or to die shortly after birth although outcomes vary according to the form of ART used. The higher death rate for ART births is largely attributable to a higher incidence of pre-term delivery and a higher proportion of multiple births,⁶⁵ although a small proportion of deaths are due to severe birth defects.⁶⁶ Multiple embryo transfer also increases the likelihood of multiple births and of perinatal death. The Australian Reproductive Technology Accreditation Committee guidelines now recommend that clinics transfer only one embryo in women under 35 and no more than two in women over 35.⁶⁷

McNair points out that there is still some debate about whether IVF increases the risk of birth defects and, if so, the cause of these defects.⁶⁸ There is also debate about whether the ICSI technique, which is generally used to overcome some forms of male infertility, will result in children inheriting genetic abnormalities relating to their father’s infertility and other rare genetic disorders.⁶⁹

The commission has not been asked to address the issue of health risks involved in the use of ART because it does not impact on the question of eligibility for treatment, which is the scope of our review. However, patients should be fully informed about the health risks to the potential child involved in the use of ART, for example the desirability of minimising risks by restricting transfer of multiple embryos.

It is also important to point out that ART can have a range of effects on the health and wellbeing of women undergoing treatment.⁷⁰ Treatment often involves the administration of drugs to stimulate ovulation in order to enhance the prospects of conception. These drugs have been associated with serious side effects and even death.⁷¹ Both IVF and ICSI procedures require women to undergo surgery to collect eggs for fertilisation in a laboratory. During our review we heard from a number of women who described the often invasive and debilitating effects of these treatments, both medically and psychologically.⁷²

PSYCHOLOGICAL AND SOCIAL OUTCOMES

There is an increasingly large body of research on the psychological and social effects of having been born as a result of the use of donated gametes or embryos. Research projects focus on different issues. Some studies examine the effects of donor conception on children born into a range of family types, where the principal research questions generally focus on the impact of late disclosure of the method of the child's conception, the capacity to identify the donor and the quality of the parent-child relationship. Other studies relate specifically to children born to parents in same-sex relationships and seek to determine whether these children are worse off on accepted indices of well-being than children born into families with heterosexual parents. A few similar studies have been conducted in relation to children born to single women by choice, and children born as a result of surrogacy arrangements.

In the following sections of this chapter we discuss some of the key research findings of these studies.⁷³

Parents in Same-sex Relationships

During the course of the reference, the commission has examined numerous social science studies which report on the characteristics of parenting by lesbians and gay people and the effects on children of growing up in families with parents in same-sex relationships. The commission has drawn on this substantial body of research in the course of its investigations and deliberations. A selection of the major studies which investigate the experience of lesbian and gay parents, and their children is summarised in Appendix 1.

The studies reported represent a collection of relatively recent empirical data on gay and lesbian parenting which have been published in academic, peer-reviewed journals. They specifically relate to outcomes for children and families.

Initially, many studies focused on the gender identification and sexual preference of those who had been brought up by lesbians and/or in fatherless families.⁷⁴ This research direction was largely a response to an initial trend within courts in family law matters not to grant custody of children to mothers who identified as lesbian. Some advocates argue that having a lesbian parent may have an impact on the gender identification or sexual preference of the children, such that they would themselves become gay or lesbian as adults. There have also

59 Submission CP 32 (Endeavour Forum Inc).

60 Submission CP 59 (Ian Seal).

61 See Appendix 1 for summaries of research findings on donor conception and families, and children raised by gay and lesbian parents.

62 Ruth McNair, *Outcomes for Children Born of A.R.T. in a Diverse Range of Families* (2004).

63 Wise (2003), above n 17.

64 Waters et al (2006), above n 38, 22. See also McNair (2004), above n 62, 34. The increased rate of multiple births after ART can be attributed to the practice of multiple embryo transfer, and also to the use of fertility enhancing drugs that increase the number of eggs released each cycle: McNair (2004), above n 62, 32-3.

65 In 2003 26.6% of babies conceived with the use of ART were pre-term compared with 7.9% of all babies born in Australia in the same year. This may be due to the higher rate of multiple births. The peri-natal death rate (still-births of at least 20 weeks gestation or 400 grams birth weight and deaths of babies within 28 days of birth) was 18.7 deaths per 1000 ART births, compared with 10.1 peri-natal deaths per 1000 births reported in Australia: Waters et al, above n 38, (2006), 27, 29. Note that ART does not include artificial insemination using sperm from either a woman's partner or sperm donor: 46.

66 McNair (2004) above n 62, 31. Note also that some birth defects may be attributable to the fact that women undergoing ART treatments are generally older than women who conceive conventionally.

67 Reproductive Technology Accreditation Committee, *Code of Practice for Assisted Reproductive Technology Units* (2005), 4.6.

68 McNair (2004), above n 62, discusses the various studies. One recent study found that although overall risk of defects is small (less than 3% for assisted conceptions versus 2% for unassisted conception), specific defects are notably higher in ART: 'New study links birth defects with fertility treatments' *BioNews*, 16 February 2007, <www.bionews.org.uk> at 27 February 2007.

69 McNair (2004), above n 62, 36-7. The European Society for Human Embryology recommends that patients be counselled on the current state of knowledge about a higher risk of abnormalities in children conceived using ICSI: JA Land and JH Evers, 'Risks and Complications in Assisted Reproduction Techniques: Report of an ESHRE consensus meeting' (2003) 18(2) *Human Reproduction* 455, 456.

70 See Infertility Treatment Authority, *Are there Adverse Outcomes Arising from Infertility Treatment? Information for Consumers* <www.ita.org.au> at 22 March 2007.

71 Stimulating ovulation can lead to a condition called ovarian hyperstimulation syndrome. The effects of this can range from mild pelvic discomfort to blood clotting which can be life threatening: Monash IVF, 'Fact Sheet: Ovarian Hyperstimulation Syndrome' (November 2006) <www.monashivf.edu.au> at 23 February 2007.

72 For example, submissions CP 38 (Jacqui Tomlins), CP 107 (Kerrie Plant), CP 140 (Anonymous).

73 See Appendix 1, Table 1: Studies of Children Raised by Lesbian and Gay Parents 1986-2006 and Table 2: Studies of Donor-conception and Families, 1995-2006, for a summary of findings.

74 For example, Susan Golombok et al, 'Children in Lesbian and Single-Parent Households: Psychosexual and Psychiatric Appraisal' (1983) 24(4) *Journal of Child Psychology and Psychiatry* 551; Frederick Bozett (ed), *Gay and Lesbian Parents* (1987); Frederick Bozett, 'Social Control of Identity by Children of Gay Fathers' (1988) 10(5) *Western Journal of Nursing Research* 550.

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been a few studies which examine step-families, where one or the other member of a lesbian or gay couple brings children from a previous relationship.⁷⁵

More recent studies are a response to what has been described as a lesbian ‘baby boom’ and tend to focus on decisions made by lesbian mothers about conception and relationships with donors and fathers,⁷⁶ social acceptance of lesbians as mothers⁷⁷ and the experiences of children with lesbian mothers in schools and social networks.⁷⁸

There are some methodological challenges in undertaking research on outcomes for children born into families with parents in same-sex relationships.⁷⁹ These include the issue that lesbian and gay couples may be reluctant to participate in such studies because of stigma associated with their sexuality, problems of bias which may arise in interviewing volunteer participants, the possibility that parents may focus on positive outcomes for children and not report difficulties, and the fact that there is a comparative lack of studies of children’s wellbeing over time.

These studies are often criticised for using small and/or self-selecting samples of participants and for their lack of statistical power.⁸⁰ Social scientists have recognised these difficulties⁸¹ and have developed various techniques to overcome them. For example Susan Golombok and her team recruited lesbian families from a population of 14,000 families in a region of the United Kingdom to overcome problems of selection bias.⁸² Fiona Tasker and Susan Golombok⁸³ used multiple measures (standardised interviews and questionnaires) and multiple respondents (mothers, children and teachers) to overcome the problem that mothers may tend to present themselves and their children in the best possible light because of the social concerns which exist about children with lesbian and gay parents.

Many studies use comparative methodology, with control groups. In the area of research into children with lesbian mothers and/or gay fathers, many studies draw on comparisons with heterosexual single and/or coupled mothers⁸⁴ and/or children conceived by heterosexual mothers with the assistance of donor insemination.⁸⁵ Some studies are longitudinal, documenting family functioning over time and as children grow up.⁸⁶

Although many of these studies involve relatively small numbers of families, their results have been aggregated. Several analyses and literature reviews of gay and lesbian parenting studies have been published over the past two decades. These meta-analyses confirm that there are no significant discrepancies between studies which report favourable outcomes for children brought up by same-sex couples.⁸⁷

This research provides strong evidence that it is the quality of family processes and relationships which determines emotional, social and psychological outcomes for children, rather than the structure of the family into which they are born.⁸⁸ Relevant processes are such things as the quality of parenting, the quality of relationships within the family, including the level of cooperation and harmony between parents, the family’s social support and level of connection with others, and the family’s access to resources. Family structure, such as the gender of parents and the number of parents, is not shown to be a significant factor in child outcomes.⁸⁹

The research indicates that children with lesbian and gay parents do not differ at all, or significantly, from children with heterosexual parents when assessed according to a range of standard criteria measuring parent–child relationships, socio-emotional development, psychiatric ratings and gender development.

In their longitudinal study of children raised in fatherless families, Fiona MacCallum and Susan Golombok found there were no major differences in child development between families headed by lesbian and single heterosexual mothers compared to coupled heterosexual mothers, and no evidence that the sexual orientation of the mother influences parent–child interaction or the socio-emotional development of the child.⁹⁰

Nanette Gartrell’s longitudinal study measured children with lesbian mothers at 10 years old and found their social competence and behaviour was normal, that they did well academically and related well to their peers.⁹¹ More than half of the children reported being open about having a lesbian mother and all were positive in describing what is special about having a lesbian mother.

Some studies have found that being raised in households run by women, and in which no men are present, has particular advantages for children, including strikingly diminished figures for physical and sexual abuse.⁹² In addition, lesbian couples tend to balance work and family more equitably, and each member of the couple tends to be able to give time and attention to children.⁹³

Although outcomes for children are generally favourable there are some studies which indicate that children in gay or lesbian families may experience bullying and discrimination because of their parents' sexuality, and as a result may hide their parents' sexuality from their peers.⁹⁴ Despite, or perhaps because of this experience, these children tend to be more broad-minded, tolerant and empathetic than children born into conventional families.⁹⁵ Nanette Gartrell's longitudinal study was conducted through interviews with the mothers prior to birth and when the children were aged 2, 5 and 10. Gartrell found that by the age of 10 nearly half of the children had experienced homophobia and were affected by these experiences. At the same time, the children 'displayed a sophisticated understanding of diversity and tolerance'⁹⁶ and 'had very thoughtful responses to their peers when they made negative comments about their moms' lesbianism'.⁹⁷

Having conducted a comprehensive review of the studies on outcomes for children growing up in lesbian families compared with children in heterosexual families, McNair summarises her findings as follows:

- no difference in cognitive function;
- no difference in emotional function;
- no difference in psychological and behavioural development;
- gender role behaviour: children tend to play gender-typical games, however, some male and female children of lesbian parents show less traditionally gender-ascribed traits;
- no differences in sexuality identity for adult offspring of lesbian and non-lesbian families, although some adults from lesbian families are more likely to consider the possibility of not being heterosexual, and are more likely to report same-sex experience;
- children show more awareness and understanding of diversity more generally; and
- while some children report reduced self-perceived academic and physical competence, they actually have equal levels of competence when tested by teachers.⁹⁸

- 75 Jean Lynch, 'Considerations of Family Structure and Gender Composition: The Lesbian and Gay Stepfamily' (2000) 40(2) *Journal of Homosexuality* 81.
- 76 For example, Kathryn Almack, 'Seeking Sperm: Accounts of Lesbian Couples' Reproductive Decision-Making and Understandings of the Needs of the Child' (2006) 20(1) *International Journal of Law, Policy and the Family* 1.
- 77 For example, McNair et al (2002), above n 22.
- 78 For example, Vivien Ray and Robin Gregory, 'School Experiences of the Children of Lesbian and Gay Parents' (2001) 59 *Family Matters* 28.
- 79 McNair (2004), above n 62, 52–5.
- 80 See for example, Robert Lerner and Althea K Nagai, *No Basis: What the Studies Don't Tell Us About Same-Sex Parenting*, Marriage Law Project (January 2001), available at <www.marriagewatch.org/publications/nobasis.pdf> at 6 March 2007; George Rekers and Mark Kilgus, 'Studies of Homosexual Parenting: A Critical Review' (2002) 14 *Regent University Law Review* 343.
- 81 See for example, Fiona Tasker and Susan Golombok, 'Adults Raised as Children in Lesbian Families' (1995) 65(2) *American Journal of Orthopsychiatry* 203, 213 and the other studies cited in the article; Fiona MacCallum and Susan Golombok, 'Children Raised in Fatherless Families from Infancy: A Follow-Up of Children of Lesbian and Single Heterosexual Mothers at Early Adolescence' (2004) 45(8) *Journal of Child Psychology and Psychiatry* 1407.
- 82 Susan Golombok et al, 'Children with Lesbian Parents: A Community Study' (2003) 39(1) *Developmental Psychology* 20.
- 83 Tasker and Golombok (2005), above n 81.
- 84 For example, Susan Golombok et al, 'Children Raised in Fatherless Families from Infancy: Family Relationships and the Socioemotional Development of Children of Lesbian and Single Heterosexual Mothers' (1997) 38(7) *Journal of Child Psychology and Psychiatry* 783.
- 85 Ibid.
- 86 For example, Nanette Gartrell et al, 'Interviews with Prospective Mothers' (1996) 66(2) *American Journal of Orthopsychiatry*; Nanette Gartrell et al, 'Interviews with Mothers of Toddlers' (1999) 69(3) *American Journal of Orthopsychiatry*; Nanette Gartrell et al, 'Interviews with Mothers of Five-Year-Olds' (2000) 70(4) *American Journal of Orthopsychiatry*; Nanette Gartrell et al, 'The National Lesbian Family Study: 4. Interviews with the 10-Year-Old Children' (2005) 75(4) *American Journal of Orthopsychiatry* 518; Nanette Gartrell et al, 'The USA National Lesbian Family Study: Interviews with Mothers of 10-Year-Olds US' (2006) 16(2) *Feminism & Psychology* 175.
- 87 For example, Cheryl A Parks, 'Lesbian Parenthood: A Review of the Literature' (1998) 68(3) *American Journal of Orthopsychiatry* 376; Charlotte J Patterson, 'Family Relationships of Lesbians and Gay Men', (2002) 62(4) *Journal of Marriage & the Family* 1052; Jenni Millbank, *Meet the Parents: A Review of the Research on Lesbian and Gay Families* (2001); Judith Stacey and Timothy Biblarz, '(How) Does the Sexual Orientation of Parents Matter?' (2001) 66 *American Journal of Sociological Review* 159.
- 88 See for example Tasker and Golombok (1995), above n 81, 213 (this study involved interviews with children previously included in a 1976 study of 37 children of lesbian families); MacCallum and Golombok (2004), above n 81; Gartrell et al (2005), above n 86. The National Family Study is 'the largest prospective longitudinal investigation of lesbian families in the United States': 518.
- 89 Australian Institute of Family Studies, *Introducing the Longitudinal Study of Australian Children* LSAC Discussion Paper No 1 (2002); Ann Sanson and Virginia Lewis, 'Children and Their Family Contexts' (2001) 59 *Family Matters* 4; Wise (2003), above n 17. Raymond Chan et al, 'Psychosocial Adjustment Among Children Conceived via Donor Insemination by Lesbian and Heterosexual Mothers' (1998) 69(2) *Child Development* 443; Elizabeth Vandewater and Jennifer Lansford, 'Influences of Family Structure and Parental Conflict on Children's Well-Being' (1998) 47(4) *Family Relations* 323.
- 90 MacCallum and Golombok (2004), above n 81, 1407.
- 91 Gartrell et al (2005), above n 86.
- 92 Ibid.
- 93 Gillian Dunne, 'Opting into Motherhood: Lesbians Blurring the Boundaries and Transforming the Meaning of Parenthood and Kinship' (2000) 14(1) *Gender and Society* 11, 31.
- 94 Tamar Gershon et al, 'Stigmatization, Self-Esteem, and Coping Among the Adolescent Children of Lesbian Mothers' (1999) 24(6) *Journal of Adolescent Health* 437; Vivien Ray and Robin Gregory, 'School Experiences of the Children of Lesbian and Gay Parents' (2001) 59 *Family Matters* 28.
- 95 McNair (2004), above n 62, 63; see also Gartrell et al (2005), above n 86.
- 96 Gartrell et al (2005), above n 86, 523.
- 97 American Psychological Association, 'A 'crucial time' for LGB research' (2005) 36(4) *Monitor* 84. One study, conducted by Sotirios Sarantakos, has different conclusions to the majority of the research on the experience of children raised in various family formations: see Appendix 1, Table 2 for a summary of the findings.
- 98 McNair (2004), above n 62, 7–8.

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'... there is no evidence ... that lesbian women or gay men are unfit to be parents or that psychosocial development among children of lesbian women or gay men is compromised relative to that among offspring of heterosexual parents.'

Similar findings have been made in relation to children in male homosexual parented families,⁹⁹ although McNair comments that '[t]his area of study has not yet reached the level of sophistication that has been possible in the lesbian families literature'.¹⁰⁰

This body of social research on same-sex parenting has also been considered by organisations with a professional interest in its conclusions. For example, the American Psychological Foundation examined research addressing concerns that children born in families with lesbian or gay parents would show disturbances of gender identity, show problems in personal development or have difficult relationships with peers and other adults. The foundation concluded that:

there is no evidence... that lesbian women or gay men are unfit to be parents or that psychosocial development among children of lesbian women or gay men is compromised relative to that among offspring of heterosexual parents. Not a single study has found children of lesbian or gay parents to be disadvantaged in any significant respect relative to children of heterosexual parents. Indeed, the evidence to date suggests that home environments provided by gay and lesbian parents are as likely as those provided by heterosexual parents to support and enable children's psychosocial growth.¹⁰¹

The commission also examined a number of articles and commentaries about research on same-sex parenting, some of which were cited in or annexed to submissions.¹⁰² Some submissions which opposed removal of the marital status requirement for reproductive technology treatment equated homosexuality with paedophilia and argued that children whose parents were in same-sex relationships were at a higher risk of abuse.¹⁰³ The commission also met with representatives of the Australian Family Association and Endeavour Forum.¹⁰⁴ These organisations claimed there was a higher incidence of violence in homosexual relationships than in heterosexual relationships and that children of same-sex parents were more likely to be sexually abused. These organisations also referred us to studies conducted in the United States indicating that there is a high incidence of sexually-transmitted disease, alcohol abuse, violence, mental health problems and suicide among gay and lesbian people.¹⁰⁵

The commission stresses that the research of primary relevance to the question of whether eligibility for ART and adoption should be expanded relates to outcomes for children—both the research that looks at the factors influencing outcomes in families generally, and the research that examines outcomes for children with parents in same-sex relationships. Moreover, the propositions advanced by the Australian Family Association have been refuted by international research. Gartrell, for example, found that physical and sexual abuse was virtually nonexistent in the lesbian-parented families she studied.¹⁰⁶ This finding has been replicated in British research.¹⁰⁷ It is a well-established research finding that heterosexual men are the most common perpetrators in the sexual abuse of children.¹⁰⁸

It is difficult to obtain reliable figures on the prevalence of violence in intimate relationships, whether they are heterosexual or homosexual.¹⁰⁹ The Women's Safety Australia survey conducted by the Australian Bureau of Statistics reported that 23% of women who have ever been in a relationship had experienced physical violence from a male partner.¹¹⁰ Although research into the prevalence of violence in same-sex relationships is limited, it has been argued that violence occurs at a level comparable to that in heterosexual relationships.¹¹⁰ In Chapter 5 the commission recommends a process for dealing with cases where there is a concern that a child will be at risk of harm, which will apply to all people seeking assisted reproductive treatment, irrespective of their sexuality or relationship status.

Submissions which said that treatment should be limited to heterosexual (usually married) couples also relied on studies relating to the effects on children of being brought up in a family where there is no father present. This research is discussed in more detail below. These studies may have limited relevance to the children born to single women or to lesbian couples, as they are predominantly concerned with children born in heterosexual families who are being brought up by a sole parent following divorce or separation. Sociologist Michael Flood notes that people who rely on this body of research to support arguments against same-sex parenting

often conflate and misconstrue research on at least three distinct forms of fatherless families: those produced through divorce and separation; those due to unwed, and usually young, single motherhood; and those arising from intentional lesbian parenthood.¹¹²

Single Mothers by Choice

Some single women choose to have children through donor insemination or other donor treatment procedures. These women are often referred to as 'solo mothers' or 'single mothers by choice'. The commission received a number of submissions from single mothers by choice in Victoria who had conceived their children either as a result of privately arranged self-insemination or, where they were eligible for treatment, through clinic-based donor insemination in Victoria or interstate.¹¹³

There is substantial literature examining the wellbeing of children brought up in single-parent families, as compared with children in two-parent families. Although 'most children in single-parent families do just as well as the average child in a two-parent family',¹¹⁴ research has shown that children raised in single-parent families do less well on educational and psychological measures than children in two-parent families.¹¹⁵

However, it may be misleading to compare studies of children in divorced families with children conceived by single mothers as a result of donor insemination. When children being brought up by single parents show negative effects this can generally be attributed to factors associated with their parents' separation, such as parental hostility and the economic consequences of divorce, rather than fatherlessness itself.¹¹⁶

By contrast, the single mothers by choice who made submissions to our review appeared to be well prepared for single parenthood prior to conception, both emotionally and financially.

Research on outcomes for single mothers and their donor-conceived children is relatively limited and is often performed as part of larger projects studying donor conception. For example, Susan Golombok included single lesbian and heterosexual mothers in her 2003 study of a larger group of families.¹¹⁷ Clare Murray and Susan Golombok have conducted studies focusing directly on a group of single mothers by choice.¹¹⁸

The single women interviewed for the 2003 Golombok study reported more negative relationships with their children than mothers with same-sex or opposite-sex partners. Teachers also reported that these children had more psychological problems than children of heterosexual or same-sex couples.¹¹⁹ McNair suggests that reduced social support is one possible explanation for these differences.¹²⁰

Murray and Golombok compared solo-mother families and families parented by married couples with donor-conceived children.¹²¹ Their studies revealed that the solo-mother families

- 99 Ibid 64–6. McNair cites Frederick Bozett (ed), *Gay and Lesbian Parents* (1987), who found that children were no different in social activities, problem solving ability or levels of autonomy than children in heterosexual families. She also cites several studies which have shown that the sexual orientation of these children is no different from the sexual orientation of children brought up in heterosexual families.
- 100 McNair (2004), above n 62, 64.
- 101 Charlotte J Patterson, 'Lesbian and Gay Parents and their Children: Summary of Research Findings', in American Psychological Foundation, *Lesbian & Gay Parenting* (2005) 15, available at <www.apa.org/pi/lgbcc/publications/lgpconclusion.html>. The survey noted the need for longitudinal studies to follow families with lesbian and gay parents over time.
- 102 For example, Roslyn Phillips and David Phillips 'Homosexual Parenting: The Effect on Children', *Australian Festival of Light Resource Paper* (May 2001); George Rekers and Mark Kilgus, 'Studies of Homosexual Parenting: A Critical Review' (2002) 14 *Regent University Law Review* 343; Timothy J Dailey, 'Homosexuality and Child Sexual Abuse' (2004) 247 *Family Research Council Insight* <www.frc.org> at 10 May 2006.
- 103 For example, submissions CP 61 (Neil Ryan), CP 81 (Suryan Chandrasegaran), CP 127 (Salt Shakers).
- 104 Consultation with David Perrin (Australian Family Association), Charles Francis QC and Babette Francis (Endeavour Forum), and Bill Muehlenberg on 6 June 2006.
- 105 Endeavour Forum Inc, (November 2005) 120 Newsletter, which includes part of a paper produced by Timothy J Dailey, 'Negative Health Effects of Homosexuality', 232 *The Family Research Council* (27 June 2005), available at <www.frc.org> provided to the commission by Babette Francis on 6 June 2006.
- 106 Gartrell et al (2005), above n 86.
- 107 Golombok et al (2003), above n 82.
- 108 See, for example, Australian Institute of Criminology, *Child Sexual Abuse: Offender Characteristics and Modus Operandi*, Trends and Issues in Crime and Criminal Justice, No 193 (2001) which found that 94.9% of 182 respondents self-reported as heterosexual.
- 109 Victorian Law Reform Commission, *Review of Family Violence Laws: Report* (2006) 21, 41–2.
- 110 Australian Bureau of Statistics, *Women's Safety Australia* Catalogue 4128.0 (1996) 50.
- 111 Lee Vickers, 'The Second Closet: Domestic Violence in Lesbian and Gay Relationships: A Western Australian Perspective' (1996) 3(4) *E Law—Murdoch University Electronic Journal of Law* [18].
- 112 Michael Flood, *Fatherhood and Fatherlessness* (2003) 14.
- 113 For example, submissions CP 114 (Anonymous), CP 144 (Jane), CP 187 (Brenda).
- 114 Wise (2003), above n 17, 6.
- 115 See Flood (2003), above n 112, 13–18.
- 116 See *ibid* 13–14.
- 117 Golombok et al (2003), above n 82.
- 118 Clare Murray and Susan Golombok, 'Going it Alone: Solo Mothers and Their Infants Conceived by Donor Insemination' (2005a) 75(2) *American Journal of Orthopsychiatry* 242; Clare Murray and Susan Golombok, 'Solo Mothers and Their Donor Insemination Infants: follow-Up at Age 2 Years' (2005b) 20(6) *Human Reproduction* 1655.
- 119 Golombok et al (2003), above n 82.
- 120 McNair (2004), above n 62, 55.
- 121 Murray and Golombok (2005a), above n 118; Murray and Golombok (2005b), above n 118.



did not differ markedly from the married-couple families, although the solo mothers had a lower level of interaction with and lower responsiveness to their children in the first year of life. The researchers reported that the solo mothers' decision to have a child through donor insemination was not a hasty one, and that '[m]ost women did not initiate treatment until they had good social support networks in place and had carefully considered the financial and other responsibilities of being a sole parent'.¹²² The authors followed up the families when the children were two years old and concluded that solo-mother families were functioning well. They found that the mothers displayed greater joy and less anger towards their children, who indicated fewer emotional and behavioural difficulties than children of the married couples. Some of the explanations advanced for the more positive experiences of the solo mothers were their greater willingness to be open about the method of the child's conception and the absence of stress related to their own or a partner's infertility.¹²³

Murray and Golombok caution that this area of research is in its early stages. We also stress that more research is needed before firm conclusions can be drawn about outcomes for children born to single mothers by choice.

Donor-conceived Children

The commission has also examined local and international studies about donor conception. Studies in this field report on outcomes for children and adults who are donor-conceived, the psychosocial wellbeing of parents and children, and parenting of donor-conceived children. Studies also pay particular attention to attitudes to donor anonymity and the impact of donor anonymity (or disclosure) on people who are donor-conceived. Differences between sperm and egg donation are also canvassed, as are the experiences of both heterosexual and same-sex parented families. The commission has summarised a number of recent studies about these topics in Appendix 1, Table 2.

The studies adopt a range of methodologies to address diverse research questions. Many use control groups, for example, to assess the effects of secrecy about conception in a family, or to compare approaches to anonymity across different groups. Other studies focus solely on the experiences of a particular group of people, such as donors or donor-conceived children. As with the research about same-sex parented families discussed above, there are also methodological limitations associated with these studies. The sample sizes are relatively

small, the participant children are generally quite young, and there may be a tendency for some participants to overstate positive outcomes.

For these reasons it is impossible to make confident generalisations about outcomes for donor-conceived children and adults. However, we have been able to draw the following broad conclusions about the emerging research of the experiences of donor-conceived people and their families from the studies we have examined:

- Donor-conceived children function well and the absence of a genetic link does not appear to have a negative impact on parent-child relationships. The most commonly identified difference in these families is the tendency for parents to display higher levels of emotional involvement in their children's lives, which may be explained by a desire to compensate for a lack of genetic connection.¹²⁴
- Rates of non-disclosure of donor status remain quite high. Many of the studies reveal that a significant proportion of parents have not told and do not intend to tell their children about the involvement of a donor in their conception.¹²⁵ Disclosure of donor-status is more common in families with lesbian parents and single mothers by choice.¹²⁶
- Reasons cited for non-disclosure include a desire to protect the non-biological parent and the child from the stigma associated with infertility and donor conception.¹²⁷ On the other hand, those parents who have disclosed or intend to do so in the future are committed to openness and honesty within their families, and wish to avoid accidental discovery.¹²⁸
- Some recent studies suggest that parents are becoming more inclined to tell their children about their genetic origins, however many feel the need for more professional support to assist them to tell in the way and at the time that is most appropriate for them and their children.¹²⁹
- Where children have always been aware of their donor status, they report being comfortable with the fact. Very few seek out parental-child relationships with their donors, although many are curious about the donor and would like to discover his or her identity with a view to making contact in the future.¹³⁰
- Those people who did not discover their donor origins until late adolescence or adulthood have reported significant negative effects, including shock, ongoing

mistrust in the family, frustration and loss, and a feeling of lack of genetic continuity.¹³¹ In many cases these effects are compounded by the inability to discover the identity of the donor, because no records were kept at the time of conception and/or the donation was made on the condition of anonymity.

The commission has, in the process of considering these findings, been mindful of the different levels of significance people place on genetic connection in parent–child relationships. Dr Maggie Kirkman has examined the ways in which parents, donors and children interpret the interaction between genetic connections and familial relationships and found that responses vary. While many people prioritise the importance of loving and supportive relationships, regardless of genetic connection, Kirkman warns that ‘denial of the significance of genes conflicts with the claims by donor-conceived people that it is their right to know their genetic inheritance’.¹³²

The adverse effects of denying people conceived from donated gametes information about their genetic origins suggests that parents should be informed about the importance of telling the child about the circumstances of their conception from an early age and should receive counselling and other forms of support to do so. In Chapter 15, we explore the experiences of those donor-conceived people who participated in our consultation process and make recommendations about the management and disclosure of donor information.

Surrogacy Arrangements

There is relatively little empirical data on outcomes for children conceived as the result of surrogacy arrangements, although small studies suggest they are ‘psycho-socially well adjusted’.¹³³ Because most of these children are still young, findings are generally based on reports made by parents.¹³⁴ A United Kingdom study showed that there was little conflict between surrogates and commissioning parents, with only one mother and one surrogate mother expressing slight doubts about the arrangement during the handover period. The study also found that parents planned to tell the child about their conception.¹³⁵

In a small Victorian study, which involved interviews with 13 women who had IVF treatment to become a gestational surrogate, none of the women said that they had experienced feelings of maternal loss or grief. All except two of these surrogates were related to the commissioning parents.¹³⁶ This study did

- 122 Murray and Golombok (2005a), above n 118, 252.
- 123 Murray and Golombok (2005b), above n 118, 1659.
- 124 Susan Golombok et al, ‘Non-Genetic and Non-Gestational Parenthood: Consequences for Parent-Child Relationships and the Psychological Well-Being of Mothers, Fathers and Children at Age 3’ (2006) 21(7) *Human Reproduction* 1918.
- 125 Firouz Khamsi et al, ‘Some Psychological Aspects of Oocyte Donation from Known Donors on Altruistic Basis’ (1997) 68(2) *Fertility and Sterility* 323; Clare Murray and Susan Golombok, ‘To Tell or Not to Tell: The Decision-Making Process of Egg-Donation Parents’ (2003) 6 *Human Fertility* 89; Clare Murray et al, ‘Egg Donation Parents and Their Children: follow-Up at Age 12 Years’ (2006) 85(3) *Fertility and Sterility* 610; Emma Lycett et al, ‘School-Aged Children of Donor Insemination: A Study of Parents’ Disclosure Patterns’ (2005) 20(3) *Human Reproduction* 810.
- 126 Katrien Vanfraussen et al, ‘An Attempt to Reconstruct Children’s Donor Concept: A Comparison Between Children’s and Lesbian Parents’ Attitudes Towards Donor Anonymity’ (2001) 16(9) *Human Reproduction* 2019; J E Scheib et al, ‘Choosing Identity-Release Sperm Donors in the Parents’ Perspective 13–18 Years Later’ (2003) 18(5) *Human Reproduction* 1115; J E Scheib et al, ‘Adolescents with Open-Identity Sperm Donors: Reports from 12–17 Year Olds’ (2005) 20(1) *Human Reproduction* 239; Murray and Golombok (2005a), above n 118.
- 127 Lycett et al (2005), above n 125; A Brewaeys et al, ‘Donor Insemination: Dutch Parents’ Opinions About Confidentiality and Donor Anonymity and the Emotional Adjustment of Their Children’ (1997) 12(7) *Human Reproduction* 1591.
- 128 Lycett et al (2005), above n 125.
- 129 Dorothy Greenfeld and Susan Causo Klock, ‘Disclosure Decisions Among Known and Anonymous Oocyte Donation Recipients’ (2004) 81(6) *Fertility and Sterility* 1565; Scheib et al (2003), above n 126; Susan Golombok et al, ‘Families Created by Gamete Donation: Follow-Up at Age 2’ (2005) 20(1) *Human Reproduction* 286; Infertility Treatment Authority, Victoria, *Telling About Donor Assisted Conception: Interviews with Donor Conceived Adults, Parents and Counsellors* (2006).
- 130 Scheib et al (2005) above n 126; Vanfraussen et al (2001), above n 126.
- 131 A J Turner and A Coyle, ‘What Does It Mean to be a Donor Offspring? The Identity Experiences of Adults Conceived by Donor Insemination and the Implications for Counselling and Therapy’ (2000) 15(9) *Human Reproduction* 2041.
- 132 Maggie Kirkman, ‘Genetic Connection and Relationships in Narratives of Donor-Assisted Conception’ (2004) 2(1) *Australian Journal of Emerging Technologies and Society* 1, 17.
- 133 McNair (2004) above n 62, 47.
- 134 Fiona MacCallum et al, ‘Surrogacy: The Experience of Commissioning Couples’ (2003) 18(6) *Human Reproduction* 1334. This was a study of 42 heterosexual couples who used surrogacy, and their children.
- 135 McNair (2004), above n 62, 48.
- 136 Gina Goble, *Carrying Someone Else’s Baby: A Qualitative Study of the Psychological and Social Experiences of Women who Undertake Gestational Surrogacy* (Master in Psychology (Counselling Psychology) Thesis, Swinburne University of Technology, 2005). We thank Ms Goble for providing us with a copy of her thesis.



not examine outcomes for children born as a result of the arrangements, although parents said that they would tell their children about the circumstances of their conception. Further details about outcomes in surrogacy arrangements are provided in Chapter 19.

LAW REFORM

Over the last century the law has gradually been reformed to respond to changes in family structures. Adoption laws were passed early in the twentieth century, at a time when unmarried mothers were stigmatised and neither contraception nor abortion was widely available. At that time it was expected that single women would relinquish their children to be brought up by married couples. When death rates were higher than is the case today and there was little state support available for widows with children, adoption also allowed people caring for orphaned children to be recognised as their legal parents. The effect of adoption was to transfer parental status from the child's parent or parents to the people who would bring up the child.¹³⁷

In the late 1960s and early 1970s Australian states enacted legislation to abolish the status of illegitimacy, which had historically treated children born to unmarried parents as 'children of no-one'.¹³¹ In the 1980s, states passed laws to permit a fair distribution of property after breakdown of a heterosexual de facto relationship and to recognise de facto relationships for other legal purposes.¹³⁹ During the 1980s state laws also recognised relationships between children conceived through donated gametes and their social parents.¹⁴⁰ In the last ten years states began to extend laws which recognised de facto relationships to couples living in same-sex relationships.¹⁴¹

Courts have also responded to changes in families when interpreting and applying laws. The Family Court of Australia is charged with making decisions on a daily basis about what parenting arrangements are in the best interests of children after their parents have separated. In some cases the court is asked to resolve cases where one of the child's parents is living in a same-sex relationship. The Family Court takes the view that sexual orientation alone provides no basis for making assumptions about a person's capacity to care for children.¹⁴² In 1996, the then Chief Justice Alastair Nicholson commented that 'sexual orientation, in and of itself, has been held to be an irrelevant matter in disputes about children under the Family Law Act unless it somehow impinges upon the best interests of the child'.¹⁴³

The recommendations in this report have been influenced by information about the composition of Australian families and the way that their structure has changed over time. Whether or not Victorian laws regulating eligibility for treatment are changed, the number of children born to same-sex couples, and as a result of surrogacy arrangements is likely to increase in the future. We argue that further law reforms are necessary to meet the needs of children who are living in diverse families and to recognise the parental status of people who care for, love, and financially support children conceived in a diversity of family types, through assisted reproduction.

The commission is also aware that inadequate and outmoded laws can reinforce social attitudes which stigmatise non-nuclear families and may have a negative effect on children born to single women or women in lesbian relationships, even where there is also a high level of support and acceptance of these families. By extension, laws that recognise these families can play an important role in fostering respect for and acceptance and tolerance of diversity.

137 *Adoption Act 1928*. The current provisions are in *Adoption Act 1984*: see Chapter 10.

138 See for example *Status of Children Act 1974* (Vic). Other states have similar legislation.

139 The *De Facto Relationships Act 1984* (NSW) provided a model for similar legislation in all other states. Other aspects of de facto relationships had previously been recognised; see New South Wales Law Reform Commission, *De Facto Relationships Issues Paper* (1981) Section 3. South Australia had recognised de facto relationships for a limited range of purposes in the *Family Relationships Act 1975* (SA).

140 See for example *Status of Children (Amendment) Act 1984*, inserting ss10A–10F into the *Status of Children Act 1974*.

141 See for example *Statute Law Amendment (Relationships) Act 2001*; *Statute Law Further Amendment (Relationships) Act 2001*.

142 *Re K* (1994) 17 Fam LR 537, 556.

143 Alastair Nicholson, 'The Changing Concept of Family: The Significance of Recognition and Protection' (1996) 3(3) *E Law—Murdoch University Electronic Journal of Law* [58].

Chapter 3 Regulation

CONTENTS

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A licensed clinic is the term used to describe a place where assisted reproductive procedures are carried out.

The regulation of assisted reproductive technology (ART) is contentious because it must take account of and respond to a range of issues, including patients' rights, scientific and technological change, professional autonomy, ethical concerns, standards for treatment and community expectations.

The commission has not been asked to review the entire regime for regulation of ART in Victoria. In our review of the *Infertility Treatment Act 1995*, we have been asked to examine the issues of eligibility for treatment and the regulation of altruistic surrogacy. However, in addressing these matters, we have also had to consider the fundamental question of whether the State should play a role in controlling or overseeing the provision of ART.

In this chapter we outline the regulatory framework that governs the provision of ART services in Victoria and other jurisdictions. Regulation of access to treatment, status of children, access to donor information and surrogacy are examined in greater detail in later sections of the report. We also explore some of the debates about the extent to which ART should be subject to regulation by the State, and outline the approach adopted by the commission in this reference.

REGULATION IN VICTORIA

Victorian legislation dealing with ART was first enacted in 1984. Victoria was the first state in Australia, and the first jurisdiction in the world, to enact legislation regulating assisted reproduction. This legislation was introduced following recommendations made by a committee established in 1982 by the Victorian Government, the Committee to Consider the Social Ethical and Legal Issues arising from IVF, headed by Professor Louis Waller (the Waller Committee). The Waller Committee's terms of reference were:

To consider whether the process of IVF should be conducted in Victoria and, if so, the procedures and guidelines that should be implemented in respect of such processes in legislative form or otherwise.¹

The Waller Committee concluded that in-vitro fertilisation (IVF) and the use of donated sperm, eggs and embryos were acceptable practices, but that safeguards should be implemented to control their use. In particular, it recommended that IVF should only be conducted in authorised hospitals, and that counselling and information should be provided to people prior to treatment

to ensure free and informed consent. The committee also recommended that participants in the IVF program be married and have attempted alternative means of conception for at least 12 months before joining the program, and that admission to donor treatment programs be based on need.² The committee recommended that donors should receive counselling and provide consent prior to donation, and that a registry to enable donors, recipients and donor conceived people to obtain non-identifying information about each other be introduced.³

INFERTILITY (MEDICAL PROCEDURES) ACT

The *Infertility (Medical Procedures) Act 1984* was introduced following recommendations made by the Waller Committee. The Act, which came into effect on 1 July 1988:

- outlined a regime for regulation of IVF procedures, confining the treatment to married couples and establishing an approval process for hospitals
- established a process for people to obtain information about donors or children born as a result of IVF treatment, including the process for a donor to contact a person born with the use of his or her sperm or eggs
- prohibited commercial surrogacy arrangements and made surrogacy agreements void.

The Infertility (Medical Procedures) Act did not contain any direct reference to the best interests or welfare of children born as a result of treatment procedures.

The Act established a Standing Review and Advisory Committee on Infertility (SRACI), which was to 'consider and if appropriate, approve proposals for experiments on embryos, and to advise the Minister for Health in relation to infertility and on procedures for its alleviation'.⁴ It was required by the Act to provide an annual report to parliament, 'on all relevant procedures carried out in approved hospitals, and on its own work'.⁵

Between May 1990 and October 1991, SRACI completed a three-volume report on the Infertility (Medical Procedures) Act, which included recommendations for amendment. The Victorian Government, influenced by the impact of technological innovation and the experience of the interpretation and operation of the Act, decided to pass new legislation to regulate ART.⁶ The then Minister for Health, Marie Tehan, said the new legislation:

would make clear key aspects of current IVF laws which had been made redundant or uncertain by recent advances in scientific procedures as well as ensuring that IVF techniques are in line with community standards.⁷

INFERTILITY TREATMENT ACT

The new legislation, the *Infertility Treatment Act 1995*, came into effect on 1 January 1998. The principal differences between the new and old Acts are the abolition of the 12-month waiting period to enter the IVF program, the introduction of the right of people born as a result of donor treatment procedures to obtain identifying information about their donors, and the establishment of a new licensing authority and regulatory body, the Infertility Treatment Authority.

The main purposes of the Act are to regulate:

- fertilisation procedures and donor insemination procedures
- access to information about these procedures
- research using human eggs, sperm and embryos.⁸

The Act sets out broad principles to guide decision making, and establishes an independent regulatory authority and a licensing regime for treatment providers. It also contains provisions about surrogacy arrangements, and aims to promote research into the incidence and causes of infertility.

Guiding Principles

Guiding principles set out in the Infertility Treatment Act apply when people are undertaking any of the activities regulated by the Act. The principles are:

- The welfare and interests of any person born or to be born as a result of a treatment procedure are paramount.
- Human life should be preserved and protected.
- The interests of the family should be considered.
- Infertile couples should be assisted in fulfilling their desire to have children.⁹

The principles are listed in the order of importance they are to be given when carrying out any of those activities. It follows that the welfare and interests of the child are of paramount importance.

Treatment Procedures

The Infertility Treatment Act regulates certain activities called 'treatment procedures' and 'donor treatment procedures'. A treatment procedure is any one of the following:

- insemination of a woman with donor sperm
- transfer of an egg, or sperm, or both to the body of a woman
- transfer to the body of a woman of an embryo formed outside the body.

A donor treatment procedure includes any of the above that involve the use of donated gametes (sperm or eggs) or donated embryos.¹⁰

The Act contains provisions which determine who may undergo infertility treatment procedures, including who may use donated gametes and embryos to become pregnant, and in what circumstances. It also sets out requirements which must be met by people who donate gametes. In the second section of this report we examine these eligibility requirements in detail. In the fourth section, we discuss the regulation of surrogacy arrangements in Victoria.

Infertility Treatment Authority

The Infertility Treatment Act established the regulatory body to oversee the implementation of the Act in Victoria, the Infertility Treatment Authority (ITA). The ITA's functions include compiling and providing access to medical records, administering licensing and approvals systems, monitoring compliance, considering requests for extensions to storage periods, and approving the import or export of gametes or embryos.¹¹

Licensing

The Infertility Treatment Act limits the people who can carry out assisted reproduction procedures. Most procedures can only be carried out by an approved doctor at a licensed hospital or day procedure centre, or a licensed research institution. In this report, we will use the term licensed clinic to refer to these centres.

The ITA is responsible for approving clinics and hospitals to carry out treatment procedures and issues the conditions for licence with which licensees must comply in delivering their services.¹² The conditions include matters which are additional to the requirements under the legislation, such as compliance with the National Health and Medical Research Council's *Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research* (the NHMRC guidelines),¹³ accreditation by the Fertility Society of Australia's Reproductive Technology Accreditation Committee (RTAC),

- 1 Committee to Consider the Social, Ethical and Legal Issues Arising from In Vitro Fertilization, Victoria, *Committee to Consider the Social, Ethical and Legal Issues Arising from In Vitro Fertilization Interim Report* (1982) 1.
- 2 Ibid 24–5.
- 3 Committee to Consider the Social, Ethical and Legal Issues Arising from In Vitro Fertilization, Victoria, *Report on Donor Gametes in IVF* (1983) paras [3.14], [3.28].
- 4 Standing Review and Advisory Committee on Infertility, *Annual Report 1996*.
- 5 Ibid.
- 6 See Victoria, *Parliamentary Debates*, Legislative Assembly, 4 May 1995, 1244 (Marie Tehan, Minister for Health).
- 7 Office of the Minister for Health, 'Minister Details New IVF Legislation' (Press Release, 4 May 1995).
- 8 *Infertility Treatment Act 1995* s 1.
- 9 *Infertility Treatment Act 1995* s 5.
- 10 *Infertility Treatment Act 1995* s 3.
- 11 *Infertility Treatment Act 1995* s 122.
- 12 Infertility Treatment Authority, *Conditions for Licence: Clinics, Hospitals and Day Procedure Centres* (7th ed, 2006).
- 13 National Health and Medical Research Council, *Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research* (2004).

staffing, recordkeeping and notifications. The Conditions also provide guidance to licensees about legislative provisions which have been subject to judicial interpretation.

Donor insemination can be performed outside a licensed clinic by an approved doctor.

In July 2006, the Infertility Treatment Act was amended to allow entities other than hospitals and day procedure centres to be licensed to carry out infertility treatment.¹⁴ In the second reading speech for the amending Bill, the then Minister for Health, Bronwyn Pike, explained that the purpose of the Bill was to enable an infertility treatment provider to apply and be granted a licence to conduct treatment in their own right:

At present section 93 of the act permits the Infertility Treatment Authority to issue a licence only to a public hospital, a denominational hospital, a private hospital or a day procedure centre. There is no capacity to issue a licence for a stand-alone organisation which is a legal entity, such as, for example, Melbourne IVF or Monash IVF ...

The current licensing arrangements are not ideal for the governance of the licence. It means that the licensee may not be the clinic providing treatment, and hence there is a lack of clarity between the licensee and the clinic over legal responsibilities and obligations.

This amendment expands the category of entities that can apply for and be granted a licence to include proprietors of clinics that provide infertility treatment services and are either based within a hospital or day procedure centre or access the clinical services of a hospital or day procedure centre.¹⁵

The ITA has subsequently amended its conditions of licence to reflect this amendment.¹⁶

Donor Registers

The Act requires clinics and doctors carrying out treatment procedures to collect specified information about each treatment procedure and resulting birth, and to provide that information to the ITA. The ITA is required to maintain a register of this information. The Act sets out the rights of donor-conceived people, recipient

parents, donors and their families to access the information about donor treatment procedures recorded in the registers.¹⁷ The parties have different rights to access information according to the date on which the donation in question was made. In Chapter 15 of this report, we discuss the operation of the registers in more detail.

NHMRC GUIDELINES

The National Health and Medical Research Council (NHMRC), a Commonwealth statutory authority, has, through its Australian Health Ethics Committee (AHEC), issued national guidelines for ethical use of reproductive technology in clinical practice and research. The Infertility Treatment Act remains the primary instrument regulating ART in Victoria, but as noted above, compliance with the NHMRC guidelines is a condition of licence for Victorian treatment providers.¹⁸

The NHMRC guidelines contain nine ethical principles to guide the clinical practice of ART:

1. *Respect all participants*
2. *Respect human embryos*
3. *Use open and consistent decision making*
4. *Provide information and counselling*
5. *Obtain consent*
6. *Maintain privacy and confidentiality*
7. *Keep detailed records*
8. *Collect and report outcomes data*
9. *Respect conscientious objections.*¹⁹

The guidelines require that participants in ART be provided with relevant information, receive counselling and give informed consent to treatment. They do not address eligibility for treatment or how the welfare of the child might be taken into account in decisions about treatment outside these requirements. The guidelines do however state that clinics 'should maintain documented practices and procedures, identifying the line of responsibility for each' and should develop specific protocols for access to, and eligibility for, treatment.²⁰

The NHMRC guidelines also deal with matters such as storage arrangements for gametes and embryos, record keeping and data reporting, and the introduction of innovative procedures.

MEDICAL PRACTICE REGULATION

The NHMRC guidelines stipulate that all clinics offering ART must obtain accreditation by a recognised authority. The Reproductive Technology Accreditation Committee (RTAC) of the Fertility Society of Australia (FSA) provides accreditation. RTAC's responsibilities include setting and monitoring standards for ART centres, and publishing a Code of Practice. The ITA requires clinics to be accredited by RTAC, in order to be eligible for a licence under the Infertility Treatment Act. All Victorian clinics are RTAC-accredited and must abide by RTAC requirements in addition to complying with Victorian law.

Medical practitioners providing ART services are also subject to general medical regulation under the *Medical Practice Act 1994*, the *Health Services Act 1988* and the *Health Services (Conciliation and Review) Act 1987*, and are also expected to comply with the Code of Ethics of the Australian Medical Association.²¹

CLONING AND EMBRYO RESEARCH

As noted above, the Infertility Treatment Act regulates research using human eggs, sperm and embryos. This research is distinct from the use of human gametes and embryos in ART, which is for reproductive purposes. Stem cell research and cloning fall outside our terms of reference, but their regulation is outlined briefly below.

Developments in cloning and embryo research during the 1990s raised new ethical challenges and prompted calls for regulation. In 2002 the Council of Australian Governments agreed that nationally consistent legislation should be implemented to ban certain practices considered unacceptable, and to regulate research using gametes and embryos.

The *Prohibition of Human Cloning Act 2002* (Cth) and the *Research Involving Human Embryos Act 2002* (Cth) prohibited human cloning and several other practices considered unacceptable, including the creation of human embryos for any purpose other than for attempting to achieve a pregnancy in a woman. Certain uses of excess human embryos created through ART were permitted in accordance with licensing conditions. These Acts operated concurrently with state and territory legislation which also came into force in 2002. Accordingly, the Infertility Treatment Act sets out a regime for the ITA to approve permitted research. The Act prohibits cloning of human embryos²² and the creation of human embryos for research purposes.²³ NHMRC and RTAC guidelines also provide guidance on research practice.

The Prohibition of Human Cloning Act and the Research Involving Human Embryos Act each require that they be reviewed after two years.²⁴ Accordingly, the Acts were reviewed by the Legislation Review Committee (known as the Lockhart Review) in 2005. The committee reported to federal parliament that 'it is generally accepted that there is an ongoing need for legislation in this area',²⁵ but that an overly prescriptive approach had disadvantages. The committee recommended changes to the regulatory system to allow strictly controlled research on human embryos. It also recommended that:

- research involving the creation and use of human embryos should be subject to national legislation
- reproductive cloning should continue to be prohibited
- the creation of human embryos by nuclear transfer should be permitted, under licence, according to strict regulatory guidelines, including strong ethical guidelines for egg donation.

In response to the recommendations of the Lockhart Review, new legislation to regulate embryo research and cloning was passed in 2006. The *Prohibition of Human Cloning for Reproduction and the Regulation of Human Embryo Research Amendment Act 2006* (Cth) will enable certain types of research involving embryos to be permitted provided the research is approved by the NHMRC licensing committee. From 12 June 2007, the Act will permit the creation of human embryos by nuclear transfer for research purposes. Recently legislation has been introduced into the Victorian parliament to reflect the federal amendments.²⁶ The federal legislation must be reviewed again in three years.

STATUS OF CHILDREN LEGISLATION

In addition to regulation of the clinical aspects of ART, Victoria, along with all other Australian jurisdictions, has enacted legislation to deal with the status of children born as a result of donor treatment procedures. The *Status of Children Act 1974* was amended in 1984 to extinguish the parental status of donors and to presume the couple to whom the child is born to be the child's parents, regardless of genetic connection. The extent and consequences of these provisions are examined in detail in Chapter 11-13.

- 14 *Health Legislation (Infertility Treatment and Medical Treatment) Act 2006*.
- 15 Victoria, *Parliamentary Debates*, Legislative Assembly, 31 May 2006, 1461 (Bronwyn Pike, Minister for Health).
- 16 Infertility Treatment Authority (2006), above n 12.
- 17 *Infertility Treatment Act 1995* Pt 7.
- 18 For recent judicial consideration of the NHMRC guidelines see *YZ v Infertility Treatment Authority* (2005) VCAT 2655 (Unreported, Justice Morris, 20 December 2005). This decision is further discussed at page 66.
- 19 National Health and Medical Research Council, above n 13, paras 5.1-5.9.
- 20 *Ibid* para 5.3.
- 21 Australian Medical Association, *Code of Ethics* (2004, revised 2006).
- 22 *Infertility Treatment Act 1995* Part 4A Division 1.
- 23 *Infertility Treatment Act 1995* Part 4A Division 2.
- 24 *Prohibition of Human Cloning Act 2002* (Cth) s 25; *Research Involving Human Embryos Act 2002* (Cth) s 47.
- 25 Legislation Review Committee, Parliament of the Commonwealth, *Legislation Review: Prohibition of Human Cloning Act 2002 and the Research Involving Human Embryos Act 2002* (2005), 158.
- 26 Infertility Treatment Amendment Bill 2007, introduced by the Hon B Pike, 13 March 2007.

REGULATION IN OTHER JURISDICTIONS

The Commonwealth does not have the constitutional power to legislate over ART. This means that there are different approaches to regulation across states and territories. As in Victoria, South Australia and Western Australia have directly regulated the provision of ART services.²⁷ These states have legislation that sets out criteria for access to treatment and requires doctors providing infertility treatment to be licensed by a specific statutory agency. The legislation also provides for codes of practice that detail clinical practice standards.²⁸ The remaining states and territories in Australia adhere to national ethical standards for treatment, best practice guidelines and standards developed by national bodies, such as the NHMRC guidelines and the RTAC code of conduct.²⁹

JURISDICTION	LEGISLATION	NHMRC & RTAC GUIDELINES
New South Wales	✗	✓
Victoria	✓	✓
Western Australia	✓	✓
South Australia	✓	✓
Queensland	✗	✓
ACT	✗	✓
Tasmania	✗	✓
Northern Territory	✗ (but clinics adhere to SA legislation)	✓

The Australian Health Ethics Committee has recommended that because ART entails significant social and political, not just ethical, concerns it should be subject to legislation in all Australian jurisdictions. It also believes that without uniform legislation ‘regulation of national data collection, maintenance of a centralised database and monitoring of research could not be achieved’.³⁰ A number of submissions received by the commission also called for nationally consistent regulation.³¹ As discussed in Chapters 2 and 4, another consequence of the absence of uniform ART legislation is that people who are ineligible for treatment in one state often travel to unregulated states to undergo treatment.³²

International regulatory regimes range from prohibitive or restrictive legislation, to facilitative legislation to no legislation at all.³³ Italy and Germany, for example, have adopted a very restrictive and cautious approach to ART. Controls on the use of ART and access to treatment exist in Canada, the United Kingdom and New Zealand, where legislation contains broad principles to which practitioners must adhere when making decisions about treatment. In the United Kingdom, a code of practice operates in conjunction with a statutory licensing system to regulate the conduct of treatment. There is some control over fertility treatment in most Scandinavian countries, ranging from permissive legislation in Sweden to strict legislative control in Norway.

In the United States, there is no federal regulation of ART. Approximately 30 states have enacted legislation in the area, including one state, New Hampshire, which explicitly regulates access to treatment.³⁴ Voluntary societies, such as the American Society of Reproductive Medicine and the Society for Assisted Reproductive Technology (SART) develop practice guidelines and minimum standards for member clinics, set reporting requirements and facilitate educational programs. Over 85% of ART clinics in the United States are members of SART.³⁵

SHOULD ART BE REGULATED?

The question of whether, and to what extent, the law should govern the use of ART is controversial.³⁶ Some people think ART is simply a medical procedure which should not be regulated differently from any other treatment. According to this view, the principles of individual autonomy and reproductive freedom should prevail and decisions should be made by the treating doctor and the patient, subject to the normal requirement for a proper standard of care.³⁷ Another argument against regulation is that because there is no consensus in the community about what ethical principles should apply to reproductive choices, moral and ethical decisions should be made by the individuals concerned and not imposed by the state. Further, interference by the state may hinder developments in treatment-enhancing technologies. Proponents of this view also argue that clinical issues can be addressed through professional self-regulation in the form of guidelines and codes of practice.

On the other hand, some people argue that ART is different from other forms of medical treatment because the creation of children raises complex moral and social questions. On these grounds, it is argued that ART should be regulated by the state. As one submission commented, ART 'raises profound questions that go to the very core of our understanding of the creation of human life'.³⁸ In Victoria, one of the reasons for regulating ART has been to limit the types of people who are eligible for treatment. However, regulation can also have a range of purposes directed at achieving other specific objectives, such as:

- protecting patients and children to be born against genuine risk of harm by implementing safeguards and ensuring the quality of services
- establishing procedures to support patients through the process and ensure they are able to make informed decisions about treatment options
- prohibiting particularly harmful or unacceptable activities such as the implantation of multiple embryos, and reproductive cloning

- instilling public trust and confidence in the delivery of services using emerging technologies
- making decision-making processes fair and transparent and the people responsible for those decisions accountable
- clarifying the status of children and parents where donated gametes have been used to conceive a child
- providing access to information about a donor conceived person's genetic origins
- controlling the expenditure of public funds
- providing processes for consultation and review about future changes to legislation, particularly in response to rapidly changing technology.

Although some people argue that regulation of ART is obtrusive and interferes in matters considered to be private,³⁹ there appears to be agreement in the literature produced by policy makers and academics that a degree of careful and balanced intervention by the state in ART is justified to achieve some or all of the objectives listed above.

Martin Johnson, Professor of Reproductive Services at the University of Cambridge, has concluded that some form of external regulation of ART seems inevitable, although he argues that it is vital to ensure that such regulation 'be driven by clear, outcome-based objectives'.⁴⁰ Philosophers Leslie Cannold and Lynn Gillam argue that:

*the state has an obligation to protect the interests of its citizens and regulation is a legitimate method of achieving this. It is possible that ART can be practised in ways that threaten the interests of at least some citizens and so, in principle, it is ethically permissible for the state to regulate in such situations.*⁴¹

Helen Szoke, Lexi Neame and Louise Johnson, past and present executive officers and research and policy staff at the Infertility Treatment Authority, acknowledge that government intervention in ART is problematic, but suggest there is:

*potential for [governments] to constitute an independent player in this arena, and assist in resolving conflicts and formalising an expression of public interest. Of course, such a resolution will not satisfy all parties, as the conflict is often based on incommensurable moral values and we live in a pluralistic society.*⁴²

- 27 *Reproductive Technology (Clinical Practices) Act 1988 (SA), Human Reproductive Technology Act 1991 (WA)*. In 2003 the NSW Government released a draft Assisted Reproductive Technology Bill for the purposes of public consultation. At the time of writing the bill had not been introduced into parliament and no further details about its progress were available.
- 28 *Reproductive Technology (Code of Ethical Clinical Practice) Regulations 1995 (SA)*. In Western Australia, a code of practice has not been drafted, but the Commissioner of Health provides clinics with directions (*Human Reproductive Technology Directions*).
- 29 For a discussion of the law in the Northern Territory, ACT, NSW, Tasmania and Queensland see John Seymour and Sonia Magri, *ART, Surrogacy and Legal Parentage: A Comparative Legislative Review* (2004), 23–6.
- 30 National Health and Medical Research Council (2004), above n 13, para 1.6. See also Don Chalmers, 'Professional Self-regulation and Guidelines in Assisted Reproduction' (2002) 9(4) *Journal of Law and Medicine* 414, 428.
- 31 Submission PP1 322 (Australian Infertility Support Group).
- 32 Note that the Standing Committee of Attorneys General (SCAG) has agreed to consider drafting uniform laws for surrogacy across all states and territories: Attorney-General Phillip Ruddock, 'Nationally Consistent Surrogacy Laws a Step Closer' (Media Release 210/2006, 10 November 2006).
- 33 Helen Szoke, Lexi Neame and Louise Johnson, 'Old Technologies and New Challenges: Assisted Reproduction and its Regulation' in Ian Freckelton and Kerry Petersen (eds), *Disputes and Dilemmas in Health Law* (2006) 187, 194–6.
- 34 Seymour and Magri (2004), above n 29, 6.
- 35 Society for Assisted Reproductive Technology, 'What is SART?' available at <www.sart.org/WhatsSART.html> at 10 January 2006.
- 36 For a more detailed discussion of the arguments about regulation, see (2002) 9(4) *Journal of Law and Medicine*, Special Issue: Regulating Reproduction, for example, Chalmers (2002), above n 30, 425–8.
- 37 See, eg, submission CP 174 (Professor HWG Baker).
- 38 Submission CP 166 (Christine Campbell).
- 39 See, for example, H W Gordon Baker, 'Problems with the Regulation of Assisted Reproductive Technology: A Clinician's Perspective' (2002) 9(4) *Journal of Law and Medicine* 457.
- 40 Martin Johnson, 'The Art of Regulation and the Regulation of ART: The Impact of Regulation on Research and Clinical Practice', (2002) 9(4) *Journal of Law and Medicine* 399, 413.
- 41 Leslie Cannold and Lynn Gillam, 'Regulation, Consultation and Divergent Community Views: The Case of Access to ART by Lesbian and Single Women', *Journal of Law and Medicine* 498, 501–2.
- 42 Szoke, Neame and Johnson (2006) above n 33, 187, 206.

'In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.'

They posit that the government's role in an area of such complexity and technological development is to manage this process of change, in part by engaging the community in ongoing dialogue.⁴³

Governments, too, have broadly recognised the need for regulation of ART. As Professor Ken Daniels has observed:

Most countries seem to have accepted that there is a role for the state and that as a consequence, the implementation of that role will limit or constrain reproductive choice. Most of the debate and conflict in recent years has centred on the nature and extent of that role, rather than its appropriateness.⁴⁴

In 2005 the United Kingdom House of Commons Science and Technology Committee argued that:

there should be a balance between the freedom of individuals to make their own reproductive choices and the legitimate interests of the state, but that any intervention into reproductive choice must have a sound ethical basis and also take into account evidence of harm to children or to society.⁴⁵

In the United Kingdom, the government agreed with the committee that legislation remains necessary and has expressed its commitment 'to the principles of good regulation, which include ensuring that regulation is proportionate and appropriately targeted'.⁴⁶ The government agreed that 'the emphasis of regulation should be on improving standards and systems and the development of good practice, with the principal aim of protecting patients'.⁴⁷

The commission has paid particular attention to the ways in which legislation has addressed the objective of protecting the interests of children born as a result of ART, and how it responds to technological change.

BEST INTERESTS OF THE CHILD

The most common justification for regulation of ART is the need to protect children from any harm that may arise as a result of the method or circumstances of their conception. The rationale for this approach is that the state has a responsibility to protect the legitimate interests and needs of children because they are incapable of participating in the decision-making process in relation to their own conception.

The *Convention on the Rights of the Child*, to which Australia is a signatory, directs that:

In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.⁴⁸

The principle of best interests of the child is central to ART legislation in Victoria, South Australia, Western Australia, the United Kingdom and Canada, albeit using different terminology. In some cases the legislation refers to the 'welfare' or 'welfare and interests' and in others to the 'best interests' or 'health and wellbeing' of the child or person to be born. The legislation variously requires the welfare or best interests of the child to be the 'paramount' or 'primary' consideration, to take 'priority' or to be 'taken into account'.⁴⁹

In addition, the NHMRC guidelines state that 'clinical decisions must respect, primarily, the interests and welfare of the persons who may be born'.⁵⁰ This principle also underpins the *Family Law Act 1975* (Cth),⁵¹ and the Victorian *Adoption Act 1984*⁵² and *Children and Young Persons Act 1989*.⁵³

The best interests of the child principle has been the subject of considerable debate and controversy over the years, both as it relates to ART but also in its more general application to child protection, social welfare and family law.⁵⁴ The arguments made against requiring consideration of the best interests of children in the particular context of ART may be summarised as follows:

- The principle of best interests is contestable, subjective and indeterminate. It is often intended to reflect specific socio-cultural values, generally about 'desirable' family types and can be used to justify discrimination against non-conventional families. For example, in some jurisdictions it has been assumed that limiting access to reproductive services to heterosexual couples will act as sufficient safeguard to protect children from harm.
- It is unfair to subject people using ART to an assessment level that does not apply to people who conceive children without the assistance of reproductive technologies. There is no justification for imposing a higher standard on ART users.
- It is impossible to predict what will be in the best interests of a child who has not yet been conceived, as every person is unique. By contrast, the best interests of a child in the context of a child protection or adoption case or a family law dispute can be ascertained with some degree of certainty, because their individual needs can be identified. It is more appropriate to assess the best interests of a child born through ART, if at all, once the child has been born and some risk of harm has been identified.
- It is also argued that it is problematic, from a philosophical perspective, to suggest that non-existence would be preferable to an existence which is considered to be less than ideal.⁵⁵
- Although the principle is persuasive at a policy or ethical level, it is impossible to apply at a clinical level.⁵⁶ It is difficult and time-consuming for clinicians to obtain information from all prospective patients about their background and parenting capacity.

Despite these reservations about the best interests of the child principle, legislatures continue to adhere to it. In December 2006, for example, the United Kingdom government reported that it:

*believes that the presence of a 'welfare of the child' section in the law remains valuable and proposes to retain a duty for treatment centres to consider the welfare of the child who may be born as a result of treatment, or any other child who may be affected.*⁵⁷

Some regimes have attempted to address some of the criticisms and limitations of applying the principle. For example, in Canada the legislation prohibits discrimination against participants on the grounds of marital status or sexual orientation.⁵⁸ In the United Kingdom, the Human Fertilisation and Embryology Authority issues a code of practice to guide clinics on how to take the welfare of the child into account when assessing those seeking treatment.⁵⁹ The current guidelines contain a presumption to provide treatment to all those who request it, unless there is evidence that the child to be born would face a risk of serious medical, physical or psychological harm. Evidence is drawn from the patient's medical and social history. In South Australia, the Reproductive Technology (Code of Ethical Clinical Practice) Regulations 1995 contain presumptions against treatment of people who potentially pose a risk to children, and in limited circumstances, there is the possibility of recourse to a review panel.

Importantly, our consultations revealed that almost everyone believes the promotion of the best interests of the child should remain the primary concern in the regulation and provision of ART services, even if they differ on precisely how a child's interests should be protected in the context of access to ART.

- 43 Ibid 207.
- 44 Ken Daniels, 'Regulation and Reproductive Choice: The New Zealand Approach' (2005) 8(2) *Human Fertility* 75, 75.
- 45 House of Commons Science and Technologies Committee, *Human Reproductive Technologies and the Law* Fifth Report of Session 2004–05: Volume 1 (2005), 169.
- 46 The Stationery Office, *Government Response to the Report from the House of Commons Science and Technology Committee: Human Reproductive Technologies and the Law* Cm 6641 (2005), 6. See also Foreword by Minister of State for Public Health in Department of Health [United Kingdom], *Review of the Human Fertilisation and Embryology Act: A Public Consultation* (2005), v.
- 47 The Stationery Office (2005) above n 46, 26.
- 48 United Nations, *Convention on the Rights of the Child*, UN GAOR, 44th sess, UN Doc A/44/736 (1990) art 3(1). For a discussion of the convention and its application to ART, see John Tobin, *The Convention on the Rights of the Child: The Rights and Best Interests of Children Conceived Through Assisted Reproduction* (2004).
- 49 The Hon. Alistair Nicholson, previously Chief Justice of the Family Court of Australia, has expressed the opinion that he doubts that there is any significant difference between the terms 'welfare and interests' contained in the Infertility Treatment Act and the principle of 'best interests of the child' found in the *Convention on the Rights of the Child* and in the Family Law Act: 'Children's Rights in the Context of Infertility Treatment', paper presented to the Infertility Treatment Authority Symposium, 2 November 2006.
- 50 National Health and Medical Research Council, above n 13, para 5.1.
- 51 *Family Law Act 1975* (Cth) s 60CA.
- 52 *Adoption Act 1984* s 9.
- 53 *Children and Young Persons Act 1989* s 87.
- 54 See Emily Jackson, *Regulating Reproduction: Law, Technology and Autonomy* (2001); Kristen Walker, 'Should There Be Limits on Who May Access Assisted Reproductive Services? A Legal Perspective' in Jennifer Gunning and Helen Szoke (eds), *The Regulation of Assisted Reproductive Technology* (2003) 123, 131–2; Margaret Coady, 'Families and Future Children: The Role of Rights and Interests in Determining Ethical Policy for Regulating Families' (2002) 9(4) *Journal of Law and Medicine* 449.
- 55 Emily Jackson, *Fertility Treatment: Abolish the Welfare Principle* (2003) available from <www.spiked-online.com/Articles> at 11 June 2003.
- 56 Ken Daniels, 'An Examination of the "Best Interests of Children" in the Field of Assisted Human Reproduction' (1998) 8 *Eubios Journal of Asian and International Bioethics* 146.
- 57 Department of Health [United Kingdom], *Review of the Human Fertilisation and Embryology Act: Proposals for Revised Legislation (including Establishment of the Regulatory Authority for Tissue and Embryos)* Cm 6989 (2006)10. It should be noted that in December 2006 the UK government announced its decision to propose that the reference in the Act to the need of the child for a father be removed: Department of Health [United Kingdom], *Review of the Human Fertilisation and Embryology Act: Proposals for Revised Legislation (including Establishment of the Regulatory Authority for Tissue and Embryos)* Cm 6989 (2006) 10.
- 58 *Assisted Human Reproduction Act* (Can) s 2(e).
- 59 Human Fertilisation and Embryology Authority, *Code of Practice* (6th ed, 2003), Part 3.

TECHNOLOGICAL CHANGE

Our terms of reference ask us to consider whether changes should be made to the Infertility Treatment Act to reflect rapidly changing technology in the area of assisted reproduction. Developments in assisted reproductive technology present a significant challenge for lawmakers: legislation can quickly become redundant, unworkable or obstructive if the subject matter being regulated changes. These problems generally arise when legislation is prescriptive, that is, when it is specific about what treatments can or cannot be provided and there is no scope for flexibility in the application of the law.

Although the restrictive consequences of legislation are often intentional, because governments have made decisions about where the boundaries should lie in respect of scientific advances, a lack of flexibility can have a range of undesirable effects. In particular, it may result in legal challenges to the validity of the legislation, as in the case of *McBain v State of Victoria*,⁶⁰ or people may seek specific redress from the courts, as in the posthumous use of sperm cases of *AB v Attorney-General (Vic)*⁶¹ and *YZ v Infertility Treatment Authority*.⁶²

When there is no prospect of treatment being legally provided in Victoria, people may choose to travel to jurisdictions with less restrictive laws, sometimes with the support and encouragement of Victorian clinicians.⁶³

Another consequence of prescriptive regulation is that the body charged with administering the Act may encounter problems resolving matters of interpretation where the legislation is detailed and/or definitions of technical terms are ambiguous. In its submission, the ITA stated that during the first five years of its operation, it sought 32 legal opinions to assist it to apply provisions of the Act.⁶⁴

It may also be difficult to apply the Act to new technologies that were not envisaged when it was drafted. For example, a new technology may produce the same outcome as an older technology that is banned, but be permitted because it does not fall within the scope of the legislation.

The parliament may be called on to amend the legislation on an ad hoc basis to respond to the circumstances of particular cases. For example, in 2001 the Infertility Treatment Act was amended to permit a woman to use stored embryos in circumstances where her husband had died after the creation of the embryos.⁶⁵

The Lockhart review grappled with these issues in the context of embryo research and the prohibition of human cloning.⁶⁶ The committee reported that it was:

*widely acknowledged that prescriptive legislation has a number of disadvantages, because it is difficult to anticipate advances in knowledge and potential new uses of the technologies. This difficulty, combined with the complexity of the science involved, inevitably leads to ambiguities and difficulties in interpretation.*⁶⁷

The committee therefore advocated a more flexible regulatory approach, involving a combination of legislation, regulations, guidelines and the capacity of the licensing body to issue rulings on interpretation of legislative provisions.⁶⁸

The commission convened a meeting of a group of senior clinicians and scientists who work in the ART field.⁶⁹ The group identified a range of problems they experience as a result of restrictive definitions in the legislation governing their activities. They agreed that the legislation should establish a framework for the development of regulation by a body (such as the ITA) in consultation with the community, practitioners and patients. The group also suggested that, in order to ensure the legislation endures advances in technology, it should describe what treatment outcomes are permitted, rather than attempting to define the specific treatment procedures and technologies that are permitted.

Commentators such as Timothy Caulfield, Lori Knowles and Eric Meslin, while acknowledging the difficulty of crafting policy that is 'both comprehensive and responsive to the evolving science and bioethical considerations',⁷⁰ are critical of prescriptive approaches to the regulation of ART and reproductive genetics:

Too often, we believe, the search for a regulatory response to certain scientific developments has led governments to adopt simple bans and prohibitions. We recognise that this approach is often a

result of political or jurisdictional constraints or the result of a lack of other regulatory options. Using the law in such a manner is, however, frequently an inappropriate means of regulating behaviour in this complex and dynamic area. With rare exception, legal prohibitions are blunt—that is, they tend to be either overly permissive or overly restrictive—inflexible, and incapable of reflecting the depth and diversity of ethical views inextricably linked to the policy debates surrounding reproductive genetics.⁷¹

Proposals to address the difficulties of regulating an area of rapidly changing technology generally advocate the implementation of framework legislation, elements of which are already a feature of the Victorian Act. This is where legislation sets the framework for governance of the activities in question and articulates the relevant values and guiding principles, but leaves the details of regulation to a regulatory body.⁷² Compliance with standards of practice is ensured through a licensing system. Helen Szoke, Lexi Neame and Louise Johnson, for example:

*regard legislation which devolves the proscriptive regulations governing practice and implementing guidelines, directives or codes as a promising model for the regulation of ART in Australia in the future. However, the fact remains that without legislation there exists no watertight enforcement mechanism for such codes.*⁷³

One area which is characterised by rapid technological change, and is regulated in a more flexible way, is that of pre-implantation genetic diagnosis (PGD) of embryos. PGD is used to screen embryos where there is a risk that a child may inherit a genetic disorder, and enables selection and implantation of only unaffected embryos. The traits that can be identified and screened out through PGD are expanding rapidly. The way in which the Infertility Treatment Act regulates pre-implantation genetic diagnosis allows new developments in embryo screening to be made available to patients without the need for review or amendment of the law. The legislation does not mention PGD, nor does it list the types of conditions which may be identified through this process. Instead, the ITA approves new applications of PGD as part of its licensing function. This process is discussed in further detail in Chapter 5.

One of the most important features of regulating an area as complex and dynamic as ART is the need for ongoing community consultation and debate. As Caulfield, Knowles and Meslin conclude:

*No law or policy will or should aim to bring closure. We need to develop a regulatory regime that can work within this reality. Steps must be taken now to move towards a flexible regulatory scheme that promotes ongoing public and professional dialogue, sets limits which respect the ethical commitments we hold as a society, and fosters a climate which will promote valid scientific and clinical endeavour.*⁷⁴

COMMISSION'S APPROACH

The commission has concluded the continued regulation of ART in Victoria is justified. The use of ART raises issues which go beyond the interests of particular individuals and may affect the whole community. Different participants in ART (primarily patients, their partners, donors, and children born as a result) have different interests and needs which must be protected and balanced. The state is able to play an important role in helping to ensure this is done in a fair and transparent way.

People have a range of views about the ethical and social implications of creating children through the use of ART. This makes it particularly important that ART is open to public scrutiny and the public has the opportunity to express their views about the conditions under which it is provided. Regulation can identify the public interests which must be considered when treatment is provided and give democratic legitimacy to decisions about ethical and moral issues.⁷⁵

Self-regulation by scientists and medical practitioners is not transparent and provides limited scope for public debate about issues in which many members of the community feel they have a stake. However, in the commission's view it is appropriate for technical clinical matters to continue to be dealt with in guidelines developed by national expert bodies such as RTAC and the NHMRC.

Techniques of assisted reproduction are evolving rapidly. Many of the medical and social consequences of ART are not yet fully understood.⁷⁶ Regulation can deal with this

- 60 (2000) 99 FCR 116.
- 61 (2005) 12 VR 485.
- 62 (2005) VCAT 2655 (Unreported, Justice Morris, 20 December 2005).
- 63 See Kerry Petersen, et al, 'Assisted Reproductive Technologies: Professional and Legal Restrictions in Australian Clinics' (2005) 12 *Journal of Law and Medicine* 373, 383–4.
- 64 Submission CP 24 (Infertility Treatment Authority). This figure does not include opinions sought in relation to particular court cases.
- 65 *Infertility Treatment (Amendment) Act 2001*, s 5. Joanne Bandel-Caccamo lobbied the Victorian government to remove the prohibition on the use of stored embryos after the death of her husband. The couple had been receiving ART treatment and had embryos in storage: Fay Burstin, 'Widow wins right to IVF' *Herald-Sun* (Melbourne) 12 October 2001, 17.
- 66 Legislation Review Committee, Parliament of the Commonwealth, *Legislation Review: Prohibition of Human Cloning Act 2002 and the Research Involving Human Embryos Act 2002* (2005), 153–8.
- 67 *Ibid* 158.
- 68 *Ibid* 158, 182.
- 69 Technological Change Working Group consultation, 21 October 2004.
- 70 Timothy Caulfield, et al, 'Law and Policy in the Era of Reproductive Genetics' (2004) 30(4) *Journal of Medical Ethics* 414, 414.
- 71 *Ibid*.
- 72 *Ibid* 416; see also Sonia Magri, 'Research on Human Embryos and Cloning: Difficulties of Legislating in a Changing Environment and Model Approaches to Regulation' (2005) 12 *Journal of Law and Medicine* 483.
- 73 Szoke, Neame and Johnson (2006) above n 33, 187, 207.
- 74 Caulfield et al (2004) above n 70, 416–7. See also Belinda Bennett, 'Rewriting the Future? Biomedical Advances and Legal Dilemmas' (2006) 13 *Journal of Law and Medicine* 295, 303.
- 75 Helen Szoke, 'The Nanny State or Responsible Government?' (2002) 9(4) *Journal of Law and Medicine* 470, 477.
- 76 We discuss this in Chapter 2.

uncertainty by monitoring practices, controlling use of particular technologies, and implementing protections against identifiable harms and risks. The regulatory scheme must be able to respond to technological change, to address emerging problems and to respond to shifts in social attitudes. As the experience in Victoria has shown, constant changes and discoveries have made the present legislative scheme difficult to apply.

To this end, the commission has recommended changes to the Infertility Treatment Act which would promote a responsive and flexible regulatory regime. 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 built into those processes to ensure the legislative framework can endure developments in the technology and our understanding of the impact of ART on participants, in particular the children who are born as a result. We have proposed that the more difficult decisions to be made 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. We also believe individuals affected by the decisions made by these bodies should have a right of review.

As to the issue of protecting the interests of the child to be born, the commission believes this aim should remain fundamental to the regulation of ART, but at the same time should be carefully implemented to ensure the principle is applied fairly in each case. In Chapter 5 we discuss the different approaches regulation of this area may adopt, and propose new processes to deal with cases where a potential child may be at risk of harm.

Chapter 4 Access to Treatment

CONTENTS

52 CURRENT LAW

54 PROBLEMS WITH THE LAW

Clinical infertility is the term used to describe the medical reasons which prevent a woman from becoming pregnant.

The commission has been asked to enquire into and report on the desirability and feasibility of making changes to the law to expand eligibility criteria for access to assisted reproductive technology (ART). In this chapter, we examine the law that governs access to infertility treatment, including treatment in which donated sperm and/or eggs are used. We consider whether the Act meets its objective of protecting the best interests of any person born as a result of a treatment procedure.

CURRENT LAW

Access to ART treatment procedures in Victoria is governed by the *Infertility Treatment Act 1995*. The Act sets out criteria for access to treatment and contains guiding principles and other requirements relevant to the provision of ART services.¹

The requirements which must be met before a woman is permitted to undergo assisted insemination or a fertilisation procedure at a licensed clinic are that she must:

- be married and living with her husband or living with a man in a de facto relationship and have the consent of her husband/partner to the treatment
- be 'unlikely to become pregnant' with her own ovum or her husband/partner's sperm, other than by a treatment procedure, or be at risk of having a child with a genetic abnormality.²

The operation of these requirements has been modified by the decision in the Federal Court case *McBain v The State of Victoria*.³ In this case, the court decided that the requirement that a woman be married or in a heterosexual de facto relationship in order to access infertility treatment was inconsistent with the provisions of the federal *Sex Discrimination Act 1984*.

When a state law is inconsistent with federal law, state law is legally invalid. This means that as a result of the *McBain* decision, marital status may no longer be used as a reason to exclude a person from treatment. Women who are single, in same-sex relationships or in unmarried

heterosexual relationships where they do not live with their partner on a genuine domestic basis can now access ART if they meet the other eligibility requirements.

In the *McBain* case, it was not necessary for the court to make a decision on other eligibility criteria for access to assisted reproduction. In particular, it did not express a view on how the requirement that a person be 'unlikely to become pregnant' should be applied to a woman who does not have a male partner. Two legal opinions have been given on this question.

According to the legal opinion of Peter Hanks QC provided to the Infertility Treatment Authority (ITA) by the Fertility Access Rights Lobby, the expression 'unlikely to become pregnant' should be applied in the same way to women who do not have male partners as it applies to women who are married or in de facto heterosexual relationships.⁴

According to another opinion, provided by Dr Gavan Griffith QC to the ITA, the 'unlikely to become pregnant' criterion applies differently to women without male partners and women in heterosexual relationships.⁵ This opinion concluded that the criterion should be determined by reference to the subject matter of the Act, namely the treatment of infertility. According to this interpretation, the only permissible reason for a single woman's inability to become pregnant without treatment is clinical infertility, whereas the explanation for a married woman's inability to become pregnant without treatment may take account of her husband's fertility as well.

The ITA subsequently directed clinics to comply with the advice of Griffith. The requirement that a woman seeking treatment be unlikely to become pregnant is therefore now applied more strictly to single women and women in same-sex relationships than to women who are married or in de facto heterosexual relationships. A clinic can treat a woman who is married or in a heterosexual de facto relationship if she is unlikely to become pregnant because of her own, or her spouse's, clinical infertility, psychological reasons (for example her or her partner's aversion to penetrative sex), or, despite attempts, she has been unable to conceive for no apparent or obvious reason. On the other hand, unmarried women must be clinically infertile, which is generally limited to physiological symptoms which prevent conception (such as endometriosis, blocked fallopian tubes, mature age or a previous diagnosis of infertility).

'Clinical infertility' is a difficult term to define. 'Infertility' is not defined or mentioned in the Infertility Treatment Act. Professor Robert Jansen, Medical Director at Sydney IVF has said that infertility is often unexplained, describing it as a situation where '[p]regnancy seems possible, but it has not yet happened'.⁶ In the majority of cases, doctors assess couples' fertility as between low and normal, with only five per cent being regarded as sterile (completely infertile).⁷

The ITA has directed clinics to assess infertility of single or lesbian women based on:

- *A history of the patient's conduct indicating infertility, such as an appropriate number of previous unsuccessful treatments through donor insemination or IVF; or an appropriate period of unprotected heterosexual intercourse without achieving pregnancy; or*
- *A clinical indication of infertility which is either documented in the doctor's referral to the approved practitioner or from an investigation which the approved practitioner has undertaken, or both.*⁸

Applying the 'unlikely to become pregnant' requirement differently to women depending on whether they are married or single may be inconsistent with the provisions of the federal *Sex Discrimination Act 1984*,⁹ but this issue has not been tested in court.

In addition to these express eligibility requirements, the Infertility Treatment Act contains a set of guiding principles that must be complied with in carrying out activities regulated by the Act, including the provision of treatment procedures. These principles are:

- The welfare and interests of any person born or to be born as a result of a treatment procedure are paramount.
- Human life should be preserved and protected.
- The interests of the family should be considered.
- Infertile couples should be assisted in fulfilling their desire to have children.¹⁰

Neither the Act nor the conditions of licence established by the ITA provide any guidance on how these principles are to be applied when a clinic decides who is eligible for treatment. In the absence of guidance, interpretation of these criteria is at the discretion of individual doctors.

During our consultation process, some medical practitioners reported that if it becomes apparent that a child would be at risk, or there were concerns about the capacity of the parents to care for the child, the decision about whether to proceed with treatment would be discussed by a team of doctors, counsellors, a lawyer, and anyone else who may have an interest, on a case-by-case basis.¹¹ Sometimes, a formal ethics committee may be convened, consisting of these people, as well as a hospital representative or a person with specialist expertise.¹² The patient is made aware of this process. If the patient does not accept the decision of the team there are processes available for making a complaint or for referring the matter to a patient representative of the hospital or clinic.¹³

1 This is discussed in more detail in Chapter 3.
2 *Infertility Treatment Act 1995* s 8.
3 (2000) 99 FCR 116.
4 Legal opinion provided to the Fertility Access Rights Lobby by Peter Hanks QC, 18 August 2000, and supplied to the ITA. Copy provided to the commission by the ITA.
5 Legal opinion provided to the ITA by Dr Gavan Griffith QC, 4 August 2000. Further advice provided, 12 September 2000. Copies provided to the commission by the ITA.
6 Robert Jansen, 'Elusive Fertility: Fecundability and Assisted Conception in Perspective' (1995) 64 (2) *Fertility and Sterility* 252.
7 Jansen distinguishes between sterility (complete infertility), which means that couples who wish to achieve a pregnancy have no chance of doing so, and infertility (relative infertility) which means 'making an arbitrary distinction between normal fertility and low fertility': *Ibid* 252.
8 Infertility Treatment Authority, *Conditions for Licence: Clinics, Hospitals and Day Procedure Centres* (7th ed, 2006), 15 [4.1].
9 Anita Stuhmcke, 'Access to Infertility Treatments and Single Women: What is the State of Play?' (2001) 9 *Journal of Law and Medicine* 12,13; Kristen Walker, '1950s Family Values vs Human Rights: In Vitro Fertilisation, Donor Insemination and Sexuality in Victoria' (2000) 11 *Public Law Review* 292, 298; submissions CP 156 (Law Institute of Victoria), CP 191 (Equal Opportunity Commission of Victoria).
10 *Infertility Treatment Act 1995* s 5.
11 Access roundtable, 14 October 2004.
12 Access roundtable, 9 February 2006.
13 Access roundtables, 14 October 2004 and 9 February 2006.

'It is a sad indictment upon Australian law that a lesbian celebrates a diagnosis of an undesirable gynaecological condition just so that she can fulfil the legal criteria of 'medical infertility' and gain access to safe, identity traceable donor sperm in Victoria.'

A survey of 15 clinics in Victoria and NSW revealed that although it was unusual for clinics to apply a 'fitness-to-parent' test to patients,

there were cases in which clinics refused treatment on these grounds, based upon reports from child protection authorities or family services. One clinic had declined to treat a patient with a severe physical handicap who was not seen to be able to cope with a child.¹⁴

The Act also contains a number of other provisions aimed at protecting the interests of children. It establishes a regime to enable people born through the use of donated gametes to obtain information identifying their donor.¹⁵ It requires people undergoing treatment to give informed consent and to have counselling.¹⁶ Counselling provides a woman seeking treatment with an opportunity to discuss the implications of the treatment procedure on herself, her partner (if she has one) and on any child to be born. As outlined in Chapter 3, there are also a range of laws and professional guidelines which seek to ensure that the treatment will be of the highest possible medical standard, and that patients and children born as the result of treatment are protected from health risks, including the transmission of infectious diseases. The commission regards these measures as very important safeguards. Our recommendations assume that safeguards designed to ensure the highest standard of clinical practice will continue to apply.

PROBLEMS WITH THE LAW

The commission believes that the law is unsatisfactory in several respects. In particular, it does not protect children adequately, it excludes some women and children from the safeguards offered by the system, it has not kept pace with technology and it lacks consistency and clarity.

Although the guiding principles contained in the Act express a theoretical commitment to the welfare and interests of children conceived through assisted reproduction, there are no provisions which specify how this should be achieved in practice. In particular, the legislation does not specify how the welfare and interests of a child to be born are to be taken into account when a person or couple seek treatment, or what doctors or counsellors should do if they are concerned that the health and wellbeing of a prospective child is, or may be, at risk.

Although the commission is aware that the process adopted by clinics in difficult cases has elements of good practice, it is not formalised and there is no requirement that clinics adhere to it. Clinics are not required to seek advice from child development experts, nor is there any mechanism that would prevent a clinic from treating a person or couple where a child would clearly be at risk. As a result, it is possible for treatment to be provided to people even where it is likely that the best interests of a child to be born will be compromised. Similarly, it is possible for clinics to refuse to treat people on grounds that cannot be objectively supported. As one submission noted, '[c]autiousness needs to be taken to ensure that clinical discretion and not moral judgement is the criteria used'.¹⁷ There is a lack of transparency and accountability in the way in which clinics are able to make decisions about whether a person should be permitted to proceed with treatment.

The law excludes many women from the benefits and safeguards of the licensed clinic system. Women who are ineligible for treatment (because they do not have a male partner and are not clinically infertile) may therefore choose to self-inseminate or to go interstate or overseas for treatment.¹⁸ If women self-inseminate with sperm from donors who have not been screened for communicable diseases, both their health and the health of any children they conceive may be at risk. The mother of the child and the donor will not receive counselling prior to conception, which may contribute to disputes and litigation about arrangements for the ongoing parenting of the child. If the child is conceived interstate or overseas, information about donors may not be recorded and other safeguards provided by Victorian law may not apply. As a result, children may be unable to trace their genetic origins or to ascertain the identity of their genetic parent(s).

A single woman who wrote to the commission said:

I have a son who was born 20 months ago via donor insemination (DI). My son was conceived through a clinic in Sydney because, as a single woman, I was unable to access DI treatment in Victoria at the time. ... I was told that if I had 4 unsuccessful treatments in NSW I could undergo treatment in Victoria because I would then be considered clinically infertile. As it happened, I was monitored in Victoria but had to travel to Sydney for the actual insemination. This was extremely frustrating and costly in time and money. I was extremely fortunate that my first insemination was successful, so I only had to travel to Sydney once. I had to use an unknown donor. There were no identified donors available to me (the only one available had nominated that his sperm was to go to a couple only).¹⁹

In their submission to the commission, the organisation Prospective Lesbian Parents described the process of obtaining treatment interstate:

Deciding to travel interstate to access ART services is not an easy nor realistic option for many lesbian women. Being forced to

travel interstate to try and conceive their children—a process that has come to be called ‘reproductive tourism’—has a range of impacts on women. The financial and emotional concerns, and time-consuming nature of the process, the difficulty of securing access to ongoing health care with the same person, make it a difficult ‘choice’ for many women.²⁰

Many women wrote about the personal consequences of travel, including the economic impact:

We have been travelling to Sydney so that my partner can undergo treatment at a clinic. So far it has cost us approximately \$10,000 to try to conceive. Each trip to Sydney for treatment costs about \$1,500, including accommodation and travel. By contrast, if we were able to access treatment in Victoria it would cost about \$800 for each treatment. Monash IVF is just 15 minutes away from where we live. We now have to save up more money before we can continue with treatment in Sydney.²¹

The current law is also unfair because it applies unevenly. Some women without male partners will be eligible for treatment in Victoria and others will not. A single woman who has a genetic abnormality which could be transmitted to her child is eligible for treatment. A single woman of 45 may be eligible for treatment because her age has made her clinically infertile. By contrast, a single woman aged 35 who does not have clinical symptoms cannot be treated. These distinctions make no sense and bear no relationship to the concept of the health and wellbeing of the child.

The commission heard from many women whose experiences confirmed the uneven application of these laws. For example:

It is a sad indictment upon Australian law that a lesbian celebrates a diagnosis of an undesirable gynaecological condition just so that she can fulfil the legal criteria of ‘medical infertility’ and gain access to safe, identity traceable donor sperm in Victoria.²²

14 Kerry Petersen, et al, ‘Assisted Reproductive Technologies: Professional and Legal Restrictions in Australian Clinics’ (2005) 12 *Journal of Law and Medicine* 373, 382.

15 *Infertility Treatment Act 1995* Part 7.

16 *Infertility Treatment Act 1995* ss 9 and 11; *Infertility Treatment Regulations 1997* r 6.

17 Submission PP1 322 (Australian Infertility Support Group).

18 The commission received many submissions from women who had pursued either or both of these options because they were unable to access clinic treatment in Victoria.

19 Submission CP 187 (Brenda).

20 Submission CP 149 (Prospective Lesbian Parents).

21 Submission CP 142 (Kate Just).

22 ‘Zoe’ in submission CP 149 (Prospective Lesbian Parents).

Chapter 4

Access to Treatment

There are a wide range of views in the community about the eligibility requirements which should apply to people seeking ART treatment. But whatever view is taken it is clear that the operation of the current law produces unfair and irrational results. The Act has been criticised by the Infertility Treatment Authority as lacking a clear policy basis, particularly on issues of access. The Act has not been amended to take account of the *McBain* decision and it is not clear how the 'unlikely to become pregnant' requirement should be applied to women without male partners. This makes it necessary to review the eligibility criteria for people who wish to access ART.

In the following chapter we discuss the ways in which we believe the eligibility criteria should be revised to achieve a fair and balanced framework for access to ART in Victoria.

Chapter 5

Eligibility for Treatment

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RECOMMENDATIONS

1. The *Infertility Treatment Act 1995* 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.
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.

As discussed in the previous chapter, the commission believes that the current eligibility requirements of the *Infertility Treatment Act 1995* fail to protect effectively the best interests of children. In order to address this issue, we recommend:

- a new set of guiding principles
- a process for review by a panel or ethics committee when there is a concern that the health and wellbeing of a child may be at risk
- presumptions against treatment to deal with cases where there may be an unacceptable risk of harm to the child
- removal of the marital status requirement
- clarification of the ‘unlikely to become pregnant’ criterion.

We also recommend that the requirements for consent, counselling and the provision of information remain and that the regulatory authority retains its licensing and oversight functions.

These recommendations do not depart substantively from the interim recommendations the commission made in *Position Paper One: Access*. We have, however, refined the recommendations in light of comments and suggestions made in submissions in response to the position paper.

Our recommendations seek to strike a balance between allowing patients and clinicians sufficient scope to determine whether assisted reproductive technology (ART) is appropriate in a particular case and making clear statements about community values and standards. We believe that the processes we recommend achieve a fair and workable balance between these two objectives, as well as providing a mechanism for protecting children from the risk of harm.

GUIDING PRINCIPLES

The commission believes there should be clear statements within the legislation to provide a framework for decision-making by people who wish to access treatment, their treating doctors, counsellors, ethics committees and other bodies such as our recommended review panel. The establishment of guiding principles would provide these clear statements. The principles are also flexible enough to enable the Act to be applied in ways that are appropriate to individual cases and developments in emerging technologies and can help avoid the problems associated with prescriptive legislation. At the same time, guiding principles can encourage consistency in how the law is applied in individual cases.

The commission has reviewed the current guiding principles and believes they should be revised. The proposed new principles are:

1. The welfare and interests of the child to be born as a result of the use of assisted reproductive technology are paramount.
2. 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.
3. All children born as a result of the use of donated gametes have a right to information about their genetic parents.
4. The health and wellbeing of people undergoing treatment procedures must be protected at all times.
5. People seeking to undergo assisted reproductive procedures must not be discriminated against on the basis of their sexual orientation, marital status, race or religion.

BEST INTERESTS OF THE CHILD

The principle of best interests of the child reflects the predominant concern expressed by people in public forums, in submissions and at the roundtables conducted by the commission. It reflects the international standard articulated in the *Convention on the Rights of the Child* that '[in] all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration'.¹ It is also consistent with the policy which applies to assisted reproduction in jurisdictions which have legislated to regulate it, such as the United Kingdom, Canada, South Australia and Western Australia.

The commission has adopted the expressions 'welfare and interests' and 'paramount' as they are consistent with other Victorian legislation dealing with children such as the *Adoption Act 1984*² and the *Children and Young Persons Act 1989*.³

The commission has made recommendations concerning access to ART (see Chapter 5) which are intended to provide a process for giving effect to this guiding principle.

NON-EXPLOITATION

The principle of non-exploitation of children and parents is intended to make it clear that it is not acceptable to exploit the reproductive capabilities of men and women, or the children born as a result of ART, in trade or otherwise. The principle is consistent with section 380 of the Infertility Treatment Act which prohibits commercial trading in human eggs, human sperm or human embryos. It is also relevant when considering section 59 of that Act which prohibits commercial surrogacy arrangements.⁴ A similar provision appears in the guiding principles of Canada's *Assisted Human Reproduction Act 2003*.⁵

CHILDREN'S RIGHT TO INFORMATION

This principle enshrines children's rights to information about their genetic parentage and is consistent with the *Convention on the Rights of the Child*. We discuss this principle and the importance of telling donor-conceived children about their origins further in Chapter 15.

HEALTH AND WELLBEING

People wishing to utilise ART to achieve a pregnancy and subsequent birth of a child should not be exposed to unnecessary risks. The principle that the health and wellbeing of people undergoing ART should be protected draws attention to the nature of the treatment procedures which are provided to a patient. Women should not be subjected to treatment procedures which place them at a higher level of risk than is necessary to achieve a pregnancy.

Clinics are required to comply with the Reproductive Technology Accreditation Committee's (RTAC) code of practice⁶ and the National Health and Medical Research Council's (NHMRC) ethical guidelines.⁷ This principle is consistent with these requirements and is also closely linked to the provisions in the Infertility Treatment Act which require the provision of information to, and counselling and informed consent of, donors and patients. This serves to protect the health and wellbeing of people undergoing ART.

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

2 *Adoption Act 1984* s 9.

3 *Children and Young Persons Act 1989* s 87.

4 Issues surrounding payment for surrogacy arrangements are addressed in Chapter 18.

5 *Assisted Human Reproduction Act 2003* (Canada) cl 2.

6 Reproductive Technology Accreditation Committee, *Code of Practice for Assisted Reproductive Technology Units* (rev ed, 2005).

7 National Health and Medical Research Council, *Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research* (2004).

RECOMMENDATIONS

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.

NON-DISCRIMINATION

Australia has ratified the *International Covenant on Civil and Political Rights* and the *Convention on the Elimination of all forms of Discrimination Against Women*. Central to these treaties is the principle that people should not suffer discrimination on the basis of their sex, marital status, race, colour, political or other opinion, birth or other status. The *Convention on the Rights of the Child*, also ratified by Australia, requires parties to protect children from discrimination on the basis of the status, activities, expressed opinions, or beliefs of the children's parents (Article 2).

The principle of non-discrimination is consistent with the inclusive values upon which our community prides itself, and has been implemented in federal and state anti-discrimination laws and in Victoria's recently implemented *Charter of Human Rights and Responsibilities Act 2006*. All legislation in Victoria must now be compatible with the rights contained in the charter, including the right to enjoy human rights without discrimination and the effective protection against discrimination.⁸

Within the charter the term discrimination has the same meaning as in section 6 of the *Equal Opportunity Act 1995* which lists attributes on the basis of which discrimination is prohibited, including marital status, sexual orientation, personal association and impairment. After some deliberation, the commission decided not to include impairment or disability as one of the grounds on which discrimination in relation to access to ART should be prohibited. This is because in some cases there is a nexus between disability and risk of harm to a child (for example, some forms of severe mental illness). Such a nexus does not exist in relation to marital status or sexual orientation. This does not mean that people with a disability or impairment should be refused treatment, but that in some cases a different approach is justified. Such an approach should involve making enquiries about any potential risk to the health and wellbeing of a prospective child.

The commission believes that non-discrimination is not simply an important end in itself, but that its observance in law and practice helps to shift community attitudes and to promote the health and wellbeing of all members of our society.

The following comment made in a submission identifies the impact that discrimination in the area of ART can have on children:

What are the effects on children who have same-sex parents when they hear discussions about whether gay people are fit to be parents? ... VicHealth talks about three key areas that are important in determining whether we're mentally healthy or not, and they are: social connectedness, freedom from discrimination and violence, and economic participation. In terms of freedom from discrimination and violence it talks about opportunity for self-determination and control of one's life as being really important in supporting our mental health. So whether it's the single mums or lesbian mums or gay couples or the yet to be born children or existing children who hear about this kind of discussion, we are potentially damaging their mental health when we're suggesting there's somehow something wrong with their family unit.⁹

The elimination of discrimination in this area will also promote the health and wellbeing of children born to single women and people in same-sex relationships in a direct way, by allowing more women to have access to the benefits and safeguards offered through the licensed clinic system.

PROTECTING CHILDREN

REGULATORY MODELS

Submissions received and consultations conducted during the course of this reference demonstrated that most people believe that the best interests of children born through ART should be the paramount consideration in the carrying out of ART. The commission has given considerable thought to the ways the law should support this objective. We considered three possible ways that rules governing access to treatment could safeguard the health and wellbeing of children.

The first approach would be to rely solely on the principle that the best interests of children are paramount and to leave it to clinics and people seeking treatment to decide how this should be translated into practice. This approach would treat assisted reproduction in a similar way to conventional conception and the legislation would not prescribe who may have access to ART. Proponents of this approach argue that eligibility criteria should not apply to people accessing ART services, in the same way that the state does not interfere in the decision of other members of the community to become parents without assistance.¹⁰ The submission made by ACCESS, a national support group for infertile people, stated:

*If society believes that instituting a 'fitness to parent' code is necessary to protect the best interests of the child, then the same criteria should be applied equally to fertile people, regardless of the method of conception. To do otherwise would be to treat infertile people as a sub class in society.*¹¹

This approach is also based on the difficulties of predicting whether a person will be a good parent, or whether a child who has not yet been conceived will be at risk of harm. Arguably, these difficulties make it unjustifiable to restrict access to treatment on the basis of the health and wellbeing of the child because decisions on this matter inevitably reflect personal value judgments.

This is broadly the position taken in the recently published report of the United Kingdom (UK) House of Commons Science and Technology Committee Inquiry into Human Reproductive Technologies and the Law.¹² The report is critical of regulatory approaches which place the welfare of the child at the centre of decisions about access to ART. It concludes that the current welfare of the child provision in the UK *Human Fertilisation and Embryology Act 1990* 'discriminates against the infertile and some sections of society, is impossible to implement and is of questionable practical value in protecting the interests of children born as a result of assisted reproduction'.¹³

The second approach is to treat assisted reproduction in a similar way to adoption of children and to require people to be assessed according to a set of criteria aimed at ascertaining whether they will be good parents. People who wish to adopt children must be approved as fit and proper to parent.¹⁴ Applicants must undergo a medical examination and police record check and are assessed according to a range of factors to establish their capacity to provide a secure and beneficial emotional and physical environment for the care of a child.¹⁵ TangledWebs, a group concerned with the impact of ART on people who are conceived with donor gametes, supported use of a similar process to control access to assisted reproduction.¹⁶ TangledWebs argues that prospective parents should be vetted by the Department of Human Services, not by the medical profession, and that the assessment process should be directed primarily to the capacity of applicants to meet the specific needs of donor-conceived children.

The third approach is to implement a fair and transparent process that enables a clinic to investigate concerns about risks to children on a case-by-case basis and according to identifiable and established risk factors.¹⁷ This is the approach preferred by the commission. Such a process would apply only in certain circumstances, and would acknowledge that most people who seek ART services should not be treated any differently from people who conceive without assistance.

8 *Charter of Human Rights and Responsibilities Act 2006* s 8.

9 Submission CP 59 (Ian Seal).

10 Submission CP 192 (ACCESS).

11 *Ibid.*

12 House of Commons Science and Technologies Committee, *Human Reproductive Technologies and the Law*, Fifth Report of Session 2004–05: Volume 1 (2005).

13 *Ibid* 51.

14 *Adoption Act 1984* s 13.

15 *Adoption Regulations 1998* rr 35, 35A.

16 Consultation, 12 November 2004. It should be noted that the principal policy goal of TangledWebs is to cease the entire practice of donor conception.

17 See, eg, Danya Glaser, 'Emotional Abuse and Neglect (Psychological Maltreatment): A Conceptual Framework' (2002) 26 *Child Abuse & Neglect* 697.

RECOMMENDATIONS

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.
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.

Several submissions received in response to Position Paper One expressed strong reservations about legislating to empower institutions and individuals to exclude people from treatment, and therefore from parenthood.¹⁸ For example one person wrote:

*The issue of becoming a parent is an extremely complex one, and for many years (through forced sterilisations, child removals, and discriminatory social policy) decisions have been made by privileged white people (usually men) about who should or should not be a parent. For this reason, I have grave concerns about legitimising the refusal of treatment procedures to women where concerns exist about the health and wellbeing of potential children.*¹⁹

Notably, many proponents of this view acknowledge that there will at times be cases which present clinicians with a dilemma about whether or not treatment should be provided, even where access to treatment is unregulated. The UK Science and Technology Committee proposed that ‘these should be resolved by recourse to local clinical ethics committees’.²⁰ Kristen Walker argues that if the law is to exclude certain people from treatment ‘this should not simply be at the discretion of the doctor—there should be legislative guidance’.²¹

ETHICS COMMITTEES

For the reasons outlined above and in Chapter 3, the commission has decided that some degree of external regulation of access to treatment is warranted. However, we believe it would be inappropriate to implement an adoption model for determining access to ART because assessment in the adoption context is related to the needs of an existing, and possibly particularly vulnerable, child for whom the state is responsible. An assessment process as rigorous as that used for adoption would also be unnecessarily onerous in the context of ART. We believe that counselling already fulfils an important educative function and plays a significant role in preparing parents for the needs of donor-conceived children (this issue is addressed in Chapter 5).

Our consultation process indicated that clinics do encounter cases where they are unsure whether to treat a patient because of concerns that a potential child may be at risk.²²

Some people involved in the provision of ART services expressed the need to have clear

processes or avenues for denying treatment to a person or couple seeking ART when there is a concern about the health and wellbeing of a potential child. For example, a person or couple who otherwise meet the current eligibility criteria may have a physical or psychiatric illness, an intellectual disability, or some other problem that raises a doctor’s concern about their capacity to care for a child. While some people with these conditions may be excellent parents, in cases where a doubt arises there should be a process for decision-making which allows proper assessment of the risk to any child who may be conceived. Doctors and counsellors need a mechanism for determining whether or not to treat the person or couple which is transparent, procedurally fair and allows each case to be evaluated on its own merits.

The commission recommends that a formal system be established to:

- provide guidance and support to doctors and counsellors who are unsure about whether there is any likelihood of harm to a prospective child
- allow the clinic to seek expert advice from people with relevant disciplinary expertise in assessing risks to children, so decisions are based on factors relevant to the health and wellbeing of the child, rather than purely on medical factors or personal value judgments
- implement a decision-making process that is transparent, procedurally fair and consistent.

We therefore recommend that where a doctor or counsellor believes that a child may be at risk of abuse or neglect the matter should be referred to a clinical ethics committee. Each clinic licensed to provide treatment services should 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. The establishment of a clinical ethics committee should be a condition of licence for clinics to ensure the ITA can monitor compliance with the requirements we recommend.

The proposed process will ensure that decisions about access to treatment are not based on discriminatory assumptions about the parenting capacity of particular groups of people (for example people with a psychiatric condition). Where a doubt arises about the capacity of a person to care for a child, it will allow case-by-case evaluation to occur in a way which takes account of the health and wellbeing of any future child. The committees would be obliged to have regard to the guiding principles of the Act, including the principle of non-discrimination.

In proposing the use of a clinical ethics committee, the commission aims to build on a process that already exists in some hospitals and is currently being set up in others. Our proposal is consistent with the requirement in the NHMRC's ethical guidelines that clinical ethics committees be used when difficult decisions need to be made concerning whether or not to proceed with a treatment procedure.

Currently, most ethics committees operating in hospitals act as advisory bodies and do not make decisions which individual doctors must follow.²³ In our view, because the proposed ethics committees would have as their central consideration the health and wellbeing of children, and not merely the best interests of the patient seeking treatment, they should have a decision-making capacity. That is, if the committee decides that treatment should not be provided to a particular patient because of concerns about risk of harm to a potential child, the clinic or doctor should not be permitted to treat that person. Clinicians should not, however, be compelled to treat a person even where the ethics committee has decided there is no barrier to treatment. This is consistent with the principles that govern general medical practice.

Clinical ethics committees are usually made up of people who have experience and/or expertise in resolving dilemmas such as these or who have clinical experience in the area. However, because the primary purpose of referring the matter to the committee is to deal with a concern about a prospective child, the committee should include a child development expert, a psychologist or psychiatrist with expertise in the prediction of risk of harm to children, and a doctor with experience in ART.

There is currently a scarcity of guidance and support for clinical ethics committees, as opposed to research ethics committees. The NHMRC has issued ethical guidelines for research involving human participants that require all human research projects to be vetted by ethics committees.²⁴ There is considerable infrastructure and guidance for the operation of human research ethics committees, including requirements about membership, procedures and reporting.²⁵ No such framework exists for clinical ethics committees; there is actually no legislative requirement in Victoria for hospitals to establish clinical ethics committees.²⁶

Accordingly, we recommend that the clinical ethics committees develop their own procedural guidelines and processes; members should be provided with training and support, possibly by the Department of Human Services. The committees should have regard to the guiding principles of the Infertility Treatment Act when making decisions about each case before them, and they should be able to convene quickly to ensure cases are dealt with expeditiously. The ITA should review the operation of the committees after five years.

We have also recommended that people wishing to undergo ART treatment should have recourse to an independent decision-making body, established under the auspices of the ITA, if they disagree with a decision which has resulted in the denial of treatment. The composition of this body is discussed below.

UNACCEPTABLE RISK

In rare cases, a person seeking treatment or their partner may have previously behaved in a way which suggests there may be an unacceptable risk of harm to any child born. For example, a person or their partner may have had a child previously removed from their care by child welfare authorities, or may have committed serious sexual offences or offences involving serious violence. If this occurred many years ago, or the person's behaviour was caused by the circumstances which existed at that time, there may be no risk it will be repeated. For example, people who are convicted of offences involving violence when they were young may be excellent parents in later life.

However, if the behaviour occurred recently, or if there are other factors which suggest an unacceptable risk to the health and wellbeing of the child, the commission's view is that the person should not be assisted to conceive. The present law does not provide any mechanism for determining whether there is an unacceptable risk of harm. Nor does it provide any process for deciding whether a person should be treated if a doctor or counsellor becomes aware of these issues.

Some people argue that no restrictions of this kind apply to people who become parents without assistance and that the same approach should apply to assisted reproduction. If the child is at risk of harm after they are born an application can be made for a child protection order.

- 18 For example, submissions PP1 107 (Elizabeth Wheeler), PP1 141 (Rachel U'Ren), PP1 145 (James Magel), PP1 251 (Fertility Access Rights), PP1 319 (Women's Health West).
- 19 Submission PP1 107 (Elizabeth Wheeler).
- 20 House of Commons Science and Technologies Committee, *Human Reproductive Technologies and the Law*, Fifth Report of Session 2004–05: Volume 1 (2005), 51.
- 21 Kristen Walker, 'Should There Be Limits On Who May Access Assisted Reproductive Services? A Legal Perspective' in Jennifer Gunning and Helen Szoke (eds), *The Regulation of Assisted Reproductive Technology* (2003) 123, 129.
- 22 Access roundtables 14 October 2004 and 9 February 2006.
- 23 Consultation with Dr Les Reti, Chair of the Royal Women's Hospital Clinical Ethics Advisory Group, 1 August 2006.
- 24 National Health and Medical Research Council, *National Statement on Ethical Conduct in Research Involving Humans* (1999).
- 25 See National Health and Medical Research Council, *Human Research Ethics Committees (HRECS)*, <www.nhmrc.gov.au/ethics/human/hreecs/index.htm> at 22 February 2007.
- 26 Correspondence received by the commission by email from Dr Peter Saul, convenor of the Clinical Ethics Special Interest Group of the Australasian Bioethics Association, 8 June 2006 and Dr Lynn Gillam, University of Melbourne, 10 July 2007.

RECOMMENDATIONS

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.
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.

The commission disagrees with this view. Assisted reproduction is regulated and supported by the state and we therefore believe that the state has a responsibility to identify cases where there is an unacceptable risk of harm. There should be a process for decision-making about where the past behaviour of prospective parents suggests there may be an unacceptable risk of harm. This process should provide a transparent and fair way of making decisions about treatment. There is a substantial body of research on the parental factors which place children at risk of harm.²⁷ This information should be taken into account when assessing whether a person is eligible for treatment. This will require clinics to put in place procedures to identify whether any of the proposed risk factors exist.

Our recommendation creates a presumption against treatment where women seeking treatment and/or their partners have:

- had charges proven against them for a sexual offence²⁸
- been convicted of a violent offence as defined in clause 2, Schedule 1 of the *Sentencing Act 1991*²⁹
- had a child protection order made in relation to one or more children in their care.³⁰

The presumption against treatment of people in these categories will ensure that careful investigation is undertaken before treatment is provided. We recommend that where this presumption applies to a person or her partner, treatment should be refused unless an ITA review panel finds that there is no unacceptable risk to a child who is conceived through assisted reproduction.³¹ The review process will ensure that a person whose circumstances have changed materially since the offending conduct will not be unfairly excluded from treatment.

The presumption relating to people who have committed sexual offences is based on research which shows that some people convicted of serious sexual offences are subsequently convicted of further sexual offences,³² and a small proportion of sexual offenders are convicted of offences against both adults and children.³³ According to this view, the commission believes that the presumption against treatment of anyone who has been convicted of a sexual offence is justified because it takes a cautionary approach which minimises the risk of harm to a child conceived through assisted reproduction.

The presumption against people who have been convicted of a violent offence also extends beyond people who have been convicted of violence against children. Again, there is research indicating that sexual and other forms of violence often coexist in families³⁴ and that children brought up in a household with a violent parent are at risk of emotional and psychological harm, even if they were not assaulted themselves.³⁵

During our consultation process we were told that clinics sometimes encounter cases where a woman who seeks treatment has already had one or more children removed from her care. Child protection orders are made by the Children's Court under the *Children and Young Persons Act 1989* after detailed consideration of the needs of the child, and having regard to the need to ensure that intervention into family life should be to the minimum extent that is necessary to secure the protection of the child.³⁶ The commission views the making of a child protection order as a serious matter which may indicate that there is an unacceptable risk of harm to a child conceived as a result of ART. We therefore recommend the introduction of a presumption against treatment of people who have had a protection order made in respect of one or more children in their care. Again, the presumption is reviewable, ensuring that people whose circumstances have changed since the making of the order are not excluded unfairly.

Recommendation 12 emphasises the priority to be given to the health and wellbeing of children, but recognises that decisions to exclude a person from treatment should be subject to proper review and consideration, by an independent expert body.

The commission considered the various ways of identifying cases where a presumption against treatment could arise. The available methods are to:

- require all patients to undergo a criminal record check or a process similar to the 'working with children check'³⁷
- require all patients to make a statutory declaration about whether they have been convicted of relevant offences or had a child removed from their care
- require clinics to make independent inquiries about all patients' histories, for example by contacting their family members and general practitioners
- seek out relevant information during counselling sessions.

The commission is of the view that the most appropriate way to ascertain whether any of the presumptions apply is to require prospective patients to sign a statutory declaration. We acknowledge the limitations of this approach, in particular the risk that people may make false declarations. In South Australia, where statutory declarations are required before treatment can be provided, the regulatory body (the South Australian Council on Reproductive Technology) has recommended the requirement be abolished on the grounds that the system is open to abuse, is ineffective in protecting children and creates excessive paperwork for clinics.³⁸

However, the commission is reluctant to recommend the alternative mechanisms because we believe it would be both onerous and ineffective. A police check would be overly invasive as it might reveal convictions that are irrelevant to the health and wellbeing of children, and might not record spent convictions or convictions over 10 years old. Using a process like the working with children check, which is administered by the Department of Justice, would be oppressive and bureaucratic and would go too far in the direction of the state dictating who can or cannot have children. The commission was also concerned not to place the responsibility for conducting background checks on clinic staff, by requiring them to make third party enquiries about patients or to use counselling sessions to interview patients about their criminal records.

On balance, therefore, the commission has decided that requiring a person to make a statutory declaration in respect of the matters giving rise to a presumption against treatment is the most appropriate mechanism available.

REVIEW PANEL

The commission recommends that a review panel be established to determine whether treatment should be provided where:

- a presumption against treatment applies to a person/couple seeking treatment or
- a clinical ethics committee has decided that treatment should not be provided.

The review panel should be an independent body with decision-making functions which receives administrative and secretariat support from the ITA. The guiding principles of the Act should apply to decisions to be made by the review panel. The legislation should prescribe the following procedures to be applied:

- the right to be heard
- the right to be represented
- the right to call evidence.

27 See, eg, Victorian Department of Human Services, *An Integrated Strategy for Child Protection and Placement Services* (September 2002); The Allen Consulting Group, *Protecting Children: The Child Protection Outcomes Project: Final Report for the Victorian Department of Human Services* (September 2003); Victorian Office for Children, 'Risk Assessment: Policy Advice and Practice Guidelines for Protective Workers' (1996) in *Protecting Children: Volume 3—Policy Advice and Practice Guidelines: Part 2*, 26–32, available at <office-for-children.vic.gov.au> at 19 February 2006.

28 As defined in clause 1, Schedule 1 of the *Sentencing Act 1991*. This definition includes equivalent offences committed in the past and in jurisdictions outside Victoria.

29 This definition includes a range of serious offences, including murder, manslaughter, causing serious injury intentionally, intentionally causing grievous bodily harm, and common law kidnapping, but excludes summary offences and common law assault. It also includes offences committed outside Victoria.

30 Under the *Children and Young Persons Act 1989* s 85(1)(a).

31 A similar review panel operates in South Australia: see Reproductive Technology (Code of Ethical Clinical Practice) Regulations 1995 (SA) pt 3, Schedule.

32 It is important to note that rates of sexual recidivism are low relative to other offence types, and that sub-groups of sex offenders reoffend at different rates: Australian Institute of Criminology, *Recidivism of Sexual Assault Offenders: Rates, Risk Factors and Treatment Efficacy* (2004) 36–7.

33 For example, a 2002 United Kingdom study by Roger Hood, Stephen Shute, Martina Feilzer and Aidan Wilcox of 174 male sex offenders found that '[s]exual reoffending was largely homologous, with 62 per cent of rapists reoffending against adults only and 71 per cent of child molesters repeating their offences against children only. While the results show a degree of specialisation, a sizeable proportion of each group nevertheless switched between child and adult victims': reported in *ibid*, 35.

34 Marie Hume, 'The Relationship Between Child Sexual Abuse, Domestic Violence and Separating Families' (Paper presented at the Child Sexual Abuse: Justice Response or Alternative Resolution Conference, Adelaide, 1–2 May 2003), National Child Protection Clearinghouse, *Exploring Family Violence: Links Between Child Maltreatment and Domestic Violence* 13 (2000).

35 Victorian Department of Human Services, *Child Protection and Family Violence: Guidance for Child Protection Practitioners (Incorporating the use of Intervention Orders)* (2005); Australian Domestic & Family Violence Clearinghouse, *Domestic Violence in the Context of Child Abuse and Neglect*, Topic Paper (2003); Patrick Parkinson and Catherine Humphreys, 'Children Who Witness Domestic Violence—The Implications for Child Protection' (1998) 10(2) *Child and Family Law Quarterly* 147. The Family Court has relied on this research: see *Patsalou and Patsalou* (1994) 18 Fam LR 426, 428–9; *In the Marriage of JG and BG* (1994) 18 Fam LR 255, 260.

36 *Children and Young Persons Act 1989* ss 84, 86, 87.

37 The working with children check is a mandatory check of criminal records for people who work or volunteer in child-related work in Victoria: *Working with Children Act 2005*.

38 Information provided by Leanne Noack, Executive Officer, South Australian Council on Reproductive Technology, 30 June 2006.

RECOMMENDATIONS

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*.
26. The requirement that a woman who undergoes an assisted reproductive 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.

The process and procedure to be applied should otherwise be for the panel to determine.

The members of the panel should be appointed by the Minister and should receive training about the conduct of hearings, the principles of natural justice and procedural fairness. The 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 ART
- a psychologist or psychiatrist with expertise in families
- a person with knowledge of the ethics of clinical medical practice.

The inclusion of an ethicist is important to ensure the rights of patients are taken into account. A representative of a religious organisation is not required: religious considerations are not relevant to decisions about the health and wellbeing of children. There should be a gender balance in the membership of the review panel.

The panel should consider any relevant research and/or information available, or consult with a person or persons with expertise in a field that relates to the particular concern(s) being assessed. For example, the panel should be able to seek expert advice 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.

If the panel decides that a person should be barred from treatment, this should be conveyed to all clinics in Victoria. However, people should be able to reapply to the panel for approval of treatment if their circumstances have changed.

If the panel decides that a person is not barred from treatment, the clinic should not be compelled to provide treatment.

Decisions of the panel should be reviewable on points of law, but not on their merits, because they are decisions made by a group of specialists. A decision of the panel should be declared to be a decision for the purposes of the *Administrative Law Act 1978*, giving rise to a right to review by the Supreme Court.

MARITAL STATUS

At present, the Infertility Treatment Act requires that a woman be married or in a de facto relationship with a man in order to undergo treatment.³⁹ As we have already discussed, this requirement no longer applies as a result of the decision in *McBain*.

In recent litigation, Victorian courts have been required to interpret the Act in light of the *McBain* requirements. In *AB v Attorney-General (Vic)*,⁴⁰ Justice Hargrave heard an application by a woman for permission to use the sperm of her deceased husband in a treatment procedure. He found that as a result of the *McBain* decision it was no obstacle to treatment that the applicant was unable to comply with the marriage requirement in section 8(1).⁴¹

In *YZ v Infertility Treatment Authority*,⁴² Justice Morris went further and said that as a result of the *McBain* decision, the Act 'must be read on the basis that certain of its provisions are inoperative, or, at least, must be understood as being subject to some modification'.⁴³ As a consequence, Justice Morris said that the word 'family' in the guiding principles of the Act should be construed broadly, and could extend beyond genetic relations.⁴⁴ Specifically, he said the guiding principle 'assisting the infertile to have children' must be read in modified form and suggested the formulation 'infertile couples or persons should be assisted in fulfilling their desire to have children'.⁴⁵

Although the marital status requirement is no longer legally valid, the commission received a significant number of submissions from people opposed to the use of ART by anyone other than married couples. They argued that it is not in the best interests of children to be born to parents who are not in a married heterosexual relationship. For example, these submissions included statements that 'ART procedures and IVF should be limited to married heterosexual couples',⁴⁶ 'the best interests of a child dictate that a mother and father unit, preferably cemented by marriage, is the ideal arrangement',⁴⁷ and '[r]estriction of IVF to married couples is the best way to give children born through IVF procedures the best chance of achieving [adequate and proper parenting]'.⁴⁸

As discussed in Chapter 2, the commission has reviewed the social science research on outcomes for children born to and raised in a diversity of family types. This research does not support the view that the marital status requirement should be retained to safeguard the health and welfare of children.

Marital status and sexuality are not factors that are considered by child welfare authorities or experts to be predictors of harm to children.⁴⁹ Moreover, our research has shown that the marital status requirement, which excludes a significant number of women from treatment, actually operates to increase the potential for children to be exposed to unacceptable health risks and to be deprived of the capacity to obtain information about their genetic parents.

The commission has concluded that the marital status requirement is not only inconsistent with the principle of non-discrimination, but it also bears no relationship to the health and wellbeing of children, which must be the paramount concern of the law governing ART. It is also unsustainable as a result of the decision in *McBain*.

The commission therefore recommends that the Act be amended to make it clear that women requiring assistance to become pregnant should not be excluded on the grounds that they have no partner or have a partner of the same sex. This would bring Victorian law into line with NSW, Queensland, Tasmania, Western Australia and the ACT.

Once the marital status requirement is removed from the Act, consequential amendments will need to be made to the legislation to recognise that a woman undergoing treatment may have a partner of the same sex or may be single.

INFERTILITY

Section 8(1) of the Infertility Treatment Act, which requires a woman to be 'unlikely to become pregnant', has been interpreted inconsistently for married women, women in heterosexual de facto relationships, and women without legally recognised male partners (whether they are single, in same-sex relationships or in a relationship with a man that is not considered a de facto relationship). The stricter interpretation that is applied to women without legally recognised male partners prevents them from receiving treatment in Victoria, unless they are clinically infertile.

Inconsistent application of the law in this area is unacceptable. It has no rational basis, is discriminatory, exposes women and children to health risks and deprives some children of statutory protections afforded to other donor-conceived children. It also places clinics in an invidious position. If the different application of the 'unlikely to become pregnant' requirement was tested in court, it is possible that a clinic which refused to treat a single woman would be found to be in breach of sex discrimination legislation. At the same time, the licensing conditions imposed on clinics require them to discriminate in this way.

This raises the question of whether there should be unrestricted access for anyone wanting treatment, for whatever reason, or whether there should be some limitation on access that applies consistently to all women seeking treatment.

We received a number of submissions stating that access to ART should be subject to some constraints. It was argued that an infertility requirement is an appropriate way of setting a threshold for access to limited health resources and a means of encouraging people to explore other options,⁵⁰ that circumventing infertility was the original purpose of ART and that this should remain the case.⁵¹ Others argued that an infertility requirement might be useful for access to more invasive procedures such as IVF/ICSI, as opposed to donor insemination.⁵² Submissions which supported an infertility requirement often said that it should apply to all women equally. As one submission commented, 'the level of [in]fertility, which is required before ART services are provided, should be uniform for all women, regardless of their marital status or sexual orientation'.⁵³

39 *Infertility Treatment Act 1995* s 8(1).

40 (2005) 12 VR 485.

41 *AB v A-G (Vic)* (2005) 12 VR 485, 498.

42 [2005] VCAT 2655 (Unreported, Morris P, 20 December 2005).

43 *YZ v Infertility Treatment Authority* [2005] VCAT 2655 (Unreported, Morris P, 20 December 2005) [26].

44 *YZ v Infertility Treatment Authority* [2005] VCAT 2655 (Unreported, Morris P, 20 December 2005) [40].

45 *YZ v Infertility Treatment Authority* [2005] VCAT 2655 (Unreported, Morris P, 20 December 2005) [43].

46 Submission CP 127 (Salt Shakers).

47 Submission CP 125 (Australian Family Association).

48 Submission CP 81 (Suryan Chandrasegaran).

49 Marital status and sexuality are not included in the list of parental characteristics tracked by the Department of Human Services, nor are they grounds for initiating child protection proceedings: (2002) above n 27.

50 Submission CP 182 (Anonymous).

51 Submission CP 61 (Neil Ryan).

52 Submission CP 143 (The Bouverie Centre, La Trobe University).

53 Submission CP 156 (Law Institute of Victoria).

RECOMMENDATIONS

28. Before a woman undergoes an assisted reproductive treatment procedure a doctor must be satisfied that the woman is:
- in the circumstances in which she finds herself, unlikely to become pregnant other than by a treatment procedure or
 - unlikely to be able to carry a pregnancy or give birth to a child without a treatment procedure or
 - 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.
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.
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.

The main argument for some kind of infertility requirement was that some ART treatments create health risks for the child and the mother. The fact that some donor-conceived children experience psychological problems was also seen as a reason for limiting access. One donor-conceived person who believes that donor conception involves the unacceptable separation of a child from his or her genetic parent said in a submission:

Whilst there may be an equal opportunity discrepancy between the applications of 'unlikely to conceive' and 'clinically infertile', these two realities have many different implications for the child/adult. Donor conception already creates a subset generation of people with different rights to those conceived 'the old fashioned way'. Will not expanding the accessibility to donated gametes have more serious and far-reaching consequences?⁵⁴

On the other hand, some submissions argued that the infertility requirement should be removed. For example, some people argued that an infertility requirement unnecessarily 'medicalises' ART.⁵⁵ It was also argued that an infertility requirement is discriminatory against lesbian women because ART services are currently available to fertile heterosexual women with infertile husbands and there is no suggestion these women should conceive by having sex with another man, rather than accessing treatment in a clinic.⁵⁶

The commission has concluded that it is appropriate to limit access to ART because of its potential effects on the health and wellbeing of women and children. We do not propose that clinical infertility should be required as this would mean that some women who are married or in de facto relationships who are currently eligible for treatment would be excluded. It would also exclude women without male partners. Instead, the commission recommends that a woman be eligible for treatment if she is unlikely to become pregnant, and that her inability to become pregnant (or to carry a pregnancy or give birth to a child, or likelihood of transmitting a genetic abnormality or disease) be assessed on the basis of the circumstances in which she finds herself (whether single, married, in a same-sex relationship, psychologically averse to having sexual intercourse with a man, or otherwise). In this way, the 'inability to become pregnant' criterion would be interpreted broadly enough to permit people to seek treatment even where it is not due to clinical infertility.

If treatment is being sought for the purpose of avoiding the transmission of a genetic abnormality or disease, a doctor should be satisfied that the woman is at risk of transmitting such an abnormality. Genetic counselling should be offered to women seeking treatment for these reasons. Genetic counselling is provided by health professionals who can offer information and guidance about health issues that have a genetic basis.

There will be some situations in which treatment may be desirable for a woman who does not satisfy the requirement of being unlikely to become pregnant, or likely to transmit a genetic abnormality or disease. One example is the situation where a woman who has a living child, who is suffering from a genetic condition or other disorder, wishes to conceive a child who is a genetic match for this child. The child who is conceived through assisted reproduction may be able to donate bone marrow or some other tissue which could be used in the medical treatment of the sibling. The conception of a child to act as a 'saviour sibling' is controversial and the particular circumstances of the case would need to be carefully considered to ensure protection of the health and welfare of that child. As technology develops there may be other situations where treatment may be desirable, but where women do not meet the statutory criteria.

We recommend that the ITA review panel proposed above should be able to approve treatment for reasons other than an inability to become pregnant or the avoidance of a genetic abnormality or disease. The review panel will have the capacity to address the medical, social and ethical issues which are relevant to the particular case. The provision will also ensure the legislation is sufficiently flexible to respond to new problems. Only treatment for a therapeutic goal which is consistent with the best interests of the child should be permitted by the review panel. This would preclude the possibility of allowing a person or couple to select an embryo for a particular genetic trait, as opposed to selecting to exclude a particular trait, for non-therapeutic purposes. The review panel is the appropriate body to consider cases such as these, which raise ethical questions about new applications of ART and preimplantation genetic diagnosis (PGD) because it is centralised and independent, both of clinics and of government.

DONATED EMBRYOS

During our consultation process the ITA raised an issue about eligibility for donated embryos.⁵⁷ Currently a couple may only receive a donated embryo if neither member of the couple has viable gametes.⁵⁸ For example, if a man is fertile but his partner is unable to produce any eggs, the couple must use donated eggs to form an embryo to be transferred to the woman for gestation. This can be problematic because donated eggs are relatively scarce, in part because the process for successfully freezing and thawing eggs is still being developed. By contrast, donated embryos are more commonly available because they can be more successfully used after freezing. Further, many people in treatment programs have more embryos in storage than they need and choose to donate them once they cease treatment. The commission therefore recommends that treatment with donated embryos should be permitted even where one partner in a couple has viable gametes, in circumstances where donated gametes are not available.

ETHICAL IMPLICATIONS

Several submissions raised ethical concerns about the potential for ART to be used for purposes other than to achieve a pregnancy. These concerns were predominantly related to the practice of PGD. PGD is used by parents who wish to avoid passing a serious genetic disease to their children. Embryos are examined to determine if they are affected by a particular disease or disorder and only unaffected embryos will be transferred to the mother. There is a tension between the capacity of PGD to assist in the avoidance of specific genetic disorders and its potential to address a broader range of parental objectives. One submission argued that PGD amounts to eugenics and has negative implications for those people in the community who live with a disability.⁵⁹

A number of ethical considerations arise in the broader application of a service such as PGD. As technology develops there are likely to be more treatments and services available to people which also raise ethical considerations. The commission believes it is important for these developments to be subject to public scrutiny and discussion.

The ITA has already established an ethics panel but the existence, function and composition of this panel is not specified in the legislation. The commission recommends that an ITA ethics committee be established to consider and

advise on ethical concerns raised about new developments in and use of treatment. Such a process would be distinct from the processes we have recommended for consideration of issues that arise on a case-by-case basis (by clinical ethics committees and the review panel).

The ITA ethics committee should be a body whose members are appointed by the Minister. The ITA should provide administrative support and should have responsibility for convening the committee. It should also act on the advice of the committee when making decisions about applications and conditions for licence. This means that where the ITA becomes aware of a new development in treatment, or a new application of an existing technique (for example, a new form of PGD), the matter must be considered by the ethics committee before it permits clinics to make those treatments available pursuant to the ITA's conditions for licence. The committee would be guided in its consideration by the principles of the Act.

The membership of the committee should comprise:

- a representative from the Fertility Society of Australia (to engender consistency with national/RTAC approaches)
- a senior clinician not involved in ART, 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.

The commission believes this combination of members will have the expertise to raise and address the many issues that may arise for consideration by the committee. We therefore do not believe that the ethics committee should necessarily include a representative of a religious organisation (although it is likely that some members of the committee will hold religious and other personal beliefs). It is not possible to adequately represent the range of perspectives advocated by the diversity of religions in Australian society.

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.

54 Submission CP 60 (Confidential).
Permission to quote given on 5 July 2004.

55 Submission CP 88 (Deborah Dempsey).

56 Submission CP 82 (Anonymous).

57 Correspondence from the Infertility Treatment Authority, by email, 15 February 2007.

58 *Infertility Treatment Act 1995* s 20.

59 Submission CP 166 (Christine Campbell).

RECOMMENDATIONS

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 Infertility Treatment Authority 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.
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.

CONSENT, COUNSELLING AND INFORMATION

There was general consensus in submissions, consultations and research conducted by the commission on the importance of the consent, counselling and information provisions of the Act. These provisions all contribute to the process of ensuring that people make informed decisions that are appropriate for them and for any child that may be born as the result of treatment. The commission believes that the principles we have identified to guide and inform all aspects of ART should be incorporated into the pre-treatment processes. It is also necessary for prospective patients to be given information about the processes and mechanisms established to protect the interests of children, their right to have decisions reviewed, and their right to be heard by the ITA review panel.

LEGISLATION AND REGULATORY BODY

The commission believes that in recognition of the fact that many people who seek and undergo ART are not infertile, references to infertility should be removed from the name of the legislation and the licensing authority. The commission recommends that the Act be renamed the Assisted Reproductive Technology Act, and that the ITA be renamed the Assisted Reproductive Technology Authority.

Chapter 6

Self-insemination

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Assisted insemination is a procedure that involves the transfer of sperm into a woman's vagina, cervical canal or uterus. It may be used to assist a woman with a male partner to conceive where the woman has failed to become pregnant because her partner is infertile or for some other reason. It may also be used to enable a woman who does not have a male partner to become pregnant, using sperm provided by a donor. Self-insemination is assisted insemination done by a woman to herself.

In this chapter, we consider whether clinics should be able to provide services to assist women who wish to self-inseminate. We also consider whether self-insemination which is done without such clinical support should continue to attract criminal penalties.

CURRENT LAW

In Victoria, women who do not have male partners are not eligible for treatment under the *Infertility Treatment Act 1995*, unless they are clinically infertile.¹ For this reason, many women who want to conceive make private arrangements with male friends or acquaintances to donate sperm so they can self-inseminate. Even if a woman is eligible for treatment in a clinic, she may prefer to self-inseminate at home. Self-insemination often takes place without counselling of the woman or the donor and without medical or legal advice. There is a risk that serious health and other issues may emerge for the woman and any child who is conceived, including:

- the possibility that the mother and/or child may contract a communicable disease as the result of self-insemination with sperm from a donor who has not been screened for such diseases
- failure to record information about the identity of the donor resulting in difficulties for the child in obtaining access to this information in the future
- potential for conflict between the donor, the birth mother and her partner (if she has one) about the donor's involvement in the child's life, which might have been avoided through counselling
- the fear that the woman and her partner (if she has one) may be committing a criminal offence by self-inseminating, which may make them less willing to seek advice.

Some fertility clinics have attempted to address these concerns, within the restrictions imposed by the law, by facilitating storage of sperm from a known donor, which is screened by the clinic and then used by women to self-inseminate outside the clinic.² Licensed clinics do this under interim licensing conditions issued by the Infertility Treatment Authority (ITA) which require clinics to satisfy similar requirements to those which apply when a woman is inseminated within a clinic.³

The requirements include:

- screening and testing of donors for communicable diseases and quarantining of sperm prior to its use
- provision of counselling and information to:
 - the man who provides the sperm and his spouse or domestic partner (if any)
 - the woman wishing to utilise the sperm and her spouse or domestic partner (if any) pursuant to the requirements of the Infertility Treatment Act⁴
- consent of the donor and his spouse (if any) to the storage of sperm and recording of any conditions the donor wishes to place on the length of storage
- obtaining the donor's consent to lodge his details with the clinic so that the ITA can record them if a child is born.

In addition, the release of the sperm is conditional on the woman signing an agreement that she will use the sperm in accordance with the donor's consent and that she will notify any birth to the ITA so that the details can be entered on the central register.⁵

Melbourne IVF established a sperm storage service at the Royal Women's Hospital in December 2004 in accordance with these conditions. The service is available to all women who wish to use the sperm of a known donor, although it is expected that primarily single and lesbian women will use the service. Heterosexual couples generally have insemination performed in clinics.⁶ In 2005, 13 known donors stored sperm for release from the Royal Women's Hospital clinic, and 16 women completed agreements for sperm to be released.⁷ In 2006, six known donors stored sperm, and seven women completed agreements. At December 2006, the ITA had received no reports of children born, although one failed pregnancy was reported.⁸

Preliminary feedback about the sperm storage service has generally been positive. In its submission, the ITA reported that clinics had received positive responses to the program from

people seeking treatment.⁹ However, concerns have also been expressed about the limited availability of information about the service, which could be affecting the number of people using it.¹⁰

Conditions imposed on clinics with storage facilities provide some protection for women and for children conceived through self-insemination by sperm from a known donor, and for donors and their spouses. Sperm stored at clinics for self-insemination must be screened, tested and quarantined (in the same way as for other sperm donations) to prevent transmission of communicable diseases.¹¹ Medical expertise and insemination techniques at clinics may also optimise the chance of pregnancy.¹²

The process of sperm storage offers additional protection for all parties. The sperm donor, the woman wishing to inseminate, and both of their partners (if any) must undergo counselling in accordance with the Infertility Treatment Act. The donor (and his partner) must consent to the storage of sperm and state the name of the person who is to receive it. As discussed in Chapter 5, counselling during this process assists in informing the parties and can help to address issues that may arise through assisted conception.

The process also ensures that a donor's contact details are registered with the ITA, and creates an obligation on women to notify the ITA when a child is born.¹³ In Chapter 15, we discuss the importance of ensuring that children conceived using donated gametes have access to information about their genetic origins. The reporting requirements contained in the ITA's conditions for storage of sperm create important long-term benefits for children conceived through self-insemination.

Overall, the sperm storage service minimises potential harms that can arise from self-insemination, with benefits for women, donors and children. The service facilitates 'people who choose to self-inseminate being supported to be able to have a safe service in a healthy environment'.¹⁴

- 1 For further discussion, see Chapter 4.
- 2 See *Infertility Treatment Act 1995* ss 106, 110. The ITA obtained legal advice that allowing storage subject to conditions was not contrary to the Act. Storage for this purpose is subject to conditions imposed by the ITA.
- 3 Infertility Treatment Authority, *Storage of sperm by women using known donors for the purposes of self-insemination, Interim Conditions imposed under s 106, Infertility Treatment Act 1995* (2006a).
- 4 *Infertility Treatment Act 1995* ss 18, 19, 103, Part 7.
- 5 Infertility Treatment Authority (2006a), above n 3, condition 6.
- 6 Access roundtable, 9 February 2006.
- 7 Infertility Treatment Authority, *Annual Report* (2006b), 13.
- 8 Information provided by the Infertility Treatment Authority, 22 January 2007.
- 9 Submission PP1 337 (Infertility Treatment Authority).
- 10 Access roundtable, 9 February 2006.
- 11 Infertility Treatment Authority (2006a), above n 3, condition 1. The Reproductive Technology Accreditation Committee code of practice requires that sperm is tested for HIV virus (Types 1 and 2), hepatitis C virus, hepatitis B virus, human t-cell lymphotropic virus type 1, syphilis and microbiological contamination testing: Reproductive Technology Accreditation Committee, *Code of Practice for Assisted Reproductive Technology Units* (rev ed, February 2005), 9.9.
- 12 Submissions PP1 270 (Dr Ruth McNair), PP1 226 (Professor HWG Baker and Dr JC McBain).
- 13 Infertility Treatment Authority (2006a), above n 3, conditions 4 and 6.
- 14 Submission PP1 345 (Health Services Commissioner).

RECOMMENDATIONS

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.

CHOOSING TO SELF-INSEMINATE

The current law in Victoria leaves many women with no choice but to self-inseminate if they wish to become pregnant. However, some women also have a preference for self-insemination over treatment in a clinic.

Research has identified a number of reasons why women choose to self-inseminate. As part of the Lesbian and Gay Families Project, 136 women living in Victoria were surveyed about their methods of family formation. Twenty-eight per cent of women with children had used self-insemination to conceive. Of 43 women attempting to conceive, 33% intended to use clinic insemination and 44% intended to self-inseminate.¹⁵ Women who had self-inseminated cited a desire for the child to know the identity of all biological parents as the primary reason for their decision (96% of respondents). Half of the women also said that ineligibility for clinic treatment in Victoria was a factor in their decision. Other reasons why women prefer self-insemination identified in the study include:

- the relative affordability of self-insemination
- beliefs regarding women's rights to control their fertility
- a desire to involve their partners in the insemination process
- opposition to medical intervention.

By contrast, women who used clinic insemination cited the safety of the procedure and the desire for anonymous sperm donors as key reasons for their decision.¹⁶

Studies have also shown that self-insemination remains a preferred choice for many women even when clinic services are available. A survey of 84 lesbian women conducted in Sydney in 2000 found that self-insemination was still a preferred method of conception, even though the women were eligible for treatment in a clinic. Sixty-eight per cent of respondents self-inseminated using sperm from a known donor, and 8% used sperm from an unknown donor to self-inseminate.¹⁷

Submissions received by the commission also discussed the reasons some women elect to self-inseminate.

One submission said that:

constituting donor insemination as a treatment procedure (and failing to distinguish it from more sophisticated and physically interventionist techniques such as IVF) unnecessarily medicalises the process.¹⁸

The Fertility Access Rights group reported that 'many lesbian couples would prefer that their attempts to create a family stay within the intimate, private realm, and not be unnecessarily medicalised'.¹⁹ This statement was confirmed in submissions written by individuals wishing to conceive. One woman wrote:

My partner and I are still on our long journey to becoming parents. The process thus far has been both clinical and medical. When my time comes, we would greatly appreciate the opportunity to inseminate in our own home.²⁰

Women were also concerned not to undergo invasive ART procedures. After a number of unsuccessful inseminations, a clinic might suggest that a woman commence IVF treatment. However, some women may want to continue to attempt to self-inseminate. The commission also heard that some clinics are perceived as unfriendly by lesbian and single women.²¹ Women may also wish to self-inseminate at home because it is less expensive than accessing a clinic.²²

A submission from a man who was a known donor to a lesbian couple expressed support for the sperm storage service offered by clinics. He said:

when it became known to us that clinics would provide a sperm storage service that would be made available to lesbian couples, we embarked on this method as it would give greater comfort to the couple on the safety of the sperm used.

I agree that the women concerned should be strongly encouraged to attend the clinic and be artificially inseminated with my sperm, however, if in the end they decide they wish to self-inseminate away from the clinic then that right should not be denied to them.²³

CLINICAL SELF-INSEMINATION SERVICES

In *Position Paper One: Access*, the commission made an interim recommendation that the practice of clinics providing sperm to women so that they can self-inseminate be discontinued if our recommendations about expanding access to treatment were implemented. The commission assumed that most single and lesbian women would access clinics if they became eligible for treatment. The commission was also concerned about the uncertainties that arise when sperm is removed from a clinic, and was seeking to ensure as many women and children as possible would be protected by the full range of safeguards offered through clinic treatment. This recommendation was supported by the South Australian Council on Reproductive Technology, which stated that:

*all assisted reproduction procedures are best conducted in specialist reproductive medicine units licensed by RTAC to ensure that clients have access to the highest standard of appropriate clinical practice and counselling services.*²⁴

The safeguards provided in a clinic setting are not always present when women self-inseminate because once the sperm is removed from the premises, no controls exist on its use. Although the women must agree to provide birth details to the ITA, there is no guarantee this will occur. If the ITA is not advised of the birth, a child may be denied access to information about paternity. In some submissions, concern was expressed that self-insemination might be used to circumvent legislation requiring the donor's identity to be registered.²⁵ Other submissions argued that self-insemination should not be legitimated because it is exploitative of men's reproductive capacity.²⁶

The commission did, however, receive a significant number of submissions arguing for retention of the current arrangements for sperm screening and storage for women who intend to self-inseminate.

The benefits of a clinic sperm-screening service were highlighted in a submission from a woman who had unsuccessfully attempted to conceive at home using (unscreened) sperm from a known donor. She wrote:

I was so pleased when I heard through a friend that the Royal Women's Hospital is now running an outpatient program where women can have known-donor sperm vetted and stored, and be taught how to use it at home.

*A program like that would have been perfect for someone like me—someone who can find their own donor, would like the process to be as natural and non-intrusive as possible, yet is keen to avoid the possibility of dealing with dud sperm (like we had) or worse, the chance of disease.*²⁷

Others appreciated the increased clarity surrounding the relationship with the sperm provider that is created by using clinic services such as screening and counselling.²⁸ The Lesbian Parents' Project Group said:

*The benefits of the services that clinics can offer—sperm testing, storage, counselling, being clearly positioned as the recipient of a donation and having the donor clearly positioned as the donor—should not be underestimated (and currently extend even to such things as making it very much easier to deal with the Registry of Births, Deaths and Marriages and the Passports Office).*²⁹

The commission has reconsidered its interim recommendation about self-insemination services in light of the research findings mentioned above, and the submissions we received in response to Position Paper One. The research indicates that even if eligibility for clinic treatment is expanded, many women will continue to choose to self-inseminate. The commission is convinced that services which support self-insemination should continue to be offered because the key aim is to diminish the health and other risks associated with insemination, both for women and children. It also provides women with additional choices to control their fertility and conception and is consistent with the guiding principle contained in our Recommendation 1 that 'the health and wellbeing of people undergoing assisted reproductive treatment procedures must be protected at all times'.

The commission acknowledges that allowing sperm to be removed from a clinic environment means there is no guarantee that it will be used in accordance with the conditions set down by the ITA. However, the commission was encouraged by submissions which said that it was highly unlikely sperm would be used by anyone other than the woman intending to use it, or that women would not comply with the ITA's conditions for donor and birth registration.³⁰ The commission believes that the harm minimisation benefits of the sperm storage service outweigh the unlikely potential for the program to be misused. As the purpose of the program is to protect those who self-inseminate from a range of risks associated with the practice, we do not believe people who use the service should be subject to our proposed eligibility criteria for ART treatments detailed in Chapter 5.

- 15 Ruth McNair et al, 'Lesbian Parenting: Issues, Strengths and Challenges' (2002) 63 *Family Matters* 40, 43.
- 16 *Ibid* 44.
- 17 *Report of the Sydney Lesbian Parenting Conference* (2000), 10, cited in Jenni Millbank, *Meet the Parents: A Review of the Research on Lesbian and Gay Families* (2001) 31.
- 18 Submission CP 88 (Deb Dempsey).
- 19 Submission PP1 251 (Fertility Access Rights).
- 20 Submission PP1 254 (Anonymous).
- 21 Access roundtable, 9 February 2006; submissions PP1 341 (Dr Elizabeth Short), PP1 255 (Lesbian Parents' Project Group).
- 22 Submissions PP1 341 (Dr Elizabeth Short), PP1 226 (Professor HWG Baker and Dr JC McBain), PP1 254 (Anonymous).
- 23 Submission PP1 146 (Brenton Thomas).
- 24 Submission PP1 347 (South Australian Council on Reproductive Technology).
- 25 Submission PP1 231 (Michael Linden and Lia Vandersant).
- 26 Submission PP1 138 (The Australian Family Association).
- 27 Submission PP1 236 (Anonymous).
- 28 Submission PP1 341 (Dr Elizabeth Short). See Chapter 8 for a discussion of the legal status of donors.
- 29 Submission PP1 255 (Lesbian Parents' Project Group).
- 30 Submissions PP1 323 (Rhonda Brown), PP1 319 (Women's Health West), PP1 254 (Anonymous), PP1 341 (Dr Elizabeth Short).

RECOMMENDATIONS

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.

SUPPORT SERVICES

It is important to encourage women to have counselling and receive legal information about the implications and consequences of becoming a parent through donor conception. For women who use the services of a clinic to assist in conception, counselling and provision of information are already elements of the process. The commission believes that it is also important to make such support services available for women who choose not to use the services of a clinic.

The need for prospective parents, donors and partners to receive accurate information was acknowledged in submissions by health services such as Women's Health West, which stated that:

There is an urgent need for people in the community to receive such health information and support—a need that for a long time has been primarily met by volunteer community groups.³¹

There was particular support in submissions for the provision of counselling to all parties involved in the conception process. Fertility Access Rights said fertility clinics, as well as other health service providers, should be encouraged to support women who are self-inseminating and to ensure all parties explore the issues involved. Others said that counselling, donor screening services and advice would help to 'maximise the safety of those making this choice [self-insemination]'.³² However, submissions also drew attention to the need for counsellors to be 'trained in and sensitive to all the issues relevant to ... diverse families'.³³

The commission recommends that specialist 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.

The ITA should be empowered to accredit non-clinic-based counsellors who have received training in relation to donor conception and same-sex parented families to provide specialist counselling to women who choose to self-inseminate. The training should cover a broad range of topics relevant to donor conception, such as same-sex parenting, family arrangements, health issues, legal implications, disclosure of donor information and outcomes for children.

The commission believes the ITA should also play a role in promoting the importance of counselling and legal advice, and making resources readily available to those seeking assisted insemination. The ITA should develop resources for distribution through services beyond fertility clinics that are accessed by women who conceive through self-insemination. Places where information resources should be available include medical centres, obstetricians' and gynaecologists' practices, gay and lesbian health services, and the Registry of Births, Deaths and Marriages.

CRIMINAL LIABILITY

Section 7 of the Infertility Treatment Act states:

- (1) A person may only carry out artificial insemination of a woman using sperm from a man who is not the husband of the woman at a place other than a hospital or centre licensed ... for the carrying out of donor insemination if he or she—
- (a) is a doctor who is approved ... to carry out donor insemination; and
 - (b) is satisfied that the requirements [concerning consent, information and counselling] have been met.

Breach of section 7 attracts a criminal penalty of up to four years imprisonment and/or a fine of 480 penalty units (currently equal to \$51,566.40).³⁴

The reference in this section to ‘another person’ indicates it was not intended to apply criminal penalties to those who self-inseminate, but this qualification is not beyond doubt. The ITA has advised clinics and approved doctors that self-insemination is not regulated by the Infertility Treatment Act.³⁵ However, it appears that many people believe it is an offence. Further, it is likely that on a strict interpretation of section 7 the partner of a woman who assists her to inseminate is guilty of a criminal offence.

Self-insemination is only regulated in states that have legislation governing access to ART. In South Australia, artificial fertilisation is not illegal if carried out gratuitously,³⁶ or by a registered medical practitioner granted an exemption from licensing requirements,³⁷ or by a licensed practitioner.³⁸ The penalty for contravening these conditions is \$10,000.³⁹ Similar provisions apply in Western Australia, where artificial fertilisation procedures must be carried out by a licence holder,⁴⁰ or a medical practitioner granted an exemption.⁴¹ No licence or exemption is required if a person carries out the insemination under the direction of a licensee and agrees to provide details of the outcome of the procedure to the licensee.⁴²

Concerns about the effects of potential criminal liability were expressed in submissions.⁴³ One submission posed the following questions:

Would my partner or I be guilty of an offence by virtue of s.7 of the Infertility Treatment Act 1995 if we [use self-

insemination]? We both have jobs where police checks and evidence of good character are required. Could the simple act of attempting to fall pregnant compromise our future employment? Are we willing to take a risk, trust in the fact that such a prosecution has not been initiated before? We are in the position of having to commit an offence to become pregnant. This places us in an extraordinary conflict, as a woman who wants to parent[,] self-insemination is a possible avenue to achieve this.⁴⁴

In addition, other submissions revealed that some women:

- have been told by doctors, lawyers and government officials that what they have done or are planning to do is a crime⁴⁵
- fear seeking appropriate health or legal advice because they believe that self-insemination is illegal and subject to penalties
- are unable to obtain information from doctors who believe it is illegal to provide information that will assist women to self-inseminate.⁴⁶

Section 7 ensures that the safeguards about all aspects of clinical practice provided by the Infertility Treatment Act apply, by specifying that only licensed clinics and approved doctors can carry out assisted insemination. This is achieved by penalising health professionals or others who do not satisfy the requirements in the Act. Should criminal penalties also apply to those who self-inseminate or their partners?

We have discussed the benefits to women and their children of clinic-based insemination procedures or insemination by an approved doctor. The commission believes that while women should be encouraged to use a clinic or a doctor because of the associated safeguards, it is not desirable to criminalise women who self-inseminate, nor partners who may help them. Expansion of eligibility requirements for access to assisted reproductive services should provide an incentive to seek clinic-based treatment and may well result in fewer single women and women in same-sex relationships engaging in self-insemination. The continuation of sperm screening and storage services will also minimise the risks involved for women who still wish to self-inseminate.

- 31 Submission PP1 319 (Women’s Health West).
- 32 Submission PP1 232 (Ministerial Advisory Committee on Gay and Lesbian Health).
- 33 Submission PP1 251 (Fertility Access Rights), see also PP1 321 (Anonymous).
- 34 *Victoria Government Gazette*, No G 14, Thursday 6 April 2006 (effective 1 July 2006) available from <www.gazette.vic.gov.au>.
- 35 Infertility Treatment Authority (2006), above n 3.
- 36 *Reproductive Technology (Clinical Practices) Act 1988 (SA)* s 13(7)(b).
- 37 *Reproductive Technology (Clinical Practices) Act 1988 (SA)* s 13(7)(a).
- 38 *Reproductive Technology (Clinical Practices) Act 1988 (SA)* s 13(1).
- 39 *Reproductive Technology (Clinical Practices) Act 1988 (SA)* s 13(1).
- 40 *Human Reproductive Technology Act 1991 (WA)* s 6.
- 41 *Human Reproductive Technology (Licences and Registers) Regulations 1993 (WA)* r 2.
- 42 *Human Reproductive Technology (Licences and Registers) Regulations 1993 (WA)* r 2(3).
- 43 Submissions CP 82 (Anonymous), CP 89 (Ministerial Advisory Committee on Gay and Lesbian Health), CP 112 (A&H), CP 143 (The Bouverie Centre), CP 149 (Prospective Lesbian Parents), CP 171 (Fertility Access Rights), CP 179 (Lesbian Parents Group), CP 198 (Dr Elizabeth Short). These arguments were repeated in submissions in response to Position Paper One.
- 44 Submission CP 82 (Anonymous).
- 45 Submission PP1 255 (Lesbian Parents’ Project Group).
- 46 Submissions CP 88 (Deborah Dempsey), CP 89 (Ministerial Advisory Committee on Gay and Lesbian Health), CP 133 (Women’s Health West), CP 143 (The Bouverie Centre), CP 149 (Prospective Lesbian Parents), CP 171 (Fertility Access Rights).

RECOMMENDATIONS

46. It should not be an offence for a woman to carry out self-insemination, nor an offence for her spouse, domestic partner 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.

Criminal sanctions may themselves have adverse effects on the health of women and children. The Australian Infertility Support Group commented that:

We believe that criminal implications of self-insemination only serve to place a woman accessing unscreened sperm for the purpose of self-insemination at significant health risk. If there were fewer impediments to women accessing AI [assisted insemination] in a normal clinic environment, regardless of the woman's sexual orientation, greater scope to protect her & any prospective child/ren would exist ... Because not all locations are ideal, implements are not always sterile; self-insemination introduces a number of variables, which could endanger the woman ... Whilst we believe that self-insemination should be discouraged we do not believe that there needs to be legislation or criminal consequences applied to the act.⁴⁷

Similarly, Victoria Legal Aid opposed imposition of penalties involving a custodial sentence for self-insemination.⁴⁸

The commission believes that if a woman (and her partner if she has one) wish to carry out assisted insemination outside a clinic environment, criminal penalties are unlikely to deter them. Detection of the offence would be difficult and prosecution is extremely unlikely. Imposing penalties would also be at odds with the provision of sperm screening and storage services at clinics for the purpose of self-insemination.

For these reasons, the commission recommends that criminal penalties should not apply to women who self-inseminate or partners who assist them. The commission believes that women should be encouraged to seek treatment in a licensed clinic or by an approved doctor, but acknowledges that some women will not do so and their actions should not be criminalised. Section 7 of the Infertility Treatment Act should be amended to remove any ambiguity on this matter.

The language of the legislation should also be modified to state that no one should carry out assisted insemination as a service unless they have a licence to do so. This provision is intended to restrain people from setting up businesses that are not subject to the safeguards and compliance requirements of a licence granted by the ITA. It would not penalise someone who assists a woman to self-inseminate on a particular occasion. The woman herself, her partner and any other friend assisting would not be committing an offence.

Chapter 7 Sex Selection

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People intending to conceive may want to select the sex of their children. The reasons for wanting a child of a particular sex include:

- to avoid passing on a serious genetic condition which is associated with, or inherited through, a particular sex, for example, haemophilia, a sex-linked genetic condition which mostly affects males
- to ensure that a child to be born is the opposite sex to existing children in a family, sometimes referred to as 'family balancing'
- to fulfil personal or cultural preferences for a child of a particular sex.

Technology exists that facilitates the possibility of selection of a future child's sex prior to pregnancy. The commission's terms of reference require us to consider the desirability and feasibility of expanding access to any or all forms of ART. Sex selection is one form of ART.

In this chapter, we explain how ART can accomplish sex selection, outline the current law in Victoria, and examine the arguments for and against expanding access to the procedure.

SEX SELECTION TECHNIQUES

The two techniques used to select sex prior to conception are sperm sorting and preimplantation genetic diagnosis (PGD).

Sperm sorting is a process of separating X (female) and Y (male) chromosome-bearing sperm cells. Clinicians sort sperm and then select it for use in an insemination or IVF procedure. The likelihood of conceiving a child of the desired sex using this technique is variable.¹ Sperm sorting is not available in Australia.

The process of gene testing by PGD allows the sex of an embryo to be determined before it is transferred to a woman's body. We discuss PDG in Chapter 3.

CURRENT LAW

Sex selection by PGD is the only type of sex selection procedure permitted under Australian legislation.

The *Infertility Treatment Act 1995* bans treatment procedures which attempt to ensure a child's sex, except where it is necessary 'for the child to be of a particular sex so as to avoid the risk of transmission of a genetic abnormality or a disease to the child'.² The penalty for breach of this section is 240 penalty units (approximately \$26,000) or 2 years imprisonment, or both.³

The National Health and Medical Research Council (NHMRC) ethical guidelines on ART also prohibit sex selection by whatever means, except where it would reduce the risk of transmitting a serious genetic condition.⁴ The guidelines maintain that 'admission to life should not be conditional upon a child being a particular sex'. However, the guidelines acknowledge that 'sex selection is an ethically controversial issue' and issued the prohibition 'pending further community discussion'.⁵

OTHER JURISDICTIONS

Sex selection for non-medical reasons is not permitted in Western Australia⁶ or South Australia.⁷ In all other Australian states and territories, NHMRC ethical guidelines apply. Sex selection for non-medical reasons is prohibited in the United Kingdom,⁸ Canada⁹ and New Zealand,¹⁰ although these prohibitions have been reviewed.¹¹

In 2006, the United Kingdom government published its legislative proposal on sex selection in response to reviews by the Human Fertilisation and Embryology Authority and the House of Commons Science and Technology Committee. The UK government has decided that sex selection for non-medical reasons should continue to be prohibited, basing its decision on the strength of public opinion against sex selection and its possible ramifications, such as a preference for male children. The UK ban is intended to extend to sperm sorting as well as to PGD techniques.¹²

The American Society for Reproductive Medicine Ethics Committee recommends that sex selection for non-medical reasons should not be encouraged, and the initiation of IVF solely for sex selection purposes should be discouraged.¹³ However, sex selection for non-medical reasons is available in some US jurisdictions.¹⁴ In a 2005 survey of 186 US fertility clinics, 42% of clinics reported that they had provided PGD for non-medical sex selection.¹⁵

SUBMISSIONS

The commission received limited response to the issue of sex selection in submissions. A small number argued that sex selection for non-medical reasons should be permitted. Most of these submissions described families with two or more children of the same sex who wished for another child of the opposite sex and argued that sex selection was appropriate for reasons of family balancing. One woman, a mother of four sons said:

I have a desire as a mother and a woman, to also experience having a daughter. I feel this would complete our family and add a dimension that would give us as parents, and also the boys, a balance.¹⁶

SEX SELECTION FOR NON-MEDICAL REASONS

Selecting the sex of a child for non-medical reasons is controversial. Although the commission did not receive a large response to the issue of sex selection, we have considered various perspectives highlighted in recent debates in other jurisdictions to inform our recommendations.

Supporters of sex selection argue that choosing the sex of a child is a matter of reproductive autonomy to be determined by individuals in consultation with their doctors. Drawing on libertarian principles, they argue each person is entitled to live as they choose as long as they do not infringe upon the rights of others. The state may only interfere with these choices to prevent harm to others.¹⁷ There are no long-term studies that have tested whether children born following a sex selection procedure for non-medical reasons have been harmed as a result of their parents' choice.¹⁸ Supporters of non-medical sex selection argue that without evidence of harm there is no valid justification for banning the procedure.

However, some people who support sex selection for non-medical reasons believe that limits on its use are appropriate. Submissions to the commission argued that sex selection is acceptable where a family has one or more child of a particular sex, and would like to have a child of the opposite sex.¹⁹ Supporters say that in this context, many of the harms associated with sex selection are disposed of because family balancing encourages gender balance in the population.

Recent surveys conducted in the United States and Germany suggest that people desire a balance of gender within a family, rather than single sex dominance. Fifty per cent of 1197 respondents to a recent US survey said they desired a family with equal numbers of male and female children, whereas 27% expressed no gender preference.²⁰ A similar study of 1094 people conducted in Germany found that 58% of respondents did not care about the gender composition of their families, whereas 30% expressed a desire for equal numbers of males and females.²¹

These studies also suggest that demand for non-medical sex selection is low. Only 8% of 1197 respondents to the US survey said they would use

- 1 Sperm sorting is available using a variety of methods, at least one of which is part of a clinical trial in the United States. According to one company that offers sperm sorting, the accuracy rate of conception of males is 76% and of females is 91%: Genetics and IVF Institute, 'Microsort Current Results' <www.microsort.com> at 15 June 2006.
- 2 *Infertility Treatment Act 1995* s 50(2).
- 3 *Infertility Treatment Act 1995* s 50(1).
- 4 National Health and Medical Research Council, *Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research* (2004), 22.
- 5 *Ibid.*
- 6 Reproductive Technology Council, *Approval for Diagnostic Testing of Embryos* (2004).
- 7 *Reproductive Technology (Clinical Practices) Act 1988* (SA) s 3.
- 8 Human Fertilisation and Embryology Authority, *Code of Practice* (6th ed, 2003), 8.9.
- 9 *Assisted Human Reproduction Act* [S.C. 2004, c.2] s 5(e).
- 10 National Ethics Committee on Assisted Human Reproduction, *Guidelines on Preimplantation Genetic Diagnosis* (2005), para 8.1.
- 11 Eg, Human Fertilisation and Embryology Authority, *Sex Selection: Choice and Responsibility in Human Reproduction* (2002); Human Fertilisation and Embryology Authority, *Sex Selection: Options for Regulation* (2003); House of Commons Science and Technologies Committee, *Human Reproductive Technologies and the Law, Fifth Report of Session 2004–05: Volume 1* (2005); Assisted Human Reproduction Implementation Office, *Issues Related to the Regulation of Pre-Implantation Genetic Diagnosis under the Assisted Human Reproduction Act* (2005).
- 12 Department of Health, *Review of the Human Fertilisation and Embryology Act: Proposals for Revised Legislation (Including Establishment of the Regulatory Authority for Tissues and Embryos)* (December 2006).
- 13 Ethics Committee of the American Society of Reproductive Medicine, 'Sex Selection and Preimplantation Genetic Diagnosis' (1999) 82 (Suppl. 1) *Fertility and Sterility* S245.
- 14 There are no legal restrictions on the types of PGD tests clinics can offer: Genetics and Public Policy Center, *Preimplantation Genetic Diagnosis* (2004), 13.
- 15 Susannah Baruch et al, 'Genetic Testing of Embryos: Practices and perspectives of U.S. IVF Clinics [In Press]' (2006) *Fertility and Sterility* 5.
- 16 Submission PP1 351 (Dr Kimberley Tuohy).
- 17 See eg Edgar Dahl, 'Boy or Girl: Should Parents be able to Select the Sex of their Children' (2005) Cardiff Centre for Ethics Law & Society, available at <www.cceils.cardiff.ac.uk/literature/publications/2005/dahlpaper.html> at 24 April 2005; John Harris, 'Sex Selection and Regulated Hatred' (2005) 31 *Journal of Medical Ethics* 291; Julian Savulescu, 'Sex Selection: The Case for' (1999) 171 *Medical Journal of Australia* 373.
- 18 Some studies have considered the success rates of sex selection procedures such as sperm sorting: E F Fugger et al, 'Births of Normal Daughters after MicroSort Sperm Separation and Intrauterine Insemination, In-Vitro Fertilization, or Intracytoplasmic Sperm Injection' (1998) 13(9) *Human Reproduction* 2367; see also Human Fertilisation and Embryology Authority, *Sex Selection: Options for Regulation* (2003), [120].
- 19 Submissions CP 240 (Rhianna Crosthwaite), CP 242 (Jane Saunders), PP1 9 (Trudie Healey), PP1 351 (Dr Kimberley Tuohy).
- 20 Edgar Dahl et al, 'Preconception Sex Selection Demand and Preference in the United States' (2006) 85(2) *Fertility and Sterility* 468.
- 21 E Dahl et al, 'Preconception Sex Selection for Non-Medical Reasons: A Representative Survey from Germany' (2003) 18(10) *Human Reproduction* 2231.

preconception sex selection methods.²² Similarly, in Germany 92% of respondents reported that they would not use sex selection technology.²³ Patients already undergoing infertility treatment expressed higher levels of interest in using preconception sex selection techniques.²⁴

Opponents of the practice of sex selection argue that its use for non-medical reasons elevates the status of gender in society and contributes to sex discrimination.²⁵ By its very nature, sex selection establishes children's gender as a critical part of their identity. Historically, the performance of sex selection through different techniques demonstrates discrimination against women.²⁶ In countries such as India and China where sex selection technology is used, it reflects a preference for males.²⁷ Opponents of non-medical sex selection also say that entry to life should not be conditional upon being a particular sex, as each human has an inherent dignity that should be respected.²⁸

Another perspective that opposes non-medical sex selection focuses on the rights of the child. Proponents argue that sex selection is incompatible with the belief that the parent-child relationship involves unconditional acceptance.²⁹ Instead, sex selection for non-medical reasons places a burden on a child to fulfil a particular role.

Others argue that the purpose of ART is to help people who cannot otherwise have children or whose children would be disadvantaged without the technology. Sex selection for non-medical reasons does not fit within this criterion, and diverts medical resources to a non-medical purpose. Public funding for non-medical sex selection is difficult to justify.³⁰ However, it is also true that permitting access to genetic technology on a user-pays basis makes it available only to those who can afford it and therefore privileges the wealthy.

A common argument expressed against permitting people to select the sex of their children is that the technology sits at the top of a 'slippery slope' that leads to the selection of embryos for other genetic traits. According to this perspective, there is no principled reason for allowing selection for gender but not for other traits (if and when such technology becomes available). This argument should be balanced against the strict controls placed on the use of PGD, which we discussed in Chapter 3.

CONCLUSION

The commission believes that the current legislative ban on sex selection for non-medical reasons should remain in place.

Under the guiding principles recommended by the commission, the health and wellbeing of a child must be given priority. It is difficult to identify ways in which the best interests of the child are served by permitting sex selection for a non-medical reason. In the absence of available evidence about the likely effects on a child of having been selected for their sex, the commission has adopted a cautionary approach.

The commission did not receive submissions to indicate that there is substantial community support for repealing the ban on non-medical sex selection. Moreover, the submissions that the commission did receive focused on the rights of parents, and not the health and wellbeing of the child to be born.

The commission believes there should be significantly more community discussion and debate about sex selection for non-medical reasons before the ban could be repealed. This view is consistent with NHMRC guidelines³¹ and the UK government position.³²

22 Dahl et al (2006), above n 20.

23 Dahl et al (2003), above n 21.

24 Tarun Jain et al, 'Preimplantation Sex Selection Demand and Preferences in an Infertility Population' (2005) 83(3) *Fertility and Sterility* 649.

25 Ethics Committee of the American Society of Reproductive Medicine (1999), above n 13.

26 The President's Council on Bioethics, *Staff Working Paper* (2003) available at <bioethicsprint.bioethics.gov/background/sex_control.html> at 19 May 2005.

27 United Nations Population Fund, 'The Promise of Equality: Gender Equity, Reproductive Health and the Millennium Development Goals', *State of the World Population 2005* (2005), 67.

28 T Baldwin, 'Reproductive Liberty and Elitist Contempt: Reply to John Harris' (2005) 31 *Journal of Medical Ethics* 288-90.

29 See eg National Health and Medical Research Council (2004), above n 4.

30 Guido Pennings, 'Personal Desires of Patients and Social Obligations of Geneticists: Applying Preimplantation Genetic Diagnosis for Non-Medical Sex Selection' (2002) 22 *Prenatal Diagnosis* 1123.

31 National Health and Medical Research Council (2004), above n 4.

32 Department of Health (2006), above n 12.



Chapter 8 Gamete and Embryo Donation

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Chapter 8

Gamete and Embryo Donation

The commission's terms of reference require us to consider the expansion of eligibility criteria in relation to any form of assisted reproduction. Gamete donation is essential to assisted reproductive technology (ART) treatments which use donated sperm, eggs or embryos to achieve a pregnancy. Donors of gametes are subject to counselling, medical screening and other eligibility criteria.

In this chapter, we consider whether changes should be made to provisions governing eligibility to donate gametes. We also ask whether people who donate gametes and embryos should be able to specify the characteristics of the person or couple who benefit from that donation.

Gametes are sperm or ova (a woman's eggs).

DONOR ELIGIBILITY

The donation of gametes and embryos is regulated by the *Infertility Treatment Act 1995*, clinic licensing conditions and national guidelines on ART.

Section 41 of the Infertility Treatment Act prohibits the use of gametes, or embryos produced from the gametes, of a person younger than 18 years.¹ Upper age limits for donors are recommended in the Infertility Treatment Authority's (ITA) conditions of licence. Sperm donors should be under 55 years of age and egg donors should be under 35 years of age, unless there are exceptional reasons to depart from these limits.² Known donors may be older than the recommended age limits.³

The ITA's conditions of licence also stipulate that clinics 'must not knowingly allow the donated gametes of one person to be used to produce offspring in more than ten families'.⁴

In addition to these requirements, donors must undergo counselling, give consent to the use of their gametes, undergo medical screening and complete a tissue donation statement. Sperm must also be quarantined prior to use. These requirements are discussed below.

CONSENT AND COUNSELLING

The Infertility Treatment Act requires gamete and embryo donors, and any spouses or partners, to consent to use of their gametes in a treatment procedure.⁵ Donors of gametes and their spouses (if applicable) must receive counselling addressing their motivation for donating, the potential impact on their relationships with spouses and any children, and, if they are known to each other, the impact on relationships between donors and recipients.⁶

Donors must also provide information to be placed on the ITA's central register. They must receive advice about the rights of a person born using their gametes to obtain information recorded in the register.⁷

The commission supports these requirements because they assist donors to understand the implications of their decision to donate gametes. In accordance with Recommendation 27, the commission recommends that the definition of a donor's partner should be expanded to include a domestic partner.

HEALTH CHECKS AND TISSUE DONATION STATEMENT

Donors of gametes must undergo a number of tests which are intended to prevent recipients of donated gametes and any child born from being infected with diseases which could be transmitted during fertilisation. The health requirements include:

- Donors of gametes must complete a medical history declaration.⁸
- Donors of gametes must be tested for human immunodeficiency virus (HIV), hepatitis C virus, hepatitis B virus, human t-cell lymphotropic virus, syphilis and microbiological contamination.⁹
- In addition to these mandatory medical tests, donors may be tested for genetic conditions as well as other medical conditions.
- Sperm must be frozen for six months before use, after which time some medical tests will be repeated, for example for HIV and hepatitis C.¹⁰

Submissions to the commission were unanimous that some medical screening of donors is necessary and appropriate to protect the health and wellbeing of recipients of gametes and any children born. However, the current screening mechanisms for achieving this aim were criticised in many submissions.

Donors of gametes are screened for risk on the basis of a tissue donation statement or 'lifestyle declaration'.¹¹ Legislation does not prescribe that donors complete a tissue donation statement. However, this provides protection for doctors from liability if HIV or hepatitis C is transmitted through a gamete donation¹² and it is the practice of clinics for it to be completed. The Health (Infectious Diseases) Regulations 2001 prescribe the content of the tissue donation statement. Previously, the Reproductive Technology Accreditation Committee (RTAC) guidelines also contained a donor lifestyle declaration, but this was withdrawn from the most recent edition of the guidelines.¹³

The tissue donation statement requires the donor to answer questions about medical symptoms, sexual activity, drug use and exposure to infection, for example, through skin piercing. Some questions on the declaration are directed to certain activities; other questions seek to identify a perceived risk group. For example, Question 8 on the declaration asks:

Within the last 12 months have you:
8. Had male to male sex?¹⁴

The commission received a number of submissions which argued that the prescribed tissue donation statement discriminates against homosexual men. They argued that it excludes people based on their sexual orientation, rather than because they have been involved in activities which create a high risk of infection. Question 8 asks if a potential donor has engaged in homosexual sex, not whether sexual activities have been practised safely.

In submissions, the commission was informed that the effect of including this broad question in the screening process is that some people who wish to donate gametes are prevented from doing so, even where there is no risk they will transmit a communicable disease. Current practices for screening donors may also prevent women from using the sperm of known donors.¹⁵ One couple, who had approached a known donor, recounted their experience:

*We were outraged and upset when our donor Cameron, who was donating directly to us, was asked to sign a 'lifestyle declaration'. Even though there is a six-month quarantine period and extensive testing for blood born viruses and all STIs [sexually transmitted infections] he was still being asked about his lifestyle because he identifies as a gay man. The questions don't even ask about risk-taking or safe sex.*¹⁶

In submissions, the commission was also informed that the current form of the tissue donation statement exacerbates stigmatisation of particular groups in the community and seems to be based on the misconception that gay men are inherently diseased.¹⁷ Other people told the commission that the tissue donation statement offers no extra assurance for recipients of donations, which can only be provided through medical testing.

1 However, a gamete, zygote (cell formed from two gametes) or embryo formed from gametes produced by a person under the age of 18 may be used if the gamete was collected for use later in life due to the likelihood the person would become infertile due to treatment or illness: Infertility Treatment Regulations 1997, r 11.

2 Infertility Treatment Authority, *Conditions for Licence: Clinics, Hospitals and Day Procedure Centres* (7th ed, 2006), para 5.2.

3 The ITA's conditions for licence state that: 'Where a person or couple choose to use gametes from known donors who are over these recommended ages, they are to be offered additional counselling and clinical advice in relation to the possibility of adverse outcomes': *ibid*, para 5.2.

4 Infertility Treatment Authority, above n 2, para 5.11.

5 *Infertility Treatment Act 1995* s 12, 13, 14.

6 *Infertility Treatment Act 1995* s 16, Infertility Treatment Regulations 1997 r 7.

7 *Infertility Treatment Act 1995* s 17.

8 Reproductive Technology Accreditation Committee, *Code of Practice for Assisted Reproductive Technology Units* (rev ed, 2005), para 9.1.

9 *Ibid*, para 9.9.

10 Reproductive Technology Accreditation Committee, above n 8, para 9.9. Mandatory tests are determined by the Therapeutic Goods Administration.

11 Health (Infectious Diseases) Regulations 2001 prescribe a 'tissue donation statement'. This is sometimes referred to as a 'lifestyle declaration'.

12 *Health Act 1958* s 133. The tissue donation statement can be found in the Health (Infectious Disease) Regulations 2001, Sch 8.

13 Reproductive Technology Accreditation Committee, above n 8.

14 Health (Infectious Disease) Regulations 2001, Sch 8.

15 Submissions CP 82 (Anonymous), CP 88 (Deborah Dempsey), CP 133 (Women's Health West), CP 149 (Prospective Lesbian Parents), CP 171 (Fertility Access Rights), CP 198 (Dr Elizabeth Short).

16 'Felicity and Sarah' in submission CP 149 (Prospective Lesbian Parents).

17 Submission CP 59 (Ian Seal).

RECOMMENDATIONS

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.

Many submissions argued that the tissue donation statement should be redrafted to require doctors to focus on a donor's participation in activities which create a high risk of infection with a transmissible disease.¹⁸ The Equal Opportunity Commission of Victoria supported this approach:

*decisions about the use of donated gametes should be made on clinical grounds rather than grounds that are likely to be discriminatory or that reinforce erroneous assumptions or stereotypes.*¹⁹

There have already been some changes in clinic practices in response to these concerns. The ITA advised clinics on 20 September 2001 that the recruitment of homosexual men as donors is not automatically excluded under Victorian legislation. The ITA received advice from the Director of Public Health, Professor John Catford, that under the *Health Act 1958* a 'yes' answer to the question on the tissue donation statement does not require the person to refrain from donating until their health status is ascertained. Professor Catford advised the ITA that this 'is a matter for risk assessment by the medical practitioner or other person dealing with tissue donation'.²⁰ It is therefore at the discretion of the doctor to accept donors even if they say yes to some aspects of the tissue donation statement. The directive also leaves to the discretion of the doctor a decision about donation by a person who admits to having injected non-prescribed drugs.

The commission has been told that clinic doctors do exercise their discretion to accept donations from potential sperm donors who have answered 'yes' to having had sex with men, or any other question on the declaration. The potential recipients are advised that the donor has answered this way and are asked to sign a form to indicate they have been advised of this.²¹

However, the submissions the commission received suggest it has not been made clear to people wishing to access clinic services that a doctor may accept donors who answer 'yes' to some questions on a tissue donation statement. Women's Health West said that this uncertainty needs to be addressed:

*We also welcome any processes that would clarify clinics' obligations under the law, including their capacity to accept donations for anonymous use from gay men and from people who may have injected non-prescribed drugs.*²²

In light of the confusion regarding the criteria for eligibility to donate, particularly in relation to gay men but also to people who have ever injected non-prescribed drugs, the commission recommends the tissue donation statement be reviewed. We believe that the questions asked of donors should relate directly to identifiable risk factors and should be no more intrusive on a person's privacy than is necessary to be able to identify those factors. The commission also recommends that the format for tissue donation statements should be reviewed periodically to ensure they are consistent with current medical knowledge.

Clinics should inform people seeking to donate gametes about their use of information given in answers to questions. This will help to address current confusion about the use of the declaration.

QUARANTINE PERIOD

As noted above, the Health (Infectious Diseases) Regulations 2001 set out requirements that, if complied with, protect doctors from liability in the event that HIV or hepatitis C is transmitted through sperm used in an ART procedure. One of these requirements is that sperm is not used, or is quarantined, for six months prior to use.²³ The quarantine period is therefore framed to avoid liability for clinics and doctors, rather than being directed to the avoidance of risk of harm to women and children.

Most submissions received by the commission supported a quarantine period as part of the medical screening process. However, others said imposing a quarantine period on known sperm donations was unjustified:

Despite the fact that we have made the personal decision to use his sperm, the law requires that all sperm donations of donors be quarantined for six months, whereas for heterosexual women with male partners they can of course use his sperm (frozen or fresh) straight away as part of inter-uterine insemination for example. I understand that the six months wait is about the health of the woman and potential child, but this is more about the situation for heterosexual women using anonymous sperm. The law requiring six months quarantine doesn't allow for the fact that most lesbians by the time they have their donor leave a sperm deposit, have had him tested many months (sometimes years) before and have been using his sperm in home inseminations.²⁴

Some submissions pointed out that the quarantine period can add an extra six months to treatment when a known donor is used, as anonymous sperm has already been quarantined.

The commission has received advice that current research in the area of HIV and hepatitis C detection may support the reduction of the six-month quarantine period prescribed in the Health Regulations.²⁵

The commission believes the primary purpose of fixing a quarantine period should be to protect women and children from infection or disease. We therefore recommend that the ITA and the Department of Human Services seek advice on the quarantine period which should apply to donated gametes. The quarantine period should reflect current medical knowledge about risk factors and should be reviewed periodically.

In Chapter 3 we discussed the difficulty of fixing rules about ART in a climate of technological change. Gamete screening techniques and knowledge about the transmission of disease or infection will develop with time. The commission believes that the time period before gametes can be used in a treatment procedure should be prescribed by the ITA, rather than by legislation. This will ensure the quarantine period reflects current medical knowledge about risk factors.

- 18 Submissions CP 43 (Ian Coutts), CP 82 (Anonymous), CP 83 (Sexuality Law Reform Committee, Melbourne University Law Students Society), CP 89 (Ministerial Advisory Committee on Gay and Lesbian Health), CP 133 (Women's Health West), CP 149 (Prospective Lesbian Parents), CP 164 (Confidential), CP 171 (Fertility Access Rights). The commission also received 65 submissions in response to Position Paper One that made this point.
- 19 Submission PP1 313 (Equal Opportunity Commission of Victoria).
- 20 Correspondence from Professor John Catford to the Infertility Treatment Authority (ITA), 21 August 2001. Copy supplied to the commission by the ITA.
- 21 Information provided to the commission by Professor Gordon Baker, Melbourne IVF, 31 January 2007.
- 22 Submission PP1 319 (Women's Health West).
- 23 Health (Infectious Diseases) Regulations 2001, r 19.
- 24 Submission CP 110 (Lisa and Amanda).
- 25 Information provided by Professor Gordon Baker, Melbourne IVF, 31 January 2007.

'... it is discriminatory to allow people who are donating semen to an unknown recipient to stipulate qualities or characteristics of the recipient, and ... this practice should stop.'

DIRECTED DONATIONS

People who donate gametes and embryos to unknown recipients sometimes wish to specify the characteristics of the people who should, or should not, benefit from the donation. For example, they may wish to direct that the gametes or embryos are only made available to a person of a particular race or who is in a particular kind of family. This is referred to as directed donation. In this section we consider whether or not directed donations should be permitted.

CURRENT LAW

The conditions of licence for Victorian fertility clinics state that:

Except in the case of an identified donor (s 18.) a donor may not specify the type or class of person to whom the gametes or embryos are to be provided. Such a specification may result in a breach of federal or state discrimination laws.²⁶

The ITA obtained an opinion from the Victorian Government Solicitor on whether a clinic may or may not act on a donor's request to restrict the type of person who may be the recipient of his or her gametes.²⁷ The Government Solicitor's opinion was that a clinic may not pay regard to such a specification on the part of the donor. Treating potential recipients less favourably by decreasing the available pool of donor gametes on the basis of race, sexual preference, marital status and age would be likely to be in breach of the *Equal Opportunity Act 1995*, and on two of these bases it would also be in breach of Commonwealth Acts—the *Racial Discrimination Act 1975* (Cth) (if it was on the basis of race) and the *Sex Discrimination Act 1984* (Cth) (if on the basis of marital status).

The NHMRC ethical guidelines, however, recommend that clinics should not use gametes in a way which is contrary to the wishes of the donor,²⁸ unless state law indicates otherwise. The RTAC code of practice does not refer to directed donations and 'as such has chosen to comply with the NHMRC ethical guidelines'.²⁹

The ITA conditions of licence only apply where people donate to unknown recipients. If a donor wishes to donate to a particular person or couple (known donor donation), there is nothing to prevent this. Known donor donation is permitted under the Infertility Treatment Act.³⁰ However, people are only allowed to seek a donor by advertisement if authorised by the Minister for Health.³¹

GAMETE DONATION

Arguments for Directed Donations

Two main arguments are made in favour of allowing people to specify who should be able to use their gametes. The first argument is that permitting directed donations protects the wellbeing of the child to be born. It was noted in submissions that the legislative framework of ART supports disclosure of genetic origins,³² and the 'ethos is to foster knowledge of and contact between donors and children'.³³ Some submissions said that if the donor and the biological child later met and formed a relationship, the child might be psychologically harmed because the donor disapproved of the child's parents. For example,

if the donor is faced with a child whom has been brought up in a lesbian relationship and they do not agree with this, it may have implications for their potential ongoing relationship with the child.³⁴

Some argue that this risk justifies allowing donors to direct donations of gametes to a person or couple whose values they share.

The second main argument in favour of allowing directed donations is that donating gametes differs from other types of tissue donation because it results in the creation of a child. For this reason, it is suggested that both donors and recipients of gametes should have the right to express their wishes and to have those wishes respected.³⁵ Some infertility counsellors expressed the view that the discretion to direct donations benefits everyone involved and that it is 'crucial that all concerned ... can [express their views and] feel comfortable with the situation'.³⁶

A subsidiary argument in favour of allowing directed donations is that if people cannot make directed donations they may decide not to donate at all. This was of particular concern to doctors in Melbourne clinics, some of whom stated that:

*All should be done to promote donation from a range of people. It is very difficult to get donors from some racial groups and the inability to discriminate would make this even less frequent and promote more international reproductive tourism.*³⁷

Some people argue that without directed donations, the supply of gametes available for donation will be reduced and fewer people will be able to receive treatment.

Other submissions suggested that gametes may be seen as the property of donors, saying ‘the gametes we produce are our own to do what we want with, until such time as they are fertilised at which time we no longer have sole authority over them’.³⁸

Arguments Against Directed Donations

Most submissions which commented directly on the issue of directed donations argued against allowing this practice. The main argument against directed donations is that giving effect to a donor’s wishes may require clinics to discriminate against people of a particular racial origin or people in particular types of families. Fertility Access Rights and the Victorian Gay and Lesbian Rights Lobby said:

*it is discriminatory to allow people who are donating semen to an unknown recipient to stipulate qualities or characteristics of the recipient, and ... this practice should stop.*³⁹

Some submissions expressed the view that clinics which allow directed donations are in breach of federal anti-discrimination law⁴⁰ as well as international human rights instruments.⁴¹ Several submissions remarked on the important role of law in changing prejudicial community attitudes and argued that allowing discrimination in any form diminishes us as a community.⁴²

The Equal Opportunity Commission submitted that there should be further debate on the issue of directed donations, but commented that guidance should be given to service providers to enable them to avoid potentially discriminatory practices.⁴³ Another submission suggested that:

*Reproductive services should take no part in getting or allowing donors to stipulate which ‘types’ of women they will exclude from being the recipient of their donation ... they [should] make sure that potential donors know that the clinics give the donations to people who need them to help them have their family.*⁴⁴

In making recommendations on this issue, the commission has taken account of two guiding principles recommended in Chapter 5. The first is the principle that the law should protect the health and wellbeing of any child who may be born. The second is the principle that assisted reproductive processes should not discriminate against people on the basis of their sexual orientation, marital status, race or religion.

The commission’s view is that donors should not be able to direct that their gametes be used only for particular types of recipients, for example, those belonging to a particular race or religion, or having a particular sexual orientation or family type. A person who donates blood cannot specify that it should only be used to transfuse a white or a heterosexual person. A similar principle should apply to gamete donation. The commission acknowledges that gametes are not the same as other human cells, but believes it does not follow that the unique capacity of these cells to contribute to creating a child should enable a person who wishes to donate them to do so in a way that discriminates against others.

We are not convinced that the objective of protecting the welfare of children conceived through the use of donated gametes is served by permitting this form of discrimination. The possibility that a child who meets a donor may be adversely affected by a donor’s attitude to their parents is quite remote and does not justify breaching the guiding principle of non-discrimination which we have recommended.

The commission is also not aware of evidence supporting the view that preventing directed donations discourages people from donating to unknown recipients. In the absence of any evidence that allowing directed donations is necessary to protect the wellbeing of children, we recommend that clinics should only accept donors who are willing to donate to any patient approved by the clinic for a treatment procedure.

The commission’s recommendation that directed donations not be permitted is made in the context of a spectrum of decisions available to donors. Donors of gametes still have choices about whether they donate at all, and the law does not prevent people from donating to a known individual or family who they identify through their own contacts and networks.⁴⁵ These choices should be identified and discussed with donors in counselling.

- 26 *Infertility Treatment Authority (2006)*, above n 2, para 5.8.
- 27 Opinion by Victorian Government Solicitor, 8 August 2000, supplied to the Victorian Law Reform Commission by the Infertility Treatment Authority. The Victorian Government Solicitor noted that, in coming to this conclusion, his advice differed from the advice given to reproductive medicine units by the South Australian Council on Reproductive Technology. That advice was that, provided there were always donor gametes available for single people and treatment was not totally refused, donors could place conditions on donations and clinics could act on those conditions.
- 28 National Health and Medical Research Council, *Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research* (2004), para 6.9.
- 29 Submission PP1 338 (Fertility Society of Australia).
- 30 *Infertility Treatment Act 1995* s 18.
- 31 Section 40 of the *Human Tissue Act 1982* requires that when advertisements are placed for tissue donors, those advertisements must have the approval of the Minister for Health and must include a verification statement.
- 32 Submission PP1 313 (Equal Opportunity Commission of Victoria).
- 33 Submission PP1 226 (Professor HWG Baker and Dr JC McBain).
- 34 Submission CP 73 (Lauren Andrew).
- 35 Submission CP 52 (Helen Kane).
- 36 Submission CP 155 (Victorian Infertility Counsellors Group).
- 37 Submission PP1 226 (Professor HWG Baker and Dr JC McBain).
- 38 Submission PP1 148 (Barbara Roberts).
- 39 Submission PP1 251 (Fertility Access Rights). Many other submissions to Position Paper One supported this statement.
- 40 Submissions CP 177 (Australian Lawyers for Human Rights), CP 191 (Equal Opportunity Commission Victoria).
- 41 Submission CP 177 (Australian Lawyers for Human Rights).
- 42 Submissions CP 74 (Caitlin Coleman), CP 131 (Anonymous), CP 135 (Rebecca Olsen).
- 43 Submissions CP 191 (Equal Opportunity Commission Victoria), PP1 313 (Equal Opportunity Commission Victoria).
- 44 Submissions PP1 341 (Dr Elizabeth Short); see also CP 38 (Jacqueline Tomlins), CP 82 (Anonymous), CP 99 (Susan Koska), CP 133 (Women’s Health West), CP 137 (Melinda and Lisa), CP 143 (The Bouverie Centre), CP 149 (Prospective Lesbian Parents), CP 171 (Fertility Access Rights), CP 184 (Anonymous), CP 198 (Dr Elizabeth Short).
- 45 Note that advertisements are subject to restrictions under the *Human Tissue Act 1982* s 40.

RECOMMENDATIONS

51. Donors should not be permitted to specify the qualities or characteristics of the unknown recipients of their donated gametes and embryos.

EMBRYO DONATION

The commission also considered whether an exception to this principle of non-discrimination should apply in the case of embryo donations. People donating embryos to others have usually been successful in conceiving a child through the use of ART. They may then wish to donate the embryos, rather than disposing of them. The embryos may be genetic siblings of the donor's existing or future children.

Some submissions argued that directed donations should be possible in this case.⁴⁶ Although embryo donors are not permitted to direct their donations, in some cases clinics introduce embryo donors to potential recipients where both parties agree.⁴⁷

The commission does not agree with the practice of directed donation of embryos. The law already allows a person to donate embryos to a known recipient. Where the donation is made to an unknown recipient, the commission believes that the principle of non-discrimination should apply in the same way that it applies to gamete donation. We therefore recommend the law should not permit directed donations of embryos.

46 Submission CP 78 (Andrew McLean), PP1 226 (Professor HWG Baker and Dr JC McBain).

47 Information provided by Professor Gordon Baker, Melbourne IVF, 31 January 2007.

Chapter 9

Posthumous Use

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Posthumous use is the use of a person's sperm, eggs or embryos after his or her death.

The *Infertility Treatment Act 1995* controls the use of gametes and embryos after the death of the people from whom they originate. As part of our review of the eligibility criteria for all forms of assisted reproduction, the commission has considered whether to allow posthumous use of gametes and embryos and if so, under what conditions. We have identified four situations where conception of a child could involve posthumous use of gametes.

- A person who has been involved in an assisted reproduction treatment program has gametes in storage at a clinic. If that person dies, the surviving partner may want to use the stored gametes in a treatment procedure. At present, this usually occurs when a woman wants to use her male partner's stored sperm for fertilisation after he has died. In the future, as medical technology develops, it may also arise in relation to stored eggs. Eggs could be used by a surviving partner to create an embryo, which could be implanted in a female partner or in a surrogate.
- A person who has donated gametes to a clinic for use by unknown recipients dies.
- A person whose gametes have been used to create an embryo dies after the embryo is created and it is proposed to implant a woman with the embryo.
- A person is dying or has just died. The person's partner seeks to take gametes from the body for use in a treatment procedure after death. For example, a woman may want to have the sperm of her partner removed so it can be used to conceive a child after he has died.¹

CURRENT LAW

At present, the law does not permit use in an insemination procedure of the gametes of a person who has died. However, there is no prohibition on implanting a person with an embryo which was created using gametes from a person who has died before or after the creation of the embryo. It is also possible to retrieve gametes from people who have died, without their consent. The current law is explained in more detail below.

POSTHUMOUS USE

The law states that stored gametes or donated gametes cannot be used if the person who has provided them has died. Section 43 of the *Infertility Treatment Act* prohibits:

- inseminating a woman with sperm from a man known to be dead
- transferring to a woman a gamete from a person known to be dead.

This prohibits insemination of a woman with sperm from a man known to be dead and transferring into a woman an egg from another woman who is dead.

Although the Act prohibits posthumous use of gametes, there is no ban on a woman being implanted with an embryo which was formed from the gametes of a person while alive but who died after the fertilisation procedure. The *Infertility Treatment Authority (ITA)* has set conditions for this use,² including:

- A woman whose male partner has died and who wishes to use the couple's stored embryos must receive counselling which addresses relevant issues. The deceased's consent is not required, nor does the woman have to meet eligibility requirements for treatment.³
- A woman who re-partners but wishes to use an embryo created using her deceased ex-partner's gametes must be reassessed to be eligible for treatment in a clinic. Counselling requirements apply.⁴
- A person who wishes to use a donor embryo where a donor has died may use the embryo, but the recipient must receive counselling about the potential impact on any child born.⁵

Apparently, the Act does not prevent an embryo being created outside a woman's body using gametes from a dead person and that embryo being implanted into the woman.⁶ Similar conditions exist irrespective of the relationship between the deceased and the recipient of the gametes. Section 12(3) of the Act states that:

(3) An embryo must not be used in a treatment procedure to be carried out on a woman, if the sperm used to form the embryo is not the sperm of the husband of that woman, unless—

(a) before the embryo is formed, the man who produced the sperm consented to the use of the sperm to form an embryo to be used in the kind of procedure proposed.

A woman seeking treatment using her deceased partner's sperm, or using the sperm of a deceased donor, must meet the eligibility criteria for treatment under the Act and must receive counselling. Critically, a man who provided the sperm must have consented to it being used 'in the kind of procedure proposed'. This means that a man must specifically consent to his sperm being used posthumously, not simply to it being used to create an embryo. These provisions have been tested in Victorian courts.

The case of *AB v Attorney-General* concerned a woman (called AB) who approached the ITA seeking to use her deceased husband's sperm to become pregnant. The woman's husband had died following a car accident and the Supreme Court had authorised the retrieval and storage of his sperm.⁷ Before AB could use that sperm, she had to apply to the court for approval. In *AB v Attorney-General*, AB sought a declaration that section 43 of the Act did not prohibit the use of her deceased husband's sperm. As noted above, the prohibitions in section 43 do not refer to the *creation* of an embryo. AB wished to use the sperm to create an embryo using the IVF procedure called intracytoplasmic sperm injection (ICSI).⁸

Justice Hargrave found that section 43 of the Act did not prohibit the creation of an embryo using the deceased's sperm. However, he considered the eligibility, counselling and consent requirements of the Act and said that these

prohibited the procedure. Section 12(3), which requires the deceased's written consent to the use of his sperm, was applicable to the proposed treatment procedure. Without the deceased's express consent, use of the sperm would be unlawful.⁹

Justice Hargrave's interpretation highlights the anomalies in the Act:

- It is not possible to inseminate a woman with her partner's sperm after he dies.
- It may be possible for a woman to use her deceased partner's sperm to create an embryo outside her body if he has consented to such use.
- It is possible to use an embryo already created with the deceased's sperm even if he did not consent to such use after his death.

Following recent litigation and the commission's interim recommendations, the ITA created an advance directive interim form for people undergoing treatment procedures or wishing to store gametes. People can record their wishes with respect to posthumous use of gametes, including time limitations or other conditions.¹⁰ Clinics may also ask donors of gametes and embryos to express their wishes about use in the event that they die or become incapacitated.

Regulation around Australia

Posthumous use of gametes and embryos is also specifically regulated in South Australia and Western Australia. In South Australia, gametes or embryos must not be used for any purpose unless the people who produced them have consented to their use.¹¹ Stored sperm may only be used posthumously if the deceased consented in writing and the recipient meets the eligibility criteria for infertility treatment.¹² Embryos in storage should be destroyed if a person who has contributed gametes dies, unless they have specified how that embryo should be used.¹³ In Western Australia, clinics must not knowingly use gametes in a fertilisation procedure after the death of the gamete provider.¹⁴

- 1 The prospect of achieving a pregnancy with sperm extracted from a dead or dying man depends on the amount and quality of the sperm obtained. The underlying condition of the patient and events surrounding death may have impaired sperm production and quality, reducing its viability. At present, it is generally not possible to retrieve eggs from a dying or dead woman. While it may be theoretically possible to store and then use unfertilised oocytes (egg cells produced in the ovary) in a treatment this has not yet been done in humans: information supplied to the commission by Professor Gordon Baker, Melbourne IVF, 5 April 2005.
- 2 Infertility Treatment Authority, *Guidelines on the Posthumous Use of Gametes and Embryos* (2006).
- 3 *Ibid* 3.
- 4 *Ibid* 3–4.
- 5 Specifically, counselling 'must address the impact the death of the donor may have on the recipient(s) intention and ability to tell the child about their donor origin': *ibid* 6.
- 6 This seems to be an unintentional consequence of a 2003 amendment to the Infertility Treatment Act. The Act was amended by the *Health Legislation (Research Involving Human Embryos and Prohibition of Human Cloning) Act 2003* s 22(4)(d)(ii). These amendments, made to bring the Victorian Act in line with the *Prohibition of Human Cloning Act 2002* (Cth) and *Research Involving Human Embryos Act 2002* (Cth), changed the definition of 'embryo' which resulted, in turn, in the repeal of all references to 'zygote' in the Victorian Act. Before the amendment, there was a prohibition on the use of gametes from a person known to be dead for the formation of a zygote. When the reference to zygotes was removed, this prohibition was also repealed. Therefore, it is now possible to use a gamete from a dead person to form an embryo, provided the woman is eligible for treatment and provided consent has been given to the use of the sperm for a treatment procedure.
- 7 *AB v A-G (Vic)* [1998] (Unreported, Supreme Court of Victoria Practice Court, Gillard J, 23 July 1998).
- 8 This procedure is described in Chapter 1.
- 9 *AB v A-G (Vic)* (2005) 12 VR 485.
- 10 An 'Advance Directive Consenting to Posthumous Use of Stored Gametes by a Partner: Interim Form' is available from the ITA's website <www.ita.org.au> at 31 January 2007.
- 11 Reproductive Technology (Code of Ethical Clinical Practice) Regulations 1995 (SA), r 20. A single woman must also be infertile to access treatment: r 11.
- 12 South Australian Council on Reproductive Technology, 'Memorandum 9: The posthumous harvesting of sperm and its subsequent use', *Annual Report for 2002* (2002), 34.
- 13 Reproductive Technology (Code of Ethical Clinical Practice) Regulations 1995 (SA), r 26.
- 14 Western Australian Government, *Directions Given by the Commissioner of Health to set the standards of practice under the Human Reproductive Technology Act 1991 on the advice of the WA Reproductive Technology Council*, Western Australian Government Gazette No 201, 30 November 2004, Direction 8.9, 5435.

In other states and territories, posthumous use of gametes is permitted in accordance with National Health and Medical Research Council (NHMRC) guidelines. The guidelines note that 'circumstances where the child born will never know one of his or her genetic parents is, by analogy, a serious act of profound significance for the person born'.¹⁵ Posthumous use is only permitted where:

- the deceased person has left clearly expressed and witnessed directions consenting to the use of his or her gametes¹⁶
- the prospective parent received counselling about the consequences of such use
- the use does not diminish the fulfilment of the right of any child who may be born to knowledge of his or her biological parents
- clinicians involved 'seek advice and guidance from a clinical ethics committee ... and if necessary, seek advice regarding application of relevant laws'¹⁷
- an appropriate time is allowed for the surviving spouse or partner to grieve before conception is attempted.¹⁸

POSTHUMOUS RETRIEVAL

People involved in fertility treatment must consent to the use, and where necessary retrieval, of their gametes for use in a treatment procedure. If a person is dying or has died and consent cannot be freely obtained, the following laws apply.

If a man is dying, but is able to communicate, he can agree to the removal of sperm for use to inseminate his partner. If the man is incapable of consenting, it is arguable that the *Guardianship and Administration Act 1986* allows the Victorian Civil and Administrative Tribunal (VCAT) to authorise removal of sperm from him.

The *Human Tissue Act 1982* regulates the removal of tissue from a person who is dead. This includes the case of a person whose heart is still beating but where there has been 'irreversible cessation of all function of the brain'.¹⁹ Sections 25 and 26 of the Act allow removal of tissue for transplantation or other therapeutic, medical or scientific purposes if the person consented to removal of the tissue before his or her death, or if the senior available next of kin consents to the removal. Spouses and domestic partners are considered senior available next of kin.

These provisions were considered by the Supreme Court in the case of *Y v Austin Health*.²⁰ In this case, Y's husband fell rapidly and severely ill. Y sought permission for sperm and tissue to be removed from her husband's body, or alternatively, for it to be removed upon his death. Justice Habersberger found that the removal of gametes is subject to section 26(1)(c) of the Human Tissue Act as removal for 'medical purposes'. Y, as the deceased's senior available next of kin had the capacity to consent to the removal of her husband's gametes.²¹ Therefore under the Act, the deceased's consent is not required for retrieval after death. In *AB v Attorney-General*, Justice Hargrave also found that the deceased's wife had the capacity to consent to the retrieval of his gametes. However, as AB's husband had died in a motor vehicle accident, the consent of the Coroner to the procedure was also required.²²

EXPORT OF GAMETES AND EMBRYOS

The issue of export of gametes and embryos has arisen in the context of posthumous use cases because people may want to take gametes or embryos stored in Victoria to other parts of Australia where there are different restrictions on posthumous use.

The import and export of gametes and embryos is regulated by the Infertility Treatment Act in recognition that people may relocate within Australia and wish to continue treatment in another state or territory. Section 56 of the Infertility Treatment Act makes it an offence to import or export gametes and embryos without the written approval of the ITA. The ITA has discretion to give approval to a particular case, or class of cases, and may impose conditions. The ITA has also issued guidelines that outline procedures for import or export regarding donated gametes, posthumous use and surrogacy treatment.²³

Import and export of gametes and embryos has also been the subject of litigation in Victoria. The case of *AB v Attorney-General* was discussed above in the context of the posthumous use of gametes. The applicant in that case subsequently applied to the ITA to export her deceased husband's sperm to Sydney IVF, who agreed to provide treatment. The ITA refused the woman's application and she sought a review of this decision at the Victorian Civil and Administrative Tribunal.²⁴

Justice Morris reconsidered the woman's application (in this case called YZ) and found that export should be permitted. Justice Morris said that the Infertility Treatment Act contains a broad discretion to permit import or export of gametes and the guiding principles in the Act direct how these discretionary powers are to be exercised. In particular, he said the principle that the ITA must consider 'the welfare and interests of a person to be born' means to consider whether a person born as a result of treatment procedure 'will be nourished, loved and supported'.²⁵ After applying each of the guiding principles to YZ's case,²⁶ Justice Morris gave approval for export. He said it was not decisive that the export of the sperm was designed to overcome the ban on its use in Victoria. Justice Morris was satisfied that 'the sperm ... [would] be used responsibly' by Sydney IVF.²⁷

Following this decision, the ITA advised that it would assess each application for export of gametes where the gamete provider has died on its merits, taking into account the following factors:

- The ITA's discretion is not limited to considering whether export is consistent with the Act as a whole.
- The ITA will examine whether the child 'will be nourished, loved and supported' when looking to the welfare and interests of any person born from a treatment procedure.
- The ITA will consider what weight to attach to the NHMRC ethical guidelines on the use of assisted reproductive technology in clinical practice and research.²⁸

PROBLEMS WITH THE LAW

As the above summary illustrates, the current operation of the law leads to a number of anomalies and inconsistencies. The law is also unclear, making it necessary for people to seek approval for treatment through the courts. This can be a costly, lengthy and stressful process.

In submissions, some people argued that the prohibition against posthumous use of gametes is an appropriate response to concerns about the health and welfare of a child who is conceived after the death of one parent. However, if this is the case, the distinction between posthumous use of gametes and posthumous use of embryos

cannot be justified.²⁹ It is also anomalous that the consent of the deceased is required for some treatments (such as where an embryo is to be created) but in other situations it is not (such as where an embryo is already in storage).

It is not possible to ensure that the gametes of a donor who has died are *never* used, because clinics will not necessarily always be notified of a donor's death. The ITA submitted that monitoring cases of posthumous use where donor gametes are used would be administratively difficult.³⁰ This could potentially result in a situation where a woman who is involved in treatment before her husband dies cannot be inseminated using her dead husband's sperm, but if she remains eligible for treatment she could be inseminated with the sperm of an unknown donor who the clinic does not know has died.³¹

Courts in Victoria have allowed sperm to be taken from the body of a man who is dead for intended use in a reproductive procedure, despite the use of such sperm being prohibited for certain treatment procedures. Some submissions argued that it was anomalous to allow removal of the sperm, but not to permit its use.³²

The anomalies and inconsistencies in the law make reform necessary. The commission has considered the following questions in the process of drafting recommendations:

- Is there a justification for retaining the existing prohibition on posthumous use of sperm or eggs or should it be permitted and if so, under what circumstances?
- Should the law continue to allow posthumous use of embryos and if so, under what conditions?
- Should time limits apply to the posthumous use of gametes and embryos?
- In what circumstances, if at all, should it be possible to remove gametes from a dead or dying person for use in a treatment procedure? Who should be allowed to consent to such removal?
- What should be the status of the relationship between a deceased person and any child born from the posthumous use of gametes or embryos?

15 National Health and Medical Research Council, *Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research* (2004), 6.15.

16 Use of gametes is also permitted if a person in a post-coma, unresponsive or persistent vegetative state, or a dying person, has given consent to the use of their gametes: *ibid* 6.15.

17 *Ibid* 6.15.1.

18 *Ibid* 6.15–6.16.

19 *Human Tissue Act 1982* s 41.

20 [2005] VSC 427 (Unreported, Habersberger J, 28 October 2005).

21 The court ordered that a further court order would be required prior to use: *Y v Austin Health* [2005] VSC 427 (Unreported, Habersberger J, 28 October 2005), [67–8].

22 *AB v A-G (Vic)* (2005) 12 VR 485.

23 Infertility Treatment Authority, *Guidelines for the Import or Export of Gametes and Embryos* (2006).

24 *YZ v Infertility Treatment Authority* [2005] VCAT 2655 (Unreported, Morris P, 20 December 2005).

25 *YZ v Infertility Treatment Authority* [2005] VCAT 2655 (Unreported, Morris P, 20 December 2005) [37].

26 The guiding principles of the Infertility Treatment Act are discussed in Chapter 5.

27 *YZ v Infertility Treatment Authority* [2005] VCAT 2655 (Unreported, Morris P, 20 December 2005) [68].

28 Infertility Treatment Authority (2006), above n 23, 3.2.

29 Submissions CP 90 (Diane Blood), CP 224 (Victorian Biotechnology Ethics Advisory Committee).

30 Submission PP1 337 (Infertility Treatment Authority).

31 Submission CP 90 (Diane Blood).

32 Submission PP1 341 (Dr Elizabeth Short); Access roundtable (9 February 2006).

PRINCIPLES

WISHES OF THE DECEASED

Policy on posthumous use of gametes should take account of the wishes of the deceased.

Posthumous use of gametes without a person's consent could be seen as breaching the principle that a person's reproductive capacity should not be exploited, which is discussed in Chapter 5.

There are a number of ways these wishes could be taken into account. Some submissions suggested that *express* consent of the deceased person should be required before gametes (and/or embryos) could be used.³³ This view is consistent with NHMRC guidelines. It is argued that express consent:

- is necessary to establish an intention to conceive a child when one partner has died, which is distinct from an intention to conceive while living
- 'signals to a child conceived in these circumstances that their biological father intended for them to be born'³⁴ and may assist a child to deal with possible concerns they might have about having been conceived in these circumstances.
- provides 'an unambiguous and administratively feasible standard to determine when posthumous use should be permitted'.³⁵

However, other submissions said that express consent was an unjustly onerous requirement. They argued that although written consent may provide legal certainty, it may not be a full or accurate account of someone's wishes. In some cases, a person may die suddenly without recording consent.³⁶ Alternatively, people may change their minds after documenting their wishes but may not record their new intentions. Some submissions argued that requiring express consent created an inconsistency in the law by allowing some women to use gametes after their partner's death and preventing others from doing so, simply because in the latter case, their partners had not recorded their wishes about posthumous use. For these reasons, some submissions preferred consent to be implied from the deceased's words and conduct, and considered on a case by case basis.³⁷

Some submissions said it should be possible to infer consent in particular situations, for example where a couple was involved in treatment before one of them died.³⁸ These submissions argued that the current ban on posthumous use prevents consideration of the circumstances of the person seeking treatment. Women who wish to become pregnant using their dead partner's gametes may have the support of their late partner's family.³⁹ However, it is also possible to envisage situations where the views of the deceased's partner and the deceased's family are in conflict.⁴⁰ Another approach would be to assume consent to posthumous use of gametes by the person's partner, unless the person explicitly said he/she did not want this to occur.⁴¹

Consent requirements have been an issue in litigation in the United Kingdom. Diane Blood sought to use her deceased husband's sperm to conceive a child. The couple had been intending to have children before Mrs Blood's husband contracted meningitis and died. While Mr Blood was on life support, his sperm was extracted and stored. Mrs Blood later applied to the Human Fertilisation and Embryology Authority (HFEA) to use Mr Blood's sperm in the UK, or to export it to another country in the European Union. Mrs Blood's application was denied by the HFEA and she appealed to the Queen's Bench and later to the Court of Appeal.

As part of her case, Mrs Blood argued that the consent of her husband need not be express but could be implied from the circumstances of their relationship.⁴² The Court of Appeal maintained that express written consent is required for the storage and use of gametes in the UK, but permitted Mrs Blood to export her deceased husband's sperm to Belgium where she received treatment.⁴³

The commission believes that respect for the wishes of the deceased is integral to any consideration of posthumous use of gametes or embryos. We have considered the arguments about how to determine the deceased's wishes when making our recommendations.

WELLBEING OF THE CHILD

In Chapter 5 we argued that the health and wellbeing of children born as the result of assisted reproductive technology should be paramount in decisions about ART procedures. It follows that this principle must be taken into account in policies relating to posthumous use of gametes and embryos.

Some submissions raised concerns about the consequences of posthumous conception for the child. Some have suggested that where a couple was involved in a treatment program before the man died, the woman's grief at the death of her partner may affect her parenting capacity.⁴⁴ Others suggested that conception could interfere with grieving processes or that a child would be seen as 'a replacement of the dead person'.⁴⁵ During our consultations, some people expressly rejected this argument and submitted that the desire to have a child is distinct from a grief reaction. Rather, they argued that a person's relationships and circumstances before the death of a partner are likely to influence their readiness to have children. The nature and timing of the death will also be a factor. One submission commented that the impact of grief could be addressed in counselling prior to treatment.⁴⁶

Another concern raised during consultations is that children conceived from posthumous use of gametes may suffer psychological harm because they will never meet or know their biological father. However, this situation is not limited to the case of children conceived posthumously but could also occur if a gamete donor who was alive at the date of conception dies before the child is old enough to seek them out, or if a parent dies during pregnancy or early childhood.

There is little research on whether the health and welfare of a child is adversely affected as a result of being conceived after the death of one biological parent.⁴⁷ The European Society of Human Reproduction and Embryology recently reported that '[b]ecause the applications of posthumous reproduction are of recent date, no research has been conducted to study the consequences for the child'.⁴⁸

Joi Ellis, a New Zealand fertility counsellor, has conducted research into the outcomes of cases involving posthumous use of gametes in New Zealand. Four women who conceived a child (or children) with sperm that had been stored at a fertility clinic prior to their partner's death were interviewed. The women who sought treatment were between 28 and 36 years old and made inquiries to the clinic between one month and one year after their partner's death. Five children have been born to the women using either assisted insemination or IVF.

Ellis' research indicates that initial outcomes for the children born (aged 3 to 6 years old) are positive. The women reported that they had no regrets about becoming parents. Further, Ellis states that 'all the mothers are committed to their children being made aware of the particular circumstances of conception'.⁴⁹ When asked about any difficulties they experienced, the women linked their concerns to parenting issues, rather than the specific experience of posthumous conception.

The commission is encouraged by these early findings about outcomes for children conceived by posthumous use of gametes. However, we believe that without further evidence, a cautious approach in this area is warranted. As with all decisions about treatment under the Infertility Treatment Act, the welfare and interests of children to be born as a result of the use of assisted reproductive technology should be paramount.

- 33 Submissions CP 19 (Anita Stuhmcke), CP 78 (Andrew McLean), CP 224 (Victorian Biotechnology Ethics Advisory Committee), CP 231 (Victoria Legal Aid).
- 34 Submission PP1 203 (Professor Marian Pitts and Associate Professor Kerry Petersen).
- 35 Submission PP1 337 (Infertility Treatment Authority).
- 36 From a medical perspective, retrieval of sperm may be more successful from a person who dies suddenly than a person who has suffered a long illness. If a man is ill for a long period, sperm production may diminish, making it less likely to extract viable sperm: Access roundtable, 9 February 2006, email from Professor Gordon Baker, Melbourne IVF 5 April 2005.
- 37 Access roundtable (9 February 2006).
- 38 Submissions CP 90 (Diane Blood), CP 192 (ACCESS).
- 39 Submission CP 90 (Diane Blood).
- 40 Access roundtable, 9 February 2006.
- 41 Submissions CP 90 (Diane Blood), CP 183 (Jacinta Weston), CP 192 (ACCESS).
- 42 *R v Human Fertilisation and Embryology Authority; Ex parte Blood* [1996] 3 WLR 1776, 1181 (Sir Stephen Brown P).
- 43 *Blood* [1997] All ER 687. Diane Blood has published her account of the case: Diane Blood, *Flesh and Blood: The Human Story Behind the Headlines* (2004).
- 44 Submission PP1 117 (Julia Mangan).
- 45 Submission PP1 66 (Dr Estela Papier).
- 46 Submission CP 192 (ACCESS). For example, a woman could be encouraged to postpone treatment until she has worked through issues related to grieving.
- 47 There are some published individual accounts of posthumous conception, eg Diane Blood, *Flesh and Blood: The Human Story Behind the Headlines* (2004).
- 48 ESHRE Task Force on Ethics and Law, 'ESHRE Task Force on Ethics and Law 11: Posthumous Assisted Reproduction' (2006) 21 (12) *Human Reproduction* 3050, 3051.
- 49 Joi Ellis, 'Four Fathers and Four Families: A follow up report of the use of posthumous sperm' (2006) *ANZICA Newsletter* (November 2006) 9, 12.

RECOMMENDATIONS

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 be 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.
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.
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.

RECOMMENDATIONS

The commission has found the issue of posthumous use of gametes and embryos a particularly difficult area on which to make recommendations. Submissions that dealt with the substantive issues raised by the question of whether or not to allow posthumous use were generally in favour of allowing such use.⁵⁰ On the other hand, there are legitimate concerns about the potential consequences for children of a practice about which we know very little. The commission also agrees with the premise expressed in one submission that '[t]he law in this area needs to be principle-based, coherent and flexible enough to deal with future technological advances'.⁵¹

The commission recommends that posthumous use be permitted in certain circumstances. We recommend a rigorous process that deals with the following key issues:

- consent of the deceased
- existence of a relationship with the deceased
- approval for treatment
- counselling
- retrieval of gametes
- notification of wishes
- export of gametes and embryos
- status of the deceased and any children born.

CONSENT

In *Position Paper One*: Access the commission recommended that posthumous use and retrieval of gametes only be permitted if the deceased had expressly consented in writing to such procedures. As discussed above, some people argued that the requirement for express written consent was too onerous and might result in unfairness. They argued for a process where implied consent was sufficient to permit posthumous use or retrieval.

The commission believes that the requirement of express written consent is an important safeguard for posthumous use of gametes and embryos. It ensures that the wishes of the deceased are respected and may also be helpful to any child born. The commission recommends that the deceased's written consent must specifically contemplate *posthumous* use of gametes or embryos, not just use in a treatment procedure.

EXISTENCE OF A RELATIONSHIP

The commission believes that in the absence of research findings on outcomes for children born as a result of posthumous use of gametes, a cautious approach in this area is warranted. For this reason, we recommend that posthumous use of gametes only be permitted when there was a pre-existing relationship. Although research to date does not provide information about the possible impact of posthumous use of gametes on any children born, the fact that surviving partners are able to tell children about their deceased parents addresses some of the major concerns the commission holds.

The commission recommends that the couple need not have been involved in a treatment program prior to the deceased's death.

If the deceased has stipulated conditions about the use of his or her gametes after death, these should be followed, unless they are contrary to law. If the deceased's surviving partner has re-partnered, it may be possible for him or her to use the gametes or embryos with a new partner if they meet the eligibility requirements for treatment under the Infertility Treatment Act, and if the deceased's consent envisaged such use.

Donors

The commission has concerns about posthumous use where there is no pre-existing relationship between the deceased and the recipient. We believe that these circumstances are sufficiently different from posthumous use in the context of a pre-existing relationship to warrant a different approach. Permitting posthumous use of donor gametes or embryos will mean that some donor-conceived people will never have the opportunity to make contact with or meet their donors. The commission has heard from a number of people who will never be able to identify their donors because of past law, policy and practices (such as destroying hospital records). This fact can cause significant distress to donor-conceived children and adults.

For these reasons, the commission believes that it should not be possible to use donated gametes or embryos if a clinic is aware that a donor has died.

APPLICATIONS FOR POSTHUMOUS USE

Process

Treatment using posthumous use of gametes or embryos involves serious ethical issues. This fact is acknowledged in the NHMRC guidelines.⁵² The commission believes that approval from a clinical ethics committee is appropriate before a person may undergo treatment using gametes or embryos from a deceased person.

In New Zealand, ethics committee approval is a requirement for posthumous use. The New Zealand study discussed above reported that women found the process of mandatory approval by an ethics committee unnecessary and intrusive. All participants had been planning to conceive a child before the death of their partners. The women said their decision to conceive using their deceased partner's sperm was not a snap decision in response to bereavement. They 'objected to a group of people who did not know them judging their future, their choices and having control over them'.⁵³ Ethics approval and counselling requirements took many months. Nevertheless, the women who participated in the study also found that counselling and expressing their wishes to the ethics committee was empowering.

Despite these concerns, the commission has decided that posthumous use of gametes and embryos should only be permitted when each application is considered by a clinical ethics committee. The committee should assess possible impacts 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

The Infertility Treatment Act requires the partners of women undergoing treatment and donors to receive counselling and information and to provide relevant consent.

The commission recommends that the applicant receive counselling which addresses 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.⁵⁴

If the commission's recommendations are implemented, the deceased must have consented to use of his or her gametes but is unlikely to have undergone counselling or to have received relevant information, particularly if gametes were retrieved after death. The commission recommends that where a person is seeking treatment using the gametes of a person who has died, the counselling and information provisions in the Act should not apply in respect of the deceased person, as compliance with those requirements is clearly not possible.

It is likely that only a small number of children will be conceived through the use of posthumous donations of gametes. In accordance with the commission's cautious approach, we believe that the wellbeing of children born as a result of posthumous use should be monitored. As we discussed above, there is limited information available about the effects of posthumous use; future policy decisions would be assisted by knowledge of the psychological and developmental impacts of the practice on children. Any research in this area could only be conducted with the consent of the children's parents, and where appropriate, of the children themselves.

50 Submissions CP 19 (Anita Stuhmcke), CP 90 (Diane Blood).

51 Submission PP1 203 (Professor Marian Pitts and Associate Professor Kerry Petersen).

52 National Health and Medical Research Council, *Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research* (2004).

53 Joi Ellis, 'Four Fathers and Four Families: A follow up report of the use of posthumous sperm' (2006) *ANZICA Newsletter* (November 2006) 9, 10.

54 This recommendation aligns with the National Health and Medical Research Council, *Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research* (2004).

RECOMMENDATIONS

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.
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 or 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.
64. In making decisions about whether approval should be given to export gametes or embryos outside of 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.

Time Limits

During the course of our consultations, the commission asked whether there should be a specified period of time within which gametes must be used.⁵⁵ We also considered whether a prescribed period of time should elapse after death before gametes or embryos can be used.

A small number of submissions said that gametes should be used within five years of the provider's death.⁵⁶ However, the majority of submissions on this issue said that imposing a time limit on the use of gametes was unnecessary and unfair. Time limits could coerce women to commence treatment before they are ready⁵⁷ and may impact on decisions about family spacing or constrain the possibility of having more than one child. The ITA submitted that:

highly prescriptive legislation can create significant impediments to good regulation by imbedding inflexible processes that may result in inconsistent and unjust outcomes. A statutory time limit for the posthumous use of gametes has the potential to operate in precisely this way ... Inconsistency would occur when two women in apparently similar circumstances—wishing to use the sperm of their deceased partner with his express consent—are distinguished on the basis of a non-essential factor, namely, the time elapsed since the death of their partner.⁵⁸

Time periods for storage of gametes and embryos already exist under the Infertility Treatment Act.⁵⁹ The NHMRC guidelines do not impose a time period before conception may be attempted; they merely require that clinics 'allow an appropriate period of time before attempting conception'.⁶⁰

The commission agrees that imposing time limits on the posthumous use of gametes or embryos would be overly prescriptive. We recommend that no additional time periods should apply to the posthumous use of gametes and embryos. As discussed above, counselling should address the appropriate period of time that should elapse between the deceased's death and attempts at conception. If there are special circumstances that warrant an extension of storage time, a person may apply to the ITA. If the deceased leaves instructions about time limits when they consent to the use of their gametes or embryos, these time limits should be observed.

POSTHUMOUS RETRIEVAL OF GAMETES

Posthumous retrieval is a particularly contentious aspect of posthumous use of gametes. As discussed above, the Supreme Court has permitted retrieval of gametes where the deceased has not given consent. Posthumous retrieval often occurs at a time of distress to the deceased's family members, and the need to obtain a court order can add to concerns at this time. We received submissions about posthumous retrieval which expressed a range of views: total disagreement with the concept, acceptance of retrieval if express consent is provided, and support for retrieval in accordance with current provisions of the Human Tissue Act.

The commission has decided that the requirement of express consent is as important for the retrieval of gametes as it is for the use of gametes. We believe that the public benefits of express consent outweigh individual concerns about the limitations and possible unfairness that might arise if a person has not provided consent for posthumous use. Express consent provides certainty and practicality to all parties. This is particularly important in light of the invasive nature of retrieval, and because members of the deceased's family may hold different views about whether gametes should be removed. The commission believes the purpose of gamete retrieval sets it apart from other tissue donations covered in the Human Tissue Act that are permitted with the consent of the deceased's next-of-kin.

The commission acknowledges that it may be difficult to locate the relevant documentation in situations where a small window of time exists for retrieval of gametes.⁶¹ In an emergency situation, where express consent exists but cannot be located, the commission recommends the deceased's spouse or next-of-kin should be required to make a statutory declaration that written consent exists. This procedure would permit a doctor to retrieve gametes on the basis of this assurance. The written document expressing consent would need to be produced before the gametes could be used in a treatment procedure.

NOTIFICATION OF WISHES

The requirement that the deceased expressly consent to the posthumous use of their gametes or embryos is fundamental to the commission's recommendations in this area. However, the commission acknowledges that even where people do state their wishes in writing, they may subsequently change their mind or their circumstances may change.

The ITA's 'Advance Directive Consenting to Posthumous Use of Stored Gametes by a Partner: Interim Form' is an important mechanism to ascertain the wishes of people undergoing treatment about potential use of their gametes after death. Efforts should also be made to determine the wishes of donors of gametes or embryos.

The commission recommends that clinics should ensure that people's wishes about posthumous use of their gametes and embryos are recorded. In particular, clinics should contact all people whose gametes and embryos are already in storage to ascertain their wishes with respect to posthumous use. If a person who has gametes or embryos in storage does not respond to requests for instructions about posthumous use, it should not be possible to use those gametes or embryos to conceive a child. (This would not necessarily preclude use for research purposes, assuming the law allowed such research).

The commission agrees with the principle that it should always be possible to revoke consent. Accordingly, a subsequent document would override an advance directive form held by a clinic. The commission acknowledges that decisions, or changes to decisions, about posthumous use can occur without the mandatory counselling provided when people are formally seeking treatment. However, the decision about posthumous use is a matter for individual autonomy. Accordingly, the commission recommends that a person can only modify their consent to posthumous use of their gametes or embryos if it is in writing.

Transitional Provisions

The commission considered whether any provision should be made for situations where gametes are already in storage but the deceased did not have an opportunity to express his or her wishes about posthumous use of those gametes. The commission decided that the requirement for express consent should not be dispensed with in such situations. To do otherwise would be to afford those people wanting to use gametes or embryos already in storage rights that are

additional to the rights people may enjoy in the future, and to those that people had in the past. Transitional provisions are generally intended to ensure existing entitlements are preserved, not to extend entitlements beyond those that already exist.

Express consent should remain a fundamental requirement of any posthumous use of gametes or embryos. Where gametes or embryos of a deceased person are stored at a clinic, and the deceased did not have an opportunity to express his or her wishes about their use after death, use of the gametes should not be permitted.

EXPORT OF GAMETES AND EMBRYOS

The commission has discussed the import and export of gametes and embryos in the context of posthumous use. The decision of *YZ v Infertility Treatment Authority*⁶² raised issues about the desirability and permissibility of the ITA allowing export for use, where that use would contravene the Act if carried out in Victoria. For example, express written consent of the deceased may not be required for posthumous use in other parts of Australia.

The commission believes the ITA should retain the power to approve applications to import and export gametes and embryos. In making decisions about whether approval should be given to export gametes or embryos, the ITA should be required to take into account whether use of the gametes or embryos in another jurisdiction would be consistent with Victorian law.

STATUS OF DECEASED AND CHILD

In making recommendations that permit posthumous use in certain circumstances, the commission has considered the impact on a child who may be born. The psychological outcomes have been discussed above, and have prompted the commission to recommend a rigorous approval process for posthumous use.

The commission has also considered the legal consequences for children who are born after the death of one of their biological parents. We discuss the importance of legal parentage more fully in Chapter 11. In this section, our recommendations are specifically directed to posthumous use, namely the impact of parental status on bequests made by the deceased and on birth registration. The commission has considered steps made in other jurisdictions that deal with these legal consequences.⁶³

- 55 Victorian Law Reform Commission, *Position Paper One: Access (2005)*, Question 8.
- 56 Submissions PP1 227 (Anonymous), PP1 339 (Women's Electoral Lobby).
- 57 Submission PP1 172 (Diane Blood).
- 58 Submission PP1 337 (Infertility Treatment Authority).
- 59 Gametes may be stored for ten years, embryos may be stored for five years: *Infertility Treatment Act 1995* ss 51(1)(b), 52(4).
- 60 National Health and Medical Research Council, *Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research* (2004), 6.16.
- 61 Submission PP1 172 (Diane Blood).
- 62 *YZ v Infertility Treatment Authority* [2005] VCAT 2655 (Unreported, Morris P, 20 December 2005) [68].
- 63 For example, *Human Fertilisation and Embryology (Deceased Fathers) Act 2003* (UK).

RECOMMENDATIONS

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.

The commission recommends that any child conceived posthumously 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. The deceased should be recorded as the child's parent on his or her birth certificate. However, the legal consequences flowing from the deceased's parental status should be limited in order to provide certainty for the administration of deceased estates. A person would still be able to make provision for a posthumously conceived child in his or her will, but where no such disposition was made, the child should have no claim to the deceased's estate. Where a couple is in a treatment program and is contemplating the possibility of posthumous use, the counsellor should advise them to seek legal advice about whether and how to make provision for a posthumously conceived child in their wills.

The recommendation to permit nominal registration of a parent of a posthumously conceived child is based on the following grounds:

- The deceased was in a relationship with the child's living parent. The nominal nature of the registration arises out of the need to limit the legal obligations that flow from registration, rather than a desire to give symbolic parental status to a person who would not otherwise be regarded as the child's parent (eg a known donor).
- The deceased will have expressly consented to posthumous use of his or her gametes by his or her surviving partner, and therefore to the parental status that flows from that decision.
- Because the person is deceased there are very limited ongoing legal consequences of registration on the birth certificate. For example, there would be no requirement for the deceased to consent to the issue of a passport or enrolment at school.

Where the surviving partner is a man and he wishes to use the gametes of his late female partner to conceive a child, conception will necessarily involve a surrogacy arrangement. In such cases, assuming our recommendations on surrogacy are implemented, the question of who is to be recognised as the child's legal parents would be determined by a court.⁶⁴

64 See Chapter 19.

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Chapter 10

Adoption



In 2005–06 there were 17 infant adoptions in Victoria.

In the previous chapters we discussed the use of assisted reproductive technology in the creation of families where conception does not occur as a result of heterosexual intercourse. Adoption of children is also a means of family formation. The terms of reference for this project ask the commission to enquire into and report on the desirability and feasibility of changes to the *Adoption Act 1984* to expand eligibility criteria.

In Chapter 11, we explain the legal effect of adoption and discuss the developments in law and policy that have been implemented to avoid some of the negative consequences of adoption for parents and children.

In this chapter we identify the forms of adoption that exist and examine their eligibility criteria.

INFANT ADOPTION

Infant adoption is the adoption of a young child by a couple or individual who has no relationship to the child or the child's birth parents. The primary purpose of infant 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.¹ The children are usually aged between two months and one year. Infant adoption is relatively rare today because birth parents are encouraged to explore alternatives to adoption such as permanent care arrangements, which preserve their legal relationship with the child. In 2005–06 there were 17 infant adoptions in Victoria.²

PERMANENT CARE ORDERS

If a child is unable to remain living with his or her birth parents, the Children's Court can make a permanent care order to grant custody and guardianship of the child to other caregivers, to the exclusion of all others.³ Permanent care orders last until the child turns 18 and do not transfer full legal parental status to the caregivers. They must include conditions that the court considers to be in the interests of the child concerning access by the child's parent(s).

SPECIAL NEEDS PLACEMENTS

Special needs adoption occurs when a child has a specific disability or health condition or there are concerns about his or her development. Most children with special needs who are referred to adoption agencies are placed in permanent care arrangements and only a very small number are adopted. In 2005–06 there were 64 adoptions and permanent care placements of children with special needs in Victoria.⁴

STEP-PARENT AND RELATIVE ADOPTION

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. Step-parent adoption is generally discouraged because it permanently severs the legal relationship between the child and an existing parent and other family members, and may be used as a means to exclude the child's extended family from his or her life.⁵ To make an adoption order in favour of a step-parent, the court must be satisfied that exceptional circumstances exist and that a parenting order from the Family Court would be inadequate for the care of the child.⁶ Examples of exceptional circumstances are where a child's birth parent has died, there is a history of violence between the child's parents, or where the child was conceived by rape.⁷

Step-parents may apply to the Family Court for leave to lodge an adoption application in the County Court.⁸ If the Family Court does not grant leave, the child will continue to be regarded by the court as the child of both birth parents and their parental responsibilities under the Family Law Act will persist, regardless of any adoption order made by the County Court.⁹

In 2005–06 there were 10 step-parent adoptions in Victoria.¹⁰

Relative adoption is the adoption of the child by a relative who is not the child's mother or father, for example a grandparent or a sister. Relative adoption is now discouraged because it is regarded as potentially distorting the relationships in a child's family (for example, if adopted by a sister, the sister would become the child's legal mother), but it remains technically possible where exceptional circumstances exist.¹¹

CURRENT LAW

ADOPTION

There are extensive laws, regulations, standards and procedures that govern adoption of children in Victoria. The United Nations *Convention on the Rights of the Child* requires signatories to ensure that the best interests of the child are the paramount consideration in adoption.¹² This principle is enshrined in the Adoption Act.¹³

National standards and principles have been developed to guide the provision of adoption services. The National Principles in Adoption 1997 incorporate obligations that arise under the *Convention on the Rights of the Child* and the *Convention on Protection of Children and Co-operation in Respect of Intercountry Adoption* (the Hague Convention),¹⁴ to which Australia is a signatory. They contain policies which recognise the needs of children, parents and applicants involved in adoption. The Standards in Adoption 1986 define and describe an accepted level of practice in the provision of adoption services.

The Adoption Act and Adoption Regulations 1998 set out the legislative requirements which must be met by people applying to adopt children and prescribe the procedures which must be followed for each adoption, from obtaining consent from the birth parents to obtaining an adoption order from the court. The Act also establishes the Adoption Information Service and enables parents and children to obtain information about each other.¹⁵

The Department of Human Services produces the *Adoption and Permanent Care Procedures Manual*, which provides extensive guidance to agencies handling referrals of children for adoption and/or permanent care and applications by prospective adoptive parents.¹⁶ The manual covers issues such as counselling of birth parents; the recruitment, preparation and education of applicants; linking of applicants and children; supervision of placements; access arrangements and post-placement support.

The Adoption Act prescribes the categories of people in whose favour adoption orders may be made. An order may be made in favour of a man and a woman who have been married or in a stable de facto relationship for at least two years.¹⁷ A de facto relationship is defined as a 'relationship of a man and a woman who

are living together as husband and wife on a genuine domestic basis, although not married to each other'.¹⁸ An adoption order can therefore not be made in favour of a same-sex couple.

Single applicants can adopt if the court is satisfied that special circumstances exist which make adoption by that person desirable.¹⁹ A brochure produced by the Department of Human Services states that this generally applies to children with special needs.²⁰

Adoption applicants must be approved as fit and proper persons to adopt a child by the Department of Human Services or the principal officer of an approved adoption agency.²¹ Applicants must meet the following criteria:

- (a) *The personality, age, emotional, physical and mental health, maturity, financial circumstances, general stability of character and the stability and quality of the relationship between the applicants and between the applicants and other family members are such that he or she has the capacity to provide a secure and beneficial emotional and physical environment during a child's upbringing until the child reaches social and emotional independence.*
- (b) *If an applicant has had the care of a child before applying for approval as a fit and proper person to adopt a child, he or she has shown an ability to provide such an environment for the child.*²²

Adoption orders are made by the County Court.

PERMANENT CARE ORDERS

The above eligibility criteria only apply to adoptions. In the case of applications for permanent care orders, the Department of Human Services must have approved the applicant as suitable and the Children's Court must be satisfied that the person or people named in the application are suitable to have custody and guardianship of the child.²³ In making this decision, the court is required to have regard to the following matters:

- (a) *the personality, age, health, marital and family relationships, emotional maturity, financial circumstances and general stability of character of each person named in the application as suitable to have custody and guardianship of the child; and*

- 1 The principle that adoption is a service for children is articulated in the *National Principles in Adoption* (1997) and Department of Human Services, *Standards in Adoption* (1986) and *Adoption and Permanent Care Information Kit* (2006), <www.office-for-children.vic.gov.au> at 8 February 2007.
- 2 Department of Human Services (2006), above n 1, 12.
- 3 *Children and Young Persons Act 1989* s 112.
- 4 Department of Human Services (2006), above n 1, 12.
- 5 See Community Care Division, Victorian Department of Human Services, *Stepchildren and Adoption* (2001), Department of Human Services, *Adoption and Permanent Care Procedures Manual* (2004), 130; Family Law Council Australia, *Cinderella Revisited: Rights and Responsibilities in Step-Families: Report of the Step-Families Sub-Committee* (1986).
- 6 *Adoption Act 1984* ss 11(6), 12.
- 7 Department of Human Services (2004), above n 5, 134.
- 8 *Family Law Act 1975* (Cth) s 60G.
- 9 *Family Law Act 1975* (Cth) s 61E.
- 10 Information provided to the Victorian Law Reform Commission by Department of Human Services, 8 February 2007.
- 11 Department of Human Services (2004), above n 5, 130.
- 12 *Convention on the Rights of the Child*, UN GAOR, 44th sess, UN Doc A/44/736 (1990) art 21.
- 13 *Adoption Act 1984* s 9.
- 14 *Convention on Protection of Children and Co-operation in Respect of Intercountry Adoption*, concluded 29 May 1993 (entered into force 1 May 1995), signed by Australia 25 August 1998 (entry into force 1 December 1998).
- 15 *Adoption Act 1984* pt 6.
- 16 Department of Human Services (2004), above n 5.
- 17 *Adoption Act 1984* s 11(1).
- 18 *Adoption Act 1984* s 4.
- 19 *Adoption Act 1984* s 11(3).
- 20 Department of Human Services, *Infant Adoption* (2005).
- 21 *Adoption Act 1984* s 13(1).
- 22 *Adoption Regulations 1998* r 35.
- 23 *Children and Young Persons Act 1989* s 112.

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RECOMMENDATIONS

67. The *Adoption Act 1984* should be amended to allow the County Court to make adoption orders in favour of same-sex couples.

- (b) *the capacity of each person so named in the application to provide a secure and beneficial, emotional and physical environment for the child's upbringing until the child reaches social and emotional independence; and*
- (c) *if a person so named in the application had the care of the child before applying to the Court, the ability of that person to provide such an environment for the child; and*
- (d) *the compatibility between the religion, race or ethnic background of each person so named in the application and the child; and*
- (e) *the understanding by each person so named in the application of the importance of access by the child's parents and exchange of information concerning the child.*²⁴

There is no prohibition on an individual or couple in a same-sex relationship becoming the carer of a child under a permanent care order.

PROBLEMS WITH THE LAW

Because the pool of eligible applicants for adoption is restricted to heterosexual couples, a child in need may potentially be deprived of the opportunity to be placed with the most suitable carers. The commission believes that this restriction is contrary to one of the assumptions articulated in the Standards in Adoption document that: 'It is in the best interests of children to have the maximum range of prospective adoptive parents available'.²⁵ Although there are many more people who apply to adopt than children who are referred to adoption agencies, the process of linking children with applicants is complex and there is no guarantee that a suitable couple will be found for a particular child.

Some same-sex couples act as foster parents and permanent carers to children who are unable to live permanently with their birth parents. The commission received a submission from a gay man who has been a foster carer of two boys for over five years. In his submission, the man describes how the boys chose to live with him and his partner:

The boys had a number of options about where they could live and were told that we were gay prior to meeting us. We wanted them to be told, so they could make the decision about whether they wanted to live with a gay couple. Before making their decision about living with us they met us and came and saw our house and our dogs and cats. We told them that if they had any questions about our being gay they could just ask, it wasn't something they should be fearful of or continue to wonder about if they had any questions. Our being gay was not a major concern for them, although they did have some questions that we were willing to answer from the outset. I suspect their decision in the end was based on the merits of us as a couple and what we could provide for them as a family unit.

*Through fostering I have learnt a lot about the experiences of children being brought up by a gay couple. From talking to the boys I can tell that it has been a positive experience for them. The fact that the 19 year old has chosen to stay living with us even though he is no longer considered to be a foster child suggests that it's a positive experience for him.*²⁶

The man also provided the commission with an extract from the book *Boys' Stuff: Boys Talking about What Matters* in which the boys had made some comments about what it was like living with a gay couple. One of the boys, then aged 14, said:

*I was a bit homophobic in primary school. Then we met Brett and Ian and that helped a fair bit. Brett and Ian make me feel like I'm really special and it makes me feel good. They're kind of like role models. They tell me, 'Be yourself, believe in yourself and try not to pollute the earth'.*²⁷

This submission describes a positive outcome for two children in need who found a stable family environment through foster care. However, even if the children had wanted their relationship with their carers formalised through adoption, this would not have been possible under the current law.

It makes no sense that people in same-sex relationships are able to be approved as permanent and short-term carers of children in need, but cannot assume the full range of legal parental powers and responsibilities for those children.

RECOMMENDATIONS

SAME-SEX COUPLE ADOPTION

In Chapter 2, the commission explains why it does not believe that parenting by same-sex couples or single people is in itself harmful to children. However we acknowledge that some people in the community are opposed to children being adopted by same-sex couples. One submission, for example, stated:

*We believe that the present law should be kept, particularly in light of the fact that there are more heterosexual couples wanting to adopt than there are babies. Adoption by these couples will give the babies the experience of both a mother and a father.*²⁸

Based on the available research on outcomes for children in a range of diverse families, the commission is unable to conclude that prohibiting same-sex couples from adopting children is justified according to the principle of the best interests of the child.

The commission therefore recommends that the eligibility criteria in the Adoption Act be expanded to permit same-sex couples to adopt children in all circumstances in which heterosexual couples can.

Adoption by same-sex couples is already permitted in Western Australia, Tasmania, the ACT and several states of the United States.²⁹ At the time of writing, one same-sex couple had applied and been approved to adopt and one same-sex partner had successfully applied for a carer's adoption order in Western Australia.³⁰ So far, no applications for adoption have been made by same-sex couples in the ACT³¹ or in Tasmania.³² Same-sex couples in Tasmania became eligible to apply to adopt in January

2007. This is because a couple must have been in a registered relationship for three years before an adoption order can be made in their favour, and registration only became possible in January 2004.³³

In its submission in response to the Consultation Paper, the Victorian Standing Committee on Adoption and Alternative Families emphasised the importance of placing the best interests of the child at the centre of any decision about adoption. They stressed the need to consider whether adoption is an appropriate option for the child.³⁴ As to the eligibility of same-sex couples to adopt children, the committee stated: 'Relationship issues of the parents should not be the object of any eligibility requirements, only the rights of the child'.³⁵

The distinction between sexuality and other factors was also identified in another submission:

*It seems ridiculous to me that single people and gay couples can't adopt needy children. We need more families willing to be assessed for adoption eligibility and it is quite silly that sexuality excludes us. The things that should exclude prospective adoptive parents are things like criminal history, inadequate housing, history of abuse of children and inability to parent adequately.*³⁶

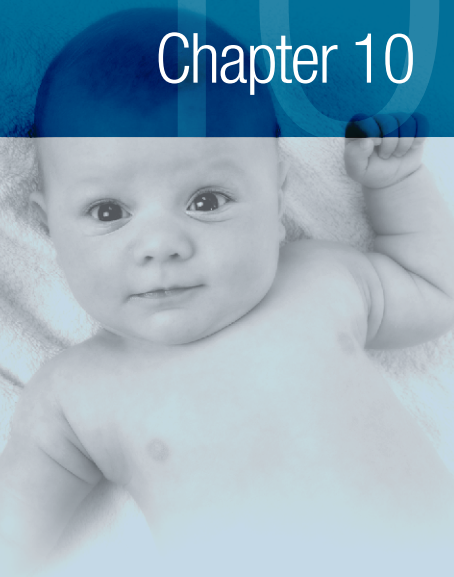
Helen Kane, a social worker who has had extensive experience with individuals and families affected by adoption, supported the capacity for same-sex couples to apply to adopt, but also pointed out that applications by same-sex couples should not receive any special consideration. She argued for 'a level-playing field for all applicants, regardless of their sexual orientation, when considered in relation to their ability to meet the needs of a particular child'.³⁷

- 24 Children and Young Persons (General) Regulations 2001 r 8.
- 25 Department of Human Services, *Standards in Adoption* (1986) [4.1.1(v)].
- 26 Submission CP 59 (Ian Seal).
- 27 Wayne Martino and Maria Pallotta-Chiarolli, *Boys' Stuff: Boys Talking About What Matters* (2001), 154.
- 28 Submission PP2 259 (Nevil & Gloria Knell).
- 29 John Seymour and Sonia Magri, *ART, Surrogacy and Legal Parentage: A Comparative Legislative Review* (2004), 56–7.
- 30 Emails received from Adoption Service, Department for Community Development (WA), 16 and 17 August 2006. The *Adoption Act 1994* (WA) permits adoption of a child by a person who 'has had, for at least 3 years, the daily care and control of the child and the responsibility for making decisions concerning the daily care and control of the child': ss 4, 67.
- 31 Email received from Client Services, Office for Children, Youth and Family Support (ACT), 25 July 2006.
- 32 Email received from Department of Health and Human Services (Tas), 21 July 2006.
- 33 See *Relationships Act 2003* (Tas), *Adoption Act 1988* (Tas) s 20.
- 34 Submission CP 77 (Victorian Standing Committee on Adoption and Alternative Families).
- 35 However, in its submission in response to Position Paper Two (submission 170), the committee stated that it did not agree with the commission's interim recommendation that adoption orders be able to be made in favour of same-sex couples. This statement may have been directed to the commission's interim recommendations about recognising the non-birth mother (see Chapter 12).
- 36 Submission PP2 87 (Anonymous).
- 37 Submission PP2 58 (Helen Kane).

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RECOMMENDATIONS

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.

Expanding eligibility criteria for adoption would not mean that same-sex couples could automatically adopt children. They would be subject to the full range of assessment criteria relevant to all people who apply to adopt children. The following provisions would remain:

- The applicants must apply to be approved as fit and proper people to adopt a child.³⁸
- The applicants must attend information and education sessions.³⁹
- The applicants must undergo medical and police checks and provide personal references and histories.⁴⁰
- The applicants must provide information about their financial circumstances.⁴¹
- The applicants must be assessed and approved as fit and proper persons to adopt.⁴²
- The birth parents must consent to the adoption.⁴³
- The birth parents are given the opportunity to be involved in the placement of the child and to express preferences about approved applicants.⁴⁴
- If the child is old enough, his or her wishes must be taken into account.⁴⁵
- The County Court must be satisfied the applicants are fit and proper persons to adopt a child before making the adoption order.⁴⁶
- The County Court may make the adoption order subject to the condition that the child's birth parents have access to the child.⁴⁷

The commission acknowledges the presumption against step-parent and relative adoption and agrees that the current policy, which favours Family Court parenting orders over step-parent and relative adoptions, is appropriate where the child already has a second parent and extended family. Assuming our recommendations about the recognition of the non-birth mother as a legal parent of the child are implemented (see Chapter 12), situations will arise where a child born to a same-sex couple has two legal parents who later separate. If either parent enters a new relationship, the commission believes the presumption against step-parent adoption should apply.

However, where there are exceptional circumstances and a Family Court parenting order would not be adequate for the care of the child, the court should be able to make an adoption order in favour of the same-sex partner of a child's parent in the same way that it can make an order in favour of a partner of the opposite sex. From a legislative point of view, this can be achieved with relative ease, by amending the definition of 'de facto spouse' in section 4 of the Adoption Act to include people living in same-sex relationships. If the child was born as a result of donor insemination to a single woman, the child will not have a legal father. If the child's mother subsequently enters into a relationship, it may be that such a situation would amount to 'exceptional circumstances' and adoption by the mother's new partner would be in the best interests of the child.

CONSEQUENTIAL AMENDMENTS

Connections, one of the agencies in Victoria that provides services for people considering adoption or permanent care for their children, expressed in-principle support for permitting same-sex couples to adopt children.⁴⁸ However, their submission commented that expanding the eligibility criteria would probably necessitate further training for staff and may raise new issues for the assessment process. For example, they suggested that there may be a greater likelihood of relinquishing parents choosing a heterosexual couple over a same-sex couple for their child as a result of current social and community attitudes. Birth parents commonly express a wish for their child to have what they are often unable to provide for them, namely a mother and a father in a stable relationship. They also suggested it may become necessary to explore whether the child would 'be exposed to adults of both genders in addition to receiving nurture from their parents', but commented that the existing assessment process would be able to include such considerations:

It was felt that the current adoption processes allow for education and complex assessment around eligibility criteria with particular focus on applicants' views on parenting, strength of the couple's relationship, motivation, commitment, attitudes to access and information exchange with a child's birth family,

*level of understanding of identity issues for adoptees, and can be extended to incorporate the gender issues noted above allowing for the selection and approval process to continue to be child-focused as well as equitable for applicants.*⁴⁹

These types of issues could be addressed in the *Adoption and Permanent Care Procedures Manual* which is currently directed to applications by heterosexual couples. We recommend that it be reviewed and modified to recognise applications from people in same-sex relationships. Adoption agency staff should receive training to provide education about same-sex parenting.

SINGLE APPLICANTS

In Chapter 5, the commission recommended that single women be permitted to access ART services. The commission believes that single people are able to provide secure and loving environments for children. Consistent with those recommendations, the commission believes it would be appropriate to remove the higher standard that is applied to single applicants applying to adopt. We believe that the adoption legislation provides an adequate process for assessing the suitability of a single person to adopt a child, without the need to prove to the court that 'special circumstances' exist. The assessment process already examines the financial circumstances of applicants, the current demands of the applicant's employment and the extent of family, friendship and community networks.⁵⁰ The commission therefore recommends that the Adoption Act be amended to make the criteria for making an adoption order in favour of a single person consistent with those that apply to the making of an order in favour of a couple.

INTERCOUNTRY ADOPTION

Intercountry adoption is the adoption of a child from another country.

In Victoria, intercountry adoption is the responsibility of the Department of Human Services and is regulated by Part 4A of the Adoption Act. Part 4A implements the provisions of the 1993 Hague Convention, which was ratified by Australia on 25 August 1998.⁵¹

The County Court is able to grant an adoption order under Part 4A of the Adoption Act if it is satisfied that 'the arrangements for the adoption of the child are in accordance with the requirements of the Hague Convention'.⁵² The convention does not specify eligibility criteria for selecting prospective parents; these must be established by the contracting states.⁵³ Victorian applicants must meet the eligibility criteria of both Victorian law and the law of the country of origin.

Victoria has intercountry adoption arrangements with nine countries: China, Ethiopia, Hong Kong, India, Lithuania, the Philippines, Korea, Sri Lanka and Thailand.⁵⁴ These arrangements operate under bilateral government-to-government agreements or the Hague Convention. None of the countries with which Victoria has an arrangement permits a same-sex couple to adopt a child. China, Ethiopia, Hong Kong and the Philippines permit single applicants to adopt.

In 2005–6 there were 81 intercountry adoption placements in Victoria.⁵⁵

The commission does not make any recommendations about intercountry adoption because, as a state-based body, our recommendations cannot affect the law of the countries with which Victoria has adoption arrangements. If same-sex couples become eligible to adopt children in Victoria, in time, Victoria may enter into arrangements with countries that also permit adoption by same-sex couples. However, recent federal government pronouncements suggest attempts may be made in the future to transfer domestic responsibility for intercountry adoptions to the Commonwealth.⁵⁶

38 *Adoption Act 1984* s 13(1).

39 Department of Human Services (2004), above n 5, 42–5.

40 *Ibid* 48–9.

41 Adoption Regulations 1998 sch 5.

42 *Adoption Act 1984* s 13(3).

43 *Adoption Act 1984* s 33 (1).

44 *Adoption Act 1984* s 15(1)(b); Adoption Regulations 1998 s 18; Department of Human Services (2004), above n 5, 60.

45 *Adoption Act 1984* s 14.

46 *Adoption Act 1984* s 15(1).

47 *Adoption Act 1984* s 59A.

48 Submission CP 122 (Connections Adoption & Permanent Care Program).

49 *Ibid*.

50 Department of Human Services (2004), above 5, 56.

51 *Convention on Protection of Children and Co-operation in Respect of Intercountry Adoption*, opened for signature 29 May 1993 (entry into force in Australia 1 December 1998).

52 *Adoption Act 1984* s 69B(2)(c).

53 *Convention on Protection of Children and Co-operation in Respect of Intercountry Adoption*, arts 5(a), 15(1).

54 Department of Human Services, *Intercountry Adoption Information Kit* (February 2007) <www.dhs.vic.gov.au> at 9 February 2007.

55 Department of Human Services (2006), above n 1, 12.

56 House of Representatives, Standing Committee on Family and Human Services, *Overseas Adoption in Australia: Report on the Inquiry into Adoption of Children from Overseas* (2005).

10

Chapter 10

Adoption



In 2004, the federal government introduced a Bill to amend the Family Law Act to prevent same-sex couples from adopting children from overseas.⁵⁷ The Bill was referred to the Senate Legal and Constitutional Legislation Committee for review on 23 June 2004. One of the matters the committee was directed to consider was whether the Commonwealth has the power to pass such legislation and whether it would interfere with state and territory responsibilities to legislate for and manage adoption processes.⁵⁸ The review was discontinued following the dissolution of parliament prior to the 2004 federal election.⁵⁹ At the time of writing, the Family Law (Same Sex Adoption) Bill was proposed for introduction in the 2007 Autumn Session of Federal Parliament. The Bill is to 'amend the Family Law Act 1975 to indicate that adoptions by same sex couples of children from overseas under either bilateral or multilateral arrangements will not be recognised in Australia'.⁶⁰

In 2005, the House of Representatives Standing Committee on Family and Human Services reviewed the practice of intercountry adoptions.⁶¹ The review did not address the eligibility of same-sex couples to adopt children from overseas, but did note that the eligibility criteria of the six most common countries of origin are generally more restrictive than in Australia, and that:

*these requirements are not negotiable. We must accept the requirements imposed by the countries of origin and it would be improper for Australian adoptive parents or governments to attempt to put a case to overseas authorities to make changes to them.*⁶²

The committee concluded that intercountry adoptions involve matters of external affairs and recommended the federal Attorney-General establish and manage overseas adoption programs. The committee also recommended that eligibility criteria be contained in regulation or in legislation, to ensure 'robust, transparent and documented practices' and 'standardised assessments across the jurisdictions'.⁶³

At the time of writing, the committee's recommendations have not been implemented.

58 The Marriage Legislation Amendment Bill 2004 (Cth).

59 Parliament of Australia, Senate Legal and Constitutional Committee, Inquiry into the Marriage Legislation Amendment Bill 2004.

60 Senator Marise Payne, Chair Senate Legal and Constitutional Committee, Letter to Senator Paul Calvert (6 September 2004) <www.aph.gov.au> at 16 November 2004.

61 Department of Prime Minister and Cabinet, Legislation Proposed for Introduction in the 2007 Autumn Sittings, <www.dpmc.gov.au/parliamentary/docs/proposed_legislation.pdf> at 6 February 2007.

62 House of Representatives, Standing Committee on Family and Human Services, *Overseas Adoption in Australia: Report on the Inquiry into Adoption of Children from Overseas* (2005).

63 Ibid 39.

64 Ibid, recommendation 3, xvii (para 3.43).

Chapter 11

Legal Parentage



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11

Chapter 11

Legal Parentage



This section of the report addresses the question of who should be recognised as legal parents of children born as a result of the use of donated gametes (in particular, children born to women without male partners), and the rights of donor-conceived children to information about their genetic origins.

The use of donated sperm and eggs in the conception of children has created challenges for the law governing the recognition of parentage. Legislation introduced in Victoria in 1984,¹ and federally in 1987,² clarified the situation for children born to married or heterosexual de facto couples. However, the law which relates to children born to women without male partners remains deficient, unclear and confusing.

In Chapter 5 we discussed the use of assisted reproductive technology (ART) by women without male partners who wish to have children. We recommended the removal of restrictions on access to clinic-based ART services to enable more women and children to benefit from the safeguards which apply when treatment is provided in a licensed clinic. We also discussed the fact that clinic-based ART is already available to clinically infertile women and that children have been, and are likely to continue to be, born as a result of self-insemination carried out by single women and women in same-sex relationships outside the clinic system. Even if the law is not changed to enable more women to undergo ART in clinics, it is necessary to clarify the parental status of the people involved in the conception of these children.

Our terms of reference ask us to make recommendations for any consequential amendments to Victorian legislation if eligibility criteria for ART are expanded. In doing so, we have been asked to have particular regard to the rights and best interests of children. In this section, we examine the law which governs the legal parentage of donor-conceived children born to women without male partners. Before turning to this issue, we explain what legal parentage is and why it is important.

The parent–child relationship gives rise to a range of important legal obligations and entitlements for parents, children and third parties. Legal parental status is principally intended to protect children; the law confers powers on parents to enable them to fulfil their duties to care for their children.³

It is important to remember that legal parental status does not itself determine whether someone will have a relationship or contact with a child. The Family Court is able to make parenting orders in favour of people who are not legal parents, including people who have no biological connection, if they are concerned with the care, welfare or development of the children.⁴ Similarly, legal parents may not have contact with their children, although their legal obligations will persist.

In this chapter, we discuss the legal obligations which accompany parenthood, and the various ways people may be recognised as parents for the purposes of the law.

PARENTAL RESPONSIBILITIES

Parental obligations are derived from federal and state legislation as well as the common law.⁵ Today, the most significant sources of parental responsibility are the *Family Law Act 1975* (Cth) and the *Child Support (Assessment) Act 1989* (Cth).

Under the Family Law Act, each of the parents of a child has parental responsibility.⁶ Parental responsibility means ‘all the duties, powers, responsibilities and authority which, by law, parents have in relation to children’.⁷ These duties and powers include responsibility for the day-to-day and long-term care of the child, the power to make decisions on behalf of the child (for example decisions about the child’s education, religion, care and medical treatment) and the power to control the child’s property, to veto the issue of a passport and to withhold consent to marriage.⁸

When the Family Court is asked to make a parenting order in relation to a child, it must base its decision on the presumption that it is in the best interests of the child for parents to have equal and shared responsibility.⁹ If the court makes an order for equal shared parental responsibility, it must then consider whether it would be in the best interests of the child to spend equal time or substantial and significant time with each of the parents.¹⁰

In making a parenting order in relation to a child, the court must regard the child’s best interests as the paramount consideration.¹¹ The primary considerations in determining what is in the child’s best interests are:

- (a) *the benefit to the child of having a meaningful relationship with both of the child’s parents; and*
- (b) *the need to protect the child from physical or psychological harm from being subjected to, or exposed to, abuse, neglect or family violence.*¹²

Parents have the primary duty to maintain their children financially.¹³ If parents separate, the parent who has ongoing day-to-day care of

children can apply for child support to be paid by the other parent. Only parents (as defined in the Family Law Act) can be ordered to pay child support for children aged under 18.

Other obligations and entitlements which arise out of the parent–child relationship and have effect at federal law include:

- entitlement to distribution of a person’s superannuation after his or her death¹⁴
- entitlement to tax concessions¹⁵
- entitlement to certain categories of social security¹⁶
- entitlement to maternity or paternity leave¹⁷
- power to consent to an application to migrate,¹⁸ or to obtain a passport for a child¹⁹
- right to be informed when a child is being questioned for terrorism-related offences.²⁰

Whether parental responsibility under these federal laws applies to a particular person depends on whether he or she is considered to be a parent under the definitions and presumptions contained in the legislation. In some circumstances, these definitions and presumptions rely on and recognise state law, but in other circumstances state law has no effect.

A broad range of obligations and entitlements which arise out of the parent–child relationship are also created under Victorian law.²¹ Such obligations and entitlements include:

- entitlement to compensation under statutory schemes in areas such as workplace or transport accident, and victims of crime compensation²²
- entitlement to a share of a person’s estate if he or she dies without making a will²³
- entitlement to distribution of a person’s superannuation after his or her death²⁴

- 1 *Status of Children (Amendment) Act 1984.*
- 2 *Family Law Amendment Act 1987* (Cth) s 24 (inserted s 60B, which was subsequently replaced by the current s 60H).
- 3 *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112.
- 4 *Family Law Act 1975* (Cth) s 65C(c).
- 5 For more information on the division of Commonwealth and state powers with respect to children and parental relationships see *Assisted Reproductive Technology & Adoption: Should the Eligibility Criteria in Victoria be Changed? Consultation Paper*, paras 2.2–2.17.
- 6 *Family Law Act 1975* (Cth) s 61C(1).
- 7 *Family Law Act 1975* (Cth) s 61B.
- 8 See Geoff Monahan and Lisa Young, *Family Law in Australia* (6th ed, 2006) [6.55–6.72]; *Halsbury’s Laws of Australia*, Title 205, Family Law, Chapter III, Children [205–1670], available at <www.lexisnexis.com.au> at 7 August 2006.
- 9 *Family Law Act 1975* (Cth) s 61DA(1). The presumption does not apply if there are reasonable grounds to believe that a person has engaged in abuse of the child or family violence (s 61DA(2)), and may be rebutted if there is evidence that it would not be in the best interests of the child for the parents to have equal shared parental responsibility: s 61DA(4).
- 10 *Family Law Act 1975* (Cth) s 65DAA.
- 11 *Family Law Act 1975* (Cth) s 60CA.
- 12 *Family Law Act 1975* (Cth) s 60CC(2). Section 60CC(3) lists the additional considerations to be taken into account.
- 13 *Family Law Act 1975* (Cth) s 66C; *Child Support (Assessment) Act 1989* (Cth) s 3.
- 14 *Superannuation Industry Supervision Act 1997* (Cth) s 10, Superannuation Industry (Supervision) Regulations 1994 r 6.17A: on the death of a member, superannuation benefits accrue to the legal personal representative or the member’s dependant.
- 15 For example, family tax benefit: *A New Tax System (Family Assistance) Act 1999* (Cth) s 22; baby bonus tax offset: *Income Tax Assessment Act 1997* (Cth), ss 61.355, 61.375.
- 16 *Social Security Act 1991* (Cth) s 5; payments include parenting payment under the *Social Security Act 1991* (Cth) s 500.
- 17 *Workplace Relations Act 1996* (Cth) ss 265, 282.
- 18 *Migration Act 1958* (Cth) s 83; Migration Regulations 1994, r1.05, 1.12, 1.12AA, visa class 1108 (class AH).
- 19 *Australian Passports Act 2005* (Cth) s 11.
- 20 *Australian Security Intelligence Organisation Act 1979* (Cth) s 34ZE.
- 21 In some instances these obligations and entitlements are also conferred on people other than parents and children: see pages 116–17.
- 22 *Accident Compensation Act 1985* ss 5, 82, 92A; *Transport Accident Act 1986* ss 3, 59; *Victims of Crime Assistance Act 1996* s 3, div 3.
- 23 *Administration and Probate Act 1958* s 52(1)(f).
- 24 If the person is a Victorian public servant: *Police Regulation Act 1958* ss 23(2), 24, 28, 45; *Country Fire Authority Act 1958* ss 110(1)(e), 110(1)(gb); *Emergency Services Superannuation Act 1986* ss 20E(1), 20E(2); *Parliamentary Salaries and Superannuation Act 1968* s 18(6); *State Superannuation Act 1988* ss 36, 37, 48, 72.



- responsibility for the supervision of children (for example to be present at certain times, to consent to a child's involvement in a dangerous activity, not to permit a child under 15 to engage in employment)²⁵
- obligation to ensure children attend school²⁶
- obligation to provide an immunisation status certificate to a child's primary school²⁷
- power to consent to the removal of tissue from a child's body (while living or upon death)²⁸ or to a blood transfusion
- power to appoint a person to be the guardian of a child after a parent's death²⁹
- power to take action on behalf of a child (for example to make a complaint or application about family violence or discrimination, or to consent to an award of damages in favour of a child)³⁰
- power to consent to the adoption, permanent care or short-term care of a child³¹
- entitlement to be consulted and heard on proceedings concerning the care and welfare of a child³²
- entitlement to be present when a child is being questioned by the police, or is being drug tested³³
- obligation to disclose existence of a parent-child relationship for the purpose of certain business activities and prohibition or permission for carrying on business activities with prescribed family members.³⁴

Whether these obligations or entitlements apply to a particular person depends on whether he or she falls within the scope of the definitions contained in the relevant Victorian legislation.

BIRTH REGISTRATION

Legal parents of children are entitled and required to be registered at the Registry of Births, Deaths and Marriages. If a person is named as a parent of a child on the birth register and the child's birth certificate, he or she is presumed to be a parent of the child. The birth certificate can be produced as evidence of the relationship between the parent and the child, and can be used to establish a range of legal obligations and entitlements. The register can be corrected if a person is inaccurately listed as a legal parent of a child. Being named on the register is not of itself the source of legal parentage; it is merely a formal recording of the existence of a legal relationship between a parent and child.³⁵

WHO IS A PARENT?

In Chapter 2 we discussed the diversity of families in our community. The law does not automatically recognise each and every relationship which exists between members of a family, although there are some clear ways in which the parent-child relationship is legally established. One of the important features of legal parentage is that parents are unable to choose to avoid the legal obligations of parenthood. Similarly, a person is unable to become a legal parent of an existing child or to assume all of the obligations and powers of legal parentage without participating in a legal process to ensure that such a step would be in the best interests of the child.

In the absence of any statutory provisions to the contrary, a child's legal parents are his or her biological parents.³⁶ Some children have legal parents who are not biologically related to them (for example adoptive parents) and other children are cared for by people who are neither biologically related to them nor regarded as their legal parents (for example step-parents or foster carers).

The law has evolved over the years to reflect the changing nature of families and relationships. Lawmakers have recognised the importance of responding to social change to ensure the needs of children are met and people do not avoid the responsibilities imposed on parents. The law has been expanded to recognise a broader range of people as legal parents through adoption legislation and statutory presumptions. These developments are discussed in further detail below.

PRESUMPTIONS OF PARENTAGE

The Family Law Act contains a number of presumptions of parentage to assist the Family Court to determine who is a parent of a child in a particular case. A person is presumed to be a parent of a child in the following circumstances:

- If a man was married to the child's mother when the child was born, he is presumed to be the father of the child.³⁷
- If a man lived with the child's mother during the period beginning not earlier than 44 weeks and ending not less than 20 weeks before the birth, he is presumed to be the father of the child.³⁸
- If a person's name is entered as a parent of a child in a register of births kept under a law of the Commonwealth or of a state or territory, he or she is presumed to be a parent.³⁹

- If a court has determined that the person is a parent of a child, that person is presumed to be a parent.⁴⁰
- If a man has executed an instrument acknowledging that he is the father of a child, he is presumed to be the father.⁴¹

The presumption arising from the finding of a court is conclusive. All the other presumptions are able to be rebutted if proof is provided to a court which demonstrates otherwise, on the balance of probabilities. If two or more presumptions are relevant to a particular case and they conflict with each other, the presumption which appears to the court to be more, or most likely to be, correct prevails.⁴²

CHILDREN BORN OUTSIDE MARRIAGE

Historically, children born outside marriage were regarded as illegitimate and were unable to inherit from their parents. The status of illegitimacy was abolished throughout Australia in the 1970s, removing the legal disadvantages suffered by children born outside marriage. These reforms were based on the view that children should not be stigmatised by the law because their parents were unmarried. Children born outside marriage now have the same legal entitlements and protections in respect of their parents as children born to married couples.⁴³

ADOPTED CHILDREN

The legal concept of adoption was introduced in Victoria in 1928,⁴⁴ at a time when society was intolerant of exnuptial births and neither contraception nor abortions were widely available. It was expected that unmarried mothers would relinquish their children to be cared for by others, often by childless married couples. Informal adoption arrangements existed prior to the introduction of this legislation but parliament believed it was necessary to formalise the process to protect all parties involved.⁴⁵ Adoption was the legal and formal means of transferring parental status from the child's birth parents to the people who would care for the child.

An adoption order extinguishes the legal parentage of a child's birth parents and confers parental status on the adoptive parents.⁴⁶ This means that the adoptive parents assume all the obligations and responsibilities of caring for a child, and provides the child with the full range of legal rights and entitlements in respect of their adoptive parents.

An adoption order made under the *Adoption Act 1984* is recognised for the purposes of the Family Law Act⁴⁷ and the Child Support (Assessment) Act.⁴⁸ It also entitles the adoptive parents to be registered as parents on the child's birth certificate.

DONOR-CONCEIVED CHILDREN

Heterosexual Couples

With the advent of IVF and the increased use of donated gametes to conceive children, the *Status of Children Act 1974* was amended to clarify the legal status of donor-conceived children. A married or heterosexual de facto couple who have a child through ART are recognised as the legal parents of the child, even if the child was conceived with the use of donor sperm or eggs.⁴⁹ The person who donated the sperm or eggs is presumed not to be a parent of the child.⁵⁰

The allocation of parental status to a child's 'social parent' is achieved through a statutory presumption or deeming provision. Presumptions and deeming provisions in legislation alter a person's legal status without the need to undergo any formal legal process. The Status of Children Act states that where a married woman becomes pregnant as a result of artificial insemination, her husband 'shall be presumed, for all purposes, to have caused the pregnancy and to be the father of any child born as a result of the pregnancy'.⁵¹ The sperm donor 'shall, for all purposes, be presumed not to have caused the pregnancy and not to be the father of any child born as a result of the pregnancy'.⁵² Similar provisions apply if a pregnancy is achieved as a result of the implantation of an embryo formed with donated sperm or eggs.

These presumptions are recognised for the purposes of the Family Law Act⁵³ and Child Support (Assessment) Act⁵⁴ and entitle the non-biological parent to be registered as a parent on the child's birth certificate.⁵⁵ This means that the non-biological parent is subject to all the legal obligations of caring for the child; having consented to the treatment as a result of which the child was conceived, he or she cannot avoid caring or providing for the child because of the absence of any biological relationship.

- 25 *Classification (Publications, Films and Computer Games) (Enforcement) Act 1995* s 10; *Firearms Act 1996* ss 20(c), 58A(2)(c); *Liquor Control Reform Act 1998* ss 119(5)(a), 123(2)(a), 123(2)(f)(ii); *Child Employment Act 2003* ss 9(2), 11(2). A parent is also deemed to be the owner of a pet owned by a child for the purposes of the *Domestic (Feral and Nuisance) Animals Act 1994* s 4.
- 26 *Education Act 1958* s 53; *Community Services Act 1970* s 74C.
- 27 *Health Act 1958* s 144(1).
- 28 *Human Tissue Act 1982* s 15(1).
- 29 *Marriage Act 1958* ss 135(3), (4), (5).
- 30 *Crimes (Family Violence) Act 1987* s 7(1)(c)(ii); *Equal Opportunity Act 1995* s 104(1)(c)(ii); *County Court Act 1958* s 39A(1).
- 31 *Adoption Act 1984* s 33; *Community Services Act 1970* s 13A; *Children and Young Persons Act 1989* ss 23, 76.
- 32 *Children and Young Persons Act 1989* ss 18(1)(a)(ii), 18(1)(c)(ii), 23(1); *Human Services (Complex Needs) Act 2003* s 24(2), 26, 28.
- 33 *Crimes Act 1958* s 464E(1)(a); *Major Crime (Investigative Powers) Act 2004* ss 34(4), 83(5), 113(5); *Sports Drug Testing Act 1995* s 11.
- 34 *Sale of Land Act 1962* ss 33(6), 33(7); *Estate Agents Act 1980* s 55(8); *Meat Industry Act 1993* s 16; *Gambling Regulation Act 2003* ss 1.4, 7.7.4.
- 35 Birth registration and certificates are discussed in further detail in Chapter 14.
- 36 Geoff Monahan and Lisa Young, *Family Law in Australia* (6th ed, 2006) [6.7]; *Re B v J* (1996) 21 Fam LR 186; *Tobin v Tobin* (1999) 24 Fam LR 635; *ND v BM* (Unreported, Family Court of Australia, Kay J, 23 May 2003); *Re Mark* (2003) 31 Fam LR 162.
- 37 *Family Law Act 1975* (Cth) s 69P.
- 38 *Family Law Act 1975* (Cth) s 69Q.
- 39 *Family Law Act 1975* (Cth) s 69R.
- 40 *Family Law Act 1975* (Cth) s 69S.
- 41 *Family Law Act 1975* (Cth) s 69T.
- 42 *Family Law Act 1975* (Cth) s 69U.
- 43 *Status of Children Act 1974* s 3.
- 44 *Adoption of Children Act 1928*.
- 45 See Department of Human Services, *Adoption and Permanent Care Information Kit* <www.office-for-children.vic.gov.au> at 22 January 2007.
- 46 *Adoption Act 1984* s 53.
- 47 *Family Law Act 1975* (Cth) s 60F.
- 48 *Child Support (Assessment) Act 1989* (Cth) s 5(a).
- 49 *Status of Children Act 1974* ss 10C(2)(a), 10D(2)(a),(c), 10E(2)(a),(c),(e).
- 50 *Status of Children Act 1974* ss 10C(2)(b), 10D(2)(b),(d), 10E(2)(b),(d),(f).
- 51 *Status of Children Act 1974* s 10C(2)(a).
- 52 *Status of Children Act 1974* s 10C(2)(b).
- 53 *Family Law Act 1975* (Cth) s 60H(1).
- 54 *Child Support (Assessment) Act 1989* (Cth) s 5(b).
- 55 *Births, Deaths and Marriages Registration Act 1996* s 16(1)(f).



Women Without Male Partners

The position of a child born as a result of a sperm donation to a woman without a male partner is different to that of a child born to a heterosexual couple in a number of respects. First, whereas both state and federal law recognise a male partner of the child's mother as a parent of the child—even if he is not genetically related to the child—the law does not recognise a female partner of the birth mother as a parent. A female partner of a birth mother is therefore unable to be registered as a parent on the child's birth certificate. She also will not be liable to pay child support if she and the birth mother separate and she no longer has day-to-day care of the child.

Second, whereas the parental status of the donor is fully extinguished for a donor-conceived child born to a heterosexual couple, the status of a donor whose sperm is used by a woman without a male partner is less clear. The Status of Children Act provides that a man who donates sperm to artificially inseminate a woman without a male partner 'has no rights and incurs no liabilities in respect of a child born as a result of a pregnancy occurring by reason of the use of that semen'.⁵⁶ The Act does not declare that the donor is not the parent of the child. The rationale behind the difference in approach in the legislation was the result of opposition to the use of ART by women without male partners⁵⁷ and concern that a child should have a 'legal father'. The statement that the donor has no rights and incurs no liabilities applies for the purposes of Victorian law. There is divided judicial opinion on whether a donor is a parent or has rights and liabilities for the purposes of the Family Law Act; this is a question which turns on the interpretation of section 60H of the Act. We will discuss this further in Chapter 13.

SOCIAL PARENTS

Children who are cared for by people who are not their legal parents are not entirely without legal protection. In some cases, social parents (such as step-parents, foster carers or a parent's same-sex partner) obtain some legal recognition of their relationship with the child by applying for a parenting order from the Family Court or, in the case of foster carers, obtaining a short-term or permanent care order from the Children's Court.⁵⁸ Such orders are generally for specific purposes and expire when the child is 18 years old. Parenting and permanent care orders do not carry all the powers and responsibilities imposed on legal parents by the common law and federal and state legislation.

However, some of the specific statutory obligations and powers which are conferred on legal parents are extended to social parents. This may be because the definition of parent or relative in a particular Act is broad, or because it stipulates a series of other people to whom the particular provision applies. For example, responsibility may also fall on a 'guardian', a 'person acting as the child's parent', a 'nominated person', 'a foster parent', an 'independent person', or 'a person who has day-to-day care and control of a child and with whom the child ordinarily resides'.⁵⁹

In 2001, the Victorian government introduced legislation to recognise the rights and obligations of partners in same-sex relationships.⁶⁰ The legislation amended provisions in statutes regulating property-related benefits, compensation schemes, superannuation schemes, health law, criminal law, consumer and business activities, guardianship and child protection. As a result of these amendments, several Acts now include the 'domestic partner' of the parent of a child in the definition of 'parent'. A domestic partner is a person who lives with another person as a couple on a genuine domestic basis, irrespective of gender.⁶¹

As a result of these amendments, in some instances the obligations and powers of legal parents have been extended to same-sex partners. For example, in the *Children and Young Persons Act 1989* the definition of a parent includes the domestic partner of the child's mother or father.⁶² Under this Act, a protection order may be made in favour of a child if his or her parents have failed or are unlikely to protect the child from physical, sexual or psychological harm.⁶³ The amendments to the *Witness Protection Act 1991* also extend the protection offered by that legislation to the children of a person's same-sex partner. The Witness Protection Act, which facilitates the security of witnesses in criminal proceedings, also contains provisions to protect the safety of a member of the family of a witness.⁶⁴ For the purposes of this Act, 'member of the family' of a witness includes 'a child of the witness or of the witness's spouse or domestic partner'.⁶⁵

In some cases, these provisions are not intended to protect children but rather have other public policy objectives. For example, the *Gambling Regulation Act 2003* regulates gambling in Victoria and aims to ensure it is conducted honestly and that the management of licensed venues is free from criminal influence. To this end, people wishing to operate gambling venues

must apply for a licence. If they or any relative of theirs is found not to be of good repute, the application will be rejected.⁶⁶ The Act defines a 'relative' of a person as:

- (a) *the spouse or domestic partner of the person;*
- (b) *a parent, son, daughter, brother or sister of the person; or*
- (c) *a parent, son, daughter, brother or sister of the spouse or domestic partner of the person.*⁶⁷

These definitions suggest that parliament has already perceived the need to recognise and respond to the diversity of relationships, including parenting arrangements, for a range of specific purposes. The law does not, however, go so far as to give full legal parental status to social parents such as the female partner of a child's birth mother. This may expose a child to significant gaps in his or her legal entitlements.

OPPOSITION TO TRANSFER OF LEGAL PARENTAGE

The commission received a number of submissions from people who object to the transfer of parental status from the genetic or biological parent of a child to a person who is not biologically related to the child. These objections are based on beliefs about the social and emotional consequences of the practices which give rise to the transfer of legal parentage, and can be summarised as follows:

- a child's genetic parents should be recognised as his or her legal parents
- to declare that a person with no genetic connection is a child's parent is to perpetuate a legal fiction or lie
- perpetuating a legal fiction is likely to cause a child grief and confusion associated with the loss of a relationship with his or her genetic parents, particularly if the social or legal parents conceal the truth about the child's genetic origins
- children have the right to grow up knowing both their genetic parents.

Many of the submissions to the commission which put these arguments were made by people, both parents and children, who have direct experience of donor conception and adoption. Past policies and practices in adoption, donor conception and child welfare have led to significant and enduring distress for many of the people involved.

ADOPTION EXPERIENCES

We received some very moving submissions from mothers who gave up their babies for adoption in the 1950s and 60s under duress and without proper consent.⁶⁸ These women, who were subject to the social disapproval of unmarried mothers prevalent at the time, continue to grieve deeply about being separated from their children, even if they have subsequently been able to establish a relationship with them. As one submission explained:

*Every child deserves to know his or her origins and many feel rejected, that their mothers did not love them or want them, despite so many women spending the rest of their lives in sometimes secret despair. Forever wondering if their child was still alive, was happy, and living the life she had been told she owed her child, that she supposedly could not provide herself, but which could have been, had she received the assistance, although meagre, available to her, a much more valuable and viable alternative than the cruel, unnatural alternative: the separation from, the unknown whereabouts of, and the loss of her child! These feelings were compounded by the false and misleading birth certificate issued to the adopters: 'as if born to them'—completely concealing the truth of the child's origins! Adoptees often had a totally comprehensible reaction to the feelings of abandonment by their own flesh and blood —IF they were ever told of their adoption!*⁶⁹

The community is now much more aware of the effects that past adoption practices have had on children who were not told they were adopted and who experienced grief, anger, confusion and a sense of betrayal when they discovered the truth of their origins.

Adoption law and practice was modified substantially during the 1970s and 1980s. The community no longer expects single mothers to relinquish their babies and very few babies are now given up for adoption. A child cannot be adopted unless rigorous legislative requirements have been met to obtain the consent of the child's parents.⁷⁰ Parents are encouraged to explore a range of options for the care of the child.⁷¹ If adoption is chosen, open adoption arrangements are encouraged so the child and birth parents may, where appropriate, have an ongoing relationship⁷² and all parties involved are able to access information about each other.⁷³ The principal feature of adoption law which remains is the transfer of legal parentage from the birth parents to the adoptive parents.

- 56 *Status of Children Act 1974* s 10F(1). The Act is silent on the status of a donor whose sperm is used to create an embryo which is then implanted into the body of a woman who does not have a male partner.
- 57 Victoria, *Parliamentary Debates*, Legislative Assembly, 18 April 1984 (Mr T Roper, Minister for Health).
- 58 Permanent care orders are discussed in further detail in Chapter 10.
- 59 The definition of a 'parent' in the *Health Act 1958* includes a step-parent, an adoptive parent, a foster parent, a guardian and a person who has day-to-day care and control of a child and with whom the child ordinarily resides: s 3. The *Victims of Crime Assistance Act 1996* defines a 'parent' as '(a) a biological parent of the child; (b) a step-parent of the child; (c) an adoptive parent of the child; (d) a foster parent of the child; (e) a guardian of the child; (f) a person who has responsibility for the care, welfare and development of the child': s 3.
- 60 *Statute Law Amendment (Relationships) Act 2001*; *Statute Law Further Amendment (Relationships) Act 2001*.
- 61 For example, the *Land Act 1958* was amended to include the definition: "'domestic partner" of a person means a person to whom the person is not married, but with whom the person is living as a couple on a genuine domestic basis (irrespective of gender)': s 3(1).
- 62 *Children and Young Persons Act 1989* s 63.
- 63 *Children and Young Persons Act 1989* s 63.
- 64 *Witness Protection Act 1991* ss 3A, 3C, 5.
- 65 *Witness Protection Act 1991* s 3.
- 66 *Gambling Regulation Act 2003* s 3.4.1.1.
- 67 *Gambling Regulation Act 2003* s 1.4(3).
- 68 Most of these women are members of the support group Adoption Origins Victoria Inc.
- 69 Submission CP 172 (Barbara Maison).
- 70 *Adoption Act 1984* pt 2, div 3.
- 71 Department of Human Services, *Legal Options for Permanent Care* (2003) <www.office-for-children.vic.gov.au> at 22 January 2007.
- 72 Department of Human Services, above n 45, 80–4.
- 73 *Adoption Act 1984* pt 6.



'... if I had the chance to write a letter to my donor I would really just be wanting to say thank you for whatever reasons he felt compelled to donate, it's irrespective. I got to be born into a family that love me and they care for me and I love them too, so that is a gift.'

DONOR-CONCEPTION EXPERIENCES

Our consultation process has also revealed that some young adults who were conceived with donated gametes have experienced similar reactions to those experienced by adopted people when they find out how they were conceived. These people are often angry and hurt that they were not told the truth about their genetic origins until later in life, and experience grief about the absence of a relationship with or information about their donor and extended genetic family. Unless the donor has provided information to the Infertility Treatment Authority's (ITA) voluntary register or consented to the release of his identity, people conceived using gametes donated before 1998 have no way of identifying their donor (or their genetic siblings) and feel extremely frustrated as a result. They may also be troubled by the clinical and 'manufactured' nature of their conception.⁷⁴

One donor-conceived person who wrote to us raised specific concerns she has about the legal and social denial of the significance of genetic connection:

Whilst we can only use 'donor', to describe the men and women donating their gametes, it's important to recognise that the term very effectively removes any implication of parental responsibility or kinship. Men and women donating their sperm and eggs are doing so in full knowledge that a child may be conceived via them. This participation I believe entails an automatic presumption of parentage and so therefore these people are mothers and fathers, even if they do not play a daily role in their genetic child's life. The term donor disrespects and devalues the importance of the connection between the genetic parent(s) and their offspring, supporting the popular rhetoric within this industry that the loss of genetic relationships can be sufficiently replaced by 'good parenting' and care provided by the recipient parents.⁷⁵

This young woman's experience has led to the conviction that donor conception can never be in the best interests of the child:

Donor Conception in any form is problematic and fundamentally flawed, an ethical nightmare that still does not, and cannot, satisfactorily address the best interests of the people it creates. The very nature of what it requires makes such an achievement impossible. The recipient parent's joy in creating a family is as a direct

result of the donor conceived person's immediate loss of family. Even the 'open' system of donation facilitates an expected loss of 18 years or more, people die, separate, divorce, migrate. You can't ensure a relationship between the genetic parent and offspring, you certainly can't ensure that it will be caring and meaningful.⁷⁶

Not all donor-conceived people respond to the knowledge of their origins in this way. Several young adults who have appeared in the media have described being at ease about their method of conception, albeit angry about being denied access to information about their donors. Appearing on the *Insight* program on SBS Television, Kirsty Taifolis, who cannot access medical information about her donor, said:

Most of the time I'm quite happy with my situation at the moment but yeah, I guess in the back of your mind there's always that gnawing little 'Who am I?'... I think that right now, even though I don't feel a need to find out who my donor was, even if I don't want to know, I still have a right to know. I guess it's become even more prominent to me since mum had breast cancer, like that information could save my life.⁷⁷

Another young donor-conceived adult, Geraldine Hewitt, has said of her donor:

if I had the chance to write a letter to my donor I would really just be wanting to say thank you for whatever reasons he felt compelled to donate, it's irrespective. I got to be born into a family that love me and they care for me and I love them too, so that is a gift.⁷⁸

She has also spoken of her wish for information about her donor:

I think it's important in developing a complete puzzle of myself, having a fuller identity, a fuller sense of self being able to place myself within the greater context of history in a sense. I also think that medical history is something that cannot be ignored. There are times where I forget that I'm donor conceived, but every time I go into a doctor's surgery it's something that I can't ignore.⁷⁹

An important factor which underlies these stories is that in each case the person's parents chose to tell their child about their origins at a young age.

I understand that [other] experiences have often been a lot more traumatic

than mine. They've often found out at an older age than when I was told about my conception. I was only five. I accepted it and incorporated it into my sense of self. It wasn't a life-shattering moment.⁸⁰

As discussed in Chapter 2, there is emerging research about outcomes for people conceived with donated gametes. To date, much of this research has concentrated on the wellbeing of children born through ART and the quality of the parent-child relationship. These studies suggest that donor-conceived children are functioning well, although there are clearly some negative outcomes which can be attributed to the non-disclosure of donor status and the effects of social stigmatisation.⁸¹ One international study of 16 adults from the UK, USA, Canada and Australia conceived with donated gametes found that although participants experienced disclosure in different ways, there were 'negative and ongoing effects of withholding secrets'.⁸² A more recent study compared families who tell their children they have been donor-conceived to families who decide not to disclose. All families were functioning well, however, the research indicated that families who had disclosed to children that they were conceived with the assistance of donors had more positive child-parent relationships.⁸³

There is evidence that many, if not most, heterosexual parents do not intend to tell their children that they were conceived using donated gametes.⁸⁴ In Chapter 15 we discuss the importance of openness and honesty in donor-conceived families and of giving children access to information about their genetic origins. The issue of non-disclosure is generally not as problematic for children of same-sex couples or single mothers as it is for those whose parents are a heterosexual couple.⁸⁵

The significance donor-conceived people attach to their donors and the absence of genetic connection with their parents has not been the subject of much research. However, a study conducted by Dr Maggie Kirkman with 87 participants, including recipient parents, donors and offspring, found that it is impossible to generalise about the comparative value of genetic connection and parental relationships.⁸⁶

The three main characters in the story of donor-assisted conception—donors, parents, and offspring—interpret the meaning of genes and relationships from different perspectives and bring different emphases to their accounts. Donors give away some of their genetic material;

participants in this research take interest in its fate but explain families with an emphasis on relationships. Recipient parents are compelled to acknowledge the significance of genes through their need for donors; they, too, stress relationships, although many cannot entirely eradicate the pain of losing genetic connection with their children. The little information we have of donor-conceived people arises solely from those who know of their origin. Those who discover it as adults may find their relationships overwhelmed by their sense of genetic lack and the disruption to their narrative identity. Those who have known from childhood are too few for generalisations to be made.⁸⁷

An important conclusion to be drawn from this analysis is that there is no defining divergence or conflict among the attitudes of the three central characters. Donors and parents want to minimise harm to donor-conceived people; all three define optimum outcomes as somehow combining the significance of relationships and genes in dynamic balance. Exactly how that may be brought about will vary not only according to their relative meaning within the family, but also according to local political, legislative, and cultural factors that this research has not specifically investigated.⁸⁸

TRADITIONAL FAMILIES

The commission also received submissions from people who strongly believe that children should be born into families where they have a mother and a father to whom they are genetically related.⁸⁹ Some of these submissions argued that same-sex partners should not be recognised as legal parents because to do so 'normalises homosexuality and is a step closer to legalising marriage of same-sex couples'.⁹⁰

The commission does not share these views. Our review of the law which applies to children born to same-sex couples has first and foremost been informed and directed by a consideration of the best interests of the children. It is important to remember that children are already living in diverse families, and will continue to do so, regardless of whether the law recognises these relationships. The law can, however, address the practical and legal disadvantages experienced by children who are part of non-traditional families. The commission also believes that the law can play a significant role in promoting tolerance and respect by recognising the diversity of family relationships and structures in the community.

74 These experiences were described in submissions from members of the group TangledWebs.

75 Submission CP 60 (Confidential submission, permission to quote granted on 5 July 2004).

76 Ibid.

77 SBS TV, 'Making Babies', *Insight*, 30 May 2006, transcript available from <www.sbs.com.au/insight> at 6 September 2006.

78 ABC TV, 'Secrets of the Fathers', *Four Corners*, 24 October 2005, transcript of interview with Geraldine Hewitt available from <www.abc.net.au/4corners> at 2 March 2007.

79 Ibid.

80 Ibid.

81 See Chapter 2 and Appendix 1, Table 2.

82 A J Turner and A Coyle, 'What Does it Mean to be a Donor Offspring? The Identity Experiences of Adults Conceived by Donor Insemination and the Implications for Counselling and Therapy' (2000) 15(9) *Human Reproduction* 2041, 2049.

83 Emma Lycett et al, 'Offspring Created as a Result of Donor Insemination: A Study of Family Relationships, Child Adjustment and Disclosure' (2004) 82(1) *Fertility and Sterility* 177-8; Emma Lycett et al, 'School-aged Children of Donor Insemination: A Study of Parents' Disclosure Patterns' (2005) 20(3) *Human Reproduction* 810, 810, 817.

84 Reviews of this research include Infertility Treatment Authority, *Donor Conception: Parents Disclosing Donor Conception to their Children: What Does the Literature Tell Us?* (2006); Anne Brewaeys et al, 'Donor Insemination: Dutch Parents' Opinions About Confidentiality and Donor Anonymity and the Emotional Adjustment of their Children', (1997) 12(7) *Human Reproduction* 1591, 1593. See further discussion in Chapter 15.

85 See Katrien Vanfraussen et al, 'An Attempt to Reconstruct Children's Donor Concept: A Comparison Between Children's and Lesbian Parents' Attitudes Towards Donor Anonymity' (2001) 16(9) *Human Reproduction* 2019; J E Scheib et al, 'Choosing Identity-Release Sperm Donors in the Parents' Perspective 13-18 Years Later' (2003) 18(5) *Human Reproduction* 1115; J E Scheib et al, 'Adolescents with Open-Identity Sperm Donors: Reports from 12-17 Year Olds' (2005) 20(1) *Human Reproduction* 239; Clare Murray and Susan Golombok, 'Going it Alone: Solo Mothers and Their Infants Conceived by Donor Insemination' (2005) 75(2) *American Journal of Orthopsychiatry* 242.

86 Maggie Kirkman, 'Genetic Connection and Relationships in Narratives of Donor-Assisted Conception' (2004) 2 *Australian Journal of Emerging Technologies and Society* 16, 16-7.

87 Ibid 14.

88 Ibid 16.

89 These submissions are discussed in further detail in Chapter 2 and Chapter 12.

90 Submission CP 120 (Dorothy Brown).



GUIDING PRINCIPLES

The question for the commission is whether the law which governs the legal parentage of children born to single women or women in same-sex relationships is in need of reform, particularly if eligibility criteria for access to ART are expanded. The commission was guided in its consideration of this question by the following principles.

- In considering the law which determines who is to be recognised as a legal parent of a child, the best interests of the child should be the paramount consideration. This is consistent with the *Convention on the Rights of the Child*.⁹¹
- All children, without discrimination, have the right to legal protection of the specific needs and interests which they have because they are children. This is consistent with the *Charter of Human Rights and Responsibilities Act 2006*.
- It is in the best interests of children that they have certainty about the legal status of their parents. Certainty about parental status at the earliest possible time minimises the potential for disputes and litigation about a person's obligations and status in respect of the child, and promotes stability in the child's life.
- It is in the best interests of children for their parents to be subject to all the usual parental obligations and responsibilities.
- It is in the public interest for people who become parents to be subject to all the laws which flow from the parent-child relationship.
- It is important for people to appreciate the responsibilities which accompany parenthood, in particular the needs of donor-conceived children, and to plan their arrangements before the child is born.
- The law should aim to eliminate discrimination against children and parents based on their family type and relationship status. Legal recognition of diverse family types is an important way of countering discrimination.

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

Chapter 12

Recognising Non-birth Mothers



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Chapter 12

Recognising Non-birth Mothers



'... the REAL MOTHER is the one who wakes in the night to change sheets, who comforts our child when she is sick, who contributes her entire wage to the support of our family, who teaches our child about her ancestors and who still loves her after a tantrum in public. Our child is fortunate because she has TWO REAL MOTHERS.'

During our consultations we heard from many people who have had, or are planning to have, children using different types of ART: heterosexual couples, single women with different sexual orientations, same-sex couples (both male and female), women who were single at the time of conception or birth and have subsequently entered into a relationship, and groups of people such as two couples or a couple and a third person. Lesbian couples were the most prominent family type we encountered in our consultations. Of particular concern to these couples was the failure of the law to recognise the relationship between the child and the partner of the woman who gives birth.

A woman who gives birth to a child (the birth mother) is automatically recognised as the child's legal parent, irrespective of her sexuality or relationship status.¹ If she has a female partner (the non-birth mother), that woman is not recognised as the child's legal parent. In this chapter we consider whether the non-birth mother should be recognised as a legal parent of the child, and if so, how this should be achieved.

Statistics derived from the 2001 Australian Census indicate that nearly 17% of lesbian couples have a child living with them.² In some cases the child was born while the mother was in a previous heterosexual relationship. However, an increasing number of lesbian couples are choosing to have children in the context of their relationship.³ The 2005 'Private Lives' survey of 5476 gay, lesbian, bisexual, transgender and intersex people found that 25.6% of the women surveyed had children and 51% of women currently without children indicated they would like to have them in the future.⁴

It is impossible to quantify the number of same-sex couples with children in Victoria. A survey conducted by the Victorian Gay and Lesbian Rights Lobby in 2001 found that 63% of the 670 participants (both male and female) aged under 30 wanted children, usually with their partners.⁵

The commission received a significant number of submissions from and on behalf of Victorian women who have had or are planning to have children with their female partners. The submissions provided detailed personal accounts of couples' decisions to have children, the planning which follows, and the arrangements made to care for the children. A key point made in these submissions was that lesbian couples consider themselves to be equal parents and share financial and other responsibilities in caring for children.⁶

I have co-parented them from their birth and been involved in every aspect of their development and growth. I have changed countless nappies, given and received thousands of cuddles and kisses and watched with pride as my beautiful boys develop into happy, healthy, well-balanced young men. Yet I have no legal rights. I am not recognised on their birth certificates, could not be listed as a parent at their kindergarten or school, could not sign a permission form for one of them to receive an emergency operation, and so it goes on.⁷

It saddens me to hear ignorant people asking 'but who's the real mother' they would never ask that of an adopted child. I always answer that the REAL MOTHER is the one who wakes in the night to change sheets, who comforts our child when she is sick, who contributes her entire wage to the support of our family, who teaches our child about her ancestors and who still loves her after a tantrum in public. Our child is fortunate because she has TWO REAL MOTHERS.⁸

This is supported by research about lesbian-parented families.⁹ For example, one study reported that '[t]he fact that the social mother is not biologically linked to the child does not prevent her from taking equal responsibility toward the children she parents'.¹⁰

CURRENT LAW

As explained in Chapter 11, when a child is born to a woman who is in a de facto lesbian relationship, the relationship between the child and the birth mother's female partner is not recognised by the law. By contrast, when a child is conceived through the use of donor sperm by a woman who is married or in a de facto heterosexual relationship, the woman's husband or partner is presumed to be the father of the child for the purposes of Victorian law¹¹ and federal law,¹² and he is entitled to be registered as the father of the child on the register of births.¹³

It is possible for the non-birth mother to take steps to create limited legal obligations in respect of the child. For example, the Family Court may make a parenting order to recognise her parental role in the child's life.¹⁴ It is also possible for the non-birth mother to make a will leaving all or part of her estate to the child and for the birth mother to make a will appointing her partner as the child's guardian should she die. As noted in Chapter 11, the provisions of some specific pieces of legislation relating to the parent-child relationship will also apply to the non-birth mother.

PROBLEMS WITH THE LAW

The commission has identified a number of problems with the failure of the law to recognise the full parental role of the non-birth mother. Principally, it has important implications for children: it affects their rights to child support and inheritance, as well as their legal relationship with the extended family of the non-birth mother. It also has implications for parents and the community generally.

LEGAL IMPLICATIONS

Legal parental status is of particular significance if a child's parents separate. Recent amendments to the Family Law Act prioritise the concept of equal shared parental responsibility, and the potential for the child to spend equal (or

substantial and significant) time with each parent following separation, if this would be in the best interests of the child. A primary consideration in determining what is in a child's best interests is the benefit to the child of having a meaningful relationship with both parents.¹⁵

In determining an application for parenting time made by a person who is not recognised as a legal parent, the Family Court would not be obliged to apply a presumption of equal shared parental responsibility, or to give priority to the consideration of an ongoing meaningful relationship with that person. Instead, the court would take into account other considerations.¹⁶ In this way, an application by a non-birth mother for parenting time with the child may not be determined in the same way as a similar application made by a person who is recognised as a legal parent.

Parenting orders granted by the Family Court do not confer the full range of parental obligations and powers on the person in whose favour they are made and do not require a person to be recorded on the child's birth certificate.

If the child's mother and partner separate, the partner is under no legal obligation to pay child support because she is not recognised as a parent under the *Child Support (Assessment) Act 1989*. This may seriously disadvantage the child.¹⁷

If parents die without leaving a will, their children are, under certain circumstances, entitled to a share of the estate.¹⁸ However, because a non-birth mother is not recognised as a parent for the purposes of the *Administration and Probate Act 1958*, if she dies without making a will, the child will not automatically be entitled to a share of her estate.¹⁹ If the non-birth mother's parents wish to leave part of their estate to the child and make a will to benefit their grandchild, the bequest will not be effective because the relationship is not legally recognised. A bequest which names the child would, however, be effective.

- 1 Although, it is important to note that in *Re Mark* (2003) 31 Fam LR 162 at 167–8, Brown J suggested that one interpretation of s 60H of the *Family Law Act* may lead to the birth mother not being recognised for the purposes of that Act. Justice Brown refers to the reasoning of Forgy J in *Re B and J* (1996) 21 Fam LR 186 and Guest J in *Re Patrick: An application concerning contact* (2002) 28 Fam LR 579 on this point.
- 2 David de Vaus, *Diversity and Change in Australian Families: Statistical Profiles* (2004) 84. For further breakdown of this figure see Australian Bureau of Statistics, *Year Book Australia 2005*, Catalogue No 1301.0 (2005), Same-sex couple families, 142–44.
- 3 See Jenni Millbank, 'Recognition of Lesbian and Gay Families in Australian Law—Part Two: Children' (2006) 34 *Federal Law Review* 205, 207.
- 4 Australian Research Centre in Sex, Health and Society, La Trobe University, *Private Lives: a Report on the Health and Wellbeing of LGBTI Australians* (2006) 36.
- 5 Ruth McNair et al, 'Lesbian Parenting: Issues, Strengths and Challenges' (2002) 63 *Family Matters* 40, 43.
- 6 Ruth McNair, *Outcomes for Children Born of A.R.T. in a Diverse Range of Families* (2004) 59; submission CP 198 (Dr Elizabeth Short).
- 7 Submission PP2 88 (Helen Thompson).
- 8 Submission PP2 87 (Anonymous).
- 9 Victorian Gay and Lesbian Rights Lobby, *Everyday Experiments, Report of a Survey into Same-Sex Domestic Partnerships in Victoria* (2001) 14; see also Appendix 1, Table 1.
- 10 Katrien Vanfraussen et al, 'Family Functioning in Lesbian Families Created by Donor Insemination' (2003) 73(1) *American Journal of Orthopsychiatry* 78, 89.
- 11 *Status of Children Act 1974* ss 10C(2)(a), 10D(2)(a).
- 12 *Family Law Act 1975* (Cth) s 60H(1); *Child Support (Assessment Act) 1989* (Cth) s 5(b).
- 13 *Births, Deaths and Marriages Registration Act 1996* s 16(1)(f).
- 14 Under s 65G of the *Family Law Act 1975* (Cth). See *Re J and M* (2004) 32 Fam LR 668. At the Melbourne and Dandenong registries of the Family Court, an artificial conception consent procedure is available to simplify this application.
- 15 *Family Law Act 1975* (Cth) s 60CC(2).
- 16 A primary consideration is the need to protect a child from harm: *Family Law Act 1975* (Cth) s 60CC(2). Additional considerations are outlined in s 60CC(3)–(4), including the views expressed by the child, the nature of the relationship with the child, and the likely effect of any changes in circumstances.
- 17 If the couple have made an explicit agreement that the partner will financially support the child, this agreement will probably be enforceable, either as a contract or under the equitable doctrine of estoppel: see *W v G* (1996) 20 Fam LR 49. It may also be possible for the Family Court to order the non-birth mother to pay child maintenance under s 66E of the *Family Law Act 1975* (Cth), but it would need to find that she was a parent for the purposes of that Act.
- 18 *Administration and Probate Act 1958* s 52(f).
- 19 The child may, however, have a claim for family provision under the *Administration and Probate Act 1958* pt IV.

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Chapter 12

Recognising Non-birth Mothers



'... obtaining the court order was very stressful and involved some cost. It should not be necessary for me to go to court to have my relationship to my son recognised. Further, the parenting order did nothing to recognise P's relationship with his extended family, particularly his grandparents (my parents) with whom he has a very close relationship.'

The *Marriage Act 1958* makes provision for the guardianship of children if one or both of their parents die.²⁰ If a child's mother dies, the father is deemed to be the child's guardian. If a child's father dies, the mother is deemed to be the child's guardian. The parents can appoint a person, by deed or will, to be the guardian of the child if they die. In lesbian parent families, if the birth mother of the child dies and she has not appointed the non-birth mother as the guardian of the child, the non-birth mother is not recognised as having any status in relation to the child unless she obtains a parenting order from the Family Court. In such circumstances the child would be left in what has been described as a 'legal vacuum'.²¹

The various statutory compensation schemes which operate in Victoria make provision for benefits to be paid to a child if a parent dies in a workplace or transport accident. If the non-birth mother dies in an accident, the child will not automatically be entitled to compensation, but will be required to prove that he or she was economically dependent on the deceased's earnings.

As discussed in Chapter 11, there is a detailed set of legal obligations and entitlements which arise out of the parent-child relationship. Most of these obligations and entitlements are intended to protect children and ensure they are adequately cared for. However, some of these laws have other policy objectives. For example, a legislative provision may require a person to disclose any interests of his or her relatives or family members, including parents and children, or may rely on the existence or non-existence of a prescribed relationship such as a parent-child relationship. Because the relationship between a non-birth mother and a child is often not recognised under this legislation, the policy objectives underpinning these laws may be compromised.

PRACTICAL IMPLICATIONS

We received many submissions from women who described the practical consequences for them and their children of the absence of legal recognition of non-birth mothers. These submissions reported that they often encounter obstacles and ignorance, and at times hostility, in their dealings with government agencies

and service providers where legal status is a relevant factor. Because a non-birth mother cannot be named as a parent on the child's birth certificate, she is unable to produce evidence of her relationship to the child unless she has taken steps to obtain a Family Court parenting order or some form of written authority from the birth mother. These steps involve expense, effort and stress and are often inadequate for a variety of purposes. As one submission explained:

*obtaining the court order was very stressful and involved some cost. It should not be necessary for me to go to court to have my relationship to my son recognised. Further, the parenting order did nothing to recognise P's relationship with his extended family, particularly his grandparents (my parents) with whom he has a very close relationship.*²²

If she has not obtained any formal authority, the non-birth mother has no status to consent to medical treatment for the child. Some women report having experienced problems with hospital staff and doctors who have not disclosed medical information to them.²³ Some couples choose to give their child the non-birth mother's surname to avoid some of the difficulties that can arise in these situations.²⁴ In one case, related to us by a friend of the couple concerned, the non-birth mother encountered difficulties when collecting her child from school:

*Our neighbours recently recounted to us a story that so perplexed me that I have thought about it often. When their first child started school, my neighbours S and R attended the school to explain their child's family situation and to alert the school that they were both G's parents. Some months later G fell ill while at school ... When R arrived at the school to pick her sick daughter up she was confronted by a member of staff at the school unaware of G's family structure. R was asked for identification and questioned as to her relationship with G. Despite telling the school staff member that she was G's mother the fact that she and G did not share a surname and R was not considered a legal guardian made the school office reluctant to permit R to take her sick daughter out of the school.*²⁵

SOCIAL IMPLICATIONS

The commission received numerous submissions from lesbian mothers describing strong and happy families which are generally respected and supported within their communities and by health professionals, teachers and childcare workers:

*Our daughter's life is rich with loving adults and she is bright and well adjusted. Our daughter's conservative traditional school respects and includes all 4 of our daughter's parents and accommodates her family by getting her to make multiple mothers and fathers day presents. The parents at the school also include our daughter in all the activities external to school regardless of the parent who is caring for her that day. We all work hard as a family to ensure that our relationships are strong with organisations and institutions in which our daughter comes in contact.*²⁶

Similarly, the 2005 'Private Lives' survey reported relatively high levels of satisfaction with pregnancy and obstetric services.²⁷ In 66% of cases where a woman who was not in a heterosexual relationship gave birth to a child, the hospital acknowledged the woman's partner. The survey report notes that '[w]hile it is not clear how many women did not have a partner, concern must be expressed for any women who were not acknowledged as a couple at this important time of family formation'.²⁸

We also received many accounts of the social, emotional and symbolic effects on the parents and the child of the non-recognition of the non-birth mother. Non-recognition of the role and status of the non-birth mother is equivalent to non-recognition of the reality of the child's family structure. This in turn reinforces the social stigma which same-sex parents and their children experience. As one submission stated:

*The lack of legal recognition of and support for our families translates, in practice, to some people regarding our families as deficient, and problematic ... Laws that aim to discourage our families from existing or that don't recognise our families as families make it harder for or more awkward for some people to include us or interact with us and our children, and can make some people feel that they can or should treat us with a lack of respect or as though we are invisible or deficient. Clearly, this state of affairs is detrimental to us, to our children and to our broader society.*²⁹

Same-sex parents feel very strongly about their inability to obtain birth certificates for their children which name both women as parents. In addition to the practical consequences of this, many women believe it serves as a very powerful symbolic denial of the reality of their families.

Non-recognition can diminish the non-birth mother's role as a parent in the eyes of extended family members and the community. It may also cause her to feel that her role in the child's life is vulnerable, which can lead to stress and anxiety, relationship problems and disputes about contact with the child if she and the birth mother separate, or if the birth mother dies:

*A day doesn't go by when I don't think about the fact that as things stand at the moment, the legal connection I have with my son is tenuous. In the back of my mind there is a constant, nagging worry that if things all went terribly wrong, I could lose him ... I find this an appalling situation to be in, and one that is very far from protecting the best interests of my child.*³⁰

The Bouverie Centre, a state-wide clinical and research agency specialising in family approaches in mental health service provision, reported an increased incidence of lesbian parents seeking counselling due to stress and anxiety about their lack of legal status.³¹ The centre also reported situations of non-birth mothers severing all contact with the child after separating from the birth mother, which may cause significant distress to children. In other cases, non-birth mothers have been denied contact with children after separation, and have declined to proceed with Family Court proceedings, believing they have no legal standing to maintain contact with the children. We received a submission from a non-birth mother who separated from her partner, the birth mother of their 14-month-old child, and was subsequently prevented from having any contact with the child:

*My grief has been overwhelming, but more than this, my child has lost a parent to which she had a significant bond, as well as her extended family. My parents were her grandparents, my sister was her godmother (her naming day was held at my parents' house) and my family was her family. I hope that one day down the track she will be able to rediscover this. It is with this history that I strongly advocate for the role of the birth mother's partner to be legally recognised, to ensure that the children in these families are provided with stability and ongoing relationships with those significant to them.*³²

20 *Marriage Act 1958* pt VII.

21 *Re J and M* (2004) 32 Fam LR 668, 673.

22 Submission CP 93 (Anonymous).

23 Submission CP 179 (Lesbian Parents Project Group).

24 Submission CP 198 (Dr Elizabeth Short).

25 Submission PP2 36 (Mark Neeson).

26 Submission PP2 87 (Anonymous).

27 Australian Research Centre in Sex, Health and Society, La Trobe University, *Private Lives: a Report on the Health and Wellbeing of GLBTI Australians* (2006) 40.

28 *Ibid.*

29 Submission CP 179 (Lesbian Parents Project Group).

30 Submission CP 38 (Jacqueline Tomlins).

31 Submission CP 143 (The Bouverie Centre).

32 Submission CP 101 (Anonymous).

12

Chapter 12

Recognising Non-birth Mothers



'We would like to see this law changed to recognise both parents legally, because this would acknowledge and confirm the reality of their family situation, and would assist to counteract the discrimination that exists in our society towards lesbian parented families. At the same time, these changes would give us, as the non biological grandparents, the security of knowing that we can be legal grandparents, to the child that we love, support and accept into our large extended family.'

It is clearly not in the best interests of children to be detrimentally affected by instability in their parents' relationships, or to be separated from parents with whom they have established significant bonds.

Many submissions argued that legal recognition of non-birth mothers would provide children with affirmation and recognition of their family structure and would help other people to understand, recognise and respect their families. A submission made by a group of lesbian parents stated:

we feel that legal recognition of our role as parents to our children is essential for their safety and social wellbeing. It is critical to children that they have reflected back to them the value and integrity of their lives, including the legitimacy of their families ... Equal familial status sends a powerfully positive message to all social institutions that have an influence on our children's lives. It obliges them to acknowledge and respect the families our children live in.³³

RECOMMENDATIONS

NON-BIRTH MOTHER RECOGNITION

The principle which has guided the commission throughout this reference is the protection of the best interests of the child. This principle is central to the question of who should be recognised as the parents of children born to same-sex couples.

It is evident that children born to same-sex couples currently lack the full range of rights and protections that are afforded to children born to heterosexual couples. These children are legally disadvantaged as a result of the legislature's disapproval or neglect of their parents' relationship, in the same way as the law once punished children born outside marriage. This is unacceptable and is inconsistent with the *Convention on the Rights of the Child* which requires parties to 'take all appropriate measures to ensure the child is protected against all forms of discrimination or punishment on the basis of the status, activities, expressed opinions, or beliefs of the child's parents, legal guardians or family members'.³⁴

It is also evident that the law is lagging behind social and attitudinal change and is contributing to ongoing stigmatisation of children born to same-sex couples. The failure of the law to recognise the parental status of non-birth mothers does not prevent lesbian women from

having children, but it does have detrimental effects for the children in several respects. Legal recognition also serves a very important symbolic purpose.

Legal recognition of non-birth mothers is also important to the children's extended family members, such as grandparents:

We write in support of our own adopted daughter, who has been in a committed relationship with her female partner for 5 years. Her partner has recently given birth to a baby daughter. Under present laws, our daughter, as the non biological mother, has no legal rights of adoption to her daughter, even though she has made a commitment to support and love their child. We would like to see this law changed to recognise both parents legally, because this would acknowledge and confirm the reality of their family situation, and would assist to counteract the discrimination that exists in our society towards lesbian parented families. At the same time, these changes would give us, as the non biological grandparents, the security of knowing that we can be legal grandparents, to the child that we love, support and accept into our large extended family.³⁵

We are the parents of a non-birth mother in a same sex relationship and the very proud grandparents to our very beautiful Grandson. We also have a lovely and loving relationship with his birth mum, as do our daughter's siblings—what a gift our 'daughter-in-law' has given us! ... Our hope is to see our daughter accepted as a mother, to be able to adopt their son, to be given the right to see her name on his Birth Certificate, to sign legal documents, to take all a parent's responsibilities (which she already does) and be recognised for it by law.³⁶

We also received submissions from some teachers, childcare workers and others who support reform to this area of the law:

I am a school teacher who has taught students who live in diverse families, including many non-traditional groupings such as families with single-sex parents. I observe that a wide variety of non-traditional families already exists in our society, and I believe that it is incumbent upon us to grant them equal recognition and equal protection before the law.³⁷

I am a heterosexual woman who works within the education industry where I manage an after-school sport program. I come into daily contact with children and their families and over two years ago met a lesbian couple and their daughter who participate in the program. Since meeting the family I have been deeply impressed by the couple's parenting and how well adjusted and 'normal' they all are. It is with concern that I learnt of the complications they face as a lesbian couple raising a child.³⁸

I am aware that R is not H's birth mother, but that the decision she and H made to create a family was as planned, considered, desired and welcomed as the decision my husband and I made. I can see no logical reason to disadvantage R's family, and in particular their daughter H, by not legally recognising and protecting them as a family unit with the same rights as my family. It can only be in H's best interests that she has certainty about her parents' legal status, just as my children have with their parents.³⁹

The following organisations expressed support for the recognition of non-birth mothers as parents in their submissions: Victorian Biotechnology Ethics Advisory Committee, ACCESS, Law Institute of Victoria, Equal Opportunity Commission of Victoria, Victoria Legal Aid and Fertility Society of Australia (FSA), which said:

The FSA supports the recommendation that the law should recognise the birth mother's female partner as a parent of the child.

This proposal will assist in the protection of the child's legal rights and re-enforce the partner's role as an integral member of the family unit.⁴⁰

As noted in Chapter 11, some people believe that a non-birth mother's relationship with a child should not be recognised by the law. Some submissions we received in response to our interim recommendations objected to the proposal to recognise non-birth mothers as legal parents, arguing that it is more appropriate for non-biological parents to obtain parenting orders from the Family Court, which are flexible and do not involve the substitution of one parent for another, as occurs with adoption.⁴¹

Others opposed the recommendation based on their views about parenting by same-sex couples and attitudes to homosexuality in general.

These people are concerned that if laws which recognise the non-birth mother are introduced, this will condone and encourage a family type to which they are fundamentally opposed. We received numerous standard form submissions stating:

It is my firmly held belief, according to God's word (the Bible), that parents of children must be a properly married man and woman: husband and wife. Every child has the right to be born with both a father and a mother who will be actively involved in their day-to-day life (excepting unforeseen eventualities e.g. death of a parent) ... The deliberate creation of single-parent families, and the creation of same-sex parent families or multi-parent families is grossly immoral and must be totally prohibited.⁴²

The organisation Salt Shakers argued in its submission that the law should not be changed to support same-sex couples because they represent only a minority of the population. They also argued that recognition of non-birth mothers would lead to confusion for children:

There are many points of concern in recognising this parental 'right' of giving this 'status' to the birth mother's female partner. The effects of legalising lesbian parenthood clearly go beyond 'access' issues or financial benefits for the adults involved ... moving to legislate on this issue will only create more confusion and ambiguity within the law, especially in consideration of the biological father. The child is likely to have to deal with confusing issues of access, imposed upon him with the possibility of three (or more) legal parents. When relationships break down these issues will be compounded. The recognition of people as parents who do not have a biological link to the child is a retrograde step for the protection of the child.⁴³

The commission has taken these views into account, but has concluded that legal recognition of the status of non-birth mothers is vital for protecting the best interests of children. In this respect we agree with the sentiments expressed by Sarah Nichols in her submission:

One issue which seems to be of tremendous concern to those opposed to such recommendations is that to entrench

33 Submission CP 179 (Lesbian Parents Project Group).

34 Article 2. See further John Tobin, *The Convention on the Rights of the Child: The Rights and Best Interests of Children Conceived Through Assisted Reproduction* (2004) 28–34. The *Charter of Human Rights and Responsibilities Act 2006* s 17 also provides that every child has the right to protection of his or her best interests.

35 Submission PP2 34 (Peter and Catherine).

36 Submission PP2 205 (Anonymous).

37 Submission PP2 224 (Anonymous).

38 Submission CP 163 (Carol Osborn).

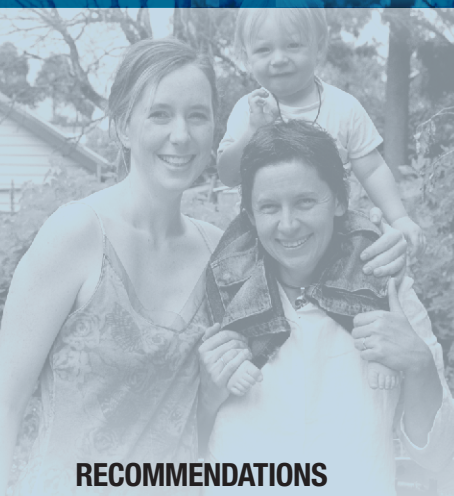
39 Submission PP2 208 (Jane Gibson).

40 Submission PP2 72 (Fertility Society of Australia).

41 Submissions PP2 58 (Helen Kane), PP2 170 (VSCAAF, Victorian Standing Committee on Adoption & Alternative Families).

42 The commission received 93 standard form submissions including this paragraph to Position Paper Two.

43 Submission PP2 189 (Salt Shakers).



RECOMMENDATIONS

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.

recognition of non-biological parents in law will be seen as support and even encouragement of same-sex relationships, gay marriage and the like. What needs to be very clearly understood is that my children already exist, and fundamentally it is their rights that are being denied. Not changing the law won't stop us forming partnerships, having families, or bearing children. What it will do is ensure that the children born into our families have the legal protection they deserve.⁴⁴

The commission therefore recommends that the status of children born to lesbian couples be brought into line with donor-conceived children born to heterosexual couples by giving legal recognition to non-birth mothers.

ADOPTION OR STATUTORY PRESUMPTION?

The commission gave detailed consideration to the most effective means to achieve legal parental status of non-birth mothers. As discussed in Chapter 11, the two principal ways in which legal parentage may be conferred on non-biological parents are the making of an adoption order and the application of a statutory presumption.⁴⁵

Some jurisdictions outside Victoria have legislated to recognise the parental status of non-birth mothers. In Western Australia and the Northern Territory, a woman who is in a de facto relationship with a woman who gives birth to a child, and who consented to the procedure by which the birth mother became pregnant, is conclusively presumed to be a parent of the child.⁴⁶ In the ACT, a woman who is the domestic partner of a woman who gives birth to a child is presumed to be a parent of the child if she consented to the procedure.⁴⁷ Western Australia, the ACT and Tasmania have all legislated to allow the same-sex partner of the parent of a child to apply to adopt the child. In Western Australia and the ACT a non-birth mother would only need to apply to adopt the child if she did not fall within the scope of the statutory presumptions in those jurisdictions, for example if she entered into a relationship with the child's birth mother after the child was born.

The Victorian provisions that presume the male partner of a woman who has a child through donor insemination to be the father of the child are recognised federally for the purposes of the Family Law Act and Child Support (Assessment) Act.⁴⁸ The Victorian provisions which relate

to the parentage of a child born to a woman without a male partner are not recognised for the purposes of federal legislation,⁴⁹ and the commission is unable to make recommendations for reforms to federal law. Creating a deeming provision which mirrors the recognition of male partners as parents would therefore not result in full federal recognition of a female partner. Such a provision would be operative for the purposes of Victorian law, but would not make non-birth mothers liable for other responsibilities such as child support.⁵⁰

For these reasons the commission initially recommended, in Position Paper Two, that non-birth mothers gain legal recognition using a new form of adoption, called deemed adoption. Under this proposal, the non-birth mother would be deemed to be the adoptive parent of the child if the child was conceived with the assistance of a licensed clinic and the couple had complied with the requirements of the laws governing access to treatment. Women conceiving outside the clinic system would be able to apply to adopt the child through a modified and abridged process.

These interim recommendations were criticised in submissions on a number of grounds, including the following:

- The proposed mechanisms would set up a system which is different from that which applies to donor-conceived children born to heterosexual couples (who have automatic recognition under the *Status of Children Act 1974*) and would therefore contradict the principle of non-discrimination, and would consequently have a negative impact on children.
- The proposed mechanisms would not have universal coverage. They would create an artificial distinction between parents based on the place of conception. Some children would be disadvantaged because of the decisions made by their parents not to conceive in a clinic and not to apply to adopt them.
- Linking parental recognition to clinic treatment would be coercive—many women will continue to conceive without the assistance of clinics, even if they become eligible to access clinic services.
- Requiring the non-birth mother to receive counselling is unnecessary and patronising; other prospective parents do not need counselling to appreciate the gravity of the decision to parent.

- Adoption is an inappropriate mechanism because it was developed for a different purpose and is now considered an option of last resort. There are complex social and psychological implications associated with past adoption practices and the harmful effects secrecy has had on many adopted people.
- There was uncertainty about whether deemed adoption would be accepted by the courts.

For example, the Lesbian Parents Project Group wrote:

The proposal for either deemed, or abridged adoption is fundamentally discriminatory because it imposes a new discriminatory regime on lesbian parents that does not apply to heterosexual parents. Further, it creates at least three categories of lesbian families, those who can 'gain' deemed adoption if they use a clinic, those who may access abridged adoption if they don't use a clinic and those who don't use a clinic and don't apply for abridged adoption.

If all children in lesbian-parented families are to benefit from legal recognition of their families, we need a simple procedure that will cover everyone, not one that may depend on: a) individuals being able to access and make sense of a relatively high level of fairly complex information; and b) individuals' willingness to initiate processes that they may find onerous, intimidating and intrusive.⁵¹

It was apparent from the submissions received in response to the interim recommendations that many people in the community would not avail themselves of the proposed mechanism, should it become available in the future. This would leave many children without the legal protections the commission was seeking to have implemented.

The commission therefore reconsidered the proposal and concluded that recognition of non-birth mothers should be by statutory presumption. This is the same mechanism that applies to heterosexual couples who have donor-conceived children. The principal factor influencing the commission's decision is the importance of extending legal protection to all children born to same-sex couples, without the need to consider their parents' decisions about the place of conception. The commission does, however, remain concerned about the limitations of this approach under federal law; these concerns are discussed below.

Statutory Presumption

The commission believes a woman should be presumed to be a parent of a child where she is the domestic partner of the child's birth mother and has consented to the treatment procedure as a result of which the child was conceived. A domestic partner is a person who lives with another person as a couple on a genuine domestic basis, irrespective of gender.⁵²

Consent is the key requirement of the presumption, as it is for the presumption that applies to heterosexual couples. In this way, if a woman becomes pregnant without the knowledge or consent of her partner, her partner will not assume the legal responsibilities of parenthood once the child is born.

If a dispute were to arise about whether the presumption applied in a particular case, the commission believes the existence of consent should be presumed, but be able to be rebutted, as is the case in Western Australia and the ACT.⁵³ If a couple has used the services of a clinic, the signed consent form required will be clear evidence that the non-birth mother has consented to the treatment procedure. If the child was conceived without clinic assistance, the evidence that the non-birth mother consented to the child's conception could be provided in different ways, including registration as a parent of the child on the register of births (see Chapter 11). The burden of proving the operation of the presumption should be on the balance of probabilities. The onus of proof may depend on who is seeking to rely on the presumption.

Our recommended provision would only apply to a woman who is in a relationship with the birth mother at the time of the procedure by which the birth mother becomes pregnant. If the birth mother is single at the time of conception and subsequently forms a relationship with a woman, either before or after the child's birth, her partner will not be recognised as a parent of the child as a consequence of the presumption. This is the same outcome for single women who enter into a relationship with a man following the conception or birth of a child conceived using ART. In such cases, if the couple agrees that the new partner will take on parenting responsibilities for the child, the only way to formalise such an arrangement is to obtain parenting orders from the Family Court. In the case of heterosexual couples, the new partner has the option of applying to adopt the child (step-parent adoption). As recommended in Chapter 10, the commission is of the view that step-parent adoption should also be available to the same-sex partner of a child's parent, to bring their options into line with those of heterosexual couples.⁵⁴

- 44 Submission PP2 204 (Sarah Nichols).
- 45 There may be other mechanisms available. For example, in Canada a non-birth mother has been recognised as a parent of a child under the *parens patriae* jurisdiction of the Ontario Court of Appeal: *AA v BB* [2007] ONCA 2. The Court found that 'It is contrary to [the child's] best interests that he is deprived of the legal recognition of the parentage of one of his mothers. There is no other way to fill this deficiency except through the exercise of the *parens patriae* jurisdiction.' (Rosenberg JA)[37].
- 46 *Artificial Conception Act 1985* (WA) s 6A; *Status of Children Act 1979* (NT) s 5DA.
- 47 *Parentage Act 2004* (ACT) s 11(4).
- 48 *Family Law Act 1975* (Cth) s 60H(1); *Family Law Regulations 1984* (Cth) r 12C, sch 6.
- 49 This is because the federal government has not prescribed any relevant Victorian laws (*Status of Children Act* s 10F) pursuant to s 60H(2) or (3) of the *Family Law Act 1975* (Cth).
- 50 In the case of *B v J* (1996) 28 Fam LR 579, Fogarty J held that a person who did not fall within the scope of the definition of a parent in s 60H of the *Family Law Act* was not a parent for the purposes of the *Child Support (Assessment) Act* and was therefore not liable to pay child support.
- 51 Submission PP2 252 (Lesbian Parents Project Group).
- 52 *Statute Law Amendment (Relationships) Act 2001*; *Statute Law Further Amendment (Relationships) Act 2001*.
- 53 *Artificial Conception Act 1985* (WA) s 6A(2); *Parentage Act 2004* (ACT) s 11(6).
- 54 The nature and limitations of step-parent adoption are discussed in further detail in Chapter 10.



RECOMMENDATIONS

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 the *Child Support (Assessment) Act 1989*.

Retrospective Application

The commission also considered whether the statutory presumption to recognise non-birth mothers should apply in respect of children born before the introduction of the presumption. That is, should legal parental status, and all its accompanying obligations, be imposed on non-birth mothers of children who have already been born? The women we heard from who are in this situation have a strong desire to be recognised as legal parents. However, some women may never have intended to take on legal responsibilities for children, and/or may now be separated from the child's birth mother and have no ongoing relationship with the child. The presumption could also potentially affect past distributions of deceased estates or wills executed before the introduction of the amendments.

The commission was guided in its consideration of this issue by presumptions of parentage introduced in the past. There are several examples of parental status being conferred on a person retrospectively. When the presumption that applies to the non-biological parent of a donor-conceived child born to a heterosexual couple was introduced in 1984, it applied in respect of all children born before the commencement of the new provisions.⁵⁵ Similarly, when the status of illegitimacy was abolished in 1974, it had retrospective effect.⁵⁶ In Western Australia and the ACT, where the non-birth mother is presumed to be a parent of the child, the presumption of parentage applied in respect of children born before its introduction.⁵⁷

The commission has concluded that the presumption of parentage should apply in respect of children who have already been born. Not only is this consistent with the operation of equivalent presumptions introduced in the past, it would also apply to a large number of women who currently lack legal status as parents, and would give their children additional legal protection. Concerns about the distribution of deceased estates or passing of property interests can be addressed by declaring that any property rights or interests which existed prior to the commencement of the provision remain unaffected.⁵⁸

PARENTAGE DECLARATIONS

The Supreme Court is currently able to make declarations of paternity where it is satisfied that the relationship of father and child exists.⁵⁹ Once obtained, a declaration of paternity can be used to prove that a man has parental responsibility in respect of a child. As already noted, a person is conclusively presumed to be a parent of a child for the purposes of the Family Law Act if a declaration of parentage has been made by a state court.⁶⁰

The Supreme Court should also be empowered to make a declaration of parentage to confirm the operation of a presumption in respect of donor-conceived children. Such a declaration would give rise to a conclusive presumption that a non-birth mother is a parent for the purposes of the Family Law Act. However, whether this presumption would actually be applied to a non-birth mother would depend on whether the Family Court chose to interpret section 60H as the exclusive source of parentage of a child born through the use of donated gametes. If this were the case, the declaration of parentage would not be relevant and would not be sufficient to confer liability on the non-birth mother to pay child support. We discuss section 60H in more detail in Chapter 13.

This same analysis applies to the presumption of parentage that arises from being named as a parent on the register of births. A person is presumed for the purposes of the Family Law Act to be a parent of a child if he or she is registered on a state birth register.⁶¹ If a non-birth mother is able to be registered as a child's parent (as we recommend she should), it would depend on the court's interpretation of section 60H as to whether this particular presumption would be operative. Again, registration as a parent would not be sufficient to confer liability on the non-birth mother to pay child support.

CONSEQUENTIAL AMENDMENTS

If the commission's recommendations are implemented, it will be necessary for all Victorian legislation to be reviewed to ensure all relevant legislation recognises that a child may have two parents of the same sex. Although many pieces of Victorian legislation already refer to a child's 'parent' or 'parents', there are also numerous references to a child's 'mother' and 'father'. We recommend that legislation referring to the parents of a child use gender-neutral language, unless gender-specific terms are necessary for a specific purpose.

FEDERAL RECOGNITION

As discussed above, the primary limitation of using a statutory presumption to give legal status to non-birth mothers is that it would not be directly recognised for the purposes of federal law, in particular the *Child Support (Assessment) Act 1989*. This is because the definition of parent in that Act does not pick up the statutory recognition of non-birth mothers in any state legislation (by contrast, it does pick up the recognition of non-biological parents in heterosexual relationships).

The commission has concerns about the lack of coverage a statutory presumption would afford under federal law. We are mindful of the complexities which arise from the interaction between different state and federal definitions of a 'parent' and believe that consistency is an important objective for protecting the best interests of children. We do, however, concede that the scope of state law dealing with parentage is inherently limited (as is the role of a state law reform commission), and acknowledge the incremental nature of law reform in an area such as this.

Several Family Court judges have identified the need for the law in this area to be clarified.⁶² These comments have generally been made in the context of grappling with the status of donors whose sperm has been used by women in same-sex relationships, but they are equally applicable to the non-recognition of non-birth mothers. In *B and J* Justice Fogarty said:

*It is a reality of life that children are born as a result of a variety of artificial conception procedures, out of non-traditional circumstances, and into non-traditional families. Legislation which deals with the personal and financial responsibility for such children should be clear and exhaustive and should recognise the reality of these situations.*⁶³

In *Re Patrick*, Justice Guest discussed the broad and diverse nature of contemporary families and noted the inadequacy of section 60H of the Family Law Act for gay- and lesbian-parented families. He called on the legislature 'to reassess s 60H of the Act and to consider the ramifications of its application' for such families.⁶⁴

*Having regard to the issues addressed in this judgment, it is time that the legislature considered some of the matters raised, including the nature of parenthood, the meaning of 'family', and the role of the law in regulating arrangements in the gay and lesbian community. The child at the centre of this dispute is part of a new and rapidly increasing generation of children being conceived and raised by gay and lesbian parents. However, under the current legislative regime, Patrick's biological and social reality remains unrecognised. While the legislature may face unique challenges in drafting reform that acknowledges and protects children such as Patrick and the family units to which they belong, this is not a basis for inaction.*⁶⁵

In *Re Mark*, Justice Brown commented that it would be useful for Justice Guest's recommendations 'to be considered, and the anomalies, inconsistencies and uncertainties which bedevil this area removed'.⁶⁶

The commission echoes these calls for legislative clarification. Reform of federal law is essential to protect the rights and interests of children born to same-sex couples. The Child Support (Assessment) Act should ensure non-birth mothers are subject to the same child support obligations as all other parents. The Family Law Act should make it clear that non-birth mothers share parental responsibility for children. If our recommendations are implemented, four Australian jurisdictions will have recognised the legal status of non-birth mothers, providing a sound platform for federal recognition.⁶⁷

We also note that the Human Rights and Equal Opportunity Commission is currently reviewing federal legislation to identify where there may be discrimination against same-sex couples and their children in the context of financial benefits and entitlements.⁶⁸ This review is likely to identify a range of other ways in which the failure of federal law to recognise the relationship between children and their non-birth mothers disadvantages children.⁶⁹

We urge the Victorian Attorney-General to lobby for reform in this area, and recommend that the specific issue of the recognition of non-birth mothers under federal law be put on the agendas of the Standing Committee of Attorneys-General and the Family Law Council.

55 *Status of Children Act 1974* s 10B(1).

56 *Status of Children Act 1974* s 3(4).

57 *Artificial Conception Act 1985* (WA) s 4(1); *Parentage Act 2004* (ACT) s 8(2).

58 See, for example, *Status of Children Act 1974* s 10B(2), *Artificial Conception Act 1985* (WA) s 4(2).

59 *Status of Children Act 1974* s 10.

60 *Family Law Act 1975* (Cth) s 69S.

61 *Family Law Act 1975* (Cth) s 69R.

62 See Justice Kay and Mai Lin Yong, 'Science Meets Family Law: Genes, Sex and Jurisprudence: Homosexual Parents in the Family Court: The Past 30 Years', Conference Handbook, *Explore Family Law in 2004: 11th National Family Law Conference: Beyond the Horizon*, 26–30 September 2004, 217.

63 *Re B and J* (1996) 21 Fam LR 186, 198.

64 *Re Patrick* (2002) 28 Fam LR 579, 652.

65 *Re Patrick* 28 Fam LR 579, 653.

66 *Re Mark* (2003) 31 Fam LR 162, 174.

67 The necessary reform would involve amendment of s 60H of the Family Law Act and the inclusion of the relevant section of the Status of Children Act in the list of prescribed laws set out in the schedules to the Family Law Regulations 1984.

68 See *Same-Sex: Same Entitlements: A National Inquiry into Discrimination against People in Same-Sex Relationships: Financial and Work-Related Entitlements and Benefits*, <www.hreoc.gov.au/samesex/index.html> at 22 June 2006.

69 Some of the submissions to the inquiry raise the issue of the lack of recognition of same-sex parents under federal law: see Castan Centre for Human Rights Law, Monash University (submission 126), Human Rights Law Resource Centre (submission 160), Victorian Gay and Lesbian Rights Lobby (submission 256): <www.hreoc.gov.au/samesex/submissions.html> at 11 August 2006.

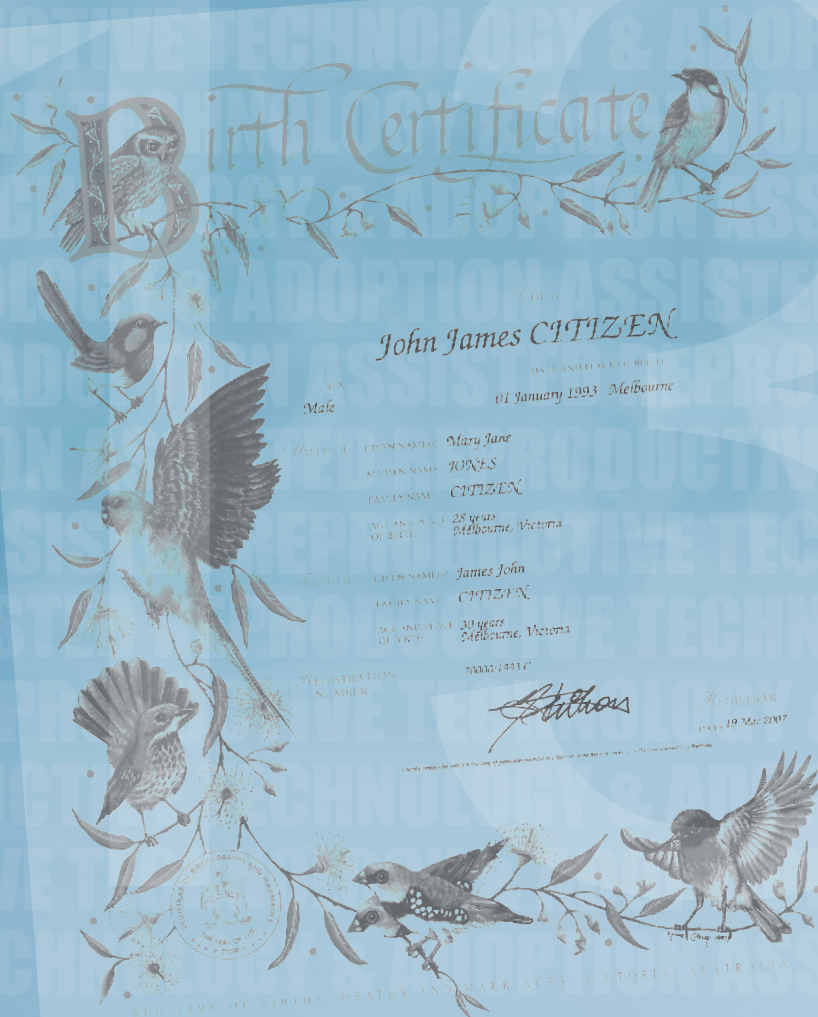
Chapter 13

Status of Donors

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A variety of different arrangements and relationships exist between gamete donors and the women or couples who use those gametes to conceive children.¹ Some donors donate to clinics and are unknown to the recipients (donors recruited through clinics). Other donors agree to donate to a particular person or couple (privately recruited donors).

Currently in Victoria, donors may be recruited through clinics in the following situations.

- Some donors are unknown and unidentified to the recipients. The donors agree to donate gametes on the basis that any child conceived is entitled to information about the donor's identity when he or she turns 18.
- Some donors are unknown to the recipients but meet before the treatment procedure is carried out. These arrangements are typically egg or embryo donations organised by clinics.
- Some donors are unknown to the recipients but meet after the birth of the child. Such meetings are facilitated by the information release provisions of the *Infertility Treatment Act 1995*.

Donors may be privately recruited in the following situations.

- Some donors meet the recipients solely for the purpose of the donation and have little or no further contact after that time. These arrangements are typically made by women who self-inseminate and do not use clinics.
- Some donors are friends, relatives or acquaintances of the recipients and maintain those relationships with the recipients after the birth of the child. These arrangements are made by people undergoing clinic-based treatment and by women who self-inseminate.

Similarly, there are a diversity of arrangements and relationships between donor-conceived children and their donors.

- Some children do not know they are donor-conceived and never meet their donors.
- Some children know they are donor-conceived and have never met their donors, either because they and/or their donors have no desire to meet each other, or because they have no way of identifying the donors.

- Some children know they are donor-conceived and the donor does not have a role in their family but is identified and introduced to the child as a genetic parent if and when the child asks.
- Some children know their donors because they are part of their parents' family or circle of friends and are acknowledged as a genetic parent of the child.
- Some children have 'donors' who are regarded as their parents and play a parenting role in their lives. In some instances, the child also regards the donor's partner as a parent.

In this chapter we examine the legal status of donors, particularly when the recipients of their gametes are women without male partners.

SPERM DONORS

Under Victorian law, in all cases where the recipient of a donor's gametes is a heterosexual couple, the donor is presumed not to be a legal parent of any child born as a result of the treatment. The donor's parental status is extinguished, regardless of the relationship he or she has with the recipients or the child.

However, the legal status of a person who donates gametes for use by a woman who does not have a male partner is less clear.

VICTORIAN LAW

In the case of a sperm donation to a single woman or a woman without a male partner, the *Status of Children Act 1974* states that the donor has no rights and incurs no liabilities in respect of a child, but is silent as to whether he is the child's father.² The Status of Children Act operates for the purposes of Victorian law. Therefore, sperm donors to single women or women in same-sex relationships cannot insist on exercising any of the powers conferred on parents under Victorian law, such as the right to be consulted in any proceedings concerning the child. Similarly, a child could not benefit from the donor's estate if he dies without making a will (unless the child was financially dependent on the donor during his lifetime).

There are certain provisions under Victorian legislation that are relevant to the parent-child relationship which cannot be described as 'rights' or 'liabilities' of a donor in respect of a child. For example, the Registry of Births, Deaths and Marriages regards the donor as a parent of the child because his parental status has not been fully extinguished and therefore insists his name be recorded on the register of births.³

FEDERAL LAW

Whether a donor has rights and liabilities in respect of a child or is a legal parent of a child born as a result of his donated sperm under federal law has been the subject of several court cases. These decisions focus on the meaning and effect of section 60H of the *Family Law Act 1975*.

Section 60H of the Family Law Act contains provisions that define who is to be regarded as the legal parent of a child born as a result of an artificial conception procedure. Section 60H confers parental status on certain people for the purposes of the Act, even if they are not biologically related to the child. These provisions ensure that a non-biological parent has full parental responsibility for the child.

Section 60H(1) deals with children born to heterosexual couples and confirms, for the purposes of the Family Law Act, that if the procedure was carried out with the consent of the couple, they are the legal parents of the child, whether or not the child is biologically theirs. The Act refers to and recognises the transfer of legal parentage that is achieved under the Status of Children Act.

However, the Family Law Act does not recognise any of the provisions in the Status of Children Act that deal with the status of a person whose gametes are used by a woman without a male partner.⁴ There has been some recent judicial consideration of whether someone who is biologically related to a child born as a result of an artificial conception procedure is a parent of the child, even if he or she does not fall within the scope of section 60H.⁵ The question to be determined by the court is whether section 60H is an exhaustive source of parental status for the purposes of the Family Law Act, or whether its function is to expand the classes of people who may be regarded as the parents of a child.

In *Re Patrick*,⁶ Justice Guest decided that the sperm donor was not a legal parent of the child because he did not fall within the scope of section 60H of the Family Law Act. In that case, the donor was seeking orders from the Family Court for contact with a child who was born to a lesbian couple through the use of his donated sperm. Even though the court found that the donor was not a legal parent of the child, it did

make orders allowing him to have contact with the child on the grounds that he was a person who was significant to the care, welfare and development of the child and had previously had some contact with him.

In *Re Mark*,⁷ Justice Brown decided that section 60H was not an exhaustive provision and did not preclude a sperm donor from being recognised as a child's parent because he was the child's biological parent. She agreed with Justice Fogarty in *B v J* that the provisions of section 60H 'enlarge, rather than restrict, the categories of people who may be regarded as the child's parent'.⁸ In *Re Mark*, the donor (and his partner) had commissioned a married woman to bear a child conceived with his sperm and a donated egg under a surrogacy arrangement. Justice Brown was satisfied that the donor and his partner were people concerned with the care, welfare and development of the child and it was in the child's best interests for orders to be made for them to have parental responsibility for the child. However, in the absence of a respondent or contradictor in the case, she declined to make a positive finding about whether the donor was a legal parent of the child.

Several Family Court cases have considered whether a sperm donor is liable to pay child support under the Child Support (Assessment) Act. Section 5 of that Act states that:

'Parent' means (a) when used in relation to a child who has been adopted—an adoptive parent of the child; and (b) when used in relation to a child born because of the carrying out of an artificial conception procedure—a person who is a parent of the child under section 60H of the Family Law Act 1975.

In *B v J*⁹ Justice Fogarty decided that, for the purposes of the Child Support (Assessment) Act, a donor of sperm to a woman without a male partner was not a parent of a child born as a result of the donation. He came to this conclusion on the ground that section 5 of the Act is an exhaustive definition. Therefore, if the donor did not fall within the scope of section 60H of the Family Law Act, he did not fall within the definition of parent under the Child Support (Assessment) Act. The Child Support (Assessment) Act therefore restricts the categories of people who are regarded as a child's parents for the purpose of that Act.

- 1 The diversity of arrangements was discussed in many submissions, including: CP 88 (Deborah Dempsey), CP 89 (Ministerial Advisory Committee on Gay and Lesbian Health), CP 143 (The Bouverie Centre), CP 149 (Prospective Lesbian Parents), CP 179 (Lesbian Parents Group).
- 2 *Status of Children Act 1974* s 10F.
- 3 The Registry of Births, Deaths and Marriages has developed a protocol for the recording of the donor's name in these cases. If the donor, the birth mother and the birth mother's partner (if she has one) all agree, the donor's name will not be recorded in the register of births as the father of the child and will not appear on the birth certificate. Instead, the donor's name is recorded in the notes section of the register.
- 4 No Victorian laws have been prescribed for the purposes of s 60H(2) or 60H(3), the sections which determine whether someone may be recognised as the legal parent of a child born as the result of an artificial conception procedure.
- 5 For further discussion of these cases, see Adiva Sifris, 'Known Semen Donors: To Be or Not to Be a Parent' (2005) 13 *Journal of Law and Medicine* 230; Jenni Millbank, 'The Status of Known Sperm Donors Under the Family Law Act' (2006) 18(4) *Australian Family Lawyer* 30; Jenni Millbank, 'Recognition of Lesbian and Gay Families in Australian Law—Part Two: Children' (2006) 34 *Federal Law Review* 205.
- 6 (2002) 28 Fam LR 579.
- 7 (2003) 179 FLR 248.
- 8 *Re Mark* (2003) 179 FLR 248, 253. Justice Brown's reasoning was approved and followed in *Re J and M* (2004) 32 Fam LR 668, 670.
- 9 (1996) 21 Fam LR 186. See also *W v G* (1996) 20 Fam LR 49.

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Whatever the legal parental status of a donor, the Family Court retains the power to make residence and contact orders in favour of any person concerned with the care, welfare and development of a child if the court considers it to be in the child's best interests. In this way, the presence or absence of legal parental status is not the factor that determines whether a child has a relationship with a particular person. Even if a donor is not considered to be a legal parent of a child, he or she may still take on a parenting role in the child's life or may be granted contact with the child by the Family Court (as was the case in *Re Patrick*).¹⁰

PROBLEMS WITH THE LAW

The uncertainty about the status of donors is detrimental to children and has implications for them, as well as parents and the community in general.

Uncertainty about the legal parental status of donors may lead to:

- stress and anxiety and make it difficult for people to plan their arrangements successfully—many women who make arrangements with known donors feel uneasy that these arrangements have no legal force
- disputes about the status of donors and their role in families
- disputes about the rights and liabilities of third parties (such as the state in relation to statutory compensation schemes) under Victorian law
- confusion about whether the name of a donor should be registered as a parent of the child on the register of births.

Concerns about these issues were raised in many submissions:

*In contrast to public stereotypes of lesbians as 'man haters', we acknowledge that a relationship with the biological father can be important to a child. We have done everything we can to try to make sure this is possible, however, the Victorian laws have made this process a messy, confusing and stressful one.*¹¹

*The fact that a known donor's name must be supplied to Births, Deaths and Marriages and will be put on the birth certificate is a great worry to us. We don't intend the donor being involved in parenting but with his name on the birth certificate are very unsure of the legal status surrounding this now and into the future.*¹²

Dr Elizabeth Short, a psychologist who has conducted research into the effects of legal uncertainty on lesbian-parented families throughout Australia, reported in her submission that:

*Women who clearly feel that the donor recognises them to be the child's parents, and that the donor understands that he is not the child's parent (other than biologically), feel far more comfortable than those who feel this is not clear to the donor and to others. ... This sense of ease and security can be very important to a mother's well-being, and hence, to her parenting. It is also very important to children that their family feels secure, clear and respected, and not vulnerable to intrusion or conflict.*¹³

Children born to single women and women in same-sex relationships in Victoria have a different status to children born in the same circumstances interstate. In NSW,¹⁴ Western Australia,¹⁵ South Australia,¹⁶ Tasmania¹⁷ and the ACT,¹⁸ the donor is presumed not to be the father of the child, regardless of the marital or relationship status of the child's mother.

RECOMMENDATIONS

The commission believes strongly that it is in the best interests of children that the status of their parents and donors be as clear and certain as possible. Certainty in the law minimises the likelihood of disputes and litigation. It also assists people to understand their rights and responsibilities and to make decisions and arrangements with the benefit of that knowledge.

We recommend that sperm donors should be presumed at law not to be the father of any children conceived by women without male partners as a result of their donation. This is consistent with the status of donors whose gametes are used by heterosexual couples, and with the status of donors in NSW, Western Australia, South Australia, Tasmania and the ACT. In a system where heterosexual couples, same-sex couples and single women can access donor sperm, and where donors are precluded from directing their donations, it does not make sense for donors to have a different legal status in relation to children depending on the relationship status of the women who receive the sperm. This is particularly the case if donors do not know who are the recipients of the sperm.

RECOMMENDATIONS

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.

Almost all of the submissions received from and on behalf of single women and women in same-sex relationships supported the extinguishment of the legal parental status of donors, on the grounds that this generally reflects the reality of their families and would provide certainty and consistency for them.¹⁹ These submissions drew a distinction between a donor and a father and argued that the legislation should recognise the different roles played by each. ACCESS also supported the clarification of the donor's status in this way.²⁰

Extinguishing the legal status of donors will mean that a child born to a woman without a male partner will not have a legal father, but it does not mean that the donor will necessarily be precluded from having any contact or relationship with the child. The parties are still able to negotiate the role of the donor in the child's life and, if they wish, approach the Family Court to obtain parenting orders conferring some parenting obligations on the donor. Our recommended approach to the status of donors cannot affect or limit the jurisdiction of the Family Court to make orders enabling a donor to have contact with a child if the court concludes it would be in the best interests of the child to make such an order.

The commission received some submissions that argued that a donor to a woman without a male partner should be declared to be the father of the child but without any rights or responsibilities in respect of the child. The Victorian Biotechnology Ethics Advisory Committee,²¹ for example, argued that maintaining the parental status of the donor would emphasise the child's right to information about his or her genetic origins and biological history. This approach would emphasise the importance of the biological connection between the child and the donor.

As mentioned in Chapter 11, some people in the community object to the extinguishment of a donor's legal relationship with a child because they believe to do so perpetuates a lie or fiction about the child's identity. The commission received submissions from people who believe that the law should 'affirm the genetic reality that the gamete donor is the actual father/mother of the child/adult conceived via an ART procedure utilising donor gametes'²² and that 'the legal definition of the term "parent" should be based on genetic truth as much as on upbringing responsibilities'.²³ These arguments

suggest that the removal of the donor's legal status is instrumental in obscuring the truth of the child's genetic origins.

The commission, however, believes that issues of legal status can and should be distinguished from children's right to information about their origins and parents' duty to be open and honest with their children. We examine this question in Chapter 15.

Our recommendation that a sperm donor should not be presumed to be the parent of a child born as a result of the donation does not completely resolve the problems that arise under federal law, as described above and in Chapter 11. Until this uncertainty is addressed by the Family Court and/or the Commonwealth government, the commission believes the most effective ways to reduce the impact of the uncertainty of the donor's status are to encourage informed decision making by providing appropriate information, advice and counselling to the parties, and to give women the choice to use sperm from clinic-recruited donors.

Our expectation is that if eligibility for ART is expanded as recommended in Chapter 5, more women and privately-recruited donors will attend counselling before treatment commences. As a result, they will be better equipped to plan their arrangements and roles in respect of the children. The provision of information and legal advice to each party will assist in minimising the possibility of future conflict. Where a woman is not in a position to negotiate an arrangement with a known donor, she will have the option of using sperm donated by a clinically-recruited donor.

DONORS AS PARENTS

Some donors do take on parental responsibilities in respect of the children born as a result of their donated sperm. We received several submissions which described arrangements where the birth mother, her partner, the donor, and sometimes his partner, all consider each other to be equal parents of the child and intend the donor to be recognised as the father of the child.

From a legal perspective, even if the birth mother, her partner (if she has one) and the donor agree that he should be regarded as the child's father, he will not have the full range of parental obligations and powers that are conferred on legal parents.

10 See also *H v J and D* [2006] FamCA 1398 (Unreported, Guest J, 12 December 2006). Note that in this case no finding was made about the parental status of the donor.

11 CP submission 110a (Anonymous).

12 PP2 submission 85 (Lynne Daniels).

13 PP2 submission 351 (Dr Elizabeth Short), referring to lesbian mothers in Western Australia and the ACT.

14 *Status of Children Act 1996* (NSW) s 14(2).

15 *Artificial Conception Act 1985* (WA) s 7(2).

16 *Family Relationships Act 1975* (SA) s 10D(1).

17 *Status of Children Act 1974* (Tas) s 10C(2).

18 *Parentage Act 2004* (ACT) s 11(5).

19 Submissions CP 82 (Anonymous), CP 83 (Sexuality Law Reform Committee, Melbourne University Law Students Society), CP 149 (Prospective Lesbian Parents), CP 167 (Victorian Gay & Lesbian Rights Lobby), CP 179 (Lesbian Parents Group), CP 198 (Dr Elizabeth Short).

20 Submission CP 192 (ACCESS).

21 Submission CP 224 (Victorian Biotechnology Ethics Advisory Committee).

22 Submission CP 154 (Michael Linden).

23 Submission CP 60 (Confidential), permission to quote given 5 July 2004.

Chapter 13

Status of Donors



RECOMMENDATIONS

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.

In *Position Paper Two: Parentage* the commission recommended that in certain limited circumstances a donor should be able to opt-in to become a legal parent by applying for an adoption order, as a means of reflecting the reality of these particular families, by providing clarity and certainty about legal powers and responsibilities. The application would require the consent of the child's parents. This recommendation was intended to apply to all types of donors and recipient families.

While some groups and individuals supported the introduction of a mechanism designed to reflect and accommodate a diversity of family arrangements,²⁴ the proposal attracted considerable criticism in the consultations conducted following the release of *Position Paper Two*. Participants at the roundtable discussion in which the proposal was debated raised a number of concerns about the concept of allowing a child to have three legal parents, including that:²⁵

- It would increase complexity and uncertainty and would therefore be contrary to the best interests of children.
- Having three legal parents could complicate practical steps such as signing parental consent forms for passports, medical treatment and school excursions.
- Dealing with cases where three or four interested adults want separate contact orders in relation to a child is already challenging. Giving more than two people parental status could make these situations even more complicated. Having three parents may challenge the legal presumptions that exist based on a two-parent model, such as presumptions about equal parental responsibility, joint residency and child support.
- The federal government may take deliberate steps not to recognise a third parent if questions about child support arose. The recommendations could create a situation where three parents are recognised in Victoria, but not federally.

In its submission, adoption agency Connections Adoption and Permanent Care Program made the following comments about the potential for a donor-conceived child to have more than two parents:

It is the group's understanding that the nature/degree of responsibility (custody or guardianship) of each parent for a child and the contact arrangements involved for

each significant person to a child, whether biological or non-biological, can be outlined and formalised in a Parenting Plan or Parenting Order and that these conditions can be varied if circumstances change over time i.e. if partnerships break down or if the child's needs change as they grow and develop. ...

In an ideal world, all adults would always aim to get along and agree to maintain the best interests of the child as a priority over their own needs thereby ensuring a good outcome for the child, however, realistically, the group felt that the more parties involved in decision-making for a child, the more complications that could arise.²⁶

The agency also stated that its preference was for 'birth certificates to remain a document stating the names of no more than two parents to minimise further dissimilarity with the rest of the population'.²⁷

Some submissions argued that recipient parents may be very fearful of the capacity of a donor to opt-in, and that the proposal might be alarming to the majority of ART users who would not want donors to be regarded as parents.²⁸

Some participants at a roundtable discussion felt that it was inappropriate to create a new form of adoption, particularly if its purpose was to confirm, rather than displace, the existence of a genetic relationship between the donor and the child.²⁹ The comment was also made that children may find it confusing or even offensive to be adopted by a genetic parent. In a similar vein, some people opposed the proposal on the basis that donors should always be recognised as legal parents in the first place.

The commission has come to the view that donors should not be able to opt in to become legal parents of children born as a result of their donated gametes. We agree with suggestions made in submissions and other consultations that Family Court parenting orders are a more flexible and appropriate way to recognise a donor's significant role in a child's life. Parenting orders can be adapted to the particular circumstances of each case, and can be adjusted to reflect the evolution of the relationship between the donor and the child as the child matures.³⁰ Many people, such as grandparents or aunts, make valuable contributions to children's upbringing and are responsible for significant levels of care, without being legally recognised as parents. They may or may not have Family Court parenting orders.

The commission also felt that the policy underlying the extinguishment of a donor's parental status is an important one which should apply universally. It would be problematic to make special provisions for particular families. In this regard we were mindful of the fact that arrangements where the donor is regarded within the family as a parent of the child are relatively rare. Sociologist Deborah Dempsey, who conducted research on parenting arrangements in the gay and lesbian community for her doctoral thesis, told us:

My own experience of talking to people planning or raising children within the lesbian and gay communities would suggest it is far more common for lesbian couples or single women to assume and want resident parental rights and caregiving responsibilities, with biological fathers assuming more distant non-resident social contact (that may or may not include part time or occasional care giving). Key informant interviews with a lawyer, doctor, midwife and self-help network convenor also supported this observation.³¹

We are aware that by not recommending a process through which a broader range of family types may be legally recognised, we have not moved beyond the two-parent model which currently exists at law. Consequently, those families where the donor is regarded as a parent of the child will not be recognised by the law in a formal sense. This will not prevent people from forming families where several people act as parents. It remains possible, therefore, that in time, a process similar to that of opting in which we recommended in Position Paper Two may emerge as a necessity for a greater number of families where the donor is regarded as a parent of the child. Legal recognition of non-birth mothers may be the first step towards developing a sense of confidence in and acceptance of diverse family types necessary for further reform.

It is important to emphasise that non-recognition of donors as parents is a separate issue from a child's right to obtain information about donors, and from the issue of whether a child will know or have a relationship with the donor. The commission again stresses the desirability of women and known donors seeking advice and assistance when entering into arrangements to ensure that the parties understand, at the outset, each others' expectations and legal status in respect of any children born.

EGG DONORS

It is unclear whether a woman without a male partner who bears a child conceived as a result of ART using a donated egg is the child's legal mother. The Status of Children Act does not make reference to this situation and whether a woman in this position is considered to be the mother of the child at common law has also not been tested. In the absence of any dispute, she is likely to be registered as the mother of the child on the birth register, giving rise to a presumption that she is the child's mother. By contrast, where a woman with a legally recognised male partner bears a child conceived with a donated egg, the Status of Children Act expressly states that she is presumed to be the mother of the child.

Uncertainty about the legal parental status of the egg donor to a woman without a legally recognised male partner may also cause stress and anxiety and lead to disputes about the rights and obligations of the birth mother, the egg donor and third parties. It may also discourage women who would otherwise wish to become egg donors.

RECOMMENDATIONS

The commission is of the view that Victorian law should expressly clarify that when a child is conceived as a result of an egg donation, the birth mother is the mother of the child and the egg donor is not, regardless of the relationship status of the birth mother. This would bring Victorian law into line with that of Western Australia, South Australia, the ACT and the Northern Territory.

Amending the Status of Children Act will not necessarily clarify the status of birth mothers and egg donors in this situation for the purposes of federal law. In order to achieve this, it would be necessary for the amended provisions to be prescribed or recognised in federal law. It should be noted, however, that the Family Law Regulations 1984 (Cth) do recognise comparable provisions to those recommended by the commission in the relevant legislation from South Australia and the Northern Territory.³²

Finally, we note that the current provisions in the Status of Children Act that apply to donors and parents of donor-conceived children appear to us to be unnecessarily lengthy and complex. They make distinctions between sperm donors and egg donors and between different types of treatment procedures which may not be necessary for achieving the Act's objectives. The provisions could easily be expressed more concisely, as they have been in equivalent legislation in Western Australia³³ and the ACT.³⁴

24 Submissions PP2 196 (Fertility Access Rights and the Victorian Gay and Lesbian Rights Lobby), 245 (Dr Ruth McNair), 270 (ITA).

25 Parentage roundtable, 6 February 2006.

26 Submission CP 122 (Connections Adoption and Permanent Care Program).

27 Submission CP 122 (Connections Adoption and Permanent Care Program).

28 Submissions PP2 270 (Infertility Treatment Authority), PP2 351 (Dr Elizabeth Short).

29 Parentage roundtable, 6 February 2006.

30 Jenni Millbank, 'Recognition of Lesbian and Gay Families in Australian Law—Part Two: Children' (2006) 34 *Federal Law Review* 205.

31 Submission CP 88 (Deborah Dempsey).

32 Family Law Regulations 1984 (Cth) sch 7.

33 See *Artificial Conception Act 1985* (WA) ss 5–7.

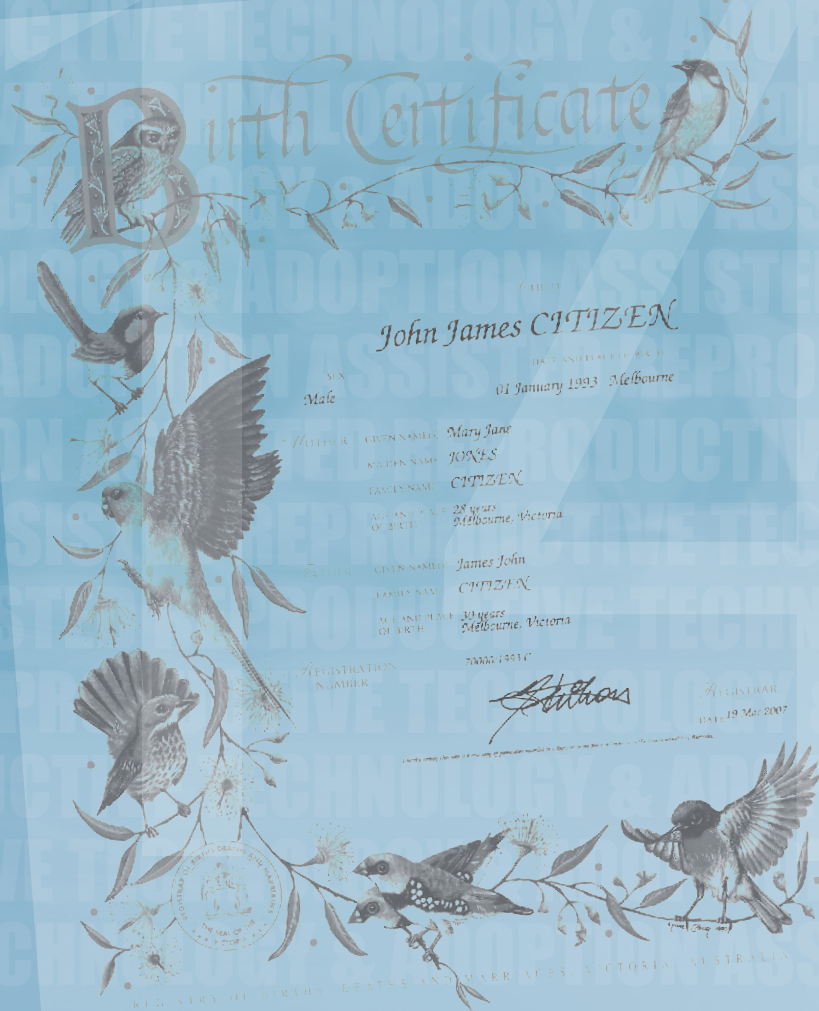
34 See *Parentage Act 2004* (ACT) s 11.

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Birth Registration



'It saddens us that the non-biological mother of our son has no recognition on his birth certificate, and that there is a huge gap on the certificate next to 'Father'. Our son has two loving, caring parents who carefully planned his conception and really wanted him.'

Birth certificates and the process of birth registration for donor-conceived children attracted substantial attention during our consultation process, and a variety of opinions emerged.

Many same-sex couples with children feel strongly that the reality of their family structures should be reflected on their children's birth certificates and that this can be achieved by listing the non-birth mother, and not the donor, as the other parent of the child:

It saddens us that the non-biological mother of our son has no recognition on his birth certificate, and that there is a huge gap on the certificate next to 'Father'. Our son has two loving, caring parents who carefully planned his conception and really wanted him—perhaps more than some 'heterosexual conceptions', and yet one of his parents has not recognition on the legal document of his birth.¹

I feel extremely saddened that I am not allowed to be on H's birth certificate as her parent. Not just for myself but also for H, whose family is not adequately represented nor legally recognised in the community. By not being on the birth certificate as H's parent I feel alienated and somehow not considered by the community as H's parent even though I do everything any other parent does.²

Some same-sex couples would like to have the name of the donor recorded on their child's birth certificate if the donor has a parental role in the child's life, or if they simply would like to formally acknowledge the donor's role in the child's conception:

Many families would like to have the option of listing their known donor on the certificate, along with the birth and non-birth mothers if they are a couple. They have chosen to conceive through a known donor, and often to also involve him to some extent in their family, through contact that can vary from annual or occasional to weekly. They want their child's birth certificate to reflect the reality of their conception and the make-up of their family.³

During our review we were contacted by several single women who have had children as a result of donor insemination or IVF. Some of these

women reported that they do not want the birth certificate to list the donor as the father, nor do they want the certificate to record the father as unknown. They want the option of recording only one parent:

When my son was born I did not want the donor's name to appear on his birth certificate. When I went to the Registry of Births Deaths and Marriages I encountered significant hostility from the staff about my intention not to register his name. I was told that my child would never be able to get a birth certificate unless I put the donor's name on the certificate. I was not given any other options about the way in which the donor's details could be registered. I tried to explore what would happen if I told them that my son's father was unknown, but was told that I would have to prove that that was the case before the Registry would record him as unknown. In the end I approached the donor and he agreed to have his name appear on the birth certificate, which was not part of our original arrangement. I have since discovered that there are other options available for the registration of a donor's name (without having it appear on the birth certificate). I believe that the Registry staff should explain these options to people in my position. In any event, my son would always have known who his father was.⁴

My son's birth was registered in Victoria. I was able to produce a letter from the clinic confirming that my son had been conceived via DI so I did not encounter any problems about not naming a father. I wanted to make sure that the section for the father's name on the birth certificate did not read 'unknown' and I succeeded in having it remain blank.⁵

Some people, in particular donor-conceived people, and people involved in adoption, told us they believe that birth certificates should always display the names of a child's genetic parents, to reflect the biological truth about his or her parentage, and to guard against the secrecy that has historically accompanied donor conception and adoption:

I find it absolutely disgraceful that even today, almost 22 years later, donor conceived people's birth certificates are still legally forged. We are the only people on

earth whose birth certificates are untrue. Why is it up to the parents of people like myself to tell us about who we are? A document that is supposed to be our primary source of identity is false. What does this tell me about the entire practice of donor conception? It tells me that when we want something kept a secret, it is usually because we are not comfortable with what that secret entails.⁶

The adoption agency Connections Adoption and Permanent Care proposed that:

*perhaps there could be a different type of Birth Certificate issued to people born of donated gametes so that if they have not been told as a child of their origins, and the Infertility Treatment Authority or the like has not contacted them for permission to release identifying information to the donor, they could in fact still find out about their origins via the Registry of Births, Deaths and Marriages as is the case with Adoption.*⁷

Other submissions proposed that people should be able to choose what information about their parents is recorded on their birth certificates. Some suggested that people should have more than one birth certificate: one that records all the relevant information about a child's parentage, and another that contains only the information which is required for official purposes.⁸

*We do not believe that the gamete donor's name should appear on the birth certificate as the father. ACCESS recommends that separate provision be made on birth certificates for a section that has details of the person who has donated gametes, but only if access to such information could [be] provided exclusively to the person born, at their request.*⁹

*An example would be for Births Deaths and Marriages to maintain a record that identifies all parties to the conception, (from clinical treatment, self insemination, adoption) with the conceived individual having access to the complete record with a less detailed standard certificate for requirements around proof of identity.*¹⁰

In this chapter we discuss the function and role of birth registration and birth certificates and examine what information about a child's parents should be recorded in this way.

BIRTH CERTIFICATES

A birth certificate is an official document setting out the key information about a child recorded on the register of births. It has important legal effects. Its primary function is to provide evidence of a person's identity, age, place of birth and parentage for a range of practical and legal purposes. A birth certificate issued by the Registry is admissible in legal proceedings as evidence of the facts recorded in it.¹¹ As noted in Chapter 11, being named as a parent on the register of births is not of itself the source of legal parentage; it is merely a formal recording of the existence of a legal relationship between a parent and child. Registration as a parent gives rise to a presumption of parental responsibility under the Family Law Act and numerous other pieces of legislation.

REGISTERING NON-BIRTH MOTHERS

If our recommendation that non-birth mothers be presumed to be parents of children born as the result of donor conception is implemented, it follows that they should be officially recorded as legal parents on the register of births. The proposed statutory presumption would entitle non-birth mothers to be registered as parents under section 16 of the *Births, Deaths and Marriages Registration Act 1996*. A non-birth mother would be required to sign the form applying to register the child's birth (the birth registration statement) and be named as a parent on the child's birth certificate. This, in turn, would mean that the non-birth mother would be considered a parent for all purposes under state law and for several purposes under federal law, including the *Australian Passports Act 2005* (Cth). The non-birth mother's consent would be required before a passport could be issued to the child.¹²

The register of births and birth certificates currently allows for the registration of a child's 'mother' and 'father'. If the non-birth mother is to be registered, it will be necessary to enable her to be recorded as a second 'mother' or as a 'parent'. Western Australia and the ACT both provide these options and have produced revised forms for that purpose. The Victorian Registry of Births, Deaths and Marriages should follow this lead.

Recording non-birth mothers as parents on birth certificates will provide evidence of legal status for a range of purposes, such as consenting to medical treatment and enrolling children at school. It will also meet some of the concerns about the symbolic effects of a failure to recognise the reality of a child's family on his or her birth certificate.

- 1 Couple 'C' quoted in submission CP 149 (Prospective Lesbian Parents).
- 2 Submission PP2 35 (Kate Coghlan).
- 3 Submission CP 149 (Prospective Lesbian Parents).
- 4 Submission CP 144 (Jane).
- 5 Submission CP 187 (Brenda).
- 6 Submission CP 255 (Narelle Grech).
- 7 Submission CP 122 (Connections Adoption and Permanent Care Program).
- 8 Submissions CP 143 (The Bouverie Centre), CP 155 (Victorian Infertility Counsellors Group), CP 192 (ACCESS).
- 9 Submission CP 192 (ACCESS).
- 10 Submission CP 155 (Victorian Infertility Counsellors Group).
- 11 *Births, Deaths and Marriages Registration Act 1996* s 46(2).
- 12 *Australian Passports Act 2005* (Cth) ss 6, 11.



RECOMMENDATIONS

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.

EXISTING BIRTH CERTIFICATES

The commission has recommended that there be retrospective application of the recognition of non-birth mothers as legal parents (Recommendation 75). When this occurs, the child will already have a birth certificate which does not include the name of the non-birth mother and may or may not include the name of the donor as the child's father. If the child's parents wish to have the birth certificate amended to include the non-birth mother as a parent it would be necessary to make an application to the Registry of Births, Deaths and Marriages.

Section 17 of the Births, Deaths and Marriages Registration Act already permits applications for amendment of the register of births. Applications must be accompanied by a statutory declaration verifying the basis of the application. If a father is to be recorded where previously no father was listed, the applicant must fill in an 'Addition of Father's Details' form and pay a small fee. The nominated father must consent to being registered. If the father does not consent or the application is to replace the name of a person already registered as a father with the name of another person, the registry requires either a court order or DNA evidence of paternity.

In Western Australia, the process to add the name of a non-birth mother to a register of births, if she was not listed when the birth was first registered, is the same as the process used to add paternity details for heterosexual parents.¹³ This process applies irrespective of the year of birth of the child. Both parents must complete an application form and pay an amendment fee. If an application is made by only one parent (for example, if the other parent is deceased) it must be accompanied by documentary evidence such as DNA test results or a court order.

In Western Australia, if a non-birth mother applies to be recorded as a parent, evidence that she consented to the fertilisation procedure by which the child was conceived is required. This information is usually available from the fertility clinic or Commissioner of Health. If the fertilisation procedure was a private arrangement, a court order would be required.¹⁴

In Victorian, cases where the birth register already records a donor as the father of a child, the situation is more complex. Currently, the registry regards the donor as the legal father, even though he has no rights or liabilities in respect of the child. However, not all same-sex couples record the donor as the father. If all parties agree, the process used by the registry is

to record the name of the donor on the register but not to name him as the father on the birth certificate.

If a donor's name appears on a register as the child's father and the couple wishes to have his name replaced with the name of the non-birth mother, it seems appropriate for the registry to require a court order before such an amendment could be made.

The commission therefore recommends that where a woman wishes to be regarded as a parent of a child as a result of the retrospective application of the presumption we have recommended, it should be possible 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. We do not believe that evidence from a clinic, such as is required in Western Australia, should be required. 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.

The staff of the Registry of Births, Deaths and Marriages should receive training on the proposed changes to ensure minimum confusion and disruption to the timely recording of a child's birth.

DONOR INFORMATION

The submissions received by the commission identified a number of problems and inconsistencies in the registration of the birth of a child born as a result of a donor treatment procedure to a woman without a male partner.

CURRENT PRACTICE

When a heterosexual couple registers the birth of their donor-conceived child, the registry makes no enquiry about the circumstances of the child's birth and makes no attempt, other than requiring the parents to complete a birth registration statement, to confirm whether they are the child's biological parents or whether a donor was involved. The Births, Deaths and Marriages Registration Act permits the registrar to rely on the presumptions made in the Status of Children Act when recording the identity of a child's parents and no further enquiry is legally required.¹⁵

When a child's mother submits a birth registration statement without naming the child's father, the registry tries to identify the father so his name can be recorded.¹⁶ There are many reasons why a woman may not include the name of the father on the registration form: she and the father may have agreed that his name will not appear on the birth certificate; she may not know who the father is; there may be a history of violence with the father and she may fear that identifying him will expose her and her child to further violence; the birth may be the result of a sexual assault; or the child may have been born as the result of donor insemination.¹⁷

If a woman underwent a treatment procedure in a clinic using sperm from an unknown donor, the registry will accept a letter from the clinic as evidence that the father cannot be named. In these instances, the field reserved for the name of the child's father remains blank and the registry makes a note that the birth was the result of donor insemination carried out in a clinic.

If a woman informs the registry that she self-inseminated with sperm from a known donor, the registry regards the donor as the father of the child (because his parental status has not been fully extinguished) and will insist that the woman identify him. Some women are willing to have the name of the donor recorded on the child's birth certificate, but many are not. Many women who self-inseminate with sperm from a known donor do not regard the donor as the child's father and object to having his name recorded on the birth certificate because it does not reflect the reality of the child's family. Some women have also reported difficulties with government authorities and service providers who, having sighted the child's birth certificate naming the donor as the father of the child, require the donor's consent to the issue of a passport or to medical treatment for the child.¹⁸ This can be problematic where the mother has no ongoing contact with the donor.

In response to these concerns, the registry has developed a protocol to deal with the registration of the births of children born as the result of privately arranged donor insemination.¹⁹ If the mother and the donor agree, the donor's name will not be recorded in the field reserved for the father's name on the births register or birth certificate. Instead, the donor's name will be recorded in the notes section of the birth register. The legal status of this information is not clear.²⁰

SUBMISSIONS

Some people we consulted argued that birth certificates should list all people relevant to a child's birth, including donors and surrogate mothers where relevant. They argue that this information is fundamental to a child's identity, and that if it is recorded on the birth certificate, many of the problems associated with parents not telling their children about their conception would be avoided.

Several other submissions called for flexibility and choice in who should be able to be named as parents of a child on the birth certificate.²¹ The group Prospective Lesbian Parents, for example, argued that:

*there be the option for donors to be recorded on the birth certificate as 'father' alongside the birth and non-birth mother, without any legal ramifications in terms of rights and responsibilities, ie that families be allowed to define for themselves what different roles mean within their families. This is what people do unofficially, it should be reflected in official forms.*²²

One of the group's members stated:

*We believe it should reflect the family situation and have provision for parents (multiple and possibly up to four), siblings and donor (if desired but not compulsory). The current Mother/Father preprint form is out of date and causes unnecessary complications and stress, often at a time when the family is adjusting to life with a new baby.*²³

COMMISSION'S VIEW

The commission has considered these arguments, but also recognises the primary role that birth certificates play as documents with legal consequences. Having regard to these consequences, the commission believes that only those people who are recognised as the legal parents of the child should be named on the birth certificate. Given our recommendation that in all cases donors should be presumed at law not to be parents, it follows that a donor should not be recorded on the register of births or on a child's birth certificate.

Although birth certificates do have symbolic value for many people, that is not their primary purpose. To include information on the birth certificate that does not give rise to legal obligations and which does not assist in identifying a person for legal and administrative

13 *Births Deaths and Marriages Registration Act 1998 (WA)* s 19.

14 Information provided by Births, Deaths and Marriages (Department of Justice) Western Australia (30 March 2006).

15 *Births, Deaths and Marriages Registration Act 1996* s 16(1)(f).

16 The registrar is empowered to conduct an inquiry to ascertain the particulars of a birth: *Births, Deaths and Marriages Registration Act 1996* s 42.

17 These and other reasons are listed in the Registry's registration of parentage details procedures.

18 Submissions CP 179 (Lesbian Parents Group), CP 198 (Dr Elizabeth Short).

19 Meeting with the Registry of Births, Deaths and Marriages, 18 February 2005.

20 The registry informed us that the notes can only be accessed by registry staff, and the information contained in the notes would be provided to the registered person upon request: meeting with Registry of Births, Deaths and Marriages, 18 February 2005.

21 For example, submissions CP 143 (The Bouverie Centre), CP 149 (Prospective Lesbian Parents).

22 Submission CP 179 (Prospective Lesbian Parents).

23 'Kate', quoted in submission CP 179 (Prospective Lesbian Parents).

14

Chapter 14

Birth Registration



purposes would create confusion about a person's legal status in respect of the child. This could lead to problems with organisations such as government agencies, schools and health providers. It is also likely that a birth certificate listing such information would not be accepted for official purposes both within Australia and internationally.

If a man is named as the father of a child on the birth certificate, he is presumed for legal purposes to be the father and the certificate may be produced in court as evidence that he is a parent of the child in order to establish a legal right or obligation.²⁴ For example, if a donor is named as the father on the child's birth certificate, the child could produce the birth certificate in support of a claim to the man's deceased estate. This would clearly conflict with the provisions of the Status of Children Act that remove any legal responsibilities from the donor.²⁵ Although the presumption could be rebutted by reference to section 10F of the Status of Children Act, it is undesirable for this conflict to arise in the first place.

In the next chapter we discuss where information about both known and unknown donors should be recorded, and how that information is and should be managed.

24 *Births, Deaths and Marriages Registration Act 1996* s 46; *Status of Children Act 1974* s 8; *Family Law Act 1975* (Cth) ss 69R, 102.

25 If it can be proven that the man is not the father of the child (either because he is not biologically the child's father or because his legal parental status has been extinguished), the presumption can be rebutted and changed on the births register and the birth certificate: *Births, Deaths and Marriages Registration Act 1996* s 43.

Chapter 15


Access to Information

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Victorian law recognises the right of donor-conceived people to obtain information about their genetic origins. The *Infertility Treatment Act 1995* established a new regime for the collection of and access to donor information considered to be of fundamental importance to people conceived using donated gametes. Whereas once donors were guaranteed anonymity, their identity can now be released to the child once he or she is 18 years old.

Victoria's regime for the collection of and access to donor information is considered to be at the forefront of public policy in this area. However, some people believe that the current system does not go far enough and others believe that in some areas it goes too far. The following specific questions have been raised during our consultations.

- Should there be a legal obligation imposed on parents to inform children that they were conceived through the use of donated gametes?
- Should donors be able to access information about children conceived through the use of their gametes?
- Should women who self-inseminate outside the clinic system be required to identify the name of the donor to be included on the central donor register?
- Should donor-conceived children be able to apply for access to information about their donors before they are 18 years old?
- Should people conceived through the use of gametes donated prior to 1 January 1998 (before the new regime came into effect) be given access to information about their donors even where the donor was guaranteed anonymity?
- Should the donor registers be managed by the Registry of Births, Deaths and Marriages instead of the Infertility Treatment Authority (ITA)?

In this chapter we address each of these questions and make recommendations for law reform.

CURRENT LAW

The ITA maintains registers which include information about births arising from the use of donor sperm, eggs or embryos. The registers are not accessible to the public, unlike the register of births. The registers contain the following information: the name and sex of each child born as a result of a donor treatment procedure carried out in a licensed clinic or by a licensed doctor; the donor's code number, name and contact details; the names and contact details of

the recipient parents; and details of any physical abnormalities of any of the parties.¹

The Infertility Treatment Act governs who may obtain access to the information contained in the registers, and under what conditions. Different provisions apply according to when the donation was made. Table 15.1 summarises the contents of the various registers maintained by the ITA, and Tables 15.2 and 15.3 contain statistics on the number of people whose details were included on the registers as at 31 December 2006. In the following section, we explain the scope of the registers in more detail.

DONATIONS AFTER 1 JANUARY 1998

On 1 January 1998, the Infertility Treatment Act introduced a new legal regime covering applications for release of information about gamete donations. The Act established the 1995 central register, which contains information about all births arising from donations made on or after 1 January 1998.

Since this date, anyone undergoing a donor treatment procedure has been provided with counselling in relation to advising children about their donor origins and rights to information.²

Under the Act, donors, children and recipient parents can make applications for the release of identifying and non-identifying information about the other parties. Before releasing any information contained in the registers, the ITA must refer the applicant to counselling and must make reasonable efforts to find the person to whom the information relates to advise him or her that the information is about to be released.

People conceived with gametes donated on or after 1 January 1998 are able to obtain information identifying their donors when they are 18 years old, without the need to obtain the donor's consent.³ If they wish to access this information before they are 18 years old, the application must be made by their parents and the release of the information is subject to the donor's consent.⁴ If the donor does not consent to the release of his or her identity, non-identifying information can still be provided to the child's parents.⁵

Donors may apply for information about people born through the use of their gametes and about the recipient parents.⁶ The ITA can only release information that identifies children if the recipient parents consent or, with the child's consent if he or she is 18 years or over. If the ITA receives such an application from the donor, it must try to contact the recipient parents or donor-conceived person to advise them of the application, seek their consent and refer them to counselling.⁷

DONATIONS BEFORE 1 JANUARY 1998

Prior to the introduction of the 1995 central register, information about births arising from donor treatment procedures was recorded in the 1984 central register.⁸ This register contains information about births arising from donor treatment procedures carried out using gametes donated between 1 July 1988 and 31 December 1997.

Parents, donor-conceived people over 18 years of age and donors are able to access non-identifying information contained in the 1984 central register.⁹ Identifying information can only be released if the person to whom the information relates has consented.

Gametes donated prior to 1 January 1998 continued to be used until 31 May 2006. This means that some children born after 1 January 1998 do not have an automatic right to access the identity of their donor when they are 18 years old, while children born through the use of gametes donated since 1998 do have access. From 1 June 2006, gametes donated prior to 1998 can no longer be used for the formation of new families, but may be used for the formation of siblings in existing families.¹⁰

DONATIONS BEFORE 1 JULY 1988

Prior to 1 July 1988, the only information identifying donors was kept in hospital or doctors' records. The only way for people to obtain information about births arising out of treatment procedures carried out before this date is if the information has been voluntarily

provided to the ITA or if a clinic is able to contact the people who donated gametes at that time. The ITA has notified us that it now has access to the records from the infertility treatment centre that used to operate at Prince Henry's Hospital (now closed).¹¹

VOLUNTARY REGISTERS

In 2001, the ITA established a voluntary register to record information about treatment procedures which occurred before 1 July 1988.¹² People born as a result of treatment procedures before that date, donors, parents and relatives can ask the ITA to enter their names and addresses and preferences for exchange of information.

The ITA also maintains a register which contains information that has been voluntarily provided by donor-conceived people, recipient parents and donors associated with donor procedures since 1 July 1988 (the post-1988 voluntary register).¹³ This register enables donors to indicate in advance that they agree to the release of their identity if the recipient parents or child apply for information.

The ITA may only release the information contained in the voluntary registers in accordance with the wishes of the person to whom it relates.¹⁴ The information recorded on the voluntary registers may include a person's wishes about contact, photographs, letters and medical information. The voluntary register is currently the only avenue (apart from informal processes such as support groups) for a donor-conceived person to locate other people conceived with gametes donated by the same donor.

Table 15.1 Summary of Registers

REGISTER NAME	APPLIES TO DONATIONS	RIGHT TO INFORMATION
1995 central register	1 January 1998 – present	Donor-conceived person aged 18 years and over can automatically obtain identifying information about the donor. Donor can only obtain identifying information about the donor-conceived person with consent of the parents, or the person born when aged 18 or over.
1984 central register	1 July 1988 – 31 December 1997	Consent of the person to whom the information relates is required for the release of identifying information.
Voluntary register (1)	Prior to 1 July 1988	Information provided voluntarily and exchanged in accordance with that person's wishes.
Voluntary register (2)	Post 1 July 1988	Information additional to that contained in the 1984 and 1995 central registers may be lodged and exchanged in accordance with contributor's wishes.

1 *Infertility Treatment Act 1995* pt 7, div 1.

2 *Infertility Treatment Regulations 1997* r 6(f)(v).

3 *Infertility Treatment Act 1995* s 79.

4 *Infertility Treatment Act 1995* ss 74, 75(2).

5 *Infertility Treatment Act 1995* s 75(1).

6 *Infertility Treatment Act 1995* s 76.

7 *Infertility Treatment Act 1995* s 77.

8 *Infertility (Medical Procedures) Act 1984* s 22 (now repealed). The 1984 register now forms part of the 1995 central register: *Infertility Treatment Act 1995* s 182(3).

9 Section 181 of the *Infertility Treatment Act 1995* applies the relevant access provisions to applications for information kept in the 1984 central register, excluding the right of the child to information that identifies the donor: see ss 184(3), (4).

10 *Infertility Treatment Authority, Conditions for Licence: Applications for Licences by Hospital and Day Procedure Centres* (6th ed, 2006), section 5.10.

11 Information provided by the Infertility Treatment Authority, 2 February 2007.

12 *Infertility Treatment Act 1995* pt 7A (inserted by *Infertility Treatment Amendment Act 2001*).

13 *Infertility Treatment Act 1995* s 82.

14 *Infertility Treatment Act 1995* ss 92F, 82.



Table 15.2 Central Register as at 31 December 2006

	BIRTH REGISTRATIONS		DONOR REGISTRATIONS	
	2006	TOTAL AT 31 DEC 2006	2006	TOTAL AT 31 DEC 2006
1984 central register	39	2538	3*	581
1995 central register	202	995	109	572

*Since 1998, no new donors have been recruited under the 1984 legislation. However registration can only occur when the ITA receives information about a birth.

Table 15.3 Voluntary Registers as at 31 December 2006

	REGISTRATIONS AT 31 DECEMBER 2006		
	DONOR	OFFSPRING	RECIPIENT FAMILY
Pre-1988 voluntary register	54	26	13
Post 1988 voluntary register	47	0*	58

*Only donor-conceived offspring over 18 years can apply directly to the registers. At the time of writing, all applications to the ITA by donor-conceived offspring have been made directly to the central register (information provided by the ITA, 27 February 2007).

TIME TO TELL CAMPAIGN

In May 2006 the ITA launched a campaign called *Time to Tell*.¹⁵ Newspaper advertisements alerted families to developments in the law and research on the experiences of families created with the assistance of donor conception. Although the Infertility (Medical Procedures) Act had been in operation since 1988, some provisions only came into practical effect from 1 July 2006. From this date, the children recorded on the 1984 central register began turning 18, and acquired the right to make applications for information about donors in their own right, without the consent of their parents. At the same time, applications by donors for identifying information about people conceived with their gametes who had now turned 18 would be sent directly to the young adults, rather than to their parents.

This development sparked fears among parents that people who were not already aware of their genetic origins would discover the truth when they received a letter from the ITA. The ITA campaign sought to allay some of these anxieties by forewarning parents and offering to assist them to tell their children, if they had not already done so. The ITA offers counselling and other support, both for parents wanting to tell their children, and for parties initiating or responding to applications for information kept on the registers.

DONOR INFORMATION

During our consultation process, we heard a variety of views about the process for the provision of information about donor conception. We also examined research about the experiences of donor-conceived people.

DISCLOSURE OF DONOR STATUS

Many children born as a result of the use of ART are not informed that they are donor-conceived, despite the fact that parents have been counselled for many years that it is in the best interests of children to know. A study conducted in Victoria found that only 37% of families surveyed had told their children that they were donor-conceived.¹⁶ The number of families willing to tell their children varies in different countries, sometimes as a result of different legislation and policy. For example, some European studies have shown that between 43%¹⁷ and 82%¹⁸ of parents plan not to tell their children. Some recent studies suggest that the decision to tell children about their conception is increasingly common.¹⁹

There are many reasons parents do not tell children they were donor-conceived. Eric Blyth and Irene Ryll list the factors which have been found to influence parents' decisions:

1. they are often advised by clinics not to tell;
2. in the case of donor insemination, disclosure reveals the father's potentially stigmatizing fertility difficulties;
3. disclosure may alienate the child and damage family relationships between the child and the non-genetically related parent, between the parents and between the family and the extended family;
4. disclosure may damage the child's self-image;
5. limited information about the donor means that parents are unable to answer any questions the child may have;
6. parents do not know how to tell their child;
7. if this information is disclosed to others, they may stigmatize the child and/or the whole family.²⁰

Several submissions argued that as society becomes more accepting of assisted reproduction and donor conception, parents will become more willing and able to tell donor-conceived children about their genetic origins. The Victorian Infertility Counsellors Group argued that society can 'through community debate and education endeavour to establish a climate within our community where couples feel comfortable about telling'.²¹ ACCESS drew a parallel between adoption and donor conception in its submission:

ACCESS considers that it would be desirable for all parents of donor-conceived children to inform their children of the circumstances of their conception. Children have a right to know their genetic heritage. However, we do not believe that imposing a legal obligation on parents would achieve this purpose. As noted, it would be impossible to enforce such an obligation. Additionally, prescribing what should occur in the family home rarely facilitates co-operation. We believe that it would be more effective to actively encourage parents to disclose this information to their children, and to educate them about the pros and cons of the issue.

As an analogy, it was once rare for adoptive parents to tell their children about their adopted status. However, over the last few decades, this notion of secrecy and shame has been debated, discussed and debunked and it has now become commonplace for adoptive parents to disclose the fact of their adoption to their children. It is, in fact, taken for granted. We would hope that there will come a time when such disclosures are just as common and relaxed for the parents of donor children.²²

The emerging research conducted into outcomes for children conceived with donated gametes indicates that some donor-conceived children have experienced negative outcomes associated with the method of their conception, some of which relate to the impact of delayed discovery of their genetic heritage and/or the inability to discover the identity of their donors.²³ The commission also received submissions from and consulted with a number of donor-conceived people who have experienced frustration, grief, anger and other reactions since discovering that they were donor-conceived.²⁴

However, some recent international studies examining families with donor-conceived children suggest that parents are increasingly committed to telling children about their genetic origins, and that those children who have been informed from a young age are generally reconciled to the situation. The research indicates that the families are functioning positively.²⁵

Overall, with few exceptions, the youths appeared positive and comfortable about their origins and looked forward to obtaining their donors' identities.²⁶

The commission is strongly in favour of parents informing their children of their genetic origins from a very early age, as are people who work in this area, including doctors, counsellors, researchers, policymakers and regulators.²⁷ Early disclosure is clearly an important factor in avoiding some of the negative outcomes experienced by donor-conceived people.

In Chapter 5 we recommended that a new guiding principle be introduced into the new Act, namely that 'all children born as a result of the use of donated gametes have a right to information about their genetic parents'. This principle reflects the findings of studies which

- 15 For details about the *Time to Tell* campaign see the ITA's website: <www.ita.org.au>.
- 16 Jenny Blood et al, *Parents Decision to Inform Children of their Donor (Sperm) Conception and the Impact of a Register which Legislates to Enable Identification of Donors* (Unpublished, Royal Women's Hospital Melbourne and the University of Melbourne), copy provided by Jenny Blood.
- 17 E Lycett et al, 'School-Aged Children of Donor Insemination: A Study of Parents' Disclosure Patterns' (2005) 20(3) *Human Reproduction* 810, 813.
- 18 Susan Golombok et al, 'Social Versus Biological Parenting: Family Functioning and the Socioemotional Development of Children Conceived by Egg or Sperm Donation' (1999) 40(4) *Journal of Child Psychology and Psychiatry* 519, 524.
- 19 E Lycett et al, 'School-Aged Children of Donor Insemination: A Study of Parents' Disclosure Patterns' (2005) 20(3) *Journal of Child Psychology and Psychiatry* 810, 810-11; Anne Brewaeys et al, 'Anonymous or Identity-Registered Sperm Donors? A Study of Dutch Recipients' Choices' (2005) 20(3) *Human Reproduction* 820, 820.
- 20 Eric Blyth and Irene Ryll, 'Why Wouldn't You Tell? Telling Donor Conceived Children about Their Conception' (2005) 15(1) *Health Ethics Today* 4, 4.
- 21 Submission CP 155 (Victorian Infertility Counsellors Group).
- 22 Submission CP 192 (ACCESS).
- 23 A J Turner and A Coyle, 'What Does it Mean to be a Donor Offspring? The Identity Experiences of Adults Conceived by Donor Insemination and the Implications for Counselling and Therapy' (2000) 15(9) *Human Reproduction* 2041.
- 24 Submissions PP2 265 (Myfanwy Walker), PP2 214 (Narelle Grech), CP 91 (Karen Clarke), CP 234 (Christine Whipp); consultation with TangledWebs, 12 November 2004.
- 25 See J E Scheib et al, 'Adolescents with Open-Identity Sperm Donors: Reports from 12-17 Year Olds' (2005) 20(1) *Human Reproduction* 239, 240; Emma Lycett et al, 'Offspring Created as a Result of Donor Insemination: A Study of Family Relationships, Child Adjustment, and Disclosure' (2004) 82(1) *Fertility and Sterility* 172; E Lycett et al, 'School-Aged Children of Donor Insemination: A Study of Parents' Disclosure Patterns' (2005) 20(3) *Human Reproduction* 810, 815; Clare Murray and Susan Golombok, 'To Tell or Not to Tell: The Decision-Making Process of Egg-Donation Parents' (2003) 6 *Human Fertility* 89, 94.
- 26 J E Scheib et al, 'Adolescents with Open-Identity Sperm Donors: Reports from 12-17 Year Olds' (2005) 20 (1) *Human Reproduction* 239, 248.
- 27 This was evident through numerous consultations including our roundtable discussions (held on 4 October 2004 and 6 February 2006) and in submissions the commission received, including submissions PP2 72 (Fertility Society of Australia), PP2 206 (Victorian Committee, Donor Conception Support Group), PP2 270 (Infertility Treatment Authority), PP2 350 (South Australian Council on Reproductive Technology).



RECOMMENDATIONS

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.

have highlighted the importance of children being told they were donor-conceived and having access to the identity of their donors. It can also be argued that the *Convention on the Rights of the Child* creates such a right.²⁸ Incorporating this principle in the legislation that regulates the provision of ART services in Victoria would reinforce the expectation that parents tell their children about their donor-conception.

The commission agrees with those people who argued in submissions that a legal obligation should not be imposed on parents to inform their children of their genetic origins.²⁹ Such an obligation would be intrusive and unenforceable. Many people we consulted have also argued that if such an obligation were to be imposed on parents of donor-conceived children, the obligation to tell children about their genetic origins should also be imposed on all parents.

Instead, the commission recommends that more supportive strategies be adopted to encourage parents to tell their children. Education and counselling should continue to remain central to donor treatment procedures, not only before the procedure, but also after the child is born. Parents need to be supported and provided with assistance to begin to tell their children about their genetic origins early in life. The ITA's *Time to Tell* campaign is an important and substantial step in this direction. The ITA has informed the commission that within the first seven weeks of the campaign, it received requests for support and counselling from 40 parents, 24 donors, four donor-conceived young adults and two relatives of donor-conceived people. A number of the parents seeking support have since confirmed that they had told their children they are donor-conceived and that this had been a positive experience.³⁰

As part of this campaign, the ITA released the results of its own research with donor-conceived families, *Telling about Donor Assisted Conception*.³¹ The researchers interviewed 34 people, including donor-conceived adults, recipient parents, an egg donor and infertility counsellors. The research revealed that even where parents intend to tell their children about their conception, they find it difficult to do so and would value specific guidance on when and how to tell. The report concludes that:

Resources are needed for donor-conceived children or adolescents who have always known about their conception and those who have only recently been told, and should cater for a variety of family types.

*Counselling and resources must also recognise the diverse individual responses to donor-assisted conception. Donor-conceived adults may need help in identifying their donors and opportunities to meet other donor-conceived people. Although not everybody felt in need of counselling, the service should take account of 'telling' as a process and not an event, and thus be available long after donor-assisted conception has taken place, for parents, donor-conceived people and families.*³²

Professor Ken Daniels, a social worker who has worked closely with parents of donor-conceived children and has been involved in numerous international studies of donor-conceived families, believes that the key to encouraging people to be honest with their children is to work with them to build confidence about how they have created their families.³³ Professor Daniels advocates sharing information with friends and family, and other families who have used donated gametes, and preparing parents to talk to children about the story of their creation.

The Donor Conception Support Group has also advocated equipping parents with resources to tell their children about their genetic origins:

This should take as many forms as possible. Information kits, counselling, seminars, videos and any other method available should be employed.

But in the rush, do not forget to equip the children to come to terms with this new information. The same range of services and facilities should be available to them as for their parents but these facilities and services should be aimed specifically at the child/adult. These services should include counselling, support networks etc.

*Another important resource would be ... information packs for schools. This would allow teachers to appreciate what these children are going through. This should include guidance on the issues that these children might have and the type of support that they may need.*³⁴

Several children's books about donor conception are now available.³⁵ Parents can use these books to help children understand how they were conceived. The Donor Conception Network (UK) has produced a DVD and four booklets to support and guide parents in telling their children about their conception at different developmental stages, including adulthood.³⁶

DONOR ACCESS TO INFORMATION

Donors are able to request identifying information about people born as a result of donor treatment procedures using their gametes and/or the parents of those people. For such information to be released, the donor-conceived person, if he or she is aged over 18, must consent. If the child is aged under 18, both of the child's parents or a guardian must consent. If a donor approaches the ITA and requests information identifying a child born using his or her gametes who is now over 18, the ITA is required to contact the donor-conceived person to seek consent to the release of the information.

This provision has recently been subject to considerable debate. Some stakeholders, in particular those in the medical profession, have called for it to be repealed. They fear that people who were previously unaware of their origins will be traumatised as a result of being contacted by the ITA to advise them of the donors' application. Submissions received from doctors practising in this area also regard this as an invasion of the child's and recipient family's privacy, and an inappropriate role for the state to play. Professor Gordon Baker, for example, wrote:

I believe this is an unacceptable infringement of privacy and interference in the family. This part of the law should be removed and donors should not have the right to identifying information about the child. Because of this section, the Infertility Treatment Authority is intending to send patients a relatively open letter once they are informed of the birth of a child after a donor procedure, explaining that this contact with the child might occur. This letter might be seen as an attempt by the ITA to coerce the parents to tell the child of the involvement of the donors in their conception. I do not believe the parliamentarians understood that this would be the result of the provisions in the Infertility Treatment Act 1995. The sections about donor gametes and embryos should be revised to leave the decision about telling the children of the mode of conception to the parents.³⁷

Similar arguments were made by Professor Robert McLachlan:

To return to the current ITA legislation, one cannot begin to imagine the traumatic and devastating effect of the revelation, that they were ... donor conceived. This

could have a catastrophic effect on their relationship with their social parents and may have profound adverse effects on other aspects of their psychological health.

In summary, I believe that the ITA legislation must be changed such that only the adult donor-conceived person can initiate any correspondence after their 18th birthday. I reiterate that I personally believe that couples should be open, but I cannot see that it is ethically necessary or legally possible for them to be compelled to do so. Further the State would be committing a grave error by an unannounced re-entry into the lives of the child and the parents many years later. The revelation of their likely DI [donor insemination] origin could have devastating effects that, in essence, would be much more serious than the child having never been told.³⁸

However, some argue that this provision serves an important purpose in supporting the child's right to know about his or her genetic origins. Because so many parents have not informed their children they are donor-conceived, being contacted by the ITA may be the only way the child will find out. The prospect of the child being contacted by the ITA may also act as an incentive for parents to inform their children from an early age:

Since this is the only provision which may encourage parents to tell (it doesn't force parents to tell), and disclosure is considered of paramount importance to the well-being of the child, it seems that removing this provision is only serving to alleviate the concerns of some doctors and some parents. How can it be an invasion of privacy if the donor can't actually receive identifying information without consent? If the concern is actually that contact via the ITA may expose secrecy within the family, surely the only conclusion can be that honesty is the best policy and ultimately in the best interests of the donor-conceived adult.³⁹

Although being contacted without warning by the ITA may be traumatic, ultimately children may come to appreciate having received this information, as has been the case with many adopted people who have been sought out by their birth parents. Some people consulted by the commission also suggested that the ITA should send letters to every donor-conceived person once they are 18 years old, as another means of ensuring that people will find out that they were donor-conceived.⁴⁰

- 28 John Tobin, *The Convention on the Rights of the Child: The Rights and Best Interests of Children Conceived Through Assisted Reproduction* (2004) 35–40.
- 29 Submissions CP 143 (The Bouverie Centre), CP 149 (Prospective Lesbian Parents), CP 155 (Victorian Infertility Counsellors Group), CP 174 (Professor HWG Baker), CP 167 (Victorian Gay and Lesbian Rights Lobby), CP 192 (ACCESS), CP 231 (Victoria Legal Aid).
- 30 Information provided by Infertility Treatment Authority on 31 July 2006.
- 31 Infertility Treatment Authority, Victoria, *Telling About Donor Assisted Conception: Interviews with Donor Conceived Adults, Parents and Counsellors* (2006).
- 32 Ibid 2.
- 33 Ken Daniels, *Building a Family with the Assistance of Donor Insemination* (2004).
- 34 Submission PP2 206 (Victorian Committee, Donor Conception Support Group).
- 35 The Donor Conception Support Group website lists a range of resources about donor conception for parents and children <www.dcsq.org.au> at 18 July 2006. The ITA website also has links to some resources: <www.ita.org.au> at 18 July 2006.
- 36 The booklets are available from the Donor Conception Network's website: <dcnetwork.org> at 19 July 2006.
- 37 Submission CP 174 (Professor HWG Baker).
- 38 Submission CP 237 (Professor Robert McLachlan).
- 39 Submission PP2 265 (Myfanwy Walker).
- 40 Consultation with TangledWebs, 12 November 2004.

RECOMMENDATIONS

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 the person is 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.

In its submission, the Donor Conception Support Group emphasised the entitlement of donor-conceived people to be made aware of their origins:

The DCSG experience in speaking to donor conceived adults makes one thing very clear and compelling. They maintain that it is a child's right to know of their genetic origins. The news should ideally come from their parents but if the parents are not willing to tell them then someone else should do so ... In the case where the offspring have reached 18 and are therefore adults, their rights in these matters can in no way be considered subordinate to those of their parents ...

It should be remembered that for an adult offspring the passing of years can introduce special issues:

- *Ill health or a medical condition may prompt genetic testing which will reveal that they are not a genetic match with their parents.*
- *The death of a parent or the donor may rob the offspring of the opportunity to ever talk to them.*

There are no doubt other equally unsatisfactory circumstances in which an adult offspring may accidentally learn of their genetic origins. But by learning the truth in these circumstances, they must contend with the news on top of an already traumatic situation.⁴¹

The commission has considered these competing arguments. Because Victoria is the first jurisdiction in the world to legislate for the exchange of information between donors, parents and donor-conceived people, there is no direct experience to guide policy decisions on this topic. However, we do know that at present the majority of donors with whom the ITA has had contact respect the privacy of the recipient families and have no intention of applying for information about the person conceived with their gametes.⁴² Instead, they are willing to make themselves available should the child or young adult wish to make contact in the future.

The commission believes that once a donor-conceived person reaches adulthood, she or he should be the only party able to apply for information on the central register. The donor registers have been established for the benefit of donor-conceived people, who should have ownership of the process of information exchange. A donor should therefore not have the

right to apply for identifying information about a person conceived with their gametes.

The most appropriate way for children to discover they are donor-conceived is for them to be informed by their parents. The state should not do so, whether as the result of an application by the donor, by letter, or by some sort of annotation on the child's birth certificate. Parents should be encouraged to inform their children of their genetic origins through education and the provision of support and assistance. Gradually, the community and parents will become more open and honest about donor conception, just as they did with adoption. Implementing provisions designed to coerce parents to inform their children would be heavy-handed and may even encourage parents to undertake measures to avoid having their child's birth registered on the central register.

We do not believe that donors should be treated in the same way as the birth parents of an adopted child. Donors have never been regarded as parents of the children conceived and have never had relationships with the children that would justify enabling them to initiate contact.

Removing the donor's capacity to apply for identifying information will not necessarily preclude the donor from ever having contact with the child. If the child is younger than 18, the donor can apply to contact the recipient parents and the parents may consent to contact while the child is a minor. When the child reaches 18 years of age, he or she may initiate contact with the donor. Donors should continue to be able to register their wishes about contact and this information should be provided if the donor-conceived child or adult chooses to seek them out.

The commission believes that the only circumstance in which it should be possible for donors to prompt the ITA to contact people conceived with their gametes is where a donor becomes aware of a medical condition which may have been transmitted to the child. In these circumstances, donors should be encouraged to provide the relevant information to the ITA to be passed on to the donor-conceived person. Such information would relate to any genetic disease which has emerged since the time of donation. We recommend the following process be implemented:

- Donors should be encouraged to advise the ITA 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.

- The ITA should pass on any information received at any time from the donor to the parents of the donor-conceived person, if that person is under 18. Otherwise the information should be provided directly to the donor-conceived person.
- When passing on the information to the donor-conceived person, the ITA should offer him or her information and counselling about the significance of the information.
- If a clinic becomes aware of relevant genetic information about donors, it should pass that information on to the ITA.

The commission believes that these changes should have retrospective effect. That is, people who have already donated gametes which have been used in the conception of a child should no longer be able to initiate contact with the donor-conceived person. We acknowledge that this proposal would affect the existing rights of some donors, and therefore recommend that donors have a window period of 12 months in which to make an application for information under existing provisions. After this time period, all donors should be subject to the new procedures, regardless of the date on which they made their donation.

GENETIC SIBLING INFORMATION

Access to information about genetic siblings was not discussed in the position papers, but it was subsequently raised as an issue in consultations. The ITA submitted that there is considerable interest from donor-conceived children to obtain information about any donor-conceived siblings. Particular issues for donor-conceived children include fears of unknowingly entering into incestuous sexual relationships and the desire to know one's biological family. These concerns are heightened within particular social or ethnic communities where there may only be a small number of donors available. Currently, linkage of siblings only occurs via the voluntary registers. There is no provision in the Infertility Treatment Act for siblings to make applications for information from the central register.

The Australian and New Zealand Infertility Counsellors Association (ANZICA) raised similar concerns in its submission. ANZICA suggested that it should be possible for donor-conceived people to access information about siblings or half-siblings which could be aligned with donors' rights of access to information. The NHMRC guidelines also support the entitlement of donor-conceived people to information about their genetic siblings, although they state that

if a donor-conceived person has not registered consent to being contacted by a genetic sibling, no identifying information about the sibling should be released.⁴³

The commission does not believe it is appropriate to recommend that people be able to make direct applications for information about donor-conceived siblings. The voluntary register is a more appropriate means for exchanging this information because it relies on both parties being willing to make contact and to be sufficiently mature to do so. If someone is concerned that they are related to a person with whom they are about to embark on a relationship, both parties can apply to the ITA for information about their donors to see if they have a donor in common; they can also have DNA tests.

DNA TESTING

The Victorian legislation emphasises the right of donor-conceived children to discover their genetic origins. However, as it currently operates, the donor register system cannot conclusively ensure that all donor-conceived people will discover the identity of their genetic parents, even if they are able to obtain information about the donor whose gametes were used.

It is always possible that a child was actually conceived with the sperm of the mother's husband or partner, or possibly another man with whom she has had intercourse. There is also the possibility that the information contained on the register is inaccurate, as a result of a data-entry error at the time the clinic recorded the information or when it was passed on to the ITA, or when the information was entered on the ITA registers. It should be noted, however, that the ITA is taking steps to cross-check all information on the registers to ensure, as far as possible, that the information is correct.

This uncertainty is one of the matters discussed during counselling with donors and donor-conceived people before they are put in touch with each other. DNA testing is the only way to be certain of genetic identity.

In the United Kingdom, a voluntary information exchange and contact register has been established to help people conceived with donated gametes prior to 1991 to trace their donors and genetic siblings. The organisation UK Donorlink relies on DNA test results to establish links between donor-conceived adults, donors and genetically related half or full siblings.⁴⁴

The commission considered whether DNA testing should be a requirement for people being linked through the central or voluntary

41 Submission PP2 206 (Victorian Committee, Donor Conception Support Group).

42 Information provided to the commission by the Infertility Treatment Authority on 28 April 2006.

43 National Health and Medical Research Council, *Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research* (2004) 6.1, 6.13.2.

44 See the website for UK Donorlink <www.ukdonorlink.org.uk>.



RECOMMENDATIONS

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.
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.

registers. We have concluded that access to DNA testing should remain an option to be discussed during counselling, as has been proposed by the ITA. The commission believes that it would be heavy-handed, intrusive and expensive to require people to undergo DNA testing.

CHILDREN CONCEIVED OUTSIDE THE CLINIC SYSTEM

The details of all donors whose gametes are used to conceive children with the assistance of clinics must be recorded on the ITA donor registers. By contrast, women who conceive as a result of self-insemination outside the clinic system are under no obligation to have the names of donors recorded on the donor registers. However, the Registry of Births, Deaths and Marriages regards the donors in these cases as fathers and seeks to have their names recorded on the birth register. As discussed in Chapters 6 and 14, uncertainty about the legal status of donors has caused many women to fear recording donors' names on official documents.

Many submissions from women without male partners who have had or are intending to have children using donated gametes expressed a strong commitment to telling their children and assisting them to make contact with the donors.⁴⁵ The Victorian Gay & Lesbian Rights Lobby notes that 'within the gay and lesbian community, it is common, if not universal, for parents to tell their children about the circumstances of their conception'.⁴⁶

While women who self-inseminate are likely to tell their children they are donor-conceived, it may not be possible to identify the donor, particularly in cases where the only contact the women have had with the donor is for the purpose of the donation. Registration of a donor's details would benefit a child if the mother and her partner die or become incapacitated before being able to pass on the donor's identity to the child. The commission strongly supports the right of donor-conceived people to have access to information about their donors, and believes they should have access to that information regardless of where they were conceived.

The Victorian Gay & Lesbian Rights Lobby supported the introduction of a requirement that a woman who self-inseminates with sperm from a known donor provide the donor's details to the ITA because it would provide 'equality and consistency for all children conceived in this way, whether via a clinic procedure or by self-insemination'. However, they said that such a provision 'should only be considered as part

of legislative reform that explicitly recognises that the non-birth mother is a parent ... and the known donor is not a parent'. The organisation Prospective Lesbian Parents and The Bouverie Centre both echoed these views.⁴⁷ The Bouverie Centre said that information about the donor should be recorded at the time of registering the child's birth.

As discussed in Chapter 14, the commission believes the identity of a known donor should not be recorded on the register of births. It is more appropriate for the donor's details to be registered with the ITA.

However, there are reasons why it would not be feasible to impose an obligation on women who self-inseminate to provide the names of the donors to the ITA. Such an obligation would be extremely difficult to enforce, and under the current regime it is only possible to register donors if they consent. The ITA noted that gamete donation 'exists in the context of a regulatory regime that imposes certain responsibilities on donors, and transfers certain rights to children born as a result'. However, the ITA queried whether a donor for a self-insemination procedure would satisfy the legislative definition of a donor, and therefore fall under its ambit.⁴⁸

Further, as submitted by Dr Maggie Kirkman, supportive strategies are more likely to achieve the desired outcome than the threat of penalties for non-compliance:

While it is important that all donor-conceived people have access to information about their donors, and it is a valuable addition to the register to include children conceived using a known donor outside the clinic system, I do not agree with penalties for those who fail to do so. Providing a social and legal climate in which women are not afraid of the consequences of registering the donor is more likely to be effective and will not harm children as penalties would.⁴⁹

For these reasons, the commission recommends that strategies be implemented to encourage women who self-inseminate to register the names of the donors with the ITA. When a single woman or a same-sex couple applies to register a child's birth, the Registry of Births, Deaths and Marriages could provide them with information about the donor registers, point out the importance of recording the identity of donors and refer them to the ITA to process the registration. The Donor Conception Support Group suggested that the registry offer

an information pack detailing how to record information for children.⁵⁰ Dr Ruth McNair submitted that information be made available about the security of register information, so that people feel comfortable identifying donors to the ITA.⁵¹

The ITA would need to obtain the consent of donors before entering their details onto the register, and should provide information to them about the ramifications of being registered.

CHILDREN'S ACCESS TO INFORMATION

Currently, donor-conceived children who are under the age of 18 are not independently able to access information about their donors. Applications for identifying information about donors can only be made by the parents. Accordingly, even though the right to access information about the donor is often expressed to be the child's right, the right does not come into effect until the child reaches adulthood. John Tobin argues that it is difficult to justify denying access to identifying information about donors until children are 18 years old when the available research demonstrates that the capacity to obtain access to this information is of fundamental importance to children.⁵²

The commission believes that children who want to obtain information about donors, whether identifying or non-identifying, should be able to access that information without the need for the consent or assistance of their parents. Many children become particularly curious about donors and other issues concerning their identity in their early teenage years.

We recommend that a child be able to apply for information about a donor at any age, but that the release of the information should remain subject to an assessment by a counsellor that the child has sufficient maturity to understand the nature of the information and the possible consequences of making contact with the donor. However, we do believe it would be appropriate for the views of the child's parents to be sought, and if the child would prefer that his or her parents not know about the application, that it be possible to withdraw the application at that point.

RETROSPECTIVE ACCESS TO INFORMATION

Donor-conceived people born as a result of ART using gametes donated before 1 January 1998 are unable to access information unless the donors have consented to the release of information or have applied to the ITA to be entered onto the voluntary register. Some donor-conceived people we consulted are frustrated at their inability to find out about

their genetic origins and their extended genetic families.⁵³ They are seeking retrospective access to information that would identify their donors, even where the donor was guaranteed anonymity, in the same way as adopted people were given the right to access records about their birth parents.

The commission does not support the retrospective removal of the anonymity of people who donated gametes before this date, but does believe that more can be done to facilitate approaches to donors to find out if they are prepared to provide identifying information.

During consultations, concerns were expressed about clinics contacting donors directly, and the absence of any protocols dealing with such contact. It would be preferable for people experienced in mediating contact between two parties with potentially very different interests to initiate contact with donors. Clinics have assured past donors of their anonymity. Privacy laws protect the donors' details from being provided to any other party without their consent, so it is not possible for clinics to provide donors' details to a third party such as the ITA.

The commission therefore proposes a process which involves the ITA (or the new agency we recommend below) as the mediator of contact. The ITA is already experienced in making contact with parties involved in donor conception, and can also offer support services such as counselling and the provision of information. This process would be an optional pathway for donor-conceived people who have not had any success establishing contact with their donors through voluntary registers. It would be a consistent and transparent process, and should go some way to addressing the concerns of this particular group.

The commission recommends a process intended to assist people conceived with gametes donated prior to 1 January 1998 who wish to obtain identifying information about the donor when the donor has not registered his or her wishes on the voluntary register. We have detailed this process in Recommendation 99.

DONOR REGISTERS

Currently, the ITA manages donor registers. During our consultation process, several submissions queried whether it would be more appropriate for the donor registers to be managed by or connected to the Registry of Births, Deaths and Marriages.

The commission recommends that donor registers be managed by an independent entity with connections to the registry and the ITA, in

- 45 Submissions CP 33 (Tracey Petersen), CP 36 (Mary and Rachael), CP 62 (Bit Bent Buddies), CP 67 (Susan), CP 72 (Leonie Davey), CP 73 (Lauren Andrew), CP 104 (Anonymous), CP 108 (Anonymous), CP 110 (Lisa and Amanda), CP 179 (Lesbian Parents Group). A submission received from a prospective known donor also stated an intention to inform the child: submission CP 59 (Ian Seal).
- 46 Submission CP 167 (Victorian Gay & Lesbian Rights Lobby).
- 47 Submissions CP 149 (Prospective Lesbian Parents), CP 143 (Bouverie Centre).
- 48 Submission PP2 270 (Infertility Treatment Authority).
- 49 Submission PP2 117 (Dr Maggie Kirkman).
- 50 Submission PP2 206 (Victorian Committee, Donor Conception Support Group).
- 51 Submission PP2 245 (Dr Ruth McNair).
- 52 John Tobin, *The Convention on the Rights of the Child: The Rights and Best Interests of Children Conceived Through Assisted Reproduction* (2004) 40-45.
- 53 Consultation with TangledWebs, 12 November 2004.



RECOMMENDATIONS

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.
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.

a similar way to the management of adoption information. The system would need to retain important features of the ITA registers, such as the high level of confidentiality and the referral of applicants to counselling.

The decision to locate the donor registers within an agency independent of the ITA and with links to the Registry of Births, Deaths and Marriages is based on the principle that donor information is for the benefit of the child. The parents' infertility should not prevail upon the child throughout his or her life. Centralising all information about a child's birth would also help to normalise donor conception, and would treat a donor-conceived person who has a desire for information about his or her genetic parentage in the same way as other children in a similar position.

During consultations, some people supported a more integrated approach to the exchange of donor information. There was a suggestion that exchange of information between the registry and the ITA could be facilitated by a standing or advisory committee which would pay particular attention to the legislative provisions relating to the release of information. Submissions did, however, emphasise the need to ensure the confidentiality of donor information.

On the other hand, a number of submissions, including from the ITA itself, argued strongly that the ITA should maintain responsibility for managing the registers:

The ITA now sees enormous advantages for the donor registers remaining within its umbrella, because of the complexity of the information system itself, the integral role in the daily functions and responsibility of the Authority, and the ongoing nature of service provision related to the Donor Registers. The Central and Voluntary Registers cannot be separated from each other, and the latter is the ongoing, developing communication system between various interested parties.⁵⁴

The arguments in favour of registers continuing to be administered by the ITA are:

- The ITA can ensure confidentiality; it offers counselling and linking services, and is experienced in the administrative and technological aspects of the registers.
- The ITA also manages the voluntary registers, and makes links between them and the central register.
- The ITA has ongoing responsibility for the development of policy in relation to the release of information from the registers, public education, taking public enquiries and monitoring compliance.
- The bulk of time and resources for the registers is spent on communication with clinics and individuals, information management and policy development, as well as the provision of counselling; it is not merely data entry.

While these statements about current arrangements are true, the commission does not believe a separate entity would be unable to take over the responsibility for managing donor registers, provided that it has a co-operative relationship with the ITA. The commission maintains that there should be a separation of the registry and other functions of the Authority. A child's access to birth and genetic information should be treated separately from the infertility or treatment needs of his or her parents. We also believe there is merit in establishing a separate body whose primary responsibility is data collection and management. Such an entity could provide counselling and intermediary services, and should have links with the ITA and the Registry of Births, Deaths and Marriages to ensure information is accurate and is kept up-to-date with policy developments in the area of donor conception.

Our recommendations about the laws that should apply to applications for information on the donor registers in the future should be considered in light of this recommendation.


⁵² Submission PP2 (Confidential). The Infertility Treatment Authority gave permission to quote on 1 September 2006.

Chapter 16 Surrogacy



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Altruistic surrogacy is when the surrogate mother receives no payment or is only reimbursed for reasonable expenses associated with pregnancy.

This section of the report addresses specific aspects of the law governing surrogacy. Surrogacy is a practice where a woman who is, or is to become, pregnant agrees to permanently surrender the child to another person or couple who will be the child's parent or parents. We describe the woman who bears the child as the surrogate or surrogate mother and those to whom the child will be surrendered as the commissioning person or couple.

Our terms of reference covering surrogacy are more limited than those for access and parentage discussed in the previous chapters. We have not been asked to report on the threshold question of whether or not surrogacy should be permitted, facilitated or prohibited. Instead, we have been asked to consider the meaning and efficacy of the current law in relation to:

- eligibility criteria for assisted reproductive technology (ART) procedures in altruistic surrogacy arrangements
- payments in the context of altruistic surrogacy arrangements
- the legal status of children born of such arrangements.

Altruistic surrogacy is currently permitted in Victoria. The recommendations set out in this part of the report proceed on the assumption that this will continue to be the case. We have taken this approach because it reflects the current state of the law, and because our terms of reference have asked us to consider some of the legal consequences of permitting surrogacy arrangements.

TYPES OF SURROGACY

Early surrogacy arrangements commonly involved sexual intercourse between the surrogate mother and the commissioning father. They have also involved the surrogate inseminating herself with the commissioning father's or donor's sperm (self-insemination) or being inseminated by a doctor with the commissioning father's or donor's sperm (assisted insemination).

Today, surrogacy arrangements may involve the use of other forms of ART, where an embryo is formed in a laboratory and is 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.

A child who is born to a surrogate mother may or may not be her genetic child. If the surrogate's egg is used to conceive the child, it is known as partial surrogacy. If the surrogate mother is implanted with an embryo created with an egg from another woman (either the commissioning mother or a donor) it is known as gestational surrogacy. Surrogacy arrangements may be altruistic, where the surrogate mother receives no payment or only reimbursement of reasonable expenses associated with the pregnancy, or commercial, where the mother is paid a fee for conceiving or carrying the child. In altruistic surrogacy arrangements it is not uncommon for the surrogate to be a relative of one of the members of the commissioning couple, for example a sister.

There are several situations in which a person or couple may wish to commission a surrogacy arrangement:

- A woman may wish to have a child, but be unable to become pregnant or to carry a child to term for medical reasons.
- A man may want to have a child but not have a female partner.
- A homosexual couple may want to have a child, conceived using their sperm.
- A couple who are involved in an IVF treatment program may have embryos in storage. If the woman dies, her partner may want to commission a surrogate to carry and give birth to the child.¹

A woman may be unable to become pregnant, unable to carry a baby to term or be at risk of a dangerous pregnancy for a range of medical reasons. She may have had a hysterectomy or lack part of her uterus, uterine lining, ovaries or other parts of the genital tract. The commission received several personal stories from women who had considered and/or pursued surrogacy after suffering from medical conditions that prevented them from carrying a pregnancy themselves. Two women had had hysterectomies after complications during childbirth:²

Our daughter passed away five days after birth due to a rare complication during delivery called vasa previa. Because of this complication at birth I was given an emergency caesarean where an even rarer complication called placenta accreta resulted in a hysterectomy with conservation of my ovaries. I am therefore physically unable to get pregnant. We have always wanted several children and now find ourselves looking at other ways to achieve our dreams.³

One woman had had 14 unsuccessful IVF treatments,⁴ and other women had had cancer resulting in removal of their ovaries.⁵ For one woman, pregnancy was possible but dangerous because she had been treated for a hormone-receptor-positive breast cancer. She was advised by her doctor not to become pregnant for fear that the hormones associated with the pregnancy could trigger or accelerate a recurrence of the cancer.⁶

The commission also received submissions from homosexual couples who have either pursued surrogacy arrangements overseas or would like to be able to have a child with the help of a surrogate in the future.⁷

Because gay men are unable to bear children themselves, the possible availability of surrogacy offers hope to gay men who desire to become parents. Currently, most gay men are unable to pursue this route as overseas surrogacy arrangements are often prohibitively expensive.⁸

I have been in a committed same sex relationship for over four years. When my partner and I were ready to start our own family, we turned to ART to have children of our own. Through the help of egg donation, IVF and commercial surrogacy, we are delighted to be expecting twins to be born in the USA in the next few months⁹

SURROGACY OUTCOMES

There is limited empirical research available on outcomes of surrogacy arrangements, particularly in relation to outcomes for children.

One Australian study evaluated the experiences of women who agree to act as surrogates.¹⁰ The study considered how the surrogates viewed the outcome of the arrangement, irrespective of whether a pregnancy resulted. Five of the 13 women interviewed carried a child or children to full term. Six women withdrew from the arrangement without conceiving a child. The reasons for withdrawal included a decision by the commissioning parents to withdraw after unsuccessful attempts at pregnancy, emotional and financial stresses, and a decision by the

surrogate that she was too old for a viable pregnancy.¹¹ While a child's birth was regarded by the surrogates as a successful outcome, some of those who did not give birth to a child were also satisfied with their involvement.¹² This study did not consider the outcomes of the arrangement for the commissioning parents or any children born.

Overall, the study found that the surrogates did not feel they had been coerced or victimised as a result of the arrangement, but rather that the surrogacy process had strengthened existing relationships with the commissioning parents. All surrogates 'cognitively adapted' to think of the child they were gestating as the child of the commissioning parents. The study concluded that people who decide to participate in surrogacy arrangements have special qualities that enable them to manage the experience.¹³

An ongoing research project about surrogacy arrangements in the United Kingdom has begun to examine the effects of surrogacy on commissioning parents, the surrogate and the child; four studies have been reported so far.

The first study, consisting of 42 heterosexual couples who had children through surrogacy, concluded that 'the commissioning parents had not generally found the experience of surrogacy to be problematic'.¹⁴ It also found the relationships between the commissioning couple and the surrogate mother to be generally good, involving minimal conflict. A large majority of the couples interviewed maintained contact with the surrogate after the birth of the child. The second study found that the 34 surrogates did not appear to experience psychological problems as a result of handing over the baby, and their relationships with the commissioning parents were not adversely affected.¹⁵ The third study focused on the parent-child relationship in the first year of the child's life, reporting that:

the differences that were identified between the surrogacy families and the other family types indicated greater psychological well-being and adaptation to parenthood by mothers and fathers of children born through surrogacy arrangements than by the comparison group of natural-conception parents, with the exception of emotional overinvolvement.¹⁶

- 1 We discuss posthumous use of embryos in Chapter 9.
- 2 Submissions CP 253 (Lee Holmes), CP 254 (Katrina Harrison).
- 3 Submission CP 254 (Katrina Harrison).
- 4 Submission CP 243 (Nicole Poustie).
- 5 Submission PP3 60 (Anonymous).
- 6 Submission CP 236 (Anonymous).
- 7 Submissions CP 248 (Peter Usher and Dax Purvis), CP 250 (John), CP 251 (Lee Matthews).
- 8 Submissions CP 244 (Tony Wood), CP 245 (Jeremy Sayers), CP 246 (David Johnston-Bell), CP 247 (Adrian Tuazon), CP 248 (Peter Usher and Dax Purvis).
- 9 Submission PP3 45 (Anonymous).
- 10 Gina Goble, *Carrying Someone Else's Baby: A Qualitative Study of the Psychological and Social Experiences of Women who Undertake Gestational Surrogacy* (Unpublished Master in Psychology (Counselling Psychology) Thesis, Swinburne University of Technology, 2005).
- 11 Ibid 47.
- 12 Ibid 51.
- 13 Ibid 117.
- 14 Fiona MacCallum et al, 'Surrogacy: The Experience of Commissioning Couples' (2003) 18(6) *Human Reproduction* 1334, 1340.
- 15 Vasanti Jadva et al, 'Surrogacy: The Experiences of Surrogate Mothers' (2003) 18(6) *Human Reproduction* 2196, 2203.
- 16 Susan Golombok et al, 'Families Created Through Surrogacy Arrangements: Parent-Child Relationships in the 1st Year of Life' (2004) 40(3) *Developmental Psychology* 400, 408.

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Chapter 16

Surrogacy



'Do I feel like something that's been manufactured? No, I don't. All I feel is that my parents couldn't make their own bundle of expense (aka bundle of joy), so they got scientists to do it for them. The genetics matter less than the relationships when it comes to mum, dad and child.'

There were no differences in infant temperament between the different family types included in the study.¹⁷ The most recently published study, conducted when the children were three years old, reported no differences in child psychological development between families formed through surrogacy arrangements and other family types included in the study.¹⁸ However, one difference identified in this study was that:

couples who had become parents through a surrogacy arrangement were much more likely to have been open with their child about the circumstances of their birth than were couples whose children had been conceived by gamete donation.¹⁹

It should be emphasised that these studies have been conducted while the children were infants. Further research will be necessary to examine the psychological development of the children as they grow up and are able to understand the circumstances of their birth.²⁰

The Kirkman case in Victoria has also provided us with an insight into the experience of Australia's first child born through a gestational surrogacy arrangement.²¹ In 1995, when only seven years old, Alice Kirkman first published her thoughts on her surrogate birth:

I am seven years old and it is amazing I was born. It is amazing that my Mum and Dad even thought of having a child this way. It is amazing that Linda said 'Yes'. She gave birth to me. Linda is really my aunt because it was Mum's egg and because it was my parents who wanted to bring me up and not Linda, and even because Linda didn't want another child. I am her niece ... My family is the best family ever, but my Mum and Dad are the best. In my family, there's Linda and Jim, Cynthia and Bruce, Heather, Will, Andrew, Chris, Mark and Grandma (usually called Vonnie). There's also Dad's family, but I'm only talking about the Kirkmans. Grandpa had a good life but died last year. He was very proud of me ...²²

At 14, Alice Kirkman reflected further on her conception:

Do I feel like something that's been manufactured? No, I don't. All I feel is that my parents couldn't make their own bundle of expense (aka bundle of joy), so they got scientists to do it for them. The genetics matter less than the relationships when it comes to mum, dad and child. Being born by donor insemination (DI) and IVF surrogacy causes much less trauma than

being adopted, I think ... I knew that both my parents did want me, and that Linda, my aunt, was just helping them.²³

In contrast to the Kirkman case and the positive results reported in the studies conducted in the United Kingdom, there have been cases in which significant difficulties have arisen in the course of the arrangement.²⁴

Problems can occur if the surrogate decides she does not want to relinquish the child, if the commissioning parents decide they do not want the child because, for example, he or she is born with a disability, or if the parties have different views about how the pregnancy and childbirth should be managed. Another risk is that the surrogate has been coerced into carrying the child on behalf of a family member or friend and is not acting autonomously.

The case of *Re Evelyn* illustrates the conflict that may arise between commissioning parents and a surrogate mother.²⁵ In this case, Mr and Mrs S offered to bear a child for Mr and Mrs Q, who were unable to have children because Mrs Q had had a full hysterectomy. The child, 'Evelyn', was conceived with Mrs S's egg and Mr Q's sperm. Evelyn lived with the Qs in Queensland for a short period after her birth. Friction developed shortly after Evelyn was born, until Mrs S came to the realisation that she could no longer abide by the agreement and relinquish the child. Mrs S travelled to Queensland and removed Evelyn from the Qs' care and both of them returned to South Australia, where they lived. The Family Court ordered that Evelyn reside with the Ss, with the Qs to have contact, and dismissed an appeal by the Qs against this decision. Each couple wanted to raise Evelyn, and as Justice Jordan noted in the original case, each couple had 'the capacity to provide a very high standard of care'.²⁶ All of the adults loved Evelyn and were committed to her welfare. The court's decision to order that Evelyn live with the Ss was based on an assessment of what would be in Evelyn's best interests.

Some surrogacy arrangements in the United States have illustrated the possibility of conflict between surrogate mothers and commissioning parents. In *The Matter of Baby M*, the surrogate used her own egg in the conception of the child. After the birth of the child she found she could no longer agree to relinquish it. The commissioning father sued for enforcement of the surrogacy contract, which was found to be invalid.²⁷ Other disputes have arisen over the 'enforcement' of surrogacy contracts in both gestational and partial surrogacy arrangements.²⁸

In another case legal custody of triplets was initially granted to a gestational surrogate, but was later granted to the commissioning father after many years of litigation.²⁹

As with all pregnancies, surrogacy arrangements involve some risk to the woman who gives birth to the child, as well as risk to the baby. Women may find it difficult to enjoy their pregnancy because of the prospect of relinquishing the child born. Some women acting as surrogates have reported difficult pregnancies and labours. In one case, a British surrogate died from a heart attack 90 minutes after giving birth to the child she had carried on behalf of a commissioning couple. The surrogate had been inseminated with the sperm of the commissioning father. The surrogacy agreement between the parties had required the commissioning parents to take out a life insurance policy for the surrogate, which after her death was paid to her family and two children. The child born as a result of the surrogacy was handed over to the commissioning couple one week after the birth, although the surrogate's mother subsequently announced she would challenge their custody of the child.³⁰

The problems that can arise in the course of a surrogacy arrangement have been carefully considered by the commission. In this chapter we outline our approach to the regulation of surrogacy in light of these complexities.

APPROACHES TO REGULATION

The practice of surrogacy challenges social norms and opinions about family formation. The question of whether it should be prohibited, or permitted and regulated, has been considered in a substantial number of Australian government inquiries and reports.³¹

Regulation to control surrogacy arrangements is controversial in two respects. It can be seen as official endorsement of a practice which some people in the community see as objectionable. The commission received submissions from some people who argued that surrogacy should not be permitted or facilitated in Victoria in any way because, they argue:

- surrogacy is not in the best interests of the child³²
- surrogacy is exploitative of women's reproductive capacity³³
- surrogacy is consumerist and selfish³⁴
- surrogacy degrades the family unit.³⁵

17 Ibid.

18 Susan Golombok et al, 'Non-Genetic and Non-Gestational Parenthood: Consequences for Parent-Child Relationships and the Psychological Well-Being of Mothers, Fathers and Children at Age 3' (2006) 21(7) *Human Reproduction* 1918, 1921.

19 Ibid 1923.

20 MacCallum et al (2003), above n 14, 1341.

21 For an account of the Kirkman case, see Maggie Kirkman and Alice Kirkman, 'Sister-to-Sister Gestational 'Surrogacy' 13 Years On: A Narrative of Parenthood' (2002) 20(3) *Journal of Reproductive and Infant Psychology* 135.

22 Alice Kirkman, 'Amazing' (1995) 2(7) *ACCESS National Newsletter* 2, 5.

23 Alice Kirkman, 'And here's one we prepared earlier ... the biotech baby fourteen years on' in Heather Grace Jones and Maggie Kirkman (eds), *Sperm Wars: The Rights and Wrongs of Reproduction* (2005) 181, 182.

24 Eg, *Re Evelyn* (1998) 23 Fam LR 53; *In the Matter of Baby M*, 537 A. 2d 1227 (Supreme Court of New Jersey, 1988).

25 *Re Evelyn* (1998) 23 Fam LR 53.

26 *Re Evelyn* (Unreported, Family Court of Australia, Jordan J, 19th December 1997) 10.

27 *In the Matter of Baby M*, 537 A 2d 1227 (Supreme Court of New Jersey, 1988).

28 *Johnson v Calvert*, 19 Cal Rptr 2d 494 (1993).

29 *JF v DB* 897 A.2d 1261 (PA, 2006).

30 BioNews, 'Legal battle over dead surrogate's baby' (7 February 2005) available at <www.bionews.org.uk>.

31 Australia Family Law Council, *Creating Children: A Uniform Approach to the Law and Practice or Reproductive Technology in Australia: Report of the Family Law Council, Incorporating and Adopting the Report of the Asche Committee on Issues Relating to AID, IVF, Embryo Transfer and Related Matters* (1985); National Bioethics Consultative Committee, *Surrogacy: Report 1* (April 1990); National Bioethics Consultative Committee, *Discussion Paper—Surrogacy 2: Implementation* (October 1990); Attorney-General [ACT], *Discussion Paper: Surrogacy Agreements in the ACT* (October 1993); New South Wales Law Reform Commission, *Artificial Conception—Surrogate Motherhood: Australian Public Opinion*, Research Report 2 (1987); NSW Law Reform Commission, *Artificial Conception: Surrogate Motherhood*, Discussion Paper 18 (1988); New South Wales Law Reform Commission, *Surrogate Motherhood*, Report 60 (1988); Special Committee Appointed by the Queensland Government to Enquire into the Laws Relating to Artificial Insemination, In Vitro Fertilisation and Other Related Matters, *Report* (1984); Legislative Council of the South Australian Parliament, *Report of the Select Committee of the Legislative Council on Artificial Insemination by Donor, In-Vitro Fertilisation and Embryo Transfer Procedures and Related Matters in South Australia* (1987); Committee to Investigate Artificial Conception and Related Matters, *Final Report* (June 1985); Committee to Consider the Social, Ethical and Legal Issues Arising from In Vitro Fertilization, *Report on the Disposition of Embryos Produced by In Vitro Fertilization*, (1984); Committee of Inquiry, *Report of the Committee Appointed by the Western Australian Government to Enquire into the Social, Legal and Ethical Issues Relating to In Vitro Fertilisation and its Supervision* (October 1986); Health Department of Western Australia, *Reproductive Technology Working Party, Report to the Minister for Health for Western Australia* (1988).

32 Submissions PP3 6 (Caroline Chisholm Centre for Health Ethics Inc), PP3 11 (Judith Bond), PP3 8 (VANISH), PP3 17 (David Perrin), PP3 29 (Victorian Standing Committee on Adoption & Alternative Families), PP3 32 (Anonymous), PP3 36 (Bill Muehlenberg), PP3 50 (Peter Phillips), PP3 54 (Adoption Information Services Forum), PP3 58 (Hannah Spanswick).

33 Submissions PP3 20 (Dr John Gill), PP3 37 (Julia Mangan), PP3 38 (Atala Ladd).

34 Submission PP3 22 (Dr D Clarnette).

35 Submissions PP3 26 (Pat Healy), PP3 40 (Anonymous), PP3 49 (Salt Shakers), PP3 53 (Rev Geoff Harvey).



Regulation of surrogacy may also be perceived as an unwarranted intrusion by the state into the reproductive choices of individuals.³⁶ Because our terms of reference about surrogacy are limited, we do not discuss debates on these questions. However, we do believe that regulation of surrogacy can play an important role in minimising the potential for disputes and in protecting all parties, including the child, from possible harm.³⁷

In their comparative review of surrogacy legislation in Australia, the United Kingdom, Canada and the United States, Adjunct Professor John Seymour and Sonia Magri described the range of legislative approaches to surrogacy as a spectrum:

At one end of the spectrum are the Acts prohibiting all types of surrogacy arrangements; the prohibition may be reinforced by provisions imposing criminal penalties on those entering into such an arrangement. Alternatively, the prohibition may apply only to arrangements of a commercial character. Midway along the spectrum are the Acts which, while not prohibiting surrogacy contracts, declare them to be void and unenforceable. At the other end of the spectrum are laws which recognise the legitimacy of altruistic surrogacy contracts. These statutes accept the parties' intentions should be realised, provided certain conditions are fulfilled.³⁸

AUSTRALIA

In Australia, most jurisdictions permit altruistic surrogacy and some regulate it. Commercial surrogacy arrangements are generally illegal. In the 1990s the National Bioethics Consultative Committee recommended the facilitation of altruistic surrogacy subject to various controls,³⁹ but its recommendations were not accepted by Australian health and welfare ministers at the time.⁴⁰

Five jurisdictions in Australia have legislation regulating surrogacy: Victoria, South Australia, Queensland, Tasmania and the Australian Capital Territory (ACT). Table 1 sets out the types of provisions that are contained in that legislation. Such provisions include:

- prohibition on procuring surrogacy arrangements and/or arranging surrogacy services
- prohibition on entering into surrogacy agreements
- prohibition on making or receiving payments in surrogacy arrangements
- prohibition on advertising in surrogacy arrangements
- prohibition on the provision of technical or professional services in surrogacy arrangements
- making surrogacy agreements void or unenforceable
- a process for recognising the commissioning couple as the legal parents of the child (ACT only).

Table 1: Surrogacy Legislation in Australia

	VICTORIA	QUEENSLAND	TASMANIA	SOUTH AUSTRALIA*	ACT
Practices	<i>Infertility Treatment Act 1995</i>	<i>Surrogate Parenthood Act 1988</i>	<i>Surrogacy Contracts Act 1993</i>	<i>Family Relationships Act 1975 (Part 2B)</i>	<i>Parentage Act 2004</i>
Altruistic surrogacy prohibited/illegal	-	✓	-	(But no penalty) ✓	-
Commercial surrogacy prohibited/illegal	✓	✓	✓	✓	✓
Arranging surrogacy service prohibited	<i>Commercial agreements only</i>	✓	-	✓	<i>Except by a party to the agreement</i>
Entering into a surrogacy contract prohibited	<i>Commercial agreements only</i>	✓	✓	✓	<i>Commercial agreements only</i>
Advertising surrogacy services prohibited	✓	✓	✓	✓	✓
Receiving payment is prohibited	✓	✓	✓	-	<i>Payment of expenses reasonably incurred is allowed</i>
Surrogacy agreement is void or not enforceable	✓	✓	✓	✓	✓
Provision of technical/professional services is illegal	-	-	✓	-	<i>Commercial agreements only</i>

* On 27 September 2006, a proposed amendment to permit altruistic surrogacy in South Australia was referred to the Legislative Council Social Development Committee: see Statutes Amendment (Surrogacy) Bill 2006 (SA).

These five jurisdictions prohibit commercial surrogacy. Queensland prohibits altruistic surrogacy and South Australia makes all surrogacy contracts illegal and void. The ACT expressly facilitates altruistic surrogacy subject to a range of conditions.⁴¹ The criteria for participating in a surrogacy agreement are overseen by clinical ethics committees, which approve or reject applications for surrogacy.⁴² In Tasmania altruistic surrogacy is not prohibited, although providing technical or professional services to achieve a pregnancy that is the subject of a surrogacy contract is an offence, and surrogacy contracts are void. In Victoria the legislation is silent on whether altruistic surrogacy is permitted, although surrogacy agreements are void.

- 36 Helen Szoke, 'Surrogacy: All the Features of a Relationship that Could Go Wrong?' (2001-02) 28 *Melbourne Journal of Politics: The Politics of Technology Special* 56, 60-2.
- 37 For further discussion of this point, see Imogen Goold, 'Surrogacy: Is There a Case for Legal Prohibition?' (2004) 12 *Journal of Law and Medicine* 205.
- 38 John Seymour and Sonia Magri, *ART, Surrogacy and Legal Parentage: A Comparative Legislative Review* (2004), 49-50.
- 39 National Bioethics Consultative Committee, *Surrogacy: Report 1* (April 1990); National Bioethics Consultative Committee, *Discussion Paper—Surrogacy 2: Implementation* (October 1990). The Western Australian Select Committee on the *Human Reproductive Technology Act 1991* also recommended that legislation be enacted to facilitate altruistic surrogacy: Legislative Assembly of Western Australia Select Committee on the Human Reproductive Technology Act 1991, *Report* (1999).
- 40 Szoke (2001-02) above n 36, 58; Goold (2004) above n 37, 206.
- 41 *Parentage Act 2004* (ACT). See Chapter 19 for details of the conditions that must be met before a parentage order may be made for a child born of a surrogacy arrangement.
- 42 Canberra Fertility Centre, *Surrogacy Information Pack* (September 2004); Sydney IVF, *Surrogacy at Sydney IVF* (September 2005).

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Chapter 16

Surrogacy



In NSW, Western Australia and the Northern Territory, there is no legislation about surrogacy but the practice is regulated by ethical guidelines.⁴³ In these jurisdictions altruistic surrogacy is permitted, however the National Health and Medical Research Council (NHMRC) guidelines state that:

Noncommercial surrogacy (whether partial surrogacy or full surrogacy) is a controversial subject ... clinics must not facilitate surrogacy arrangements unless every effort has been made to ensure that participants:

- *have a clear understanding of the ethical, social and legal implications of the arrangement; and*
- *have undertaken counselling to consider the social and psychosocial significance for the person born as a result of the arrangements, and for themselves.*⁴⁴

Clinics in these jurisdictions are precluded from providing services to people pursuing commercial surrogacy arrangements under the NHMRC guidelines. The guidelines state that it is 'ethically unacceptable to undertake or facilitate surrogate pregnancy for commercial purposes. Clinics must not undertake or facilitate commercial surrogacy arrangements'.⁴⁵

A recent surrogacy case drew attention to the divergent legislative approaches in Australian jurisdictions. Media reports revealed that a Victorian-based couple had travelled interstate to pursue a surrogacy arrangement because of the restrictions that exist in Victoria.⁴⁶ Apparently in response to this case, in November 2006, federal Attorney-General Philip Ruddock announced that the Standing Committee of Attorneys General (SCAG) had agreed to consider drafting uniform laws for surrogacy across all states and territories.⁴⁷ Mr Ruddock expressed concerns that some couples had been forced to go interstate to seek out suitable arrangements:

*In a federation like Australia, it is not satisfactory that people are forced to effectively forum-shop for the best deal ... This can be distressing for people who have already faced difficulties starting a family.*⁴⁸

UNITED KINGDOM, CANADA AND UNITED STATES

The United Kingdom (UK), Canada, New Zealand and numerous states in the United States (US) have enacted legislation dealing with surrogacy.⁴⁹ Virtually every jurisdiction disapproves of commercial surrogacy, but they adopt different approaches to altruistic surrogacy.⁵⁰ In the UK and various US states, procedures have been established to enable the commissioning couple to be recognised as the legal parents of the child provided certain conditions are met. For example, in the UK, under the *Human Fertilisation and Embryology Act 1990*, a court may order that the commissioning couple be treated as the parents of the child if it is satisfied that: they are married, the gametes of at least one of them have been used to conceive the child, the child is living with the couple, and no money or other benefit (other than for expenses reasonably incurred) has been given or received under the surrogacy agreement.⁵¹ Some US states permit courts to scrutinise and approve surrogacy agreements before the arrangement commences.⁵² In New Zealand the commissioning parents must adopt the child.⁵³

In some of these jurisdictions it is permissible for the surrogate to receive payment to reimburse her for expenses she incurs during and as a result of the pregnancy. In Canada the *Assisted Human Reproduction Act 2004* permits the surrogate to be reimbursed for expenditure and loss of income incurred in relation to the surrogacy,⁵⁴ and in the UK payment of reasonable expenses is allowed. In New Zealand payment is permitted for expenses related to pregnancy and childbirth but not in lieu of employment.⁵⁵

VICTORIAN LAW

The *Infertility Treatment Act 1995* governs the use and provision of assisted reproductive technology in Victoria. Part 6 of the Act addresses surrogate motherhood. The relevant sections of the Act are as follows:

- Section 3 defines ‘surrogacy agreement’ as an agreement, arrangement or understanding, whether formal or informal, under which a woman agrees (whether or not for payment or reward) to become pregnant with the intention (or a pregnant woman agrees) that any child born as a result of the pregnancy is to be treated as the child not of her but of another person or persons.
- Section 59 makes it an offence for a person to ‘make, give or receive or agree to make, give or receive a payment or reward in relation to or under a surrogacy agreement’.
- Section 60 makes it an offence for people to advertise their willingness to enter into a surrogacy agreement.
- Section 61 makes all surrogacy agreements void. This means that no surrogacy agreements can be enforced in a court.

Apart from the provisions discussed above, the existing legislation does not deal with altruistic surrogacy. This appears to reflect differences of view among the members of the advisory body—the Standing Review and Advisory Committee on Infertility—that existed at the time the Infertility Treatment Act was implemented.

In a report to the then Health Minister, Maureen Lyster, four members of the committee did not support prohibition of certain kinds of legal and medical assistance for surrogate mothers, while the other four members believed that parliament originally intended that all surrogacy arrangements be illegal and called for the intention to be made clear in the Act.⁵⁶

In 1993 the Victorian government proposed amending the *Infertility (Medical Procedures) Act 1984*⁵⁷ to allow fertile women to participate in the IVF program as part of ‘voluntary’ surrogacy arrangements.⁵⁸ The government reversed its decision in the face of concerns raised by members of the community and some backbenchers, and the amendments did not eventuate.⁵⁹

The subsequent Infertility Treatment Act prohibits commercial surrogacy arrangements but remains silent on altruistic surrogacy. Altruistic surrogacy is therefore not prohibited under criminal law, however altruistic surrogacy agreements have no status under the civil law because they are unenforceable.

There is no legislation in Victoria which prohibits a woman self-inseminating with sperm from a

commissioning parent or with donated sperm and then allowing the commissioning couple to care for the child. However, the law does not recognise the commissioning person or couple as the parents of the child. Nevertheless, they could apply for a parenting order in the Family Court to confirm living arrangements and ensure that they have responsibility for caring for the child.

The Infertility Treatment Act makes it almost impossible for surrogacy arrangements to proceed in Victoria if treatment in a clinic is required. This is because the provisions in the Act which regulate who may undergo ART treatment procedures apply to prospective surrogate mothers in the same way as they apply to all women seeking ART.⁶⁰

Under the Act, a potential surrogate mother must herself be assessed as being unlikely to become pregnant or likely to pass on a disease or genetic abnormality to meet the eligibility criteria for treatment. If the treatment is to involve an embryo transfer using donated eggs and sperm, both the surrogate and her partner must be infertile.⁶¹ The likelihood of finding a woman who meets these criteria and who is also willing to act as a surrogate is extremely low.

This makes it virtually impossible for people to make surrogacy arrangements using eggs from a commissioning mother or a donor. Because of these legal complexities, no clinic in Victoria is offering surrogacy services.⁶² The Infertility Treatment Authority (ITA) conditions of licence require clinics to prospectively notify the ITA where a surrogacy arrangement is to be undertaken. To date, no notifications have been received.⁶³

The law is also problematic in other respects. There are no criteria for determining who should be able to commission a surrogacy. The provisions in the Infertility Treatment Act that ban payment or reward do not clearly define what these terms mean. Further, the *Status of Children Act 1974*—the Act that determines how legal parentage is defined where a child is born through the use of donated sperm and eggs—does not adequately address legal parentage of a child born of a surrogacy arrangement. These problems are discussed in more detail in the following chapters.

It is clear to the commission that reform of the law concerning surrogacy is necessary. As one submission noted,

*the laws regarding surrogacy in Victoria are nearly twenty years old and with current knowledge, advancements in technology, better medical outcomes for women and children and carefully regulated screening, successful outcomes would be achieved.*⁶⁴

43 As expressed in the National Health and Medical Research Council, *Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research*, (2004). On 1 March 2007 the Surrogacy Bill 2007 was introduced into the West Australian Parliament by the Hon J McGinty.

44 Ibid, para 13.2.

45 Ibid, para 13.1.

46 Matthew Franklin and Patricia Karvelas, ‘Conroy Plight Shows Laws Out of Step’, *The Australian* (Sydney), 8 November 2006, 2.

47 Attorney-General Phillip Ruddock, ‘Nationally Consistent Surrogacy Laws a Step Closer’ (Media Release 210/2006, 10 November 2006).

48 Ibid.

49 See Seymour and Magri (2004) above n 38, Chapter 3.

50 In several US states commercial surrogacy is permitted, either because there are no laws dealing with surrogacy (eg California), or, if the law expressly permits surrogacy arrangements, there is no prohibition on paying the surrogate (eg Arkansas: Ark Code Ann § 9-10-201). For information on the surrogacy laws in each US state, see Human Rights Campaign Foundation, *Surrogacy Laws: State by State* <www.hrc.org> at 8 February 2007.

51 *Human Fertilisation and Embryology Act 1990* (UK) s 30.

52 Eg, New Hampshire, Virginia, Florida and Texas: see Seymour and Magri (2004) above n 38, 36–42.

53 National Ethics Committee on Human Assisted Reproduction, *Guidelines on IVF Surrogacy* (2005) 4.

54 *Assisted Human Reproduction Act 2004* (Can) s 12.

55 National Ethics Committee on Human Assisted Reproduction, *Guidelines on IVF Surrogacy* (2005), above n 53, 4.

56 Standing Review and Advisory Committee on Infertility, *Annual Report 1996*.

57 This is the Act that preceded the current *Infertility Treatment Act 1995*.

58 W Weeks, ‘Will Victoria Also “Proceed with Care” in Relation to Reproductive Technology?’ (1994) 38 *Health Issues* (Vic) 35.

59 Penne Watson Janu, ‘Surrogacy Arrangements in Australia: Analysis of the Legal Framework’ (1995) 9 *Australian Journal of Family Law* 201, 206.

60 *Infertility Treatment Act 1995* ss 8, 20.

61 Sections 8 and 20 as interpreted by the ITA based upon the opinion by Gavan Griffith QC, 16 May 2002. Copy provided to the commission by the ITA.

62 Information provided by Dr Gordon Baker, Melbourne IVF, 20 November 2006.

63 Information provided by the Infertility Treatment Authority, 31 July 2006.

64 Submission PP3 60 (Anonymous).

COMMISSION'S APPROACH

The commission's view is that if the government decides the law should continue to permit altruistic surrogacy, it should be regulated with great care. The outcomes for children and surrogate mothers have not been researched in enough detail to justify allowing surrogacy arrangements to occur without careful scrutiny. Safeguards are necessary to protect surrogates, commissioning parents and children. The processes we have recommended may require review in the future as knowledge of surrogacy outcomes develops.

We will examine the problems we have identified with the relevant provisions of the Infertility Treatment Act in the following chapters on eligibility, expenses and legal parentage in surrogacy arrangements. In summary, the commission has concluded that:

- It is anomalous to apply the eligibility criteria in sections 8 and 20 to the surrogate mother rather than the commissioning couple.
- It is unclear whether the ban on payment and reward in section 59 applies to the making of gifts or the payment of the surrogate mother's medical and other expenses in altruistic arrangements.
- The current law is inadequate to deal with parental relationships arising from surrogacy.

If the government decides that the present law permitting altruistic surrogacy should remain unchanged, the commission believes the following should occur:

- The anomalies in the application of the current eligibility criteria should be corrected and new provisions should be introduced to protect the parties involved.
- Payment of expenses incurred by the surrogate mother as a result of the pregnancy should be allowed, but the law should make it clear that a surrogate should not obtain any material advantage as a result of the arrangement.

- The law should provide a mechanism for the commissioning person or couple to be recognised as the child's legal parents, and children born through surrogacy should have a right to access information about their genetic heritage.

The commission is also in favour of pursuing nationally consistent or uniform legislation to regulate surrogacy, which may reduce the need for people to travel to other jurisdictions to access treatment for surrogacy if they cannot do so in their home state.

Alternatively, if the government's position is that it does not accept any form of surrogacy arrangement, the Infertility Treatment Act should be amended to prohibit all surrogacy arrangements, whether or not made for reward.

RECOMMENDATIONS

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
 - the 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.

In Chapters 4 and 5, we discuss the eligibility criteria which apply to people seeking access to infertility treatment in Victoria. In this section, we consider how these criteria apply to surrogacy arrangements. We also make recommendations about eligibility for surrogacy.

CURRENT LAW

Altruistic surrogacy is legally permitted in Victoria, but the criteria which determine who is eligible for assisted reproductive technology (ART) services in a licensed clinic mean the circumstances in which a woman may act as a surrogate mother are extremely limited.

If an embryo formed with the commissioning mother's eggs and the commissioning father's sperm is to be used, or if the surrogate's own eggs need to be fertilised using ART, it will be necessary for the surrogate to undergo treatment in a clinic.

The *Infertility Treatment Act 1995* sets out the requirements that must be met before a woman may undergo artificial insemination or a fertilisation procedure at a licensed clinic. We examined these requirements in detail in Chapter 4. If a woman is married or is in a heterosexual de facto relationship,¹ she must be unlikely to become pregnant with her own egg, or with her partner's sperm, other than by a treatment procedure.² Alternatively, she must be at risk of having a child with a disease or genetic abnormality.³ Her partner must consent to her being treated.⁴

An embryo created with an egg and sperm produced by people other than the woman undergoing treatment and her partner can only be used in a treatment procedure if the woman undergoing treatment is unlikely to become pregnant from her own egg and her partner's sperm.⁵

If the woman does not have a male partner, she is only eligible for treatment if she has been assessed as clinically infertile⁶ or is likely to transmit a disease or genetic abnormality to a child.

These conditions apply to a potential surrogate mother in the same way as they apply to a woman wanting to become pregnant with her own child. The fact that the commissioning person or couple may meet these conditions is of no relevance under the Act. The failure of the Act to distinguish between a woman who is seeking treatment to overcome her own inability to become pregnant and a woman who is seeking treatment for a surrogacy arrangement has the following possible consequences.

If a surrogate is to receive treatment in a clinic involving the use of her eggs (partial surrogacy) she must be:

- unlikely to become pregnant other than by a treatment procedure or likely to transmit a disease or genetic abnormality to a child (if married or in a de facto heterosexual relationship) or
- clinically infertile or likely to transmit a disease or genetic abnormality to a child born as a result of the pregnancy (if she does not have a male partner).

If a surrogate is to receive treatment in a clinic involving implantation of an embryo created using eggs from another woman (gestational surrogacy) she must be:

- unlikely to become pregnant other than by a treatment procedure or likely to transmit a disease or genetic abnormality to a child (if married or in a de facto heterosexual relationship) or
- clinically infertile or likely to transmit a disease or genetic abnormality to a child born as a result of the pregnancy (if she does not have a male partner).

In either of these situations, if the treatment also involves the commissioning father's sperm and the surrogate has a male partner, the partner must also be infertile.⁷

There are very few situations in which a woman who is willing and able to act as a surrogate mother will be able to meet these statutory criteria. The law therefore creates a significant barrier to altruistic surrogacy even though it is not actually prohibited under the Act.

PROBLEMS WITH THE LAW

We do not know how frequently surrogacy arrangements involving self-insemination occur in Victoria, if at all.⁸ However, we do know that no treatment procedures involving surrogates are being carried out in clinics in Victoria because of the eligibility requirements imposed by the present law.⁹ As a result of these restrictions, some people may decide not to continue their efforts to have a child, while others travel interstate and overseas to pursue surrogacy arrangements.

Some people seek treatment in the ACT or NSW but receive counselling and other medical support in Victoria. In some cases, the surrogate gives birth to the child in Victoria.

The inability of people to seek treatment in their home state has serious implications. First, it puts the commissioning parent(s) and the surrogate to unnecessary inconvenience. Second, it means that the legal relationships between the parties involved are uncertain. In most cases, the surrogate mother will be presumed to be the legal parent of the child born, and the commissioning parents must seek a formal transfer of legal obligations. The laws regarding parentage in surrogacy arrangements are discussed more fully in Chapter 19.

The uncertainty surrounding the legal status of a child born of a surrogacy arrangement interstate may mean that parties do not disclose the nature of the conception upon their return to Victoria. During the pregnancy, it is possible that a surrogate mother may not disclose to medical staff that she is carrying the child on behalf of someone else. It is also possible that a surrogate may assume the identity of the commissioning mother while in hospital so that the child is recorded as having been born to the commissioning mother and not the surrogate.¹⁰ The true nature of the arrangement may not become apparent to medical staff unless the child needs medical treatment after birth. Without clarity as to who is the legal parent, there could be conflict between the commissioning parents and the surrogate mother at a time when critical medical decisions have to be made.

Excluding people from the Victorian clinic system means that the surrogate mother, commissioning parents and the child will not be protected by the safeguards offered by Victorian law. For example, if treatment was provided in a jurisdiction which does not require registration of such information, the child may not have the right to access information about his or her genetic origins where donated gametes have been used.

The commission also received submissions from people who have pursued, or are considering pursuing, surrogacy arrangements in the United States (US) because they are unable to access treatment in Victoria or other Australian jurisdictions. These arrangements involve substantial expense. One man wrote:

Because my partner and I have been forced to go overseas in order to fulfil our dream of having children who are biologically related to us, we have been required to expend an enormous amount of money—several hundred thousand dollars—to do so. This was our choice, and with our children due in a few months, we certainly do not regret a cent.¹¹

In some of these cases, as in the one above, the parties travel to jurisdictions where commercial surrogacy is permitted. Commercial surrogacy arrangements are clearly contrary to public policy in all Australian jurisdictions.¹²

If the government continues to permit altruistic surrogacy in Victoria, the commission believes the anomalies in the application of the Infertility Treatment Act eligibility criteria should be corrected to remove the barriers that currently exist for surrogacy arrangements. It makes no sense to prevent fertile women from acting as surrogates.

If the statutory barrier to treatment is removed, criteria to regulate access to surrogacy services should be implemented. The commission has considered the following questions in determining those criteria:

- Should people entering into surrogacy arrangements be subject to the same requirements as people seeking other forms of ART? Alternatively, should they have to meet other requirements?
- What criteria should apply to the commissioning person or couple?
- What criteria should apply to the surrogate mother?
- Should eligibility criteria be set out in legislation, or should they take the form of clinical guidelines?

- 1 *Infertility Treatment Act 1995* s 8(1).
- 2 *Infertility Treatment Act 1995* s 8(3)(a).
- 3 *Infertility Treatment Act 1995* s 8(3)(b).
- 4 *Infertility Treatment Act 1995* s 8(2).
- 5 *Infertility Treatment Act 1995* s 20(3)(a).
- 6 Interpretation of section 8 of the *Infertility Treatment Act 1995* according to opinion of Gavan Griffith QC, 4 August 2000. Copy provided to the commission by the Infertility Treatment Authority.
- 7 Interpretation of section 20 of the *Infertility Treatment Act 1995* according to opinion by Gavan Griffith QC, 16 May 2002. Copy provided to the commission by the Infertility Treatment Authority.
- 8 There are reports that surrogacy arrangements involving privately arranged self-insemination do occur: Clare Masters, 'Warning Over Home Insemination Baby Boom' *The Daily Telegraph* (Sydney) <www.news.com.au/dailytelegraph> 10 February 2007.
- 9 Information provided by Dr Gordon Baker, Melbourne IVF, 20 November 2006. In one of its submissions to the commission, the ITA reported that it was aware of a case where 'the husband of a woman who wished to act as an altruistic surrogate underwent a vasectomy ... it seems reasonable to believe that the man's decision to undergo a vasectomy was influenced by the requirements of section 20(3) of the *Infertility Treatment Act 1995*': Submission PP3 52 (Infertility Treatment Authority). The commission has no information about whether this surrogacy proceeded.
- 10 This practice was reported in the US case *Doe v Doe*, 710 A 2d 1297 (Conn 1998).
- 11 Submission PP3 45 (Anonymous).
- 12 The terms of reference for this inquiry required the commission to consider the legislation 'in relation to altruistic surrogacy' and not in relation to commercial surrogacy. However, some submissions argued that commercial surrogacy should be permitted in Victoria: submissions CP 247 (Adrian Tuazon), CP 245 (Jeremy Sayers), CP 244 (Tony Wood), CP 248 (Peter Usher and Dax Purvis), CP 246 (David Johnston-Bell), PP3 45 (Anonymous).

RECOMMENDATIONS

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 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, 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.

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.

The commission's consideration of these questions has been assisted by submissions made by members of the public, our consultation with people who have experience in the practice of surrogacy and the legal frameworks governing it, and our research on approaches adopted in other jurisdictions. Further consultations were held in response to the commission's interim recommendations made in *Position Paper Three: Surrogacy*.

In this chapter, we will discuss the criteria which should apply to people entering into surrogacy arrangements. The commission's broad position is as follows:

- Any eligibility criteria based on fertility should apply to the commissioning couple or person and not to the surrogate mother.
- Women wishing to act as surrogate mothers should be required to undergo medical assessment and should (with their partners, if any) receive counselling to establish whether they are capable of being surrogates.
- There should be a legislative requirement that the commissioning couple or person receive counselling to establish whether they are capable of being able to deal with a surrogacy arrangement.
- If there is a concern that a child to be born could be at risk of harm from the surrogate and her partner (if any), or the commissioning person or couple, there should be a process for assessing that concern.

SURROGACY: A SPECIAL CASE

In Chapter 5 the commission made recommendations for eligibility criteria that should apply to people seeking ART. These criteria would supplement the existing requirements that people seeking treatment give informed consent and receive counselling and information about the implications of the treatment procedure. In summary, the commission's recommendations for additional eligibility criteria are:

- If a doctor or counsellor believes that any child who might be born as a result of a treatment procedure may be at risk of abuse or neglect, the doctor or counsellor must seek advice from a clinical ethics committee about whether to proceed with the treatment procedure. It should be possible that the decision of the ethics committee be reviewed by the ITA review panel.¹³
- A clinic should not be able to treat a person, without approval of the ITA review panel, where the woman seeking treatment and/or her partner has had charges proved against them for a serious sexual offence, been declared a serious violent offender under the *Crimes Act 1958*, or had a child protection order made for one or more children in their care under a child welfare law.¹⁴
- The requirement that a woman undergoing treatment be married or in a heterosexual de facto relationship should no longer apply, and, if a woman does not have a male partner, that should be sufficient to satisfy a doctor that she is unlikely to become pregnant.¹⁵

The commission has considered whether these criteria would be sufficient for surrogacy cases or whether additional criteria should apply.

The commission's assessment of surrogacy is that it is sufficiently different from other forms of ART to warrant a cautious regulatory approach, with an additional set of requirements for access to treatment services. Our view is that the eligibility criteria that apply to surrogacy should address the risks associated with surrogacy arrangements that do not arise in other forms of ART. In particular, surrogacy involves another party (the surrogate mother) who carries the child throughout pregnancy but will be asked to relinquish that child upon birth.

Because surrogacy involves the relinquishment of a baby by the woman who gives birth to it, the commission views it as having important similarities to adoption. As a community, we have learnt in the past that the adoption of children has caused significant grief and distress, both for the women who have relinquished their babies and for the children who have struggled with the emotional consequences of adoption.¹⁶

The commission recognises the differences between surrogacy and adoption, but does not want to ignore the lessons of the adoption experience in the context of surrogacy. The protection of children and surrogate mothers must be the primary concern of any law regulating surrogacy.

Our cautious approach is also informed by the lack of detailed and longitudinal research into the potential impact of surrogacy on children and surrogate mothers. Although recent research conducted in Australia and the United Kingdom (UK) suggests the outcomes are generally positive, we do not yet have any data on the long-term consequences for children.

In addition, the commission has been reminded that surrogacy arrangements can and do go wrong, and that this can be painful and damaging for all involved.¹⁷ The commission recognises this and notes that although only 4–5% of surrogates refuse to relinquish the child in countries where altruistic surrogacy is permitted, the pain caused in these cases could be profound.¹⁸ Any conflict over child custody has the potential to be very damaging for all parties involved. Women who act as surrogates may experience distress during pregnancy or after birth at the prospect of relinquishing the baby. The commissioning person or couple may feel deprived of ‘their’ child, the surrogate and her family (if any) may find themselves responsible for a child not originally intended to be theirs, and the child, whose infancy may be the subject of protracted legal proceedings and conflict, may suffer as a result.¹⁹ These possibilities cannot be ignored.

RECOMMENDATIONS

ELIGIBILITY

Earlier in this chapter we described the eligibility requirements that currently apply to surrogacy arrangements in Victoria. In order to meet these requirements, the surrogate (and her partner) must be unlikely to become pregnant, be clinically infertile or likely to transmit a disease or genetic abnormality to a child born.²⁰

The commission received submissions that highlighted the illogical and ‘absurd’ nature of current eligibility requirements.²¹ The Fertility Society of Australia said:

It makes little sense to require the surrogate to be infertile when she is attempting to relieve the infertility of the commissioning person/couple.²²

One submission posed the question:

Why would an infertile woman be a surrogate for someone else when she by the term ‘infertile’ has had her own difficulties starting a family?²³

The commission also heard from people who had considered surrogacy, but were prevented from accessing treatment in Victoria because of the current eligibility criteria. These people pointed out that while altruistic surrogacy is not illegal in Victoria, the law makes it virtually impossible to pursue.²⁴

One couple investigated surrogacy after nine years of unsuccessful IVF treatment. In Victoria, the surrogate, not the commissioning couple themselves, had to meet eligibility criteria. As a result of these restrictions, the couple eventually sought treatment in NSW. The commissioning father wrote of his experience:

The Victorian legislation was explained to us by our IVF physician ... It seemed incredulous that treatment was not available to us in Victoria but we could achieve our objective via the Canberra Fertility Clinic or Sydney IVF.²⁵

The commission agrees that any eligibility criteria based on fertility should apply to the commissioning couple, not the surrogate (or her partner). Further, the fertility of the surrogate’s partner should have no bearing on a clinic’s decision to provide ART to the surrogate.

13 Recommendations 3 and 10.

14 Recommendation 12.

15 Recommendations 26 and 28.

16 See Chapter 2 for discussion of this point.

17 Surrogacy roundtable, 20 October 2004.

18 Department of Health [UK], *Surrogacy: Review for Health Ministers of Current Arrangements for Payments and Regulation* Cm 4068 (1998) 26.

19 Ibid.

20 See page 170.

21 Submissions PP3 35 (Dr Maggie Kirkman), PP3 42 (Anonymous).

22 Submission PP3 18 (Fertility Society of Australia).

23 Submission PP3 24 (Katrina Harrison).

24 Submissions CP 236 (Anonymous), PP3 24 (Katrina Harrison).

25 Submission PP3 31 (Robert Rushford).

Chapter 17

Eligibility for Surrogacy

RECOMMENDATIONS

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 parents 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.

The commission believes it is important for people pursuing surrogacy arrangements to have a serious and genuine reason for wishing to do so. Those reasons should relate broadly to an inability to become pregnant, carry a pregnancy to term or avoid any risk to their life or health, or that of the child.

The commission believes that it is appropriate to require the person or couple seeking to commission a surrogacy arrangement to meet the eligibility criteria that apply to all people seeking ART. In Chapter 5 the commission recommended that if there is a concern that a prospective child will be at risk of harm from one or both of his or her parents, treatment should be refused (with a right of review). We recommend that the commissioning person or couple be subject to those criteria, as well as all counselling, consent and information provisions contained in the Infertility Treatment Act. The relevant provisions would need to be modified to apply to the circumstances of surrogacy arrangements.

We believe it is appropriate that the criteria relating to notification of a child's potential risk of abuse or neglect also apply to the surrogate and her partner because it is possible they may remain the primary carers of the child. We discuss and make recommendations in relation to parentage in surrogacy arrangements in Chapter 19.

The commission also received submissions from gay men who wished to commission surrogacy arrangements but who were unable to have access in Victoria. The commission does not believe it is justified to require people who are commissioning a surrogacy arrangement to be married or in a heterosexual de facto relationship. This reflects the commission's conclusion that a person's marital status or sexuality are not factors that are considered by child welfare authorities or experts to be predictors of harm to children.²⁶ As discussed earlier, excluding people from access to ART services may result in their seeking arrangements elsewhere in Australia or overseas. This may increase the potential for negative outcomes for children, for example, by depriving them of the capacity to obtain information about their genetic origins or the circumstances of their birth.

COUNSELLING

The commission believes that some criteria additional to those which apply to surrogates should apply to the commissioning person or couple because of the complexity of surrogacy arrangements.

In Position Paper Three, the commission recommended that the commissioning person or couple undergo psychological assessment, including a home study, to determine whether they are able to cope with all stages of the surrogacy. We also suggested that the commissioning person or couple receive counselling on specific matters regarding surrogacy.

Among the responses to the Position Paper, the commission heard from people who had participated in or are intending to participate in surrogacy arrangements. People involved in surrogacy arrangements were generally supportive of the counselling process.²⁷ Some people who had accessed treatment in other Australian states because of restrictions in Victoria commented on the process they underwent, which included medical and psychological assessment, counselling and legal advice:

We were grateful for the insights gained by following the above protocol and agreed after its completion all parties were capable of undertaking the surrogacy arrangement ... The process followed by us prior to commencing medical treatment was thorough and of high standard. It allowed us to fully understand the surrogacy process and beyond.²⁸

A woman considering commissioning a surrogacy told the commission:

Counselling prior to a surrogacy arrangement does seem important, both to make sure all parties make the right choices, and to prevent surrogates being pressured into surrogacy. Many infertility clinics already have excellent, well qualified counselling staff who might be able to fill this role.²⁹

Professionals involved in ART also supported counselling for the parties. Counselling is already a standard requirement of participation in ART programs.³⁰ Dr Ruth McNair observed that more than one counselling session would be required, and that information and support would be necessary at all stages of the process.³¹

However, some people expressed concern about a potential requirement that a person or couple must be assessed as ‘fit and proper people to enter into a surrogacy arrangement’, on the grounds that a person who has no other option than to have a child through surrogacy should not have to have their fitness to parent assessed. One woman considering acting as a surrogate commented:

Couples are already subject to scrutiny by a doctor and counsellor, and need to convince their surrogate that they are worthy parents before an arrangement can go ahead. Furthermore, they are likely to have already explored multiple other avenues to have a child.³²

In a roundtable discussion on surrogacy convened by the commission, participants agreed that people who undertake surrogacy are generally well-informed about the medical process, the legal implications and the potential conflicts involved in surrogacy before they make the decision to seek professional assistance.³³

There was also confusion about the distinction between psychological assessment and counselling, and about the purposes of each process. In surrogacy arrangements conducted interstate, counselling is sometimes provided by the same psychologist who assesses the parties’ capacity to participate in a surrogacy arrangement.³⁴

In response to these concerns, the commission has reviewed its interim recommendations. We have decided that assessment of the commissioning parents should not be conducted as a separate process, but should instead form part of the counselling process. The clinical ethics committee of the clinic where treatment is sought should review all applications for surrogacy.

The purpose of counselling is to ensure that the parties to a surrogacy arrangement are aware of and have considered the issues which arise in surrogacy arrangements. The matters to be addressed in counselling should be listed in regulations (in the same way as the matters to be addressed in counselling for ART are set out in the regulations).³⁵ Counselling should address three broad themes including the parties’ attitudes towards pregnancy, birth and relinquishment of a child born, the implications of surrogacy for relationships between the parties and the possibility that the arrangement does not proceed as intended by the parties.³⁶

LEGAL ADVICE

It is also important that all parties to a surrogacy arrangement are aware of the legal consequences that may arise. The laws surrounding surrogacy are especially complex because of the inconsistencies and conflicts between federal and state laws regarding parentage of the child.³⁷ There are a number of areas of unsettled law which create additional uncertainty.³⁸

People who have participated in surrogacy arrangements and those intending to commission a surrogacy told the commission that they support a requirement to obtain independent legal advice.³⁹ They cited numerous areas of legal uncertainty which affect their families, including acquiring passports, accessing medical treatment, determining estate entitlements, and child support obligations.⁴⁰ The commission is aware that obtaining legal advice will not necessarily solve or avoid the legal complications that might arise, but it should help clarify existing rights and obligations. We also note that it will be important to ensure that independent legal advice be affordable, particularly for the surrogate mother.

The ITA should develop guidelines about the application of the regulations about counselling and legal advice, in consultation with clinics, and should evaluate and monitor their effectiveness over time.

The commission is aware that in Australia parties to surrogacy arrangements are counselled by a clinic’s senior counsellor. We support this practice. If the counsellor considers it prudent, independent psychological testing (in accordance with accepted professional standards) or a home study should be permitted; however, these steps should not be mandatory.

APPROVAL

In Chapter 5 we recommended that all licensed clinics establish a clinical ethics committee to consider particular cases where there are concerns about the welfare of children to be born. The commission believes that the clinical ethics committee should also oversee all surrogacy arrangements. Before a surrogacy can proceed, a clinical ethics committee should decide whether treatment can proceed, based on an assessment that the parties:

- are aware of and understand the personal and legal consequences of the surrogacy arrangement

26 See the discussion in Chapter 5.

27 Surrogacy roundtable, 21 February 2006.

28 Submission PP3 31 (Robert Rushford).

29 Submission CP 236 (Anonymous).

30 Submission PP3 39 (Rhonda Brown).

31 Submission PP3 28 (Dr Ruth McNair).

32 Submission PP3 27 (Katherine Harding).

33 Surrogacy roundtable, 21 February 2006.

34 Surrogacy roundtable, 21 February 2006.

35 Infertility Treatment Regulations 1997 rr 6 and 7.

36 The matters to be addressed in counselling have been adapted from the specific issues addressed in counselling for people undergoing surrogacy in the ACT: John James Memorial Hospital Ethics Committee, ‘Guidelines for Independent Clinical Psychologist Initial Assessment’, *Guidelines for Surrogacy* (January 2003). The Reproductive Technology Accreditation Committee also provides guidelines for issues to be addressed in counselling: Reproductive Technology Accreditation Committee, *Code of Practice for Assisted Reproductive Technology Units* (rev ed, 2005) [1.3], 80.

37 See Chapter 11.

38 See Chapter 11.

39 Surrogacy roundtable, 21 February 2006.

40 Surrogacy roundtable, 21 February 2006.

Chapter 17

Eligibility for Surrogacy

RECOMMENDATIONS

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.
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.
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.

- 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.

The approval should be based on a report from a counsellor that the parties have been supplied with all relevant required information, and have sought and obtained legal advice. The parties should also be required to acknowledge they have received the relevant information and advice.

Although these requirements will add additional steps to the process usually required for ART, the commission considers this to be justified because of the unknown and potentially significant ramifications of surrogacy arrangements. The process is consistent with the commission's recommendations in Chapter 5 which require that decisions about complex cases are referred to specialist bodies such as ethics committees.

The decision of the ethics committee should be reviewable in the same way as decisions about access to other forms of ART (as described in Chapter 5). The review panel should be able to review the committee's decision; further judicial review should be available by the Supreme Court.

SURROGATE MOTHERS

A woman intending to act as a surrogate mother should also have to meet some additional criteria before the surrogacy can proceed. Leaving aside the criterion 'unlikely to become pregnant', a woman intending to act as a surrogate should be assessed for eligibility in the same way that applies to other woman undergoing ART, as recommended above.

During the consultation process, the commission explored whether a woman should have reached a particular age before being able to act as a surrogate. It was suggested to us that an age requirement might assist in establishing that a surrogate has reached a level of maturity to understand the implications of the arrangement.⁴¹ Others said that age was only one factor in assessing maturity and that the purpose of the age requirement could be addressed in counselling.⁴²

The commission's view is that a woman intending to act as a surrogate should be at least 25 years old. A woman acting as a surrogate requires a sufficient level of maturity to be able to understand the implications of entering into the arrangement. Becoming a surrogate should not be seen as the mere exercise of a legal right attained on turning 18, but rather a decision that requires a level of maturity that most people have not developed at that age. It is worth noting in this context that although people become legal adults at 18, the United Nations' definition of youth extends to anyone under 25.⁴³ Requiring the surrogate to be at least 25 years old may also act as an additional protection against any unequal bargaining power between her and the commissioning parents.

The commission has also considered whether it should be a requirement that the surrogate have already experienced pregnancy and childbirth. The Fertility Society of Australia said that a potential surrogate should have experienced pregnancy and childbirth so that she is 'able to give informed consent as to the task she proposes to undertake'.⁴⁴ Others argued that a prior pregnancy could be a factor in assessing maturity and capacity to be a surrogate, but that it should not be a requirement.⁴⁵ It was also suggested that some women who have not had children may wish to become surrogates and may be quite capable of doing so.⁴⁶

The commission has concluded that although it is desirable that the intending surrogate has experienced pregnancy and childbirth, this should not be a steadfast requirement. Exceptions should be allowed where it is apparent that the surrogate understands the implications of the arrangement, and is able to make an informed decision.

GENETIC CONNECTION

The commission has considered whether the gametes of at least one of the people commissioning the surrogacy should be used to conceive the child and whether the surrogate should be prevented from using her own eggs in the conception of the child. Imposing either of these conditions would limit the forms of altruistic surrogacy permitted in Victoria.

Surrogate Mothers

Some commentators argue that only gestational surrogacy should be permitted because a surrogate mother is less likely to experience difficulty in giving up a child who is not genetically related to her.⁴⁷ The surrogate may find it easier to regard the commissioning couple as the child's parents if their gametes have been used in the conception of the child. This would also mean that a child born as a result of a gestational surrogacy arrangement will not be the genetic sibling of any other children of the surrogate mother.

In an Australian study of women who acted as gestational surrogates, not being a genetic parent of the child was found to be an important factor.⁴⁸ The participants in this study indicated that using the commissioning couple's gametes helped them to treat the pregnancy differently to their previous pregnancies with their own children. One woman said:

[The baby is] not part of me ... It's their egg, their sperm ... Basically I am just growing it, so it's no part of me. I am just helping it grow. I couldn't do it if it wasn't my sister and it was any part of [my partner] and myself.⁴⁹

The study revealed a common attitude among the surrogate mothers who felt that after birth, they were not required to 'relinquish' the child. Goble reported that the women did not see themselves as 'the true mothers of the babies' but that the children 'rightfully belonged to the commissioning couple who were the true parents'.⁵⁰ Some women also used specific language such as 'babysitter' or 'doing a job' to emphasise their roles as surrogates. Women who used their own eggs were not part of this study.

In the ACT, surrogacy is only permitted when genetic parentage and gestation are separated.⁵¹ Under the *Parentage Act 2004* (ACT), the commissioning couple can only be recognised as the parents of the child if the surrogate and partner are not the genetic parents of the child, and at least one of the commissioning couple is a genetic parent of the child.⁵²

On the other hand, some people argue there are many circumstances in which a surrogate should be able to use her own eggs in conception. This is known as partial surrogacy.

If a commissioning parent does not have any eggs to contribute, it may be difficult to find both an egg donor and a surrogate. A surrogate may be quite willing to use her own eggs to conceive a child. This was the case for one

woman who participated in Goble's study. After agreeing to act as a gestational surrogate, the woman considered partial surrogacy:

She (commissioning mother) was a bit worried about her age, so I said if her eggs were not very good, she could have a couple of mine.⁵³

Partial surrogacy is less likely to expose the surrogate to medical hazards because conception can normally be achieved by assisted insemination. If using assisted insemination, a woman may not need to take medication to induce ovulation. Sometimes, the medications used to induce ovulation cause serious side effects. Assisted insemination is also significantly less expensive than other more invasive forms of ART.

Often the surrogate is related to the commissioning parents, for example, she may be a sister of one of them. In such cases the child will have some genetic links with the surrogate, whether or not the surrogate's eggs were used to conceive the child. If the commissioning mother is unable to provide eggs and her sister is acting as the surrogate (which is quite common), she may wish her sister's eggs to be used to preserve a genetic connection with the child.

Commissioning Parents

Some submissions argued that the gametes of at least one of the commissioning couple should be used to conceive the child because it is important for the child to have a genetic connection with at least one of the parents. Some would argue that if neither of the commissioning parents is able to contribute their gametes, then surrogacy might not be an appropriate method for having a child, and that perhaps parties should instead consider adoption.⁵⁴

However, others argue that there should be no such requirement because:

- this would discriminate against people who are infertile and do not have gametes
- donated embryos are more readily available than donated eggs
- people undergoing other forms of ART are permitted to use donated embryos if they are both infertile.

Having considered these arguments in depth, we have concluded that it is difficult to generalise about the value of genetic connections in family relationships. As we discuss in Chapters 11 and 15, individuals place different weight on genetic connection to their parents and children. Outcomes for children are not necessarily dependent on whether they are genetically related to the people who parent them.

- 41 Submissions PP3 18 (Fertility Society of Australia), PP3 8 (VANISH), PP3 45 (Anonymous), PP3 54 (AIS Forum), PP3 56 (Melbourne IVF Counselling Service).
- 42 Submission PP3 28 (Dr Ruth McNair), PP3 32 (Anonymous), PP3 55 (Fertility Access Rights).
- 43 United Nations Educational, Scientific and Cultural Organization, *Resolution on the Role of UNESCO in Improving the Situation of Young People and the Contribution of UNESCO to International Youth Year*, General Conference, 22nd sess., Paris, 1983.
- 44 Submissions PP3 18 (Fertility Society of Australia), see also PP3 45 (Anonymous), PP3 56 (Melbourne IVF Counselling Service).
- 45 Submission PP3 48 (Women's Health West).
- 46 Submission PP3 55 (Fertility Access Rights).
- 47 ABC Radio National, Paul Barclay interview with Dr Martyn Stafford-Bell, 'Surrogacy', Australia Talks Back, 9 November 2006; Sydney IVF, *Surrogacy at Sydney IVF* (September 2005), Surrogacy roundtables, 20 October 2004 and 21 February 2006.
- 48 Gina Goble, *Carrying Someone Else's Baby: A Qualitative Study of the Psychological and Social Experiences of Women who Undertake Gestational Surrogacy* (Unpublished Master in Psychology (Counselling Psychology) Thesis, Swinburne University of Technology, 2005), 70–72.
- 49 'Kay', quoted in *ibid* 71.
- 50 *Ibid* 68.
- 51 Canberra Fertility Centre, *Surrogacy Information Pack* (September 2004); Sydney IVF, *Surrogacy at Sydney IVF* (September 2005).
- 52 *Parentage Act 2004* (ACT) s 24.
- 53 'Carla', quoted in Goble (2005), above n 48, 72.
- 54 Some submissions said that adoption is sometimes suggested as an alternative to surrogacy without consideration of the eligibility requirements or availability of adoption: submissions PP3 52 (Infertility Treatment Authority), PP3 24 (Katrina Harrison).



RECOMMENDATIONS

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.
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 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 parents is to be preferred, but people should not be excluded from commissioning a surrogacy arrangement if they are unable to contribute their own gametes.

For these reasons, the commission has concluded that partial surrogacy should be permitted, but that caution needs to be exercised because there is limited research on outcomes for children and surrogates in these arrangements. If the surrogate mother is using her own eggs, counselling must address the implications of this in the relinquishment of the child and the relationship between the surrogate and the child once it is born. The clinical ethics committee should confirm these matters have been the subject of counselling.

The research to date on outcomes in surrogacy arrangements suggests that a genetic connection between the child and the commissioning parents is to be preferred. However, people should not be excluded from commissioning a surrogacy if they are unable to contribute their own gametes. In other forms of ART people are able to conceive using donated embryos if their own gametes are unviable.

The commission has concluded that if surrogacy is to be permitted at all, both gestational and partial surrogacy should be carefully regulated. In each case, the surrogate mother should be protected from exploitation or coercion. Even if the law permits gestational but not partial surrogacy, the surrogate should retain the right to refuse to consent to the transfer of parentage of the child upon birth. Submissions to the commission highlighted the fact that genetic relatedness can create variable and subjective connections between people.⁵⁵ Some women acting as surrogates may place significance on the use of their own gametes; others may not.⁵⁶ Even if the surrogate is not genetically related to the child, she may still find handing the child over to the commissioning parents difficult. It should be recognised that a surrogate mother without any genetic connection to the child may feel a responsibility towards, and a close connection to, the child she has carried and to whom she has given birth.

Moreover, the bond that a surrogate may form with the child should not always be viewed as a negative outcome. There are reasons to encourage a continuing relationship between the gestational mother and the child born, regardless of genetic connection. A continuing connection means that the child need not fantasise about the woman who may be thought of as 'giving me away', and the gestational mother can feel confident that she will be able to follow the development of the child to whom she gave birth.⁵⁷ This may promote better mental health for the surrogate, with the additional advantage of reducing stress when it comes to relinquishing the child to the commissioning parents.

55 Different academic and personal viewpoints were submitted to the commission, eg, submissions PP3 35 (Dr Maggie Kirkman), PP3 15 (Gina Goble), PP3 51 (Laura Clark and Dominic Dillon), CP 243 (Nicole Poustie).

56 The study by Vasanti Jadva et al, 'Surrogacy: The Experiences of Surrogate Mothers' (2003) 18(10) *Human Reproduction* 2196, concluded that '[a]lthough it may be assumed that genetic surrogate mothers would be more likely to feel a special bond towards the child, this was not found to be the case. Genetically related surrogate mothers were, however, more likely than genetically unrelated surrogate mothers to wish the child to be told about the surrogacy arrangement': 2203.

57 Surrogacy roundtable, 21 February 2006 (Dr Maggie Kirkman).



Chapter 18 Surrogacy Expenses

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180 ALTRUISTIC SURROGACY

In this chapter we discuss the payment of expenses in surrogacy arrangements. These expense could include medical costs, lost earnings and legal expenses. We also discuss and make recommendations in relation to commercial surrogacy.

CURRENT LAW

Our terms of reference ask us to consider the meaning and efficacy of section 59 of the *Infertility Treatment Act 1995* in relation to altruistic surrogacy. Section 59 states:

A person must not make, give or receive or agree to make, give or receive a payment or reward in relation to or under a surrogacy agreement or an arrangement to act as a surrogate mother.

Penalty: 240 penalty units or 2 years imprisonment or both.

Under section 59, commercial surrogacy arrangements are prohibited in Victoria. This is consistent with the guiding principle recommended by the commission in Chapter 5 that:

at no time should the use of reproductive technologies be for the purpose of exploiting (in trade or otherwise) either the reproductive capabilities of men and women or the children resulting from the use of ART.¹

The section does not clearly define the terms 'payment' or 'reward'. As a consequence, there is some uncertainty about whether the ban extends to making gifts to the surrogate or reimbursing her for expenses she incurs during the pregnancy. The Infertility Treatment Authority's publication *Conditions for Licence: Clinics, Hospitals and Day Procedure Centres*, for example, states that 'on balance, it is likely that the payment of fees for ordinary medical and related services provided as part of an altruistic surrogacy treatment is not a breach of [section 59]'.² In this chapter we discuss whether payments or rewards of this nature should be permitted.

ALTRUISTIC SURROGACY

The commission has heard contrasting opinions on whether gifts or payment in altruistic surrogacy arrangements should be permitted.

In submissions, some people expressed concern that a woman should not be disadvantaged as a result of acting as a surrogate.³

The surrogate mother should be seen as a volunteer. This means that they are volunteering their efforts for no financial advantage. However we argue that as volunteers, surrogate mothers should not be materially disadvantaged either.⁴

In these submissions there was support for payment of 'reasonable' expenses. Some people argued that prohibiting payment of reasonable expenses would prevent women from acting as surrogates.⁵

In her submission, Gina Goble reported on her research into outcomes of surrogacy arrangements in Australia.

The commissioning couple generally took the payment of medical and other reasonable expenses as their responsibility. In one case, where the gestational surrogate mother was materially advantaged, she paid for the travel, accommodation and medical expenses herself.⁶

People in favour of payment for reasonable expenses generally stated that such expenses should be limited to specified categories.⁷ Women's Health West said 'there should be provision for payment of all reasonable medical and associated expenses, as well as for income lost as a result of treatment, pregnancy and childbirth'.⁸

Interestingly, the *Adoption Act 1984* permits the adoptive parents of a child to make payment 'in respect of the hospital and medical expenses reasonably incurred in connexion with the birth of the child or the ante-natal or post-natal care and treatment of the mother of the child or of the child', as long as the payment has been approved by the Secretary to the Department of Human Services, or the court.⁹ Payment of legal expenses is permitted, and the secretary and court are empowered to authorise other payments or reward.¹⁰ However, the provision is never used in local adoptions.¹¹

'The surrogate mother should be seen as a volunteer. This means that they are volunteering their efforts for no financial advantage. However we argue that as volunteers, surrogate mothers should not be materially disadvantaged either.'

Some submissions argued that allowing any payment to the surrogate mother could bring Victoria into the realm of commercial surrogacy and for this reason should not be allowed.¹² An overriding concern was that sanctioning payments could lead to surrogacy arrangements being an option only for the wealthy, and that it could add to the possibility of the surrogate being exploited. Authorising payments might also introduce a notion that the foetus is 'owned' by the commissioning parents which could impact on decision making, particularly during pregnancy.

In *Position Paper Three: Surrogacy*, the commission made an interim recommendation that payment for any loss of earnings incurred by the surrogate should not be permitted. This decision was based on a concern that the possibility of deriving a financial benefit could influence a woman's decision to become a surrogate. Submissions to the commission in support of this interim recommendation said that permitting payment for loss of earnings could blur the line between commercial and altruistic surrogacy arrangements and could provide financial incentive to surrogates.¹³

However, during the course of our review, we were alerted to situations where it may be in the best interests of the child and the surrogate mother for the surrogate not to work during pregnancy. If there are medical complications during pregnancy, she may be advised to rest for health reasons and this could cause financial hardship. Allowing payment for loss of earnings could avoid a situation where a child is put at risk because of the potential for financial hardship faced by a surrogate mother.¹⁴

Irrespective of whether people approve or disapprove of payments to surrogates, participants in roundtable discussions recognised that it would be difficult to monitor payments between parties.¹⁵ In private arrangements, it would be possible to conceal payments, or to provide in-kind financial assistance.

The commission's view is that if altruistic surrogacy arrangements continue to be permitted in Victoria, the overriding principle should be that the surrogate should not obtain material advantage for her role.

Accordingly, the commission recommends the Infertility Treatment Act be amended to provide that a woman must not receive any material benefit or advantage as the result of an arrangement to act as a surrogate mother. Consistent with this principle, reimbursement of prescribed payments actually incurred should be permitted.

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
- 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 has been advised by her doctor that she should stop working earlier than anticipated
- any reasonable legal expenses associated with the surrogacy arrangement.

The commission suggests that the principle that a surrogate must not receive material advantage should be expressed in legislation, and the detail of permitted payments should be specified in regulations.

In determining the scope of the prescribed payments, the commission has been guided by the principle that a woman should not receive any material benefit or advantage for her role in a surrogacy arrangement. As such, any reimbursement of expenses should only apply to an actual loss incurred.

A surrogate's lost earnings may only be reimbursed in the absence of leave entitlements that would otherwise be provided. A two-month time limit is set for the value of lost earnings to cover the likelihood that she may not be able to work or wish to work immediately before and after the birth of the child.

The commission's recommendation that additional lost earnings or medical expenses be available as a prescribed payment is only to apply in special circumstances. This would include the situation in which a woman acting as a surrogate

- 1 Recommendation 1.
- 2 Infertility Treatment Authority, *Conditions for Licence: Clinics, Hospitals and Day Procedure Centres* (7th ed, August 2006) 17.
- 3 Submissions PP3 2 (Anonymous), PP3 18 (Fertility Society of Australia), PP3 48 (Women's Health West).
- 4 Submission PP3 48 (Women's Health West).
- 5 Submissions PP3 42 (Anonymous), PP3 45 (Anonymous).
- 6 Submission PP3 15 (Gina Goble).
- 7 Eg, submissions CP 19 (Anita Stuhmcke), CP 71 (Simon and Adam), CP 132 (Australian Infertility Support Group), CP 156 (Law Institute of Victoria), PP3 18 (Fertility Society of Australia) PP3 28 (Dr Ruth McNair), PP3 56 (Melbourne IVF Counselling Service).
- 8 Submission PP3 48 (Women's Health West).
- 9 *Adoption Act 1984* s 119(2).
- 10 *Adoption Act 1984* s 119(2).
- 11 Information supplied by Catherine Burnett, Department of Human Services (8 February 2007). The *Adoption and Permanent Care Manual* does not refer to the provision: Department of Human Services, *Adoption and Permanent Care Manual* (2004).
- 12 Eg, submissions CP 81 (Suryan Chandrasegaran), CP 89 (Ministerial Advisory Committee on Gay and Lesbian Health), CP 159 (Association of Relinquishing Mothers (Vic)), CP 169 (Social Questions Committee—CWL Victoria and Wagga Wagga), PP3 39 (Rhonda Brown).
- 13 Submissions PP3 39 (Rhonda Brown), PP3 56 (Melbourne IVF Counselling Service).
- 14 Surrogacy roundtable, 21 February 2006.
- 15 Surrogacy roundtable, 21 February 2006.

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Chapter 18

Surrogacy Expenses

RECOMMENDATIONS

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.

is advised by her doctor to stop working earlier than anticipated. Additional medical expenses could arise from complications or unforeseen events during pregnancy or after birth. Because additional payments are only to be available in special circumstances, the potential for financial benefits to influence a woman's decision to become a surrogate is reduced.

In the next chapter we propose a mechanism for scrutinising whether the parties to a surrogacy arrangement have complied with these restrictions. We recommend a process for enabling the transfer of legal parentage from the surrogate mother and any partner to the commissioning parent(s). This process would require a court to be satisfied that the surrogate has not received any material advantage as a result of her role in the surrogacy arrangement.

Section 61 of the Infertility Treatment Act provides that surrogacy contracts are void. The commission believes that section 61 should remain in place, subject to one exception. If parties to a surrogacy arrangement have agreed to the reimbursement of expenses in accordance with the legislation, that aspect of the agreement should be enforceable.



Under a surrogacy arrangement, the intention is that the person or couple who commission the arrangement, not the surrogate, will care for and be the parent(s) of the child, regardless of whether they are genetically related to the child. The commission's terms of reference ask us to consider clarification of the legal status of any child born as the result of a surrogacy arrangement.

In this chapter we explain the current law that determines the parentage of children born of surrogacy arrangements. We examine alternative ways that parenting status could be clarified to protect the interests of all parties—particularly the child. We then recommend a mechanism to transfer legal parentage from the surrogate to the commissioning parent(s).

CURRENT LAW

In Victoria, the participants in a surrogacy arrangement cannot decide between themselves who will be regarded as the legal parents of any child born. The *Infertility Treatment Act 1995* makes all surrogacy agreements void.¹ This means that agreements will have no legal effect and cannot be enforced in a court, including agreements:

- for the child to be the child of the commissioning parent(s) (whether by adoption, agreement or otherwise) and not the child of the surrogate mother
- to transfer guardianship of the child to the commissioning parent(s)
- to surrender permanently the right to care for the child to the commissioning parent(s).²

Instead, legal parentage will be determined according to the *Status of Children Act 1974*.³ The parental status of each of the parties involved will differ according to whether the surrogate has a male partner and whether donated sperm or eggs (either from the commissioning parent(s) or from third parties) have been used to conceive the child.

If the child is conceived through sexual intercourse between the surrogate and a commissioning man, the surrogate is legally regarded as the mother of the child and the man is legally regarded as the child's father.⁴

If the child is conceived from a treatment procedure using donated gametes, the surrogate is married or in a de facto heterosexual relationship and her partner has consented to the conception procedure:

- the surrogate is regarded as the mother of the child and her partner as the father⁵
- the commissioning couple are not regarded as the parents of the child even if they have provided their own sperm and/or eggs⁶
- if a third party has donated the sperm and/or eggs used to conceive the child, that person is presumed not to be a parent of the child.⁷

If the surrogate is single, in a same-sex relationship, or does not have the consent of her male partner to the treatment procedure, the man who donated the sperm used to conceive the child has no rights and incurs no liabilities for the child.⁸ This provision would apply to a commissioning father who provided his sperm for the purpose of conception.

The Status of Children Act does not say that a sperm donor to a woman in this situation is not the father of the child. In Chapter 13 we recommend that the donor should be presumed not to be a parent of the child in these circumstances, in the same way as he is not considered a parent of a child born to a married woman.

However, as discussed in Chapter 11, a person may apply for parenting orders at the Family Court under provisions of the *Family Law Act 1975* (Cth). It is possible that a donor may be regarded as a parent of the child for the purposes of the Family Law Act.⁹ In *Re Mark*, Justice Brown of the Family Court considered whether a man who commissioned a surrogacy arrangement in the United States, using his sperm, was the legal parent of the child born of that arrangement.¹⁰ She said:

Having regard to the provisions of the Family Law Act and authorities cited, it may well be that Mr X is Mark's parent for the purposes of the Family Law Act.¹¹

However, as there was no contradictor or respondent in this case to make opposing arguments, Justice Brown refrained from making a positive finding that the man was a legal parent of the child.¹² She did make orders recognising the man's (and his partner's) parental responsibility for the child.

The surrogate is considered the mother if her own egg is used to conceive the child. However, the Status of Children Act is silent about whether the surrogate is regarded as the mother of a child conceived with donated eggs if she does not have a male partner.¹³

In most situations, the commissioning parent(s) who provided the gametes used to create a child have no legal relationship with the child and the surrogate and her partner (if any) are legally regarded as the child's parents. If the commissioning person or couple wish to be recognised as the legal parent(s) of the child they have two options.

The first option is to apply for a parenting order from the Family Court. However, as discussed in Chapter 11, the effect of parenting orders is limited because they do not confer full parental status on a person but rather a range of powers and responsibilities in relation to the child.

The second option is to adopt the child. However, privately arranged adoptions are not permitted in Victoria, except where one of the adopting parents is a relative of the child.¹⁴ Adoption is only possible where the surrogate is a relative of one of the commissioning parents, as in the Kirkman case where the surrogate was the sister of the commissioning mother and therefore the aunt of the child.¹⁵

No matter who is recognised as the legal parent(s), it is important to understand that the Family Court retains the power to make parenting orders in favour of any person concerned with the care, welfare and development of a child if the court considers it to be in his or her best interests.¹⁶ This means that even if the commissioning couple were recognised as the legal parents of the child under state law, the surrogate may still apply for parenting orders in the Family Court. Alternatively, if the surrogate and her partner (if she has one) are recognised as the legal parents of the child (as is currently the case under the Status of Children Act), the commissioning couple may apply for parenting orders.

PROBLEMS WITH THE LAW

The current law does not recognise the intentions of commissioning parents and surrogates in relation to parentage of a child born of a surrogacy arrangement. In Chapter 11 we explained why legal parentage is important. Inability to be recognised as a parent means that the people who care for the child do not have legal responsibility and lack many of the powers necessary to make decisions for the benefit of the child. If the commissioning couple separate, the person who no longer has the day-to-day care of the child will not be liable to pay child support, and if one parent dies without naming the child in his or her will, the child will have no automatic right to a share of the estate.

During our consultations we heard from people who had commissioned surrogacy arrangements and were caring for the child but who were not legally recognised as the child's parents. One commissioning couple who made a submission argued 'the law needs amendment to recognise the people who intend to bring up the child' and said that 'the commissioning couple should be identified at law as the parents of a child born from a surrogacy'.¹⁷

The commission received a submission describing the predicament of one family created through surrogacy.¹⁸ The commissioning woman was physically unable to carry a pregnancy to term, so she and her husband arranged a surrogacy. The surrogate gave birth to twins using sperm and eggs provided by the commissioning couple.¹⁹ The surrogate and her husband appear as the mother and father of the twins on their birth certificates. As a consequence, each time parental permission is required for school or medical purposes, the commissioning parents have to approach the surrogate and her husband to provide their permission to the relevant agency. The commissioning couple find this both inconvenient and belittling.

Other difficulties which can arise because the surrogate and her partner are the legal parents of a child include that:

- a passport cannot be obtained without the consent of the surrogate
- various organisations, such as scouts, require the consent of the legal parents for a child to be enrolled
- the surrogate and her partner, but not the commissioning parents, can claim social security and taxation allowances.²⁰

- 1 *Infertility Treatment Act 1995* s 61.
- 2 *Infertility Treatment Act 1995* s 3 (definition of 'surrogacy agreement').
- 3 These provisions are discussed more fully in Chapter 11.
- 4 Generally, if a woman who is married or in a de facto relationship with a man gives birth to a child, her partner is presumed to be the father of the child: *Status of Children Act 1974* s 5; *Family Law Act 1975* (Cth) ss 69P, 69Q. The presumption can be rebutted by evidence that a man other than the woman's partner is the father of the child: see H. A. Finlay et al, *Family Law in Australia* (1997) para 7.7; *Family Law Act 1975* (Cth) s 69U.
- 5 *Status of Children Act 1974* ss 10C, 10D, 10E.
- 6 *Status of Children Act 1974* ss 10D, 10E.
- 7 *Status of Children Act 1974* ss 10C, 10D, 10E.
- 8 *Status of Children Act 1974* s 10F.
- 9 There are conflicting decisions on this point in *Re Patrick* (2002) 28 Fam LR 579 and *Re Mark* (2003) 31 Fam LR 162: see discussion page 123.
- 10 *Re Mark* (2003) 31 Fam LR 162.
- 11 *Re Mark* (2003) 31 Fam LR 162, 174.
- 12 *Re Mark* (2003) 31 Fam LR 162, 174.
- 13 See Chapter 13 for further discussion of parental status where a donated egg has been used by a woman without a male partner.
- 14 *Adoption Act 1984* s 122. 'Relative' is defined in s 4. It is also possible that the Secretary or principal officer of an approved agency could approve the commissioning parents as 'fit and proper persons' to adopt the child, if they had complied with all other adoption regulations (s 13). The commissioning parents would then have to be approved by the court. In NSW, where the same restriction applies, there have been reported cases in which the court has made an adoption order in favour of the commissioning couple where the surrogate was the sister of the commissioning mother: *Re A and B* (2000) 26 Fam LR 317; *Re D and E* (2000) 26 Fam LR 310. In each case, the court was satisfied that an adoption order would be in the best interests of the child. See also *W: Re Adoption* (1998) 23 Fam LR 538.
- 15 Relative adoptions are permitted only where 'exceptional circumstances exist which warrant the making of an adoption order': *Adoption Act 1984* s 12(b).
- 16 *Family Law Act 1975* (Cth) ss 64B, 65C, 60CA.
- 17 Submission PP3 31 (Robert Rushford).
- 18 Submission CP 195 (Tammy Lobato MP, Member for Gembrook).
- 19 The surrogate was implanted with the commissioning couple's embryos at a clinic in Canberra: Julie Tullberg, 'Parents, but it's not legal' *Lilydale & Yarra Valley Leader* (Melbourne), 15 January 2007, 1.
- 20 Submission PP3 12 (Berry and Associates Family Lawyers).

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Chapter 19

Parentage and Surrogacy



'Why should our daughter's birth certificate state [that the surrogate is her parent]? She is our family and will inherit from our estate, she is not my sister's child and is not entitled to their family's assets, so her birth certificate should state that we are her legal parents.'

It is possible for the commissioning parent(s) to obtain parenting orders from the Family Court which will provide them with the necessary parental powers and responsibility to care for the child. However, parenting orders are not equivalent to full legal parental status and only last until the child reaches the age of 18. They do not extinguish the parental status of the surrogate and her partner (if any). This means that the surrogate and her partner may be technically liable to pay child support and if one of them dies without making a will, the child will be entitled to a share of their estate, along with the surrogate's own children.

Other commissioning parent(s) made submissions about the difficulties they experience as a result of not being recognised as legal parents. In one instance, after nine years of unsuccessful IVF treatment, the commissioning mother's sister offered to act as a surrogate. The sister carried an embryo created by the commissioning couple and gave birth to a child:

Our daughter is now five years old and we continue to love her dearly. She has a very special relationship with her aunty, uncle and two cousins and fully understands that she was grown in her auntie's tummy but she is her mummy and daddy's special darling daughter ...

Why should our daughter's birth certificate state [that the surrogate is her parent]? She is our family and will inherit from our estate, she is not my sister's child and is not entitled to their family's assets, so her birth certificate should state that we are her legal parents.²¹

The commission has also been informed that some people who enter into surrogacy arrangements have agreements drawn up by lawyers prior to conception to clarify each party's intentions about the arrangement. Even though such an agreement will not determine who are the legal parents of the child, and cannot be enforced, it can provide a framework which assists the parties to clarify their intentions and may help to reduce disputes about surrogacy arrangements.²²

DETERMINING LEGAL PARENTAGE

The commission has identified three broad options for determining the legal parentage of children born of surrogacy: determining parentage after the birth of a child, court orders prior to the birth of a child, or an automatic deeming provision to establish parentage. The commission has considered the following policy questions in deciding which model is the most appropriate:

- Should the commissioning person or couple be recognised as the legal parents of the child? If so, should this occur at conception or only after the child is born?
- What should happen if the surrogate wants the child to live with her rather than with the commissioning parents?
- Should the commissioning person or couple be required to undergo any form of assessment of their fitness to parent?
- Should it be necessary to obtain a court order for the transfer of legal parentage?

In most jurisdictions in Australia the law about parentage in surrogacy arrangements is similar to that in Victoria, that is, the surrogate mother and her partner are regarded as the legal parents of the child.

The ACT is a notable exception because it provides a mechanism for the transfer of legal parentage from the surrogate to the commissioning couple after the birth of the child. The *Parentage Act 2004* (ACT) does not directly regulate who is eligible to enter into a surrogacy arrangement or what conditions should be met before such an arrangement may proceed. Eligibility for treatment is covered in guidelines issued by clinics offering surrogacy. Instead, legal intervention occurs after the birth of the child, when the court is empowered to transfer the legal parentage of the child from the surrogate and her partner to the commissioning couple, provided a number of conditions have been met.

The ACT Supreme Court may make a parentage order in favour of the commissioning couple (called the 'substitute parents') if the child was conceived as a result of a procedure carried out in the ACT and the following conditions are met:

- neither the surrogate nor her partner is a genetic parent of the child
- there are two substitute parents, at least one of whom is a genetic parent of the child
- the court is satisfied that the making of the order is in the best interests of the child
- both the surrogate and her partner (if any) freely, and with a full understanding of what is involved, agree to the making of the order.²³

The court is to take a number of matters into consideration, including:

- whether the child's home is with both substitute parents
- whether both substitute parents are aged at least 18
- whether payment or reward (other than for expenses reasonably incurred) has been given or received for, or in consideration of, any aspect of the surrogacy arrangement
- whether the surrogate and her partner (if any) and substitute parents have received appropriate counselling and assessment from an independent counselling service
- anything else the court considers relevant.²⁴

A parentage order is given substantially the same legal effect as an adoption order.²⁵ The provisions of the *Adoption Act 1993* (ACT) which enable adopted people to obtain information identifying their birth parents apply to children for whom parentage orders have been made. This means that children born through recognised surrogacy arrangements in the ACT have the right to obtain identifying information about their surrogate mothers once they turn 18, or earlier if they have the consent of the surrogate and their parents.²⁶

As noted in Chapter 10, adoptive parents are recognised as legal parents for the purposes of the Family Law Act and the *Child Support (Assessment) Act 1989*. Whether a parenting order made in the ACT will be given the same status as an adoption order under federal law has not yet been tested in the courts.

A similar process to that operating in the ACT applies in the United Kingdom (UK).²⁷ In the absence of any order to the contrary, the surrogate and her partner are treated as the legal

parents of the child.²⁸ The commissioning couple may apply to the court for a parental order in their favour provided the following conditions are met:

- the commissioning couple are married and aged at least 18
- the gametes of the husband or the wife, or both, were used to create the embryo
- the application to the court is made within six months of the birth of the child
- at the time of the application the child's home is with the commissioning parents
- no money or other benefit (other than for expenses reasonably incurred) has been given or received in respect of the surrogacy agreement.

A different approach to determining the parentage of children born of surrogacy is followed in some United States (US) jurisdictions. In some states, a court can determine parentage before the child is born.²⁹ To obtain a pre-birth order the commissioning parents and surrogate must apply to the court before the birth of the child for an order approving the arrangement and declaring the commissioning parents to be the legal parents. In some jurisdictions, additional criteria apply, such as the existence of a genetic relationship between at least one commissioning parent and the child to be born, in addition to the requirement that the commissioning parents be married. Once an order is made, the commissioning parents automatically become the child's legal parents at the moment the child is born. Other US jurisdictions allow court approval of surrogacy arrangements, but the transfer of parentage does not occur until after birth.³⁰

In a recent report, the New Zealand Law Commission has recommended a similar process for determining parentage to that available in these US states. It recommends a pre-birth interim order that would become final 21 days after birth, provided certain matters have been proved and no aspect of the agreement is in dispute.³¹ The New Zealand government has expressed support for the transfer of parentage in surrogacy arrangements, but has not decided on the mechanism for doing so.³² At the time of writing, no steps have been taken to implement these recommendations.³³

- 21 Submission PP3 33 (Fiona Rushford).
- 22 Surrogacy roundtable, 20 October 2004.
- 23 *Parentage Act 2004* (ACT) ss 24, 26(1). The commissioning parents must also reside in the ACT: s 24(e).
- 24 *Parentage Act 2004* (ACT) s 26(3).
- 25 *Parentage Act 2004* (ACT) s 29.
- 26 *Adoption Act 1993* (ACT) ss 66, 68.
- 27 *Human Fertilisation and Embryology Act 1990* (UK) s 30. Where the conditions are not met (for example, the commissioning couple is not married) they cannot obtain a parenting order. They may apply to adopt under the *Adoption and Children Act 2002* (UK): *Human Fertilisation and Embryology Authority, Code of Practice* (6th ed, 2003).
- 28 *Human Fertilisation and Embryology Act 1990* (UK) ss 27, 28.
- 29 States that do not have legislation dealing with surrogacy, and appear to permit pre-birth orders include: California, Alaska, Colorado, Connecticut, Kansas, Maine, Maryland, Mississippi, North Carolina, Oklahoma, Pennsylvania, Rhode Island, South Dakota: see John Seymour and Sonia Magri, *A.R.T., Surrogacy and Legal Parentage: A Comparative Legislative Review* (2004); Steven Snyder and Mary Byrn, 'The Use of Prebirth Parentage Orders in Surrogacy Proceedings' (2005) 30 *Family Law Quarterly* 633, 643.
- 30 New Hampshire, Virginia, Texas, Utah, Illinois and Florida: Snyder and Byrn (2005), above n 29, 651 5.
- 31 New Zealand Law Commission, *New Issues in Legal Parenthood*, Report 88 (2005) 93–7.
- 32 New Zealand Government, *Government Response to Law Commission Report on New Issues in Legal Parenthood* (March 2006).
- 33 The New Zealand Law Commission reports that 'fuller policy work is being considered towards implementing the recommendations relating to the presumption of paternity, DNA parentage testing and surrogacy arrangements': *New Zealand Law Commission Annual Report (2005-06)* (2006).

RECOMMENDATIONS

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.

An alternative option we considered was to deem the commissioning couple to be the parents of the child. The *Status of Children Act* could be amended to provide that the people who commission a surrogacy arrangement are deemed to be the child's legal parents from birth, and that the surrogate be presumed not to be a parent of the child. Such a presumption would recognise the intention of the parties before the birth of the child. It would have automatic effect and would not require the commissioning couple to take any steps or undergo any process to be recognised as the child's parents.

To implement a deeming provision it would be necessary to clarify that the existing presumptions in the *Status of Children Act* which apply to donors (that is, that donors are not the parents of a child, or have no rights and incur no responsibilities for a child born using their gametes) do not apply to commissioning parents who donate gametes as part of a surrogacy arrangement.

Under this model, the commissioning parent(s) would be recorded as the parents on the child's birth certificate. If the surrogate decided not to relinquish the child after birth, the matter would need to be resolved by the Family Court. If the court found that it was in the best interests of the child to remain with the surrogate, it could make a parenting order in her favour but she would not be recognised as a legal parent of the child.

RECOMMENDATIONS

As long as surrogacy is legally permitted in Victoria, the law that deals with parental relationships arising from such arrangements should be clarified. Failure to recognise the parental role of the people who make the decision to have a child, who are caring for the child and who are regarded in every other sense as the parents of the child cannot be in the child's best interests. Surrogacy arrangements are based on the premise that the surrogate and her partner (if any) do not intend to become parents. The law's failure to recognise the parental relationship between the commissioning parent(s) and the child has serious consequences for children.

However, the commission believes that there are sufficient complexities in surrogacy arrangements to justify a cautious approach when dealing with legal parentage. The welfare of the child must be the paramount consideration and the interests of both the commissioning parents and the surrogate must be protected. For this reason, the commission has concluded that the transfer of legal parentage from the surrogate to the commissioning couple should not be automatic. Instead, it should involve a process which treats the surrogate as the parent of the child and requires all parties to meet certain specified criteria before legal parentage can be transferred.

PROTECTING SURROGATE MOTHERS

The commission received mixed responses in submissions on how to balance the competing need to protect the surrogate from being forced to relinquish the child if she changes her mind, against the commissioning parent(s)' desire for certainty that the child will be relinquished to them.

At one roundtable discussion on surrogacy convened by the commission, some people were of the view that the parties' intentions regarding parentage should be enforceable. Participants said that certainty of parentage would assist the surrogate to cope with the pregnancy and relinquish the child.³⁴

The commission also heard from people who believe the surrogate should be protected against pressure to hand over the child to the commissioning parents.³⁵ Arguments made in support of protecting the surrogate's decision not to relinquish the child included:

- the genetic connection of the commissioning parents (if it exists) should not necessarily displace the connection that the surrogate has as a result of gestating the child
- the intention and/or capacity of a person to parent a child can change over time. Intentions should not be viewed as fixed determinants of what is in the best interests of the child
- in contested situations, determinations of parentage should be made according to the best interests of the child.

The commission believes that it is not possible to devise legislation that will guarantee certainty of parentage in a surrogacy arrangement. Although people may enter into an agreement with strong intentions and expectations, these sentiments can change during the pregnancy or at the birth of the child. There is always the risk that a surrogate will decide she wants to keep the child, even if the commissioning parent(s) have been recognised as the child's legal parent(s). It is not possible to legislate to eliminate this risk.

State law cannot exclude the federal jurisdiction of the Family Court. If a dispute arises about where or with whom the child should live, the Family Court has the power to hear and determine the dispute, regardless of the legal parental status of the surrogate and/or the commissioning parent(s) under state law. The dispute would be determined in accordance with section 60CA of the Family Law Act, which requires the court to regard the best interests of the child as the paramount consideration when deciding whether to make a particular parenting order for a child.

However, legal rules and processes can create a framework for surrogacy arrangements that support the parties. The commission has recommended that parties to a surrogacy arrangement receive counselling and obtain independent legal advice (see Chapter 17).

This will not necessarily guarantee certainty in outcome, but it will assist in making the parties aware of the range of possible outcomes and able to appreciate the risks involved. Surrogacy arrangements in Australia are currently characterised by a high level of trust between the commissioning parent(s) and the surrogate.³⁶ Fostering trust between the parties is an important factor in minimising potential conflicts.

The commission has concluded that the law should not compel the surrogate to hand over the baby to the commissioning couple if she decides that she cannot bring herself to do so. As discussed in Chapter 17, the lessons learnt from the experience of relinquishing mothers in adoption cannot be ignored.³⁷ The surrogate mother should be recognised as the parent of the child unless she consents to the making of a court order transferring parentage to the commissioning parent(s) after the child is born. Before an order can be made, the child must have lived with the commissioning parents for a specified period. This principle should apply whether or not the surrogate is genetically related to the child.

LEGAL PROCESS

In *Position Paper Three: Surrogacy*, the commission recommended that adoption be the mechanism to transfer parentage in surrogacy arrangements because it is an established and recognised regime and has as its guiding principle the paramountcy of the welfare and interests of the child. Several submissions objected to the use of adoption as a mechanism because of the negative connotations associated with it, and because adoption is a mechanism for a different purpose to surrogacy.³⁸ One submission from a commissioning parent said the process of adoption would be 'onerous and humiliating'.³⁹

Other submissions said that because in many surrogacy cases the commissioning parents are the genetic parents of the child, it is artificial to require them to adopt their child.⁴⁰ Concern was also expressed about the delay between birth and the transfer of parentage, and permitting the surrogate to withhold her consent once the child is born.⁴¹ A delay in transferring parentage could also have implications for decisions about postnatal care.⁴²

34 Surrogacy roundtable, 21 February 2006.

35 Surrogacy roundtables, 20 October 2004 and 21 February 2006.

36 Surrogacy roundtable, 21 February 2006.

37 See page 173.

38 Submission PP3 54 (AIS Forum).

39 Submission PP3 2 (Anonymous).

40 Submissions PP3 2 (Anonymous), PP3 12 (Berry and Associates Family Lawyers), PP3 24 (Katrina Harrison), PP3 27 (Katherine Harding).

41 Submissions PP3 45 (Anonymous), PP3 55 (Fertility Access Rights).

42 Submission PP3 27 (Katherine Harding).

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Chapter 19

Parentage and Surrogacy



RECOMMENDATIONS

126. A substitute parentage order should have the same status and effect as an adoption order made under the *Adoption Act 1984*.
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.
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.
129. The central register maintained under the Infertility Treatment Act 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.

The commission has concluded that the terminology and operation of a substitute parentage order, as provided for in the ACT Parentage Act, would address some of the concerns raised about using adoption as the mechanism to transfer parentage from the surrogate to the commissioning parent(s). The commission believes that the use of substitute parentage orders to recognise parentage would be preferable to adoption. We agree that adoption can have connotations of abandonment for the child, which should not be imported into the surrogacy context.

The commission recommends that an application for a substitute parentage order should be made by the commissioning parent(s) (the applicants) to the County Court no earlier than 28 days and no later than six months after the birth of the child. The order should be declared to have the same status as an adoption order.

The commission recommends that before the court is able to make the substitute parentage order it would need to be satisfied that:

- the order is in the best interests of the child
- at the time of the application the child's home is with the applicant(s)
- the applicant(s) have met the eligibility criteria for entering into a surrogacy arrangement
- the surrogate 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 freely consents to the making of the order.

There may be circumstances in which the surrogate mother is unable to give her consent to the making of the order, for example if she has died during childbirth. In such cases the provisions for dispensing with consent in adoption should be applied.⁴³ The consent of the surrogate's partner (if any) should be a relevant, but not decisive factor in the court's decision.

It is possible that at the time the application for a substitute parentage order is made, the commissioning parents may no longer be in a relationship, even if they were together for the pre-treatment processes and at the time the pregnancy was achieved. The law concerning parentage in surrogacy arrangements needs to be able to deal with this situation.

If the application is made by a person who had a partner who consented to the arrangement at the outset but has not consented to the application for a substitute parentage order, there should be a presumption that the former partner will become a legal parent of the child as well. This is by virtue of his or her participation in the consent, counselling and information provision processes at the outset of the arrangement. It is also consistent with the law that applies to parents of children conceived through the use of donated gametes, where consent to treatment is the key factor in transferring parentage to a non-biological parent.

The commission believes that a substitute parentage order should only be available to people who have undertaken surrogacy arrangements with the assistance of a clinic, and have met all of the counselling, consent and information requirements of the legislation. The court should not have to make independent enquiries about these requirements: the clinic should certify that the applicants have met all of the relevant criteria.

People who undertake private surrogacy arrangements would need to pursue options, where available, under the *Adoption Act* and the *Family Law Act* to formalise their arrangements.

COMPLETED SURROGACY ARRANGEMENTS

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 applicant(s)
- the applicant(s) 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.

PROVIDING INFORMATION

The commission received submissions from families who have or are intending to commission surrogacy agreements about the information that appears on their child's birth certificate. One woman considering commissioning a surrogacy arrangement wrote:

*As [the law] stands our surrogate and her husband will have to register the birth. They will be registered as the mother and father and their children will be listed as siblings even though biologically they are not.*⁴⁴

Some submissions described the practical difficulties that arise because the commissioning parents are not listed on the birth certificate. Other submissions placed symbolic value on birth certificates:

*She was and is my precious daughter and my sister made a wonderful gesture for us to bring her into the world. I believe very strongly that her birth certificate should reflect this information.*⁴⁵

The commission has decided that once a substitute parentage order has been made, the surrogate's name should not appear on the child's birth certificate. This is consistent with the commission's recommendations about birth certificates of children born through donor treatment procedures generally, where only a child's legal parents are listed on the birth certificate.⁴⁶ Similarly, if a substitute order is not made for any reason, and the surrogate and her partner remain the legal parents of the child, the names of the commissioning parent(s) should not appear on the child's birth certificate, even if they are the child's genetic parents.

Parents are required to complete a birth registration statement within 60 days of a child's birth.⁴⁷ The statement allows the Registry of Births, Deaths and Marriages to issue a birth certificate for the child. It is likely that in most cases, the child's birth would be registered prior to the granting of a substitute parentage order, and the birth certificate would list the surrogate and her partner (if she has one) as the parents. In such cases, the birth register and certificate should be amended to record the commissioning parent(s) as the parents of the child. This is the practice in the ACT, where the birth may be re-registered only after the court makes an order under the *Parentage Act 2004* (ACT).⁴⁸

In Chapter 15 we discussed the importance of children being informed of their genetic origins and having the option to discover the identity of the person who donated the gametes used in their conception. It is equally important for children born through surrogacy arrangements to be told about their birth and to be able to identify the woman who acted as the surrogate mother.

At a roundtable on surrogacy, some participants said that disclosure of information about conception was more likely in surrogacy arrangements than for other forms of ART. It has been reported that in cases of donor conception, approximately only one third of donor-conceived children are told about their conception.⁴⁹ However, in one UK study of surrogacy outcomes, 77% of surrogates felt that the child should be told about his or her origins and no surrogates said the child should not be told.⁵⁰ In another research project examining outcomes for children conceived using ART, 44% of commissioning parents in surrogacy arrangements had begun to tell their three year old children about their method of conception, whereas only 5% of donor insemination parents had done so.⁵¹ Fifty-three percent of the surrogacy parents planned to tell their children about their origins (three per cent were undecided).⁵²

In surrogacy arrangements, the parties' social networks are often aware of the surrogacy and it is difficult to hide this information from children. Submissions to the commission reflected this, with one surrogate writing:

*We have never kept any information surrounding the birth of P from our two children and have always explained the circumstances surrounding her arrival. They fully understand that she grew up in her mummy's tummy, but that she is R and F's baby.*⁵³

The commissioning parents wrote:

*Our daughter is now five years of age. She knows that she has a special aunty and she is extremely close to her cousins. She has been told that she came from 'L's tummy' and that message is repeated regularly. Her cousins (now aged 7 and 9) know the special role L had in the birth of our daughter and this message is also repeated regularly.*⁵⁴

43 *Adoption Act 1984* s 43.

44 Submission PP3 24 (Katrina Harrison).

45 Submission PP3 33 (Fiona Rushford).

46 See Chapter 14.

47 *Births, Deaths and Marriages Registration Act 1996* s 18.

48 *Births, Deaths and Marriages Registration Act 1997* (ACT) ss16A and 16B.

49 See Chapter 15, page 150.

50 Vasanti Jadva et al, 'Surrogacy: The Experiences of Surrogate Mothers' (2003) 18(10) *Human Reproduction* 2196, 2202.

51 Susan Golombok et al, 'Non-Genetic and Non-Gestational Parenthood: Consequences for Parent-Child Relationships and the Psychological Well-Being of Mothers, Fathers and Children at Age 3' (2006) 21(7) *Human Reproduction* 1918, 1922.

52 *Ibid.*

53 Submission PP3 51 (Laura Clark and Dominic Dillon).

54 Submission PP3 31 (Robert Rushford).

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Chapter 19

Parentage and Surrogacy



RECOMMENDATIONS

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.

The commission acknowledges that these examples only indicate that disclosure in surrogacy arrangements is more likely to occur; they do not remove the need to stress that disclosure is important. If altruistic surrogacy is facilitated in Victoria, the commission recommends that identifying information about the surrogate be registered and released to the child in the same way as information about donors is recorded and released.

Research suggests that it is common for the parties to a surrogacy arrangement to maintain contact after the birth of the child.⁵⁵ However, ongoing contact is made more difficult when people travel outside Victoria to access surrogacy. One man, who with his partner commissioned a surrogacy arrangement in the US said:

While we enjoy a very close relationship with our surrogate and envisage this continuing long into the future the sheer distance between us makes keeping in touch difficult. We hope that our surrogate will remain a part of our children's lives, amongst other things, so that they can feel a sense of connection with where they came from in an open and transparent manner.⁵⁶

The counselling provided before the surrogacy will clearly play an important role in assisting parents to appreciate the importance of informing children of their origins. However, we also believe that commissioning parent(s) should be provided with ongoing counselling and support after the birth of their children to equip them to inform the children about their origins.

55 Fiona MacCallum et al, 'Surrogacy: The Experience of Commissioning Couples' (2003) 18(6) *Human Reproduction* 1334: 64% of the commissioning mothers interviewed had regular contact with the surrogate after the birth of the child.

56 Submission PP3 45 (Anonymous).

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Appendix 1

Table 1: Studies of Children Raised by Lesbian and Gay Parents 1986–2006*

This table presents a summary of findings of recent empirical studies on children raised by lesbian and gay parents.

AUTHOR AND YEAR	TOPIC	METHODOLOGY	RESULTS	CONCLUSIONS
Almack (United Kingdom, 2006) ¹	Lesbian couples' reproductive decision-making and understandings of the needs of the child	<ul style="list-style-type: none"> Qualitative study of 20 families with two lesbian parents where first child conceived using donated sperm Interviews, with analysis based on socio-legal context 	<ul style="list-style-type: none"> 13 of 20 couples chose to make private arrangements with a known donor. Two key risks identified: known donors seeking more involvement than agreed and potential claim by donor of legal rights in relation to the child. 	<ul style="list-style-type: none"> Despite different entry points into motherhood and family formation, needs of the child are the overarching priority for lesbian mothers.
Bailey, Bobrow, Wolfe & Mikach (United States, 1995) ²	Sexual orientation of adult sons of gay fathers	<ul style="list-style-type: none"> 55 gay or bisexual fathers (all earlier married, 91% separated or divorced) and 82 adult sons Sons aged 17–43 Interviews with fathers, mailed questionnaire for sons (43 replied) 	<ul style="list-style-type: none"> Of sons whose sexual orientation could be rated with confidence, 91% were heterosexual and 9% non-heterosexual. Sexual orientation was not positively correlated with the amount of time sons and fathers lived together. 	<ul style="list-style-type: none"> The large majority of sons of gay fathers were heterosexual. Any environmental influence of gay fathers on their sons' sexual orientation was minimal.
Bos, van Balen & van den Boom (The Netherlands, 2003, 2004) ³	Planned lesbian mother families: motivation to have children	<ul style="list-style-type: none"> 100 lesbian two-mother families and 100 heterosexual couple families Lesbians conceived through DI at a clinic or self-inseminated Children aged 4–8 and all born into family of origin Questionnaires 	<ul style="list-style-type: none"> Happiness more important motive for lesbian social mothers than for fathers. Well-being, identity development and social control less important motives for lesbian social mothers than for fathers. Lesbian biological mothers and social mothers spent more time reflecting on decision to have children than heterosexual mothers and fathers. 	<ul style="list-style-type: none"> Lesbian parents and heterosexual parents ranked their parenthood quite similarly. Lesbian parents especially differed from heterosexual parents in that their desire to have children was stronger. Lesbian parents have spent more time thinking about their motives for having children and their desire to have children was stronger.
	Planned lesbian mother families: experience of parenthood, couple relationship, social support and child-rearing goals		<ul style="list-style-type: none"> Lesbian parents no less competent nor more burdened than heterosexual parents. Both lesbian and heterosexual parents consider it important to develop qualities of independence in their child, but 'conformity' as a child-rearing goal is less important to lesbian mothers. Lesbian social mothers feel they must justify the quality of their parenting more often than fathers. 	<ul style="list-style-type: none"> There were few differences between lesbian couples and heterosexual couples as parents, except that lesbian mothers appear less attuned to traditional child-rearing goals and lesbian social mothers seemed to defend their position as mothers more often.
Bozett (United States, 1988) ⁴	Social control strategies of sons and daughters of gay fathers	<ul style="list-style-type: none"> 19 children aged 14–35 (13 females, 6 males), representing 14 gay fathers Unstructured in-depth interviews 	<ul style="list-style-type: none"> 16 of 19 children reported to have heterosexual preference. Children employ range of social control strategies: boundary control, nondisclosure and disclosure. Use of these strategies is influenced by perceptual, situational and maturational factors. 	<ul style="list-style-type: none"> An exploration of children's feelings as well as contact and support from other gay fathers and children of gay fathers may be a powerful way to reduce homophobia.

Abbreviations: DC = donor-conceived; DI = donor insemination; TC = traditionally conceived;

* The presentation of this table draws on Norman Anderssen, Christine Amlic and Erling André Ytterøy, 'Outcomes for Children with Lesbian or Gay Parents: A Review of Studies from 1978 to 2000' (2002) 43 *Scandinavian Journal of Psychology* 335.

AUTHOR AND YEAR	TOPIC	METHODOLOGY	RESULTS	CONCLUSIONS
Brewaeyts, Ponjaert, van Hall & Golombok (Belgium/The Netherlands, 1997) ⁵	Child development and family functioning in families with lesbian mothers	<ul style="list-style-type: none"> • Comparative study: 30 DC children in families with lesbian mothers, 38 DC children in families with heterosexual parents and 30 TC children of heterosexual couples • Children aged 4–8 • Interviews and questionnaires to parents and psychological testing of child • Participants recruited through clinics and hospitals in Brussels 	<ul style="list-style-type: none"> • No significant differences in mother–child interactions, child’s perception of their parents or gender role development. • Parent–child interaction with lesbian social mothers was higher than for heterosexual fathers. • Social mothers were more involved with practical childcare activities and disciplining the child than heterosexual fathers. • Lack of a genetic link did not influence child’s feelings for the parent (lesbian or heterosexual). 	<ul style="list-style-type: none"> • The quality of couples’ relationships and the quality of mother–child interaction did not differ between families of lesbian mothers and heterosexual parents. • Boys and girls raised in lesbian mother families were well adjusted in terms of emotional/behavioural development. • Gender-role development did not differ between children of lesbian mother families and heterosexual parent families. • Children’s own perception of parents was similar in all family types—social mothers in lesbian mother families were regarded as much as parents as fathers in heterosexual families.
Dundas & Kaufman (Canada, 2000) ⁶	Perceptions of mothers and children in lesbian parented families Toronto Lesbian Family Study, Stage 1	<ul style="list-style-type: none"> • 27 lesbian mothers and 20 children (primarily conceived by DI) • Children aged 0–12 • Of 17 fathers, 7 known (1 donor/rest from previous heterosexual relationships) and 10 unknown • Questionnaires and semi-structured interviews with mothers and verbal children • Longitudinal, qualitative and quantitative data 	<ul style="list-style-type: none"> • Most (25) mothers were planning to tell or had already told their children about their sexuality, as questions arose. • All mothers planned to reveal all available information about donors to children at an appropriate age. • 8 mothers worried about lack of male role models. • Children under 5 did not suggest having two mothers made their families different. • When asked, children conceived by DI said they had no father, or identified other important men in their lives as father figures. 	<ul style="list-style-type: none"> • Women who had negative early homophobic memories seemed less comfortable and open about revealing their sexuality to children. • These same women also had poorer current functioning and depressive symptoms. • Children were content with their family make-up and did not feel stigmatised by having two mothers.
Flaks, Ficher, Masterpasqua & Joseph (United States, 1995) ⁷	Comparative study of planned lesbian mother families and heterosexual parents and children	<ul style="list-style-type: none"> • 15 lesbian couples and their 3–9 year old planned DC children and 15 matched heterosexual parents and children • Assessment measures to evaluate children’s cognitive functioning and behavioural adjustment; parents’ relationship quality and parenting skills 	<ul style="list-style-type: none"> • Children of lesbian and heterosexual parents are remarkably similar, specifically in the areas of intellectual functioning and behavioural adjustment. • No gender differences were found between the groups. • Of the 24 comparisons made, 17 favoured children of lesbian parents. • Lesbian parents were more aware of skills for parenting and were superior in ability to identify critical issues in childcare situations than heterosexual parents. 	<ul style="list-style-type: none"> • There was no empirical support for the proposition that lesbian families should be treated differently from other families in the legal arena. • Neither father presence nor parental sexuality was demonstrated to be crucial for healthy child development. • Differences in parenting skills were related to parents’ gender rather than to their sexual orientation.

Abbreviations: DC = donor-conceived; DI = donor insemination; TC = traditionally conceived;

Appendix 1

Table 1: Studies of Children Raised by Lesbian and Gay Parents 1986–2006

AUTHOR AND YEAR	TOPIC	METHODOLOGY	RESULTS	CONCLUSIONS
Gartrell, Hamilton & Banks et al (United States, 1996, 1999, 2000, 2005) ⁸	National Lesbian Family Study of children born into families with lesbian mothers	<ul style="list-style-type: none"> 84 families of DC children (70 lesbian couples, 14 single lesbians) 27 with known donors and 18 with possibility of meeting donor after they reached 18 Participants self-selected 	<ul style="list-style-type: none"> Stage 1 examined parental relationships, social supports, pregnancy motivations and preferences, stigmatisation and coping strategies. 47% preferred sperm donors to be unknown, 45% elected to know identity, 8% expressed no preference. Most participants did not expect children to have involved fathers. 63% believed that children need good male role models. 	<ul style="list-style-type: none"> At Stage 1, prospective children were highly desired and thoughtfully conceived. Mothers were strongly lesbian-identified, had close relationships with friends and extended family, had established flexible work schedules and were well-educated about potential difficulties of raising a child in lesbian household.
			<ul style="list-style-type: none"> Stages 2 and 3 (children aged 2 and 5) focused on health concerns, parenting, family structure, relationships, time management and concerns about discrimination. In 75% of two-mother families, mothers shared responsibilities of child rearing and considered themselves equal co-parents. 69% found that having a child enhanced their relationships with their parents. By Stage 3, 31% of couples had split up. Of 50 couples still together, 29 shared child-rearing responsibilities equally, 17 allocated more responsibility to birth mothers and 4 allocated more responsibility to co-mothers. In 43% of cases, children of separated mothers spent equal amounts of time with each mother. 	<ul style="list-style-type: none"> Those co-mothers who had become legal adoptive parents of their children felt that the adoption significantly enhanced the legitimacy of their parenting role. After children were born, some mothers regretted having used unknown donors and felt sad about the lost opportunity for their children to know their donor fathers. Children in continuous families at Stage 3 had two actively-involved parents and most were equally bonded to both mothers. By Stage 3, 63% of grandparents were 'out' about their grandchild's lesbian parents. In situations of separation, the birth mother was more likely to retain sole or primary custody if the co-mother had not officially adopted the child.
		At Stage 4 (children aged 10) interviews conducted with children and standardised tests used to assess social and psychological functioning	<ul style="list-style-type: none"> Children were uniformly positive in describing what is special about having lesbian mothers. Social competence and behaviour of children rated as normal. 85% of children did well academically, 81% relating well to peers. 57% of children reported being open about having lesbian parent families, 39% open to some, 63% open to grandparents. 27% of children with known donor had some contact. 43% of children reported they had experienced homophobia by age 10. None of the children had experienced physical abuse; 5% of girls had experienced sexual abuse. 	<ul style="list-style-type: none"> In social and psychological development, the children were comparable to children raised in heterosexual parent families. Children of unknown donors were indistinguishable from those of known donors in psychological adjustment. Prevalence of physical and sexual abuse was substantially lower than US norms.

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AUTHOR AND YEAR	TOPIC	METHODOLOGY	RESULTS	CONCLUSIONS
Gartrell, Rodas, Deck, Peyser & Banks (United States, 2006) ⁹	National Lesbian Family Study of children born into families with lesbian mothers	At Stage 4, interviews conducted with birth mothers, co-mothers and single mothers	<ul style="list-style-type: none"> 30 couples had separated, 22 continuous co-mothers had adopted their children; 9 separated co-mothers had their children; 7/9 then co-parented after separation. 88% of birth mothers and 97% of co-mothers reported that their families of origin embraced the child. Known donors generally not regular participants in family life. 	<ul style="list-style-type: none"> Parenting was prioritised at the expense of other relationships and activities and mothers led very child-focused lives. Continuous couples shared childrearing responsibilities, domestic chores and income earning. Co-parent adoptions had legitimised the role of co-mothers, yet some mothers continued to feel jealous of the birthmother's bond with the child.
Gershon, Tschann & Jemerin (United States 1999) ¹⁰	Stigmatisation, self-esteem and coping among adolescent children of lesbian mothers	<ul style="list-style-type: none"> 76 adolescents aged 11–18 years with lesbian mothers (67% born when in heterosexual relationship) Interviews and questionnaires, using standardised measures of self-esteem and coping skills, and adaptation of measures of stigma and disclosure 	<ul style="list-style-type: none"> A perception of greater stigma was related to lower scores on self-perception of social acceptance, self-worth, behavioural conduct, physical appearance and close friendships. Scholastic competence and athletic competence were unrelated to stigma. 	<ul style="list-style-type: none"> Adolescents who perceived high stigma had lower self-esteem even when they had more effective coping skills. Adolescents who disclosed to more people about their mothers' lesbianism had higher self-esteem in the area of close friendship.
Golombok, Tasker & Murray (United Kingdom, 1997) ¹¹	Health and wellbeing of children in fatherless families	<ul style="list-style-type: none"> 30 families headed by lesbian mothers (from birth), 15 currently single and 15 living with partners (10 since birth) and 42 families headed by single heterosexual mothers Control group of 41 heterosexual couples with children Children 3–9 years old Structured interviews and questionnaires for mothers; ratings from school teachers; testing of children 	<ul style="list-style-type: none"> No differences in mothers' psychological state, children's emotions, behaviour and relationships. Mothers in father-absent households expressed greater warmth than other mothers, and lesbian mother families in particular showed greater interaction with their children. Disputes between mother and child were more severe in father-absent families. Children from fatherless families showed greater security of attachment but also perceived themselves to be less cognitively and physically competent than their peers. 	<ul style="list-style-type: none"> Mothers who were raising their children without fathers were warmer and interacted more with their children, but also reported more serious disputes with children. Absence of a father from birth does not, in itself, have negative implications for children's psychological adjustment. Lack of differences between single and lesbian mothers suggests that sexuality does not have a negative impact on child development.

Abbreviations: DC = donor-conceived; DI = donor insemination; TC = traditionally conceived;

Appendix 1

Table 1: Studies of Children Raised by Lesbian and Gay Parents 1986–2006

AUTHOR AND YEAR	TOPIC	METHODOLOGY	RESULTS	CONCLUSIONS
Chan, Raboy & Patterson (United States, 1998) ¹²	Family relationships and psychological adjustment of children conceived via donor insemination with lesbian and heterosexual mothers	<ul style="list-style-type: none"> 80 families, all conceived children via same sperm bank in California 55 families headed by lesbian parents and 25 headed by heterosexual parents; 50 couples and 30 single parents Children average age: 7 Mailed standardised questionnaires to parents and teachers; children assessed using standardised psychological tests 	<ul style="list-style-type: none"> No significant differences in biological mothers' reports of wellbeing as function of relationship status (single or coupled) or as function of sexual orientation. Parental sexual orientation or household composition was not associated with significant outcomes for children or parents. Parenting stress, love and conflict were associated with child adjustment. Generally, all reporters (biological mothers, non-biological parents and teachers) agreed that children in all family types were functioning well. 	<ul style="list-style-type: none"> Children conceived via DI developed in normal fashion and their adjustment was unrelated to parental sexual orientation or number of people in household. No significant differences in psychosocial adjustment, competence and behaviour problems between children brought up by lesbian or heterosexual parents. Children's wellbeing was more a function of parenting and relationship processes than a function of household composition or demographic factors. Parents who experienced higher levels of parenting stress, inter-parental conflict, and lower levels of love for each other had children who had more behavioural problems.
Golombok, Perry, Burston, Murray, Mooney-Somers & Stevens (United Kingdom, 2003) ¹³	Children from lesbian mother families	<ul style="list-style-type: none"> Children from 39 lesbian mothers (20 single, 19 couples) (28 children born into heterosexual families) Control group of 74 heterosexual couples and 60 single heterosexual women Based on Avon Longitudinal Study of Parents and Children Mean age of children: 7 Standardised questionnaires and interviews 	<ul style="list-style-type: none"> No significant difference in parent-child relationships, socio-emotional development, psychiatric ratings or gender development. Lesbian mothers engaged in more imaginative and domestic play and less smacking than heterosexual mothers. Children from lesbian mother families tended towards higher levels of peer problems (as reported by mothers). Children from single-parent families tended towards conduct problems (as reported by teachers). 	<ul style="list-style-type: none"> Children raised by lesbian mothers appeared to be functioning well and did not experience negative psychological consequences arising from the nature of their family environment. Findings suggest that the presence of two parents, irrespective of gender, is associated with more positive outcomes for children. Maternal sexual orientation is not a major influence on children's gender development.
Green, Mandel, Hotvedt, Gray & Smith (United States, 1986) ¹⁴	Comparative study of lesbian and heterosexual mothers and their children	<ul style="list-style-type: none"> 50 lesbian mothers with 56 children and 40 heterosexual mothers with 48 children Most children born into two parent heterosexual families Children aged 3–11 Analysis of general intelligence, sexual identity, gender-role preferences, family and peer group relationships and adjustment to single parent family Questionnaires and standard psychological tests 	<ul style="list-style-type: none"> No distinctions between groups in terms of popularity, social adjustment or self-concept as male or female. Daughters showed wider range of gender-role behaviour than sons, but not beyond normal range. Daughters of lesbian mothers were less traditionally feminine in dress, play, activity preferences and anticipated occupation. Boys in both groups were similar and quite traditionally masculine. 	<ul style="list-style-type: none"> Girls and boys raised from early childhood by a lesbian mother without an adult male in the household for about 4 years do not appear appreciably different on parameters of psychosexual and psychosocial development from children raised by heterosexual mothers, also without an adult male present.

Abbreviations: DC = donor-conceived; DI = donor insemination; TC = traditionally conceived;

AUTHOR AND YEAR	TOPIC	METHODOLOGY	RESULTS	CONCLUSIONS
Henrickson (New Zealand, 2005) ¹⁵	Lesbian, gay and bisexual people who are parents	<ul style="list-style-type: none"> Based on data on parenting and children taken from Lavender Islands: Portrait of the Whole Family national study of lesbian, gay and bisexual people Included people who had had children in previous heterosexual relationships, those who had children in same-sex relationships, single parents, adoption and fostering 	<ul style="list-style-type: none"> Parents were more likely to be women, over the age of 40, highly educated, and earning more than non-parents. Respondents from urban centres significantly more likely not to have children than those from non-urban areas. People from non-urban areas were significantly more likely to have given birth to at least one child than those from urban areas. 	<ul style="list-style-type: none"> About one third of respondents had some kind of parenting relationship to children. The strongest predictor of becoming a parent was whether they had a child prior to identifying as lesbian, gay or bisexual. The desire to reproduce and parent children among lesbian, gay and bisexual people may be quite separate from the desire for a fulfilling relationship with a partner.
Huggins (1989, United States) ¹⁶	Self-esteem of adolescent children of divorced lesbian and heterosexual mothers	<ul style="list-style-type: none"> 36 adolescent children aged 13–19 from 32 families with divorced mothers, lesbian and heterosexual Use of Coopersmith Self-Esteem Inventory assessment 	<ul style="list-style-type: none"> No significant statistical differences between the self-esteem scores of adolescent children in the two groups. Lower self-esteem correlated with feeling negative about mother's lesbianism. Both groups of children had a higher self-esteem score if their mothers were living with a lover or were remarried. Father's level of acceptance of mother's lesbianism appeared to have important influence on child's acceptance. 	<ul style="list-style-type: none"> The mother's sexual object choice did not appear to influence negatively the self-esteem of her adolescent children. The assumption that children of lesbian mothers are socially stigmatised by their mother's sexual choice was not supported.
MacCallum & Golombok (United Kingdom, 2004) ¹⁷	Health and wellbeing of children raised in fatherless families from infancy	<ul style="list-style-type: none"> 25 lesbian mother families and 38 single heterosexual mother families Children aged 12 Structured interviews and questionnaires for mothers and children; psychological tests for children and ratings from teachers Follow up of Golombok et al (1997) (see above) 	<ul style="list-style-type: none"> No group differences in mothers' or children's psychological state, mothers' expressed warmth, children's school adjustment or peer adjustment. Mothers in father-absent families showed higher levels of aggression during disputes (especially single mothers), and also reported more severe disputes than other mothers. Adolescent children in father-absent families perceived their mothers to interact with them more and to be more available and dependable. Boys in father-absent families expressed higher levels of femininity, but not lower levels of masculinity. 	<ul style="list-style-type: none"> Adolescent children raised in fatherless families did not suffer serious negative consequences (social and emotional development). There were very few differences found between the two groups, apart from higher levels of disciplinary aggression from single heterosexual mothers. There was no evidence that a mother's sexuality influences parent-child interaction. In the absence of financial hardship, parental conflict or maternal psychiatric disorder in their early years, there was no evidence that the absence of a father per se necessarily results in psychological disadvantages for children.

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Appendix 1

Table 1: Studies of Children Raised by Lesbian and Gay Parents 1986–2006

AUTHOR AND YEAR	TOPIC	METHODOLOGY	RESULTS	CONCLUSIONS
McNair, Dempsey, Wise & Perlesz (2002, Australia) ¹⁸	Report of Lesbian and Gay Families Project	<ul style="list-style-type: none"> • Study focusing on lesbian parents' health and medical issues, parental relationships, social acceptance and support • 136 lesbian women with 115 children (70 intending to parent, 71 with children) • Children aged 1–17 • Anonymous mail-back questionnaire completed by one of mothers in couples 	<ul style="list-style-type: none"> • Lack of legal recognition as a parent (particularly towards non-biological mother) and lack of legal recognition as a family were reported as the most frequent problems and created the most difficulty in parenting. • High level of knowledge about health, but low access to information for conception. • Children raised by lesbian parents were well accepted by family and friends, and were reported as having few relationship difficulties overall as a result of their parents' sexuality. • High level positive peer relationships for mothers. • Challenges included fears and experiences of community prejudice and rejection by family. 	<ul style="list-style-type: none"> • Legal insecurity was the leading challenge for lesbian parents, particularly the lack of access to assisted reproductive technology services in Victoria and the lack of legal recognition of the non-biological mother. • Parents experienced less discrimination than prospective parents predicted, probably because they carefully chose their professional and community support networks. • Lesbian parents carefully considered their children's need to access information about the biological father, safety in the conception process, optimal levels of contact between the father and children, and accessing the most supportive community and professional networks possible.
Mercier & Harold (United States, 2003) ¹⁹	Lesbian parent families and their children's schools	<ul style="list-style-type: none"> • 21 women representing 15 families (all but 1 partnered), with children aged 6m–17 (6 attended preschool, 20 enrolled in kindergarten–grade 11) • Families formed in variety of ways, including TC, DC, adoption, foster care and guardianship • Semi-structured interviews, guided by principles of feminist epistemology 	<ul style="list-style-type: none"> • Most (80%) women said they had a positive relationship with their children's schools, but nearly all interviews revealed evidence of stress. • None of the negative experiences were related to the respondents' sexual orientation. • Nearly everyone who mentioned diversity suggested that schools that value diversity of any type are more likely to respond well to lesbian parent families. • Social invisibility, especially for non-biological parents, was a significant issue. 	<ul style="list-style-type: none"> • Lesbian parents express concern about their children's experience in schools, particularly that of being different. • Lesbian parents respond to these concerns by selecting schools and teachers known for multiculturalism and openness to diversity, even when such selection involved considerable effort or inconvenience. • Managing disclosure about sexual orientation was a primary issue for many lesbian parents.
O'Connell (United States, 1993) ²⁰	Impact of divorced mothers' lesbianism on adolescent children	<ul style="list-style-type: none"> • In-depth study of 11 children whose mothers, either prior to or post divorce, came out as lesbian • Attention to adolescent developmental issues of peer affiliation and sexuality 	<ul style="list-style-type: none"> • Findings indicated profound loyalty and protectiveness toward the mother, openness to diversity, and sensitivity to the effects of prejudice. • Subjects reported strong needs for peer affiliation and perceived secrecy regarding mother's lesbianism as necessary for relationship maintenance. 	<ul style="list-style-type: none"> • Subjects had adjustment reactions like other children of divorced parents. • The loss of the original family unit was far more significant in the children's lives than the mother's change in sexual orientation.

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AUTHOR AND YEAR	TOPIC	METHODOLOGY	RESULTS	CONCLUSIONS
Patterson (United States, 1994, 1996) ²¹	Child development, maternal mental health and family functioning among lesbian mothers and their children Findings of Bay Area Families Study	<ul style="list-style-type: none"> 66 lesbian mothers and their children (26 couples, 7 single mothers, 4 in joint custody between two mothers) Children aged 4–9 Standardised questionnaires completed by mothers and standardised tests for children, including Children's Self-View Questionnaire, as well as open-ended interview of children Results compared with general population 	<ul style="list-style-type: none"> Both mothers' and children's adjustment fell clearly within the normative range and social and personal development among children was normal. Children reported greater reactions to stress, as well as a greater overall sense of well-being than children of heterosexual mothers. Lesbian couples reported that they divide household labour and family decision-making relatively evenly, but biological mothers reported performing more childcare and non-biological mothers reported spending more time in paid employment. 	<ul style="list-style-type: none"> Children raised by two women may have greater awareness and expression of emotional experience and increased openness to expression of negative as well as positive feelings. There were significant associations between division of labour among lesbian couples and psychosocial outcomes for mothers and their children.
Ray & Gregory (Australia, 2001) ²²	School experiences of children of lesbian and gay parents	<ul style="list-style-type: none"> 48 children, 39 with lesbian mothers, 6 with gay fathers, 3 with gay and lesbian parents Children aged 5–18 Mail-back questionnaire, interviews and focus groups with children; separate questionnaire for parents 	<ul style="list-style-type: none"> Parents were concerned that children would be teased or bullied at school, that discussion of lesbian and gay families would not be part of school or pre-school curriculum and that children would have to answer difficult questions. 41% of parents of children in primary school and 17% of parents of secondary school children reported no negative issues. Disclosure of parent's sexuality: 90% Prep–Grade 2, 61% Grades 3–6, 64% Years 7–10, 86% Years 11–12. Presence of bullying: No bullying for Prep–Grade 2; 44% Grades 3–6, 45% Years 7–10, 14% Years 11–12 bullied. 	<ul style="list-style-type: none"> Children of gay and lesbian parents were exposed to a high level of bullying and teasing. Children chose silence in response to bullying, use of homophobic language and a general lack of understanding of gay and lesbian families. Secondary school children in particular spent a lot of time avoiding being teased or bullied and often went to great trouble to hide their parents' sexuality. Many children felt unsafe at school and were not confident in a teacher's ability to deal with the issues. Children affirmed the advantages of having lesbian and gay parents and enjoyed being part of the gay and lesbian community.
Sarantakos (Australia, 1996) ²³	Educational, family and social development of children of married heterosexual couples, cohabiting heterosexual couples and gay and lesbian couples	<ul style="list-style-type: none"> 174 children: 58 with heterosexual married, 58 heterosexual cohabiting and 58 homosexual (47 lesbian, 11 gay) parents All children primary school age All children living with at least one biological parent All children with homosexual parent were born into previous relationship Information collected primarily from teachers Study measured academic performance, social behaviour, personality issues, school-related family issues 	<ul style="list-style-type: none"> Achievements of children varied with family type. Children of married couples achieved highest score in language, mathematics and sport. Children of homosexual couples achieved slightly better in social studies. Children of homosexual couples were reported to be more reserved and more polite. Girls of gay fathers were more boyish and boys of lesbian mothers were more effeminate in behaviour. Heterosexual parents (esp. married) had greater ambition for their children. Children of homosexual parents had more autonomy in personal life. 	<ul style="list-style-type: none"> Children of married couples are more likely to do well at school, in academic and social terms, than children of cohabiting heterosexual and homosexual couples. Findings should be treated with caution because other factors than sexuality and marital status may cause or contribute to trends. Family environments are instrumental for development of attributes which encourage educational progress and social development.

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Appendix 1

Table 1: Studies of Children Raised by Lesbian and Gay Parents 1986–2006

AUTHOR AND YEAR	TOPIC	METHODOLOGY	RESULTS	CONCLUSIONS
Tasker & Golombok (United Kingdom, 1995, 1997) ²⁴	British Longitudinal Study of Lesbian Mother Families	<ul style="list-style-type: none"> Longitudinal comparative study of female-headed families: 27 lesbian mothers and 27 single heterosexual mothers Study began in 1976–77 with follow-up in 1991–92 39 children in each group at beginning; at follow-up, 25 young adults from lesbian mother families and 21 raised by single heterosexual mothers Most women had previously been in heterosexual relationship and most children had lived at least their first year in a home with a father and mother In initial study, average age of children was 9.5 years and at follow up, average age 23.5 years Semi-structured interviews 	<ul style="list-style-type: none"> Almost all young adults were over 10 at time of mother's main lesbian relationship. Young adults who had been brought up in lesbian households described their relationship with their mother's partner significantly more positively than did those who had been raised by heterosexual mothers. Young people from lesbian mother families who felt less accepting of their family during adolescence were more likely to believe that their mothers had been too open about their sexual identity in front of the adolescents' peers. In adulthood, young adults brought up by lesbian mothers were significantly more positive about their mother's non-conventional relationships than those raised by single heterosexual mothers. 23 out of 25 young adults from lesbian mother families identified as heterosexual. 	<ul style="list-style-type: none"> Negative outcomes for children should not be assumed on the basis of a mother's sexual orientation. All children had functioned well throughout childhood and adolescence. Those raised by lesbian mothers continued to do so in adulthood and experienced no long-term detrimental effects as adults, in terms of mental health, personal relationships, or relationships with peers or partners arising from their early upbringing. No significant difference was found between young adults from lesbian and heterosexual parent backgrounds in the quality of their current relationship with their mothers and fathers. Fear of peer group stigmatisation and the experience of being teased or bullied are central elements in how children feel about being brought up in lesbian mother families. Having a lesbian mother appeared to widen the adolescent's view of what constituted acceptable sexual behaviour to include same-gender sexual relations.
Vanfraussen, Ponjaert-Kristoffersen & Brewaeys (Belgium, 2002) ²⁵	Donor-conceived children's views on growing up in lesbian mother families	<ul style="list-style-type: none"> 37 children of lesbian mothers conceived of anonymous donors (6 /24 families separated) and 37 children of heterosexual mothers (6 couples separated) Children aged 7–17 Standardised questionnaire to parents on child's wellbeing; separate interview with mothers and children, and teacher's reports Follow up of Brewaeys et al (1997) (see above) Longitudinal study 	<ul style="list-style-type: none"> 38 children had told their peers that they had two mothers; 21 said that people did not understand it. 24 children of lesbian parent families and 21 children from heterosexual parent families experienced teasing; only children from lesbian parent families mentioned family-related teasing. No significant differences in children's competence, child behaviour, emotional/behavioural functioning. Children from heterosexual parent families scored higher on externalising, aggressive and anxiety scales. Teachers reported more attention problems amongst children from lesbian mother families. 	<ul style="list-style-type: none"> Children were very selective when choosing who to tell about their family structure. Children did not find it difficult to say that they do not have a father; revealing spontaneously that they have two mothers was considered a more private matter. Almost all children were not inclined to tell people that their mothers had a lesbian relationship. Having two mothers was not an obstacle to children inviting friends home. There is no evidence to justify a decision to exclude lesbian couples from DI programs.

Abbreviations: AR = assisted reproduction; DC = donor-conceived; DI = donor insemination; DE = donor egg; IVF = invitro fertilisation; TC = traditionally conceived;

AUTHOR AND YEAR	TOPIC	METHODOLOGY	RESULTS	CONCLUSIONS
Vanfraussen, Ponjaert-Kristoffersen & Brewaeys (Belgium, 2003) ²⁶	Family functioning in lesbian parent families created by donor insemination, with attention to role of social mothers	<ul style="list-style-type: none"> • 24 lesbian parent families (6 separated couples) and 24 heterosexual parent families • Average age of children: 10 • Parent-Child Interaction Questionnaire, and interviews with both parents and children • Sample source: Brewaeys et al (1997) (see above) 	<ul style="list-style-type: none"> • Neither family type nor parental role influenced the evaluation of parent-child interaction. • All families recorded higher interaction levels with daughters; gender difference was more distinct in lesbian parent families. • Parents reported child activities were more equally shared in lesbian parent households. • In heterosexual parent families, most children discussed emotions with their mothers. 	<ul style="list-style-type: none"> • The only difference between the two types of families was found at the parental level, where parents reported that mothers in heterosexual parent families carried more parenting responsibility. • Lack of biological link between social mothers and children did not prevent them taking on equal parenting responsibility. • In comparison to fathers, social mothers were more involved in child activities and were as much a symbol of authority as fathers.
Wainwright, Russell & Patterson (United States, 2004) ²⁷	The psychosocial adjustment, school experiences and adolescent sexuality of children of same-sex parents	<ul style="list-style-type: none"> • 44 children parented by same-sex couples (38 with lesbian mothers, 6 with gay fathers) and 44 children parented by heterosexual couples • Children aged 12–18 • Standardised questionnaire data and interview with children, standardised questionnaire to parents • Source: US National Longitudinal Study of Adolescent Health, national survey 	<ul style="list-style-type: none"> • No difference in psychosocial adjustment, family and relationship processes or presences of romantic relationships. • Girls reported higher level of care from adults and peers than boys. • Adolescents with same-sex parents were more connected at school. • Adolescents showed more favourable adjustment when they perceived more care from adults and when parents described close relationships with them. 	<ul style="list-style-type: none"> • Adolescents were functioning well; adjustment was not linked with family type, but was strongly associated with qualities of relationships with parents. • Adolescents of same-sex parents had romantic lives that were much like those of other adolescents. • Adjustment was clearly linked to the quality of family relationship.

Abbreviations: DC = donor-conceived; DI = donor insemination; TC = traditionally conceived;

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Table 1: Studies of Children Raised by Lesbian and Gay Parents 1986–2006

ENDNOTES

- 1 Kathryn Almack, 'Seeking Sperm: Accounts of Lesbian Couples' Reproductive Decision-Making and Understandings of the Needs of the Child' (2006) 20(1) *International Journal of Law, Policy and the Family* 1.
- 2 J Michael Bailey, David Bobrow, Marilyn Wolfe and Sara Mikach, 'Sexual Orientation of Adult Sons of Gay Fathers' (1995) 31(1) *Developmental Psychology* 124.
- 3 Henry Bos, Frank van Balen and Dymphna C van den Boom, 'Planned Lesbian Families: Their Desire and Motivation to have Children' (2003) 18(10) *Human Reproduction* 2216; 'Experience of Parenthood, Couple Relationship, Social Support, and Child-Rearing Goals in Planned Lesbian Mother Families' (2004) 45(4) *Journal of Child Psychology and Psychiatry* 755.
- 4 Frederick Bozett, 'Social Control of Identity by Children of Gay Fathers' (1988) 10 (5) *Western Journal of Nursing Research* 550.
- 5 Anne Brewaeys, I Ponjaert, E V van Hall and Susan Golombok, 'Donor Insemination: Child Development and Family Functioning in Lesbian Mothers Families' (1997) 12(6) *Human Reproduction* 1349.
- 6 Susan Dundas and Miriam Kaufman, 'The Toronto Lesbian Family Study' (2000) 40 (2) *Journal of Homosexuality* 65.
- 7 David Flaks, Ilda Ficher, Frank Masterpasqua and Gregory Joseph, 'Lesbians Choosing Motherhood: A Comparative Study of Lesbian and Heterosexual Parents and Their Children' (1995) 31 (1) *Developmental Psychology* 105.
- 8 Nanette Gartrell, Jean Hamilton, Amy Banks, Dee Mosbacher, Nancy Reed, Caroline Sparks and Holly Bishop, 'Interviews with Prospective Mothers' (1996) 66(2) *American Journal of Orthopsychiatry*; Nanette Gartrell, Amy Banks, Jean Hamilton, Nancy Reed, Holly Bishop, Carla Rodas, 'Interviews with Mothers of Toddlers' (1999) 69(3) *American Journal of Orthopsychiatry*; Nanette Gartrell, Amy Banks, Nancy Reed, Jean Hamilton, Carla Rodas and Amalia Deck, 'Interviews with Mothers of Five-Year-Olds' (2000) 70(4) *American Journal of Orthopsychiatry*; Nanette Gartrell, Amalia Deck, Carla Rodas, Heidi Peyser and Amy Banks, 'The National Lesbian Family Study: 4. Interviews with the 10-Year-Old Children' (2005) 75(4) *American Journal of Orthopsychiatry* 518.
- 9 Nanette Gartrell, Carla Rodas, Amalia Deck, Heidi Peyser and Amy Banks, 'The USA National Lesbian Family Study: Interviews with Mothers of 10-Year-Olds US' (2006) 16(2) *Feminism & Psychology* 175.
- 10 Tamar Gershon, Jeanne Tschann and John Jemerin, 'Stigmatization, Self-Esteem, and Coping Among the Adolescent Children of Lesbian Mothers' (1999) 24(6) *Journal of Adolescent Health* 437.
- 11 Susan Golombok, Fiona Tasker and Clare Murray, 'Children Raised in Fatherless Families from Infancy: Family Relationships and the Socioemotional Development of Children of Lesbian and Single Heterosexual Mothers' (1997) 38(7) *Journal of Child Psychology and Psychiatry* 783.
- 12 Raymond Chan, Barbara Raboy and Charlotte J Patterson, 'Psychosocial Adjustment among Children Conceived via Donor Insemination by Lesbian and Heterosexual Mothers' (1998) 69(2) *Child Development* 443.
- 13 Susan Golombok, Beth Perry, Amanda Burston, Clare Murray, Julie Mooney-Somers, Madeleine Stevens and Jean Golding 'Children with Lesbian Parents: A Community Study' (2003) 39(1) *Developmental Psychology* 20.
- 14 Richard Green, Jane Barclay Mandel, Mary Hotvedt, James Gray and Laurel Smith, 'Lesbian Mothers and Their Children: A Comparison with Solo Parent Heterosexual Mothers and Their Children' (1986) 15 (2) *Archives of Sexual Behavior* 167.

Appendix 1

Table 2: Studies on Donor-conception and Families 1995–2006

This table presents a summary of findings of recent empirical studies on donor-conception, donor-conceived children and their families.

AUTHOR AND DATE	TOPIC	METHODOLOGY	RESULTS	CONCLUSIONS
Parenting and Psychosocial Wellbeing				
Chan, Raboy and Patterson (Sperm Bank of California, United States, 1998) ¹	Psychosocial adjustment of donor-conceived children and family structure	<ul style="list-style-type: none"> 55 families with lesbian mothers and 25 families with heterosexual parents (50 coupled parents, 30 single parents) Children aged 7 (average) Parents, children and school teachers completed questionnaires 	<ul style="list-style-type: none"> Parents and children were well adjusted. No significant differences in child adjustment as a function of sexual orientation or number of parents. Child behaviour problems were related to family interactions such as parenting stress, inter-parental conflict and levels of love. 	<ul style="list-style-type: none"> Children conceived by DI are developing normally. Outcomes are unrelated to parental sexual orientation. Quality of relationships within families are important. The lack of difference between single and couple parent households could be a function of the particular demographics of the sampled single mothers. The idea that only heterosexual parents can raise healthy children was not supported by the findings.
Golombok, Murray, Brinsden et al (United Kingdom, 1999) ²	Family functioning and socio-emotional development of children conceived by gamete donation	<ul style="list-style-type: none"> Cross-sectional study of 45 DI, 41 IVF and 21 DE families Children aged 4–8 Interviews with mothers, questionnaires completed by parents, psychological assessment of children 	<ul style="list-style-type: none"> No differences observed in quality of parenting, although less warmth was expressed by mothers when a child was not genetically related to the social father. No difference in children's socio-emotional development across different family types. Only one set of DE parents had told their child about their conception; 82% of DI and 38% of DE parents had decided never to tell. 	<ul style="list-style-type: none"> Absence of genetic relationship does not appear to lead to difficulties between parents and children. Families without a genetic link between mother and child showed more positive outcomes, perhaps because families using infertility treatment are more committed to parenthood.
Golombok, Brewaeys, Giavazzi et al (European Study of Assisted Reproduction Families, 2002) ³	Parenting and psychological wellbeing of children conceived by assisted reproduction	<ul style="list-style-type: none"> Longitudinal study comparing 102 IVF, 94 DC, 102 adoptive and 102 TC families Children aged 11–12 Standardised interview and questionnaire with parents and children 	<ul style="list-style-type: none"> All children conceived using AR were functioning well and did not differ psychologically to TC or adopted children. No difference between groups in marital satisfaction, expressed warmth (mothers and children), frequency or severity of disputes and fathers' contribution to parenting. Observed differences showed more positive functioning in AR families and some over-involvement by AR mothers; AR fathers showed higher levels of warmth and enjoyment in parenting. 8.6% of DC, 50% of IVF and 95% of adopted families had told their child about their conception. 	<ul style="list-style-type: none"> The absence of a genetic link between father and child does not appear to interfere with their relationships. Most DC children did not know of their conception, but were not experiencing negative consequences arising with secrecy. 'Open' families reported less conflict. AR families with an early adolescent child appeared to be characterised by stable and satisfying marriages, psychologically healthy parents, a high level of warmth between parents and their children accompanied by an appropriate level of discipline and control, and well-adjusted children.

Abbreviations: AR = assisted reproduction; DC = donor-conceived; DI = donor insemination; DE = donor egg; IVF = invitro fertilisation; TC = traditionally conceived;

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Table 2: Studies on Donor-conception and Families 1995–2006

AUTHOR AND DATE	TOPIC	METHODOLOGY	RESULTS	CONCLUSIONS
Golombok, Lycett, MacCallum et al (United Kingdom, 2004) ⁴	Parent–child relationships, parenting experiences and disclosure trends	<ul style="list-style-type: none"> • First phase of a longitudinal study of 50 DI, 51 DE, 80 TC families • Children aged 1 • Interview and questionnaire with mother and father separately 	<ul style="list-style-type: none"> • No significant difference in measures for quality of marriage, parent–infant interaction, feelings about parental role and parent’s psychological state. • Levels of involvement by gamete donation parents were higher, as were levels of warmth and enjoyment of gamete donation mothers. Gamete donation fathers were less confiding. • Disclosure of conception story: <ul style="list-style-type: none"> - 46% DI, 56% DE parents planned to tell - 24% DI, 22% DE parents were undecided - 30% DI, 22% DE parents had decided not to tell. 	<ul style="list-style-type: none"> • More positive relationships were identified in families with a child conceived by gamete donation, accompanied by greater overprotection among parents. • A greater proportion of parents were considering openness about conception with their child compared to earlier studies.
Golombok, Jadv, Lycett et al (United Kingdom, 2005) ⁵	Parent–child relationships and child’s psychological well-being in families with donor-conceived children	<ul style="list-style-type: none"> • Second phase of a longitudinal study of 46 DI, 48 DE, 68 TC families • Children aged 2 • Standardised interview and questionnaire of mother and father and child assessment 	<ul style="list-style-type: none"> • No difference in anxiety, depression, marital satisfaction, father’s quality of relationship or child’s socio-emotional and cognitive development. • Gamete donation mothers (especially DE mothers) showed greater pleasure in their child and more concern about their child’s vulnerability (especially DI mothers). • 54% of gamete donation parents intended to tell their children about their conception. 	<ul style="list-style-type: none"> • Use of donated gametes does not adversely affect parent–child relationships. • DI and DE mothers’ higher positive maternal feelings and concern for their children reflects their desire to have children. • The lack of genetic connection between father and child may be less injurious than thought previously.
Golombok, Murray, Jadv et al (United Kingdom, 2006) ⁶	Non-genetic and non-gestational parenthood, relationships and telling about conception	<ul style="list-style-type: none"> • Third phase of a longitudinal study of 41 DI, 41 DE, 67 TC and 34 surrogacy families • Children aged 3 • Standardised interview and questionnaire with mother and child assessment 	<ul style="list-style-type: none"> • No group differences found in parents’ psychological state or in child’s psychological adjustment. • AR families showed higher levels of warmth and interaction between mother and child than families with TC children. • 44% surrogacy parents had begun telling their child about conception; 7% DE and 5% DI had told their children about conception. 	<ul style="list-style-type: none"> • The absence of a genetic or gestational link does not appear to negatively impact on parent–child relationships. • Higher levels of interaction between surrogacy and DE mothers and their children could result from increased commitment to parenting or a desire to compensate for a lack of genetic link. • Low levels of disclosure among DE and DI families could be due to the difficulty of discussing donors, concern about family relationships and, unlike surrogacy, the presence of a pregnancy.

Abbreviations: AR = assisted reproduction DC = donor-conceived DI = donor insemination; DE = donor egg, IVF = invitro fertilisation TC = traditionally conceived

AUTHOR AND DATE	TOPIC	METHODOLOGY	RESULTS	CONCLUSIONS
Golombok, MacCallum, Goodman et al (United Kingdom, 2002) ⁷	Quality of parenting and child's psychological adjustment	<ul style="list-style-type: none"> Longitudinal study of 37 DI, 49 adoptive and 91 TC families Children aged 12 Parents and children participated in a standardised interview and questionnaire Follow up of 1995 study 	<ul style="list-style-type: none"> DI mothers showed comparatively higher levels of warmth, responsiveness and emotional over-involvement and were perceived by their children to be more dependable. DI mothers showed comparatively less aggression. DI fathers reported significantly less severe disputes. DI children were well adjusted socially and emotionally. No difference in marital satisfaction across groups. 	<ul style="list-style-type: none"> The issues that arise in parenting relationships are distinct for mothers and fathers. Differences identified between DI and other family types reflected more positive, not necessarily negative, relationships. The concern that DI parents are over-protective appears to be unfounded.
Murray and Golombok (United Kingdom, 2005) ⁸	Single DI mothers' and married DI mothers' psychological wellbeing and parent-child relationships	<ul style="list-style-type: none"> 27 heterosexual single DI mothers, 50 married DI mothers Children aged 6 months-1 year Questionnaire and interviews with mothers 	<ul style="list-style-type: none"> No differences in expressed warmth, enjoyment of parenting, mothers' psychological state, social support between single and coupled mothers. Single mothers showed lower levels of mother-infant interaction and lower levels of responsiveness; married DI mothers perceived their children had more difficult temperaments. 94% of single DI mothers intend to tell their child about DI compared to 46% of married DI mothers. 	<ul style="list-style-type: none"> Single DI mothers in the present study made an active choice to be a single parent and have more positive outcomes than those reported in the past for single mothers. Demographics of the group represented a particular subset of single women.
Murray and Golombok (United Kingdom, 2005) ⁹	Psychological wellbeing and relationships of single and married mothers with donor-conceived children	<ul style="list-style-type: none"> Second phase of a longitudinal study of 21 single mothers and 46 married mothers with DI children Children aged 2 Standardised interviews and questionnaires with mothers and child assessment 	<ul style="list-style-type: none"> No group differences in mothers' psychological state. Single mothers showed greater joy in parenting, lower levels of anger and perceived their child to be less 'clingy'. DI children of single mothers showed fewer problems and higher levels of competence than DI children of married mothers. 	<ul style="list-style-type: none"> Mothers from both family types were functioning well. The study found a tendency towards more positive relationships between mother and child in single parent families with DI children. Single mothers with DI children represent a distinct subgroup of single parents.
Turner and Coyle (International, 2000) ¹⁰	Donor-conceived offsprings' identity experiences	<ul style="list-style-type: none"> Qualitative analysis of semi-structured questionnaire completed by 16 adult donor offspring Offspring aged 26-55 	<ul style="list-style-type: none"> Participants reported shock at disclosure, mistrust in the family, negative feelings about being different, frustration and loss (from search for donor), lack of genetic continuity and a need to talk to a significant other. Withholding information had negative effects on identity. 	<ul style="list-style-type: none"> The diversity of experiences related to the manner of disclosure makes drawing conclusions difficult. Common experiences suggest that non-disclosure to children of DI conception is damaging.

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Table 2: Studies on Donor-conception and Families 1995–2006

AUTHOR AND DATE	TOPIC	METHODOLOGY	RESULTS	CONCLUSIONS
Donor Anonymity				
Adair and Purdie (New Zealand, 1996) ¹¹	Known donors' and recipient parents' views on anonymity	<ul style="list-style-type: none"> 30 recipients of sperm donations, 9 donors (and 7 donors' partners) Mail-back questionnaires, some follow-up interviews 	<ul style="list-style-type: none"> 75% of donors and recipients had developed a closer relationship following donation. Known donors were chosen for unique reasons. Where a relative was chosen as a donor, more recipient men identified wanting a donor from the same genetic pool. Where a donor was a friend, recipients said that related donors would affect extended family relationships. 78% of donors and 63% of recipients agreed to the donor being identified to any child born. 	<ul style="list-style-type: none"> For adults, knowledge about the donor and the ability to select the donor is beneficial. The 'best interests of the child' is not necessarily a ground for making decisions, especially regarding access to information. Parents' and donors' own interests are also factors in any decision.
Brewaeyns, de Bruyn, Louwe et al (The Netherlands, 2005) ¹²	Recipient parents' views on donor anonymity	<ul style="list-style-type: none"> 105 couples (64 heterosexual, 41 lesbian) who had used DI from the same clinic Study reviewed responses to a standard form and questions asked during clinic counselling sessions 	<ul style="list-style-type: none"> 63% of heterosexual and 98% of lesbian couples chose an identifiable donor. The most common reason for this choice was the child's 'right to know'. The major motive for choosing an anonymous donor was fear of interference by the donor. 93% of heterosexual couples using an identifiable donor said they would tell their child about their conception. 17% of those using an anonymous donor would tell their child about their conception. 	<ul style="list-style-type: none"> The number of people choosing identifiable donors is increasing. All couples realised that their interests differed from their child's. At this clinic, the child's interests prevailed. Choice for anonymous donors was associated with low socio-economic status, difficulty coping with infertility and secrecy towards the child.
Brewaeyns, Golombok, Naaktegobore et al, European Study of Assisted Reproduction Families (The Netherlands, 1997) ¹³	Views of parents of DI children on anonymity, and children's emotional adjustment	<ul style="list-style-type: none"> 38 DI, 30 IVF and 30 TC families Children aged 4–8 Interviews with parents at home and questionnaires returned by post 	<ul style="list-style-type: none"> 21% of parents of DI children and 94% of IVF parents of children had decided to inform their children about their conception. 74% of parents of DI children had decided not to inform their children about conception. 82% of these parents said that informing the child about DI would threaten the child's wellbeing. 50% of parents of DI children had told at least one other person. 57% of parents favoured an anonymous donor; 31% would like non-identifying information and 9% identifying information about the donor. No association between secrecy and emotional behavioural adjustment of the child. 	<ul style="list-style-type: none"> Secrecy is associated with DI but not IVF. Parents' uncertainty about using donor gametes rather than taboo around infertility drives the choice for secrecy. Different attitudes to anonymity between mothers and fathers suggests that the parent who lacks a genetic connection to the child views the donor as more threatening to his or her position.

Abbreviations: AR = assisted reproduction DC = donor-conceived DI = donor insemination; DE = donor egg, IVF = invitro fertilisation TC = traditionally conceived

AUTHOR AND DATE	TOPIC	METHODOLOGY	RESULTS	CONCLUSIONS
Cook and Golombok (United Kingdom, 1995) ¹⁴	Motivations and attitudes of donors	144 sperm donors completed a standardised questionnaire. Their responses were compared with responses of 136 male students and 135 female students from London universities.	<ul style="list-style-type: none"> • Payment was an important factor for 43% of donors; the desire to help others was moderately important for 45% of donors. • A greater proportion of older donors (≥25 years) would donate without payment. • 37% of donors expressed concern that they would be contacted by their offspring. • Almost all women who said they would consider donating eggs were motivated by a wish to help others. 	<ul style="list-style-type: none"> • The large majority of semen donors in the United Kingdom are young, single students motivated by payment.
Daniels, Blyth, Crawshaw et al (United Kingdom, 2005) ¹⁵	Donors' views on anonymity and recruitment	<ul style="list-style-type: none"> • 32 sperm donors aged 27–57 who donated 1998–2002 • More than 75% of donors were living with partners and children at time of donation • Semi-structured telephone interview with donors 	<ul style="list-style-type: none"> • The major motivation for becoming a donor was the desire to help others to become parents. • 75% of donors did not believe there should be payment for donations. • At the time of donation, 37.5% agreed to being identified. 50% of donors would still donate if they were required by law to be identified, 25% would not donate, 25% were undecided. • 37.5% of donors had changed their mind about anonymity from the view they recorded at the time of donation. 	<ul style="list-style-type: none"> • It is possible to recruit identifiable donors. However, the clinic studied only permits altruistic donations and the demographics of these donors are a factor in this finding. • A longer-term view of donation should be encouraged, as more than one third of donors changed their mind about anonymity.
Ellis, Blood and Warren (Australia and New Zealand, 2005) ¹⁶	Egg donors' attitudes to telling children about their conception	<ul style="list-style-type: none"> • Study of 60 egg donors who donated eggs 1997–2000 • Women completed a 25–page mail-back questionnaire 	<ul style="list-style-type: none"> • 41 of the 60 women were known donors. • Most donors felt that the child should be told about their conception but not all donors supported telling the child. • The decision not to tell is more prevalent where there is a family relationship (eg sister) between the egg donor and the recipient. 	<ul style="list-style-type: none"> • Decisions about disclosure may impact on family dynamics. The issues are particularly significant where the recipient is the donor's sister.
Scheib, Riordan and Rubin (United States, 2003) ¹⁷	Parents' perspective on identity release donors	<ul style="list-style-type: none"> • Parents from 45 households who had used DI programs (40% lesbian, 38% single, 22% heterosexual) • Children aged 13–18 • Analysis of a mail-back questionnaire 	<ul style="list-style-type: none"> • 97% of parents chose open-identity donors to give the child the option of gaining more information. • 95% felt moderately to very positive about the upcoming release of the donor's identity. • 93% had told the child about their donor conception (including 70% of heterosexual couples); 68% of children had neutral or no response to this knowledge. • 91% of parents expected or knew their child was curious about the donor. 	<ul style="list-style-type: none"> • Disclosure did not appear to have a negative impact on families. • Families were open and positive about DI and their use of an open-identity donor.

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Table 2: Studies on Donor-conception and Families 1995–2006

AUTHOR AND DATE	TOPIC	METHODOLOGY	RESULTS	CONCLUSIONS
Scheib, Riordan and Rubin, The Sperm Bank of California ((United States, 2005) ¹⁸	Donor-conceived youths' responses to having 'open identity' sperm donors	<ul style="list-style-type: none"> Longitudinal study of 29 offspring from 12 lesbian-parented, 11 single-parented and 6 heterosexual couples with DC children Children aged 12–17 Mail-back questionnaire completed by children 	<ul style="list-style-type: none"> 75.9% of children reported always knowing they had a donor; learning and knowing had a neutral to positive impact on mother–child relationships. Most children were somewhat to very comfortable with their conception; 44% said it did not affect their life, 40% felt loved. No children had negative feelings towards donors, 86.2% were curious about him; 80% moderately likely to request donor's identity and pursue contact. Few children (6.9%) wanted a father–child relationship. 	<ul style="list-style-type: none"> Majority of children felt comfortable with their origins. Most children planned to obtain their donor's identity, but not necessarily at age 18. This wish stemmed from curiosity about the donor. Learning about DI origins at an early age and having 'open identity' donors contributed to children's positive outlook.
Van Berkel, van der Veen, Kimmel et al (The Netherlands, 1999) ¹⁹	Parents' attitudes to openness about donated gametes, 1980 and 1996	<ul style="list-style-type: none"> 107 male and 110 females who were recipients of gamete donation Results of a 1996 questionnaire were compared to 1980 results 	<ul style="list-style-type: none"> In 1996, 80% of couples had decided not to inform the child about use of a donor, compared to 77% in 1980. The number of couples who were uncertain about disclosure halved by 1996. In 1996, 10% of couples had decided to inform the child about their conception, compared to 3% in 1980. 	<ul style="list-style-type: none"> In 1996, couples who considered informing their child hesitated significantly less and showed more openness. There is a trend towards increased importance attached to the donor.
Vanfraussen, Ponjaert-Kristoffersen and Brewaeyts (Belgium/The Netherlands, 2001) ²⁰	Children's and parents' attitudes to donors in lesbian parent families	<ul style="list-style-type: none"> Longitudinal study of 41 children and 45 parents Children aged 7–17 In-depth interviews with mothers and children Sample drawn from Brewaeyts et al (1997)²¹ 	<ul style="list-style-type: none"> All children were aware of the donor's role in their conception. 54% of children preferred donor anonymity at this point in their life; 46% wanted to know more. Siblings in the same family unit sometimes held different views. Of 11 children who wanted to meet the donor, 9 were male. 76% of mothers preferred donor anonymity, 18% supported identity release. 	<ul style="list-style-type: none"> Mothers' and children's different views about donors may be due to their different perspectives about the genetic and parenting role of the donor. A flexible system offering different types of donors could meet the needs of each family.
Vanfraussen, Ponjaert-Kristoffersen and Brewaeyts (Belgium/The Netherlands, 2003) ²²	Desire of donor-conceived children conceived with lesbian parents to know their donors	<ul style="list-style-type: none"> Longitudinal study of 41 DI children from 24 lesbian parent families Children aged 7–17 Interview and questionnaires completed by children 	<ul style="list-style-type: none"> Children's self esteem, emotional and behavioural adjustment, and quality of parent–child relationship does not differ according to a child's desire to know donors. Children who prefer anonymity express loyalty to their social (non-biological) mothers. Curiosity and identity motivates children who seek information about their donors. 	<ul style="list-style-type: none"> Irrespective of the quality of parent–child relationship, some children wish to know more about their donors. These findings might not translate well to families with heterosexual couples where a social father is present. The manner of disclosure can be fundamental to the child's well-being.

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AUTHOR AND DATE	TOPIC	METHODOLOGY	RESULTS	CONCLUSIONS
Disclosure of Donor-conceived Status				
Blood, Pitt and Baker (Australia, 1998) ²³	Parents' experience of telling about donor conception	<ul style="list-style-type: none"> 243 recipients (134 couples) who had accessed a Melbourne clinic 1976–97 Self-administered questionnaire 	<ul style="list-style-type: none"> 76 children from 50 of the families had been told about their conception. Of the remaining 84 families, 30 couples intend to tell, 22 were undecided, 30 had decided not to tell. The most common reason for telling was a belief in the child's right to know their genetic origins. The two principal reasons for deciding not to tell were a belief that there is no need to tell and concern that it would have a negative effect on children. 	<ul style="list-style-type: none"> Parents deal with similar issues but do not always come to similar conclusions. There is a strong desire to maintain family relationships. Parents voiced a belief that the decision they made was best for their children.
Infertility Treatment Authority (Australia, 2006) ²⁴	Disclosure patterns and strategies for telling about donor-assisted conception	<ul style="list-style-type: none"> Qualitative study of 6 DC adults, 17 recipient mothers, 4 recipient fathers, 1 egg donor, 6 infertility counsellors Open-ended interviews 	<ul style="list-style-type: none"> A wide range of experiences and attitudes exist around telling about donor conception. All participants affirmed the desirability of telling children about their conception. Ideally, telling should occur at the outset or when the 'child can understand'. 	<ul style="list-style-type: none"> Donor-conceived people should be told about their conception by their parents when they are young. Resources that cater to the variety of disclosure situations are required to assist parents and their children.
Kirkman (International 2003) ²⁵	Narratives of identity for donor-conceived offspring	<ul style="list-style-type: none"> 55 recipient parents and 12 offspring Qualitative study of how parents narrate conception stories to their children Interviews in person, by email and phone 	<ul style="list-style-type: none"> Narrative accounts of donor-assisted conception exist along a continuum, from omitting any mention of a third party to talking about the donor from the time the child is born. Parents who decide to disclose a child's donor origins grapple with the same issues as parents who decide not to include it in the story: including anxiety, confusion, language, and obstacles from internal and external sources. 	<ul style="list-style-type: none"> Family stories and parents' narrative identities play a significant role in the construction of children's narrative identities. Incorporating donor assisted conception into narrative of identity is a complex task. The social and political contexts are a factor in developing narratives.
Lycett, Daniels, Curson et al (United Kingdom, 2004) ²⁶	Family relationships, child adjustment and disclosure patterns for donor conception	<ul style="list-style-type: none"> 46 DI families (18 disclosing DC status, 28 non-disclosers) Children aged 4–8 Interviews and questionnaires completed by parents, teachers and psychological assessment of child 	<ul style="list-style-type: none"> No group differences were found for parental warmth, parent–child interaction or for the incidence of psychological disorders. Disclosing families indicated more positive child–parent relationships: disclosing mothers reported less conflict and considered themselves more competent parents. 	<ul style="list-style-type: none"> Differences between family types reflected particularly positive relationships in disclosing families, rather than dysfunction in non-disclosing families. Non-disclosure may have a greater impact on a mother's relationship with her child than the father's relationship.

Abbreviations: AR = assisted reproduction DC = donor-conceived DI = donor insemination; DE = donor egg, IVF = invitro fertilisation, TC = traditionally conceived

Appendix 1

Table 2: Studies on Donor-conception and Families 1995–2006

AUTHOR AND DATE	TOPIC	METHODOLOGY	RESULTS	CONCLUSIONS
Lycett, Daniels, Curson et al (United Kingdom, 2005) ²⁷	Parents' disclosure patterns to donor-conceived children	<ul style="list-style-type: none"> 46 families Children aged 4–8 Interviews with parents about reasons and concerns regarding disclosure 	<ul style="list-style-type: none"> 13% of families had disclosed, 26% intended to disclose, 17% unsure, 43% not disclosing. Reasons for disclosure: to avoid accidental discovery (88%), desire for openness and honesty (88%). Reasons for non-disclosure: no reason to tell (61%), to protect family members (child and father) (66%). 	<ul style="list-style-type: none"> Accidental discovery because of medical or technological advances is perceived by disclosers to be a greater threat to child–parent relationships than a child's negative reaction to being donor-conceived. Experiences of disclosure were generally positive.
Nachtigall, Pitcher, Tschann et al (United States, 1997) ²⁸	Stigma, disclosure patterns and family functioning San Francisco Bay Area Study	<ul style="list-style-type: none"> Longitudinal study of 94 women and 82 men (all married) who had become parents by DI Children aged 6–16 Self-administered mail-back questionnaire about psychological indicators, stigma and disclosure 	<ul style="list-style-type: none"> The decision to disclose was related to younger age, reason for infertility, lower stigma scores, and having more than one child by DI. Husbands with high stigma ratings reported less parental warmth. 54% of parents did not intend to tell their children about their donor status, 30% intended to, 16% were undecided. No relationship found between disclosure and parenting quality or marital satisfaction. 	<ul style="list-style-type: none"> Types of infertility experienced by parents result in different levels of stigma, which in turn may affect disclosure. Husband's perception of stigma may affect father–child relationships. Increased likelihood of disclosure among young families may indicate a societal shift towards openness. Willingness to be interviewed related to disclosure of donor-conceived status.
Nachtigall, Becker, Quiroga et al (United States, 1998) ²⁹	Parents' disclosure decisions and concerns San Francisco Bay Area Study	<ul style="list-style-type: none"> 70 men and 86 women, married parents of children conceived by DI, completed a self-administered mail-back questionnaire Parents had used DI clinics from 1980–90 	<ul style="list-style-type: none"> 54% of parents did not plan to disclose donor treatment, 30% would disclose, 16% undecided. Reasons included: concern for the child 54%; parenting concerns 53%; couple relations 37%; family concerns 28%. 70% of 'disclosers' commented about honesty, 2% confidentiality. 74% of non-disclosers commented about confidentiality, 1% commented about honesty. 	<ul style="list-style-type: none"> Disclosers and non-disclosers have fundamentally different perceptions about the threat of disclosure. Gender, parenting and well-being of children are not associated with disclosure decisions. Wives may choose non-disclosure out of deference to a husband's wishes.
Rumball and Adair (New Zealand, 1999) ³⁰	Disclosure experiences	<ul style="list-style-type: none"> 78 heterosexual couples, (181 parents in total) completed a self-administered questionnaire and 20 telephone interviews were conducted Children aged 1 	<ul style="list-style-type: none"> 30% (54 parents) had given their child information about donor conception; 74% of these children were aged 3 or younger. 70% (120 parents) had not told their children. 77% of these parents intended to tell, 17% intend never to tell their children about their conception. 	<ul style="list-style-type: none"> There appeared to be an advantage in giving children information at a young age, allowing it to be processed in a factual, non-emotional way. Parents who don't tell are concerned about the appropriate age and children's comprehension of their conception story.
Saunders (New Zealand, 2005) ³¹	Attitudes about information sharing after egg donation	<ul style="list-style-type: none"> Longitudinal study of 17 families (10 recipient couples, 7 donors) Children aged 3 Yearly semi-structured interviews 	<ul style="list-style-type: none"> Recipients with a relationship to their donor are more likely to be open with their children and others. While most couples have followed their original intentions of telling, a small number have shifted to a more open approach. 	<ul style="list-style-type: none"> Factors which appear to influence information sharing include use of known donors, wanting to be the people who tell the child/fear of others telling, planning and organising to tell prior to birth, telling others prior to having treatment. Donors would prefer openness but leave it to recipients.

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AUTHOR AND DATE	TOPIC	METHODOLOGY	RESULTS	CONCLUSIONS
Egg Donation				
Abdalla, Shenfield and Latache (United Kingdom, 1998) ³²	Information available to children born from egg donation	<ul style="list-style-type: none"> 585 egg donors from 1991–97 389 anonymous donors, 196 known donors Review of responses to clinic donation forms 	<ul style="list-style-type: none"> Characteristics of donors: Relationships: 76% married, 21% single, 3% divorced. Education: 49% secondary education qualifications, 20% higher education. Employment: 33% housewives/ mothers, 19% administrative; 16% professional, 16% nurses/ carers. 94% of donors did not answer a question seeking a brief optional description of themselves. 2/38 women who did respond were known donors. 	The majority of donors did not provide a brief description of themselves. This is a concern for offspring seeking information about their donor.
Baetens, Devroey, Camus et al (Belgium, 2000) ³³	Decision to use known or anonymous donors	<ul style="list-style-type: none"> 144 DE recipient couples Analysis of data obtained through couples' counselling with psychologists at clinics 69% of couples used known donors 	<ul style="list-style-type: none"> 43% of couples intended not to tell their child about egg donation, 44% intended to tell. Donors: 79% in a partner relationship, 76% had children, 76% did not want more children, 35% were friends of the recipient women, 28% were sisters. 67% were motivated by personal relationships. 58% of donors made a distinction between the egg donated and the child born as a result. 	<ul style="list-style-type: none"> The option of treatment with known donors was motivated by reasons related to the fear of anonymity. Couples take donors' characteristics into consideration when making decisions about known or anonymous donations, especially in the context of the choices available at this Brussels clinic.
Greenfeld and Klock (United States, 2004) ³⁴	Disclosure patterns after known and anonymous egg donation	<ul style="list-style-type: none"> 92 women and 65 men from couples who had received egg donations Self-administered mail-back questionnaire containing multiple choice questions 70 women used anonymous donors, 20 used known donors 	<ul style="list-style-type: none"> 70% of known donor recipients had an ongoing relationship with their donors. Known donors were chosen because of genetic links, physical characteristics and willingness to assist. Disclosure to child—anonymous donor recipients: 10% have told, 49% plan to tell, 31% not telling, 10% unsure. Disclosure to child—known donor recipients: 10% have told, 50% plan to tell, 30% not telling, 10% unsure. 30% of anonymous recipients and 50% of known recipients support a registry of donor information. 	<ul style="list-style-type: none"> Disclosure decisions did not seem to be influenced by use of a known or anonymous donor. Women were thoughtful about their choices and were satisfied with their decisions. Women were interested in getting help with the issue of disclosure.
Kalfoglou and Gittelsohn (United States, 2000) ³⁵	Egg donors' experiences	<ul style="list-style-type: none"> 33 egg donors aged 21–36 Qualitative analysis of demographic data and in-depth interviews conducted with donors 	<ul style="list-style-type: none"> 22 anonymous donors, 3 friends with the recipient, 3 clinic recruited, 4 internet recruited, 3 multiple donations. Approximately 50% were motivated to donate eggs primarily by financial compensation; some became more altruistic. Others were motivated to help an infertile couple. 	<ul style="list-style-type: none"> No participants regretted the experience. Satisfaction was affected by the physical process, retrieval process, side effects suffered, compensation paid, quality of medical care, level of involvement required/permitted by the recipients.

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Table 2: Studies on Donor-conception and Families 1995–2006

AUTHOR AND DATE	TOPIC	METHODOLOGY	RESULTS	CONCLUSIONS
Khamsi, Endman, Lacanna et al (Canada, 1997) ³⁶	Psychological aspects of egg donation	<ul style="list-style-type: none"> 10 families who received egg donations and their donors Semi-structured interview of recipient couples and their donors 	<ul style="list-style-type: none"> Donors ranged from 21–34 years, 80% were married, 90% had at least one child. All donors were unpaid and expressed their primary motive as to help a relative or close friend. 80% of couples did not intend to disclose information about conception to their child, 20% were uncertain. 	<ul style="list-style-type: none"> Data suggests a strong trend toward privacy and confidentiality; anonymity was a primary concern for recipients and donors.
Murray and Golombok (United Kingdom, 2003) ³⁷	Parents' disclosure patterns	<ul style="list-style-type: none"> 17 DE families (14 anonymous donors, 3 known donors) Children aged 3–8 Standardised interviews with children's mothers 	<ul style="list-style-type: none"> No parents had told their child about their conception, 29% planned to tell, 24% undecided, 47% had decided not to tell. 65% of couples had told a family member, 65% had told at least one friend. Reasons for non-disclosure: protection of the child (75%), no need to tell (42%), protection of the mother (17%). Reasons for disclosure: to avoid disclosure by others (80%), child has a right to know (60%). 	<ul style="list-style-type: none"> Findings contradict previous research which showed that egg recipients are more likely to be open about donor origins. Some mothers experienced stigma about being infertile.
Murray, MacCallum and Golombok (United Kingdom, 2006) ³⁸	Quality of parenting and psychological adjustment	<ul style="list-style-type: none"> Follow up of participants from Golombok et al (1999) (see above) Comparative study of 17 DE, 35 DI, 34 IVF families (all heterosexual) Children aged 12 Questionnaires and interviews with mothers and children 	<ul style="list-style-type: none"> DE mothers demonstrated lower levels of sensitive responding than DI mothers; DI mothers were emotionally over-involved. There were no differences in a child's functioning at school; however DE children suffered less bullying. Fewer DE (35%) and DI (11%) parents had told, or planned to tell their child about conception compared with IVF parents (88%). 	<ul style="list-style-type: none"> There was no difference in the quality of parenting between DE and IVF families: a genetic link between mother and child is not essential for developing positive family relationships. Levels of over-involvement may reflect an attempt to compensate for different patterns of genetic relationships. High levels of non-disclosure suggest that DE parents also experience anxiety about their child's donor origins.
Sodestrom-Anttila, Sajaniemi, Tiitinen et al (Finland, 1998) ³⁹	Health and development of children, attitudes to disclosure	<ul style="list-style-type: none"> Comparative study of health, growth and development of 50 DE and 126 IVF children Children aged 6 months–4 years Questionnaire completed by child's mother 8 known donors, 41 anonymous donors 	<ul style="list-style-type: none"> All DE children were healthy (normal height and weight development normal, absence of eating/sleeping disorders). IVF parents expressed more concern about child's behaviour than DE parents. 38% of DE and 60% of IVF parents intended to tell the child about conception. About 55% of DE parents thought a financial reward for donors would be reasonable. 	<ul style="list-style-type: none"> DE children can develop at least as well as children born through IVF. Data reflects good parent–infant relationships and child well-being among DE parents.

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ENDNOTES

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Appendix 2: Submissions Consultation Paper

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26	David Bernard
27	Rebecca Harris
28	Elizabeth Bourke
29	Laurie Crouch
30	Faye and Colin Benjamin
31	June Smith
32	Babette Francis Endeavour Forum Inc
33	Tracey Petersen
34	Adrian Thomson
35	Patricia Coloe
36	Mary and Rachael
37	Leonie Gasper
38	Jacqueline Tomlins
39	Marie McCarthy
40	Jenny Wake
41	Sharon Phillips
42	Anonymous
43	Ian Coutts
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54	Joyce Stowers
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56	Mary Banks
57	Kate Hannah
58	Confidential
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60	Myfanwy Walker
61	Neil Ryan
62	Viv Ray Bit Bent Buddies
63	Ian Blandthorn Shop Distributive & Allied Employees' Association
64	Anna Degotardi
65	Martin Wimpole
66	J W Browne
67	Susan
68	Pat Healy
69	James Magel
70	Margaret Campi OAM
71	Simon and Adam
72	Leonie Davey
73	Lauren Andrew
74	Caitlin Coleman
75	Annette Lakey The Field Group – Legal
76	Desmond Kenneally
77	Margaret Campi OAM Victorian Standing Committee on Adoption & Alternative Families
78	Andrew McLean
79	Christopher Jones
80	Anonymous
81	Suryan Chandrasegaran
82	Anonymous
83	Tim Wright and Michael Williams University of Melbourne Sexuality Law Reform Committee
84	James and Eileen Crockett
85	Rita Carroll Australian Council for Adoption
86	R. Robinson
87	Rev Andrew Clarke Church and Nation Committee, Presbyterian Church of Victoria
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90	Diane Blood
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99	Susan Koska
100	Alec Witham
101	Anonymous
102	Hannah Spanswick
103	Michaela
104	Anonymous
105	Geoff and Janet Harvey
106	Susan Horsfall
107	Kerrie and Susan
108	Anonymous
109	Anne-Marie Quinn
110	Lisa and Amanda
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119	Nicholas Lock
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121	Ian Brown
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128	Lia Vandersant
129	Sarah Champness
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131	Anonymous
132	Diana Thompson Australian Infertility Support Group
133	Melissa Afentoulis Women's Health West
134	Anita Allen
135	Rebecca Olsen
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148	Ruth Oakden Melbourne Anglican Social Responsibilities Committee
149	Sarah Lowe Prospective Lesbian Parents
150	Sarah Nichols
151	Graham Preston Right to Life Australia
152	Patricia Boyhan Centacare Catholic Family Services
153	TangledWebs
154	Michael Linden
155	Jenny Blood Victorian Infertility Counsellors Group
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157	Mary Natoli
158	Anonymous
159	Joy O'Connor Association of Relinquishing Mothers (Vic) Inc
160	Noelle Sullivan Women's Action Alliance (Victoria) Inc
161	Lyn Kinghorn
162	Tom Wise
163	Carol Osborn
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165	Atala Ladd
166	Christine Campbell
167	Victorian Gay & Lesbian Rights Lobby
168	Peter Phillips
169	Madge Fahy and Pam Stamm Social Questions Committee, Catholic Women's League of Victoria & Wagga Wagga Inc.
170	Barbara Leach
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184	Anonymous
185	Anonymous
186	Dimitra Tsartsaris
187	Brenda
188	Julienne Lauer
189	Rosemary Neil
190	Pauline Tucker
191	Matthew Carroll Equal Opportunity Commission Victoria
192	Sandra Dill and Debbie Jeffrey ACCESS – Australia's National Infertility Network
193	Sandra Letch
194	Liz Branigan Council of Single Mothers and their Children
195	Tammy Lobato MP Member for Gembrook
196	Thomas McCarthy
197	Maureen Watson
198	Dr Elizabeth Short Key Centre for Women's Health in Society, The University of Melbourne
199	Nesta Sharp
200	Merle Kelly
201	Andrea Roberts
202	Dr Philomene Tenni
203	Fay Giddings Sunraysia Adoption Support Group
204	Jeanie Argus Mothers' Legacy Support Group, Cobram
205	Tracey Buzolich
206	Shirley Hair
207	Mark Berry
208	Malcolm Pryor
209	Patrick and Dianne McCarron
210	Victor and Crystal
211	Janna Murphy
212	Vivien Sharpe
213	James Hall
214	Carol and Robert Colman

NO	NAME
215	Helen Woodall
216	Rhonda Avasalu
217	Paul Rosenfeldt
218	Adam Hair
219	Faye Gair
220	David Roberts
221	Confidential
222	David Perrin
223	Confidential
224	Michael Gorton AM Victorian Biotechnology Ethics Advisory Committee
225	Jennifer Whately
226	Barbara Roberts
227	Keith and Shirley Jeans
228	Kerrie Ternes
229	Gavin Murray
230	Confidential
231	Tony Parsons Victoria Legal Aid
232	Jim Swinden Freemasons Hospital
233	Romana Rossi
234	Christine Whipp
235	C Heyward
236	Anonymous
237	Professor Robert McLachlan Prince Henry's Institute of Medical Research
238	Dr Nick Lolatgis
239	Rosalie Gaudiosi
240	Rhianna Crosthwaite
241	Karen Mutton
242	Jane Saunders
243	Nicole Poustie
244	Tony Wood
245	Jeremy Sayers
246	David Johnston-Bell
247	Adrian Tuazon
248	Peter Usher and Dax Purvis
249	Confidential
250	John
251	Lee Matthews
252	Confidential
253	Lee Holmes
254	Katrina Harrison
255	Narelle Grech

Appendix 2: Submissions

Position Paper One: Access

NO	NAME
1	Lee Matthews
2	Jane Saunders
3	Tony Briffa Genetic Support Network of Victoria
4	Anonymous
5	Maryse Usher
6	Andrew Forbes
7	Anonymous
8	Annette Kalkbrenner
9	Trudie Healey
10	Confidential
11	Confidential
12	Anonymous
13	Confidential
14	Chris Gill
15	Anonymous
16	Angela Neubeck
17	Gina Carlone
18	Anita Dade
19	Linda Frey
20	Rosalie Gaudiosi
21	Wendy Vaidic
22	June Smith
23	Confidential
24	Francis and Leonie Osowski
25	Jill Parris VANISH
26	Christy Jenkins
27	Margaret Canny
28	Mary McCarthy
29	M Canny
30	C Coleman
31	Margaret Gannon
32	Joan Laws
33	Mary Allman
34	Anonymous
35	Confidential
36	Anonymous
37	Anonymous
38	Michael Williams
39	Rose Woodhouse
40	David Wain
41	Jacqueline Tomlins
42	Tamara Jungwirth
43	Alison Clarke
44	Vanetia Brissenden
45	Donovan Jacka
46	Kelly Pilgrim
47	Paul Dougal
48	Madge Fahy Social Questions Committee, Catholic Women's League of Victoria & Wagga Wagga Inc.
49	Maxwell White
50	Peter Elshoug

NO	NAME
51	Carol Harrison
52	Cedric Hately
53	Robert Greville
54	M R White Ballarat Central Church of Christ
55	Debbie Kiper
56	Stephen Taylor
57	Anonymous
58	Alison
59	Olivia Williams
60	Richard Vabre
61	Brett Collinson
62	Paul Caulfield
63	Kate
64	Darren Ray
65	Martina Eaton
66	Dr Estela Papier
67	Anonymous
68	Gerard Brody
69	Amanda Gaunt
70	Anonymous
71	Anonymous
72	Katherine Raymond
73	Caitlin
74	Janine Farrell
75	Melinda Peterson
76	Sue Xerri
77	Laura Whellum
78	Marianne Love
79	Amy Chilton
80	Liz Alexander
81	Kerry Flynn
82	Michele Allen
83	Jennifer Clark and Libby Rule
84	Dr Neil Ryan
85	Stephen Kress and Edward Crosslands QueerGreens
86	Edward Crossland
87	Gemma
88	Ryan
89	Dr Liz Conor
90	Irene
91	Anonymous
92	Jeremy
93	Heather Grace Jones
94	Justine Hyde
95	Dr Darren Cundy
96	Marie McCarthy
97	Susan
98	Gabrielle Hodson
99	Judith Simpson
100	Anonymous
101	Carolyn Blake
102	Joanne Francken

Appendix 2: Submissions

Position Paper One: Access

NO	NAME
103	Dr Penelope Bryant
104	Nanette McGregor
105	Victoria Blakston
106	R Bent
107	Elizabeth Wheeler
108	Tracey
109	Rohan Bush
110	Laurie Crouch
111	Petition: Sign up here to end parenting discrimination 34 signatories
112	Petition: Sign up here to end parenting discrimination 29 signatories
113	Emily Lyons
114	Pia Cerveri
115	Confidential
116	Jessica Smith
117	Julia Mangan
118	Jemma
119	Helena Forsyth
120	Gabrielle Alexander
121	Susan Konstanty
122	Dr Keri Alexander
123	Alice Murray
124	Natalie Wallace
125	Dr Deb Verhoeven
126	Bill Muehlenberg National Vice President, Australian Family Association
127	Anonymous
128	Anonymous
129	Janet Hall
130	Liz Poole
131	James Crockett
132	Ann Raouf
133	Susan Koska
134	David Yates Australian Christian Lobby
135	Michael Wighton Victoria Legal Aid
136	Pat Healy
137	Claire Bonner Tasmanian Gay & Lesbian Rights Group
138	Dr Kerrie Allan The Australian Family Association (Vic)
139	Ariadne Lack
140	Lisa Hanlon
141	Rachel U'Ren
142	Taryn Lee-Steere
143	Vera Ray
144	Robyn Hamilton
145	James Magel
146	Brenton Thomas
147	Ian Robinson
148	Barbara Roberts
149	Natasha Gilbert
150	Lindsay Greenawalt

NO	NAME
151	Anonymous
152	Anonymous
153	Anonymous
154	Andrea Gough
155	John Modra
156	Sunil Patel
157	Tracey
158	Jacqueline Ford
159	Victoria Evers
160	Samantha
161	Helen
162	Julie Koska
163	Margot Scott
164	Frances Jones
165	Ben
166	Pete Dillon Victorian Gay and Lesbian Rights Lobby
167	Vicki
168	Sarah
169	Rowena
170	Christine Whipp
171	Viv Ray
172	Diane Blood
173	Confidential
174	Maureen van der Linden
175	Hannah Spanswick
176	Confidential
177	Ron Thiele
178	Michael Mardel
179	Lynne Daniels
180	Confidential
181	Confidential
182	Anonymous
183	Confidential
184	Confidential
185	Confidential
186	Confidential
187	P Smith
188	Robin Andrews
189	Winson Lam
190	Leslie Backhaus
191	Ian Ho Yan Mak
192	Cecilia Ross
193	James and Valerie Studd
194	Lorraine Black
195	Sid and Mary Young
196	Confidential
197	Elizabeth Hately
198	Rae Brady
199	John Harrison
200	Karen Walker
201	Ed Lenthall
202	Anonymous

NO	NAME
203	Professor Marian Pitts and Associate Professor Kerry Petersen School of Law, La Trobe University
204	Confidential
205	Alex Jewett
206	Rev Samata Elia Uniting Church of Australia (with an additional 14 petition signatories)
207	Dr Justin Oakley Centre for Human Bioethics, Monash University
208	Anonymous
209	Rev Geoff Harvey
210	Graeme Moffatt
211	Cristina Pink
212	John Kloprogge
213	Anonymous
214	Sacha Petersen and Anna Russell
215	Sally Goldner
216	Rowan Creedon
217	Patty Holten
218	Kay Lipman
219	Alan Hoysted
220	Suryan Chandrasegaran
221	Susan Costello
222	Rev Norman Ford Caroline Chisholm Centre for Health Ethics Inc.
223	Confidential
224	Craig Deitrich
225	Doug Manning
226	Professor HWG Baker & Dr JC McBain University of Melbourne Department of Obstetrics and Melbourne IVF
227	Anonymous
228	Kevin and Anne Salmon
229	Jane Munro
230	Dr Philomene Tenni
231	Michael Linden and Lia Vandersant
232	Tony Keenan Ministerial Advisory Committee on Gay and Lesbian Health
233	Peter Coventry
234	M White
235	George and Elizabeth Read
236	Anonymous
237	Bill Tracey
238	Ivor Briggs
239	David Briggs
240	Daniel Briggs
241	Naomi Briggs
242	Matthew Briggs
243	Anne Buchan
244	Sabdha and Cristi Prospective Lesbian Parents
245	Melissa Shutler
246	Lisa Thorpy
247	Laura
248	Lauren Andrew

NO	NAME
249	Stephen
250	Christina Branton
251	Felicity Martin Fertility Access Rights
252	Confidential
253	Dr John Gill
254	Anonymous
255	Lesbian Parents' Project Group
256	Astrid Tiefholz
257	Dr Daphne Hennelly National Party of Australia – Victoria, Malvern-Toorak Branch
258	Confidential
259	Anonymous
260	Confidential
261	Confidential
262	Confidential
263	Rev Anthony Parle Church and Nation Committee, Presbyterian Church of Victoria
264	Mavis Baker
265	Anne O'Rourke Liberty Victoria
266	John O'Malley
267	Anonymous
268	Peggy Ong
269	Mr and Mrs Curmi
270	Dr Ruth McNair The Department of General Practice, The University of Melbourne
271	Ann White
272	Jack White
273	Maureen McQuillan
274	Kym Ivory
275	Julianne Drayton
276	Robert McQuillan
277	Tom Ivory
278	Quentin Loke
279	Confidential
280	Chris Ong
281	Confidential
282	Confidential
283	Confidential
284	Confidential
285	Confidential
286	Confidential
287	Confidential
288	Confidential
289	Confidential
290	Confidential
291	Atala Ladd
292	Anonymous
293	Anonymous
294	Anonymous
295	Anonymous
296	Confidential
297	Confidential

Appendix 2: Submissions

Position Paper One: Access

NO	NAME
298	Gerard Flood Isaacs Federal Electorate Group The Australian Family Association
299	Serena Cheng
300	Confidential
301	Roland Soew
302	Daniel and Melissa Heinze
303	Bruce Bennett
304	John Timms
305	Paul and Elaine Balcombe
306	Ray Salmon
307	Confidential
308	P Stevenson
309	Church By The Bay
310	Anonymous
311	Noelle Sullivan Women's Action Alliance (Victoria) Inc.
312	Ian Blandthorn Shop, Distributive & Allied Employees' Association
313	Dr Helen Szoke Equal Opportunity Commission Victoria
314	Adam Pickvance The ALSO Foundation
315	Hannah Robert
316	Alan Barron
317	Sharon Isle
318	Colin Walsh Knights of The Southern Cross (Victoria)
319	Melissa Afentoulis Women's Health West
320	Anonymous
321	Dr David Filby Health System Improvement and Reform, Department of Health, Government of South Australia
322	Diana Thompson The Australian Infertility Support Group
323	Rhonda Brown The Bouverie Centre and School of Nursing & Midwifery, La Trobe University
324	Michael and Maria Palma

NO	NAME
325	Anonymous
326	Anonymous
327	Anonymous
328	Confidential
329	Anonymous
330	Confidential
331	Irene
332	Confidential
333	Anonymous
334	Tham Fuan Lee
335	Babette Francis Endeavour Forum Inc.
336	Dr Maggie Kirkman Key Centre for Women's Health in Society, The University of Melbourne
337	Louise Johnson Infertility Treatment Authority
338	Dr Adrienne Pope Fertility Society of Australia
339	Kerry Lovering Women's Electoral Lobby Victoria
340	Confidential
341	Dr Elizabeth Short Key Centre for Women's Health in Society, The University of Melbourne
342	Confidential
343	Rosemary and Malcolm Pryor
344	Simone Blair
345	Beth Wilson Health Services Commissioner
346	Anonymous
347	Rev Dr Andrew Dutney SA Council on Reproductive Technology
348	Confidential
349	Dana Gips
350	Anonymous
351	Dr Kimberley Tuohey

Appendix 2: Submissions

Position Paper Two: Parentage

NO	NAME
1	Anonymous
2	Peter Sanko
3	Anonymous
4	Tess Hempel
5	Georgina Johnson
6	Moya and Leo Morrissey
7	Paula Jackson
8	Associate Professor Jenni Millbank School of Law, The University of Sydney
9	Anonymous
10	Helen Arblaster
11	Astrid Tiefholz
12	Suryan Chandrasegaran
13	Sue
14	Brett Webb
15	Jane Wilson
16	James Studd
17	Confidential
18	Confidential
19	Malcolm Grant
20	Ian Blandthorn Shop Distributive and Allied Employees' Association
21	June Smith
22	Zully Robles
23	Confidential
24	Robin Andrews
25	Matthew Briggs
26	Naomi Briggs
27	Ivor Briggs
28	Daniel Briggs
29	David Briggs
30	Suzanne Bryne
31	Confidential
32	Susan Rogers
33	Jane Watkins
34	Peter and Catherine
35	Kate Coghlan
36	Mark Neeson
37	Margaret White
38	Babette Francis Endeavour Forum Inc.
39	Confidential
40	Confidential
41	Dr John Gill
42	Laurie Crouch
43	Dr Daphne Hennelly National Party of Australia – Victoria, Malvern-Toorak Branch
44	Anonymous
45	Anonymous
46	Dr Penelope Bryant
47	Anonymous
48	John and Joe
49	Confidential
50	Jessica Brown

NO	NAME
51	Neil Ryan
52	Robyn Hamilton
53	Allesa Lancaster
54	Nathan Wilson
55	Walter Lee
56	Confidential
57	Christopher Watson
58	Helen Kane
59	Anonymous
60	Sarah Greening
61	Heidi Yates
62	Angeliza Querubin
63	Amy Chilton and Marika Adams
64	Mishell Warner-Camp
65	Jodie, Liz and Charlotte
66	Confidential
67	Ursula Then
68	Vivien Ray and Robin Gregory
69	Confidential
70	Betty Webster
71	Confidential
72	Dr Adrienne Pope Fertility Society of Australia
73	Confidential
74	David Westaway
75	Robert Zocchi
76	Confidential
77	Julie Griffiths
78	Paul Balcombe
79	Confidential
80	Bruce Webster
81	Trudy Brunton
82	Herman Gaglione
83	Joanna Robert
84	Matt Centra
85	Lynne Daniels
86	Julie-Anne Lilienthal
87	Anonymous
88	Helen Thompson
89	Lina
90	Mirella Di Benedetto
91	Anne Roberts
92	Tracey
93	Anonymous
94	George and Geraldine
95	Carol Daniels and Tony Brown
96	Brett Collinson
97	Susan
98	Nicole vander Linden and Nadine Ellery
99	Janine
100	Anastasia Barros
101	Scott Daniels
102	Anonymous
103	Michelle Cameron

Appendix 2: Submissions

Position Paper Two: Parentage

NO	NAME
104	Dr Jacqueline Johnston
105	Anonymous
106	David Johnston-Bell
107	Donna Carrington
108	Colin Walsh Knights of the Southern Cross, Victoria
109	Janet Hall
110	Helen Sparks
111	Ian and Jan Glascott
112	Confidential
113	Nicole Hayes
114	Liz Olle
115	Margot Scott
116	Confidential
117	Dr Maggie Kirkman Key Centre for Women's Health in Society, The University of Melbourne
118	Dr Elizabeth Branigan
119	Sue
120	Anonymous
121	Warren and Brenda McGregor
122	Travis McGregor
123	Ron Daniels
124	Doug and Jan McKenzie
125	Zelda Grimshaw
126	Mary-Jo O'Rourke
127	Anonymous
128	Leonie Davey
129	Elle Morrell
130	Anonymous
131	Mary Danckert
132	Confidential
133	Astrid Tiefholz Women's Health Victoria
134	Glenn Campbell
135	Robyn Deed
136	Nathan Niessen
137	Samuel Macgeorge
138	Irene Perkoulidis
139	Confidential
140	Kerry Flynn
141	Laura Binks
142	Rebecca Harris
143	James Lascelles
144	Anonymous
145	Georgina Dawson
146	Jacqueline Davis
147	Prue Walker
148	Greg McCourt
149	Heather Stewart
150	Confidential
151	Anna McKellar
152	Leesa Womersley and Janet Patterson
153	Nadine Davidoff

NO	NAME
154	Confidential
155	Dr Zoë McCallum
156	Patricia Bodsworth
157	Marianne Love
158	Vaughn Barker and David Bryant
159	Lynne Hyett
160	Liana Freeman
161	Kate Bride
162	Emma
163	Christine Whipp
164	Anonymous
165	Hillary Conway
166	Clare Brown
167	Lisa Coffa and Meghan Lawson
168	Anonymous
169	Anonymous
170	Margaret Campi OAM Victorian Standing Committee on Adoption and Alternative Families
171	Thomas Park
172	Dallas Ambry
173	Tammy Napier
174	Alyena Mohummadally
175	Anne Mitchell Gay and Lesbian Health Victoria
176	Anonymous
177	Confidential
178	Hannah Spanswick
179	Kelly Pilgrim Australian Coalition for Equality
180	Anonymous
181	Confidential
182	Margaret Locarnini
183	Anonymous
184	Stephen Kress
185	Bernie Brown
186	Confidential
187	Confidential
188	Confidential
189	Jenny Stokes Salt Shakers
190	Pete Dillon
191	John Kloprogge
192	Donna Zander
193	Susanne Prosser and Caroline Jordan
194	Anonymous
195	Simon Scoggins
196	Felicity Martin Fertility Access Rights and Victorian Gay & Lesbian Rights Lobby
197	Confidential
198	Kat Pinder and Lianda Gibson
199	Christopher Plumridge
200	Felicity Hopkins
201	Stephen Cooper
202	Confidential

NO	NAME
203	Anonymous
204	Sarah Nichols
205	Anonymous
206	Andrew McLean The Victorian Committee and the National Committee, Donor Conception Support Group
207	Jacqueline Tomlins
208	Jane Gibson
209	Confidential
210	Anonymous
211	Chris Burns Rainbow Male Survivors Network
212	Amy Pinner
213	Sophie Anderson
214	Narelle Grech
215	Cristina Pink and Sabdha Charlton
216	Christopher White
217	Andrea and Peter Turner
218	Anonymous
219	Anonymous
220	Louise Sensi
221	Dr Aron Paul Igai
222	Jonathon Cameron
223	Pauline Brown
224	Anonymous
225	Cath Smith
226	Anonymous
227	Anonymous
228	Karina Quinn
229	Anonymous
230	Jacqui Brown
231	Anonymous
232	Lee Matthews
233	Diana Thompson Australian Infertility Support Group
234	Felicity Martin
235	Vincent Docherty
236	Susan
237	Anne Runting
238	John Kalogridis
239	Dr Megan Turner
240	Danielle McKeown
241	Ciara O'Flanagan
242	Michael and Jan Chilton
243	Confidential
244	Lauren Andrew and Narelle Frazer
245	Dr Ruth McNair The Department of General Practice, The University of Melbourne
246	Vanessa McMillan
247	Rosemary and Ron Webster
248	Hannah Robert
249	Melissa Gangemi
250	Stephen Kress and Edward Crosslands QueerGreens

NO	NAME
251	Edward Crossland
252	Ms Hall Lesbian Parents Project Group
253	Louise
254	Gerard Brody
255	Confidential
256	Confidential
257	Confidential
258	Rhonda Brown and Amaryll Perlesz The Bouverie Centre, La Trobe University
259	Nevil and Gloria Knell
260	Mary Natoli Adoption Information Services Forum
261	Confidential
262	Anonymous
263	Tony Parsons Victoria Legal Aid
264	Dr Wei Leng Kwok Women's Health in the North
265	Myfanwy Walker
266	Confidential
267	Karen Sait Women's Health West
268	Anonymous
269	Dr Philomene Tenni
270	Louise Johnson Infertility Treatment Authority
271	Kate Foord
272	Anonymous
273	Anonymous
274	Hannah Leaver
275	Anonymous
276	Anonymous
277	Jessie Bell
278	Confidential
279	Jenny Cox
280	Confidential
281	Confidential
282	Confidential
283	Confidential
284	Confidential
285	Confidential
286	Confidential
287	Rita O'Brien
288	Luke Lethbridge
289	Jennifer Lethbridge
290	Alan Gray
291	Confidential
292	Confidential
293	Confidential
294	Confidential
295	Louise Veenstra
296	Bauke Veenstra
297	Bruno Mezger
298	Confidential

Appendix 2: Submissions

Position Paper Two: Parentage

NO	NAME
299	Confidential
300	Cherryl Amery
301	Geoff Amery
302	Rod Gear
303	Confidential
304	Eunice Clay
305	Frederick Clay
306	Confidential
307	Ian Lethbridge
308	Confidential
309	Confidential
310	Confidential
311	Bernadette Heinze
312	Muriel Heffernan
313	Jenny Furniss
314	Jeannette Sell
315	Confidential
316	Confidential
317	Confidential
318	Carol Duncan
319	Confidential
320	Confidential
321	Confidential
322	Confidential
323	Confidential
324	Michelle Scott
325	Craig Scott
326	Allan Duncan
327	Justin Lethbridge
328	Kevin O'Brien
329	Confidential

NO	NAME
330	Confidential
331	Kathy Bako
332	Confidential
333	Confidential
334	Robert Cox
335	Confidential
336	Confidential
337	Michael Edwards
338	D Hill
339	Selwyn Ellemor
340	Ulrich Dolderer
341	Anonymous
342	Terry Woodcroft
343	Jane Woodcroft
344	Confidential
345	Confidential
346	Confidential
347	Amy Glynn
348	Marie McCarthy
349	Rev Alan Nichols Director of the Centre for Applied Christian Ethics, Ridley College, The University of Melbourne
350	Rev Dr Andrew Dutney SA Council on Reproductive Technology
351	Dr Elizabeth Short Key Centre for Women's Health in Society, The University of Melbourne
352	Simon and Shelley Thomas

Appendix 2: Submissions

Position Paper Three: Surrogacy

NO	NAME
1	Katherine Raymond
2	Anonymous
3	Johaen Ernest
4	Robyn Hamilton
5	Heidi Yates
6	Dr Norman Ford Caroline Chisholm Centre for Health Ethics Inc
7	Anonymous
8	Jill Parris VANISH
9	Adrian Perillo
10	Jaye Monroe
11	Judith Bond
12	Peter Berry Berry & Associates Family Lawyers
13	Margaret White
14	James Christoffelsz
15	Gina Goble
16	Peter Murray
17	David Perrin
18	Dr Adrienne Pope Fertility Society of Australia
19	Jane Munro
20	Dr John Gill
21	Doug Weller and Brett Jenkin
22	Dr D Clarnette
23	Confidential
24	Katrina Harrison
25	Adam Pickvance The ALSO Foundation
26	Pat Healy
27	Katherine Harding
28	Dr Ruth McNair, The Department of General Practice, The University of Melbourne
29	Margaret Campi OAM Victorian Standing Committee on Adoption and Alternative Families
30	David Johnston-Bell
31	Robert Rushford
32	Anonymous

NO	NAME
33	Fiona Rushford
34	Lynne Daniels
35	Dr Maggie Kirkman Key Centre for Women's Health in Society, The University of Melbourne
36	Bill Muehlenberg
37	Julia Mangan
38	Atala Ladd
39	Rhonda Brown, The Bouverie Centre and School of Nursing & Midwifery, La Trobe University
40	Anonymous
41	Gerard Brody
42	Anonymous
43	Anonymous
44	Diana Thompson Australian Infertility Support Group
45	Anonymous
46	Dr John Gill
47	Babette Francis Endeavour Forum Inc.
48	Melissa Afentoulis Women's Health West
49	Jenny Stokes Salt Shakers
50	Peter Phillips
51	Laura Clark and Dominic Dillon
52	Louise Johnson Infertility Treatment Authority
53	Rev Geoff Harvey Antiochian Orthodox Church
54	Frances McAloon Adoption Information Services Forum
55	Felicity Martin Fertility Access Rights
56	Gina Goble and Kay Oke Melbourne IVF Counselling Service
57	Beth Wilson Health Services Commissioner
58	Hannah Spanswick
59	Dr Peter Woolcock SA Council on Reproductive Technology
60	Anonymous

Appendix 3: Consultations

CONSULTATION SESSION

Creating New Families: Access to ART and Adoption in Victoria

18 May 2004

Participants: approximately 60 stakeholders

PUBLIC FORUM

Assisted Reproduction: The Rights of the Child

Research Paper Launch and Public Forum

8 September 2004

Participants: approximately 150 stakeholders and members of the public

CONSULTATION PAPER ROUNDTABLES

Parentage

4 October 2004

Facilitator: Moira Rayner

Participants: Associate Professor Kristen Walker, Leigh Johns, David Edney, Lynne Morgain, Helen Trihas, Ian Bowler, Deborah Dempsey, Dr Helen Szoke, Margaret Coady, Helen Kane, Rita Alesi, Adiva Sifris

Access

14 October 2004

Facilitator: Felicity Hampel SC

Participants: Professor Gordon Baker, Jenny Blood, Jacqui Tomlins, Dr Fiona Haines, Dr Lynn Gillam, Dr Ruth McNair, Dr Diane Sisely, Felicity Martin

Surrogacy

20 October 2004

Facilitator: Professor Marcia Neave

Participants: Associate Professor Margaret Otlowski, Dr Maggie Kirkman, Alice Kirkman, Linda Kirkman (by phone), Dr Roger Cook, Gina Goble, Dr Kate Stern, Judy Small, Professor John Leeton, Dr Leslie Cannold

Technological change working group

21 October 2004

Facilitator: Professor Marcia Neave

Participants: Professor Jock Findlay, Dr John McBain, Professor Ingrid Winship, Professor Don Chalmers (by phone), Associate Professor Agnes Bankier, Dr Chris Bayly.

POSITION PAPER ROUNDTABLES

Parentage

6 February 2006

Facilitator: Professor Marcia Neave

Participants: Justice Linda Dessau, Maureen Cleary, Narelle Grech, Dr Ruth McNair, Helen Brain, Catherine Burnett, Louise Johnson, Helen Kane, Andrew McLean, David Edney, Fahna Ammet, Ian Bowler

Access

9 February 2006

Facilitator: Professor Marcia Neave

Participants: The Honourable Alastair Nicholson, Dr Sandra Hacker, Professor Gordon Baker, Felicity Martin, Michael Gorton, Matthew Carroll, Debbie Jeffrey, Kay Oke, Myfanwy Walker, Dr Ray Cleary, Gill Callister

Surrogacy

21 February 2006

Facilitator: Professor Marcia Neave

Participants: Justice Sally Brown, Justice Nahum Mushin, Moira Rayner, Lee Matthews, Fiona Rushford, Laura Clark, Peter Berry, Louise Johnson, Lexi Neame, Dr Roger Cook, Gina Goble, Dr Maggie Kirkman, Alice Kirkman

MEETINGS AND FORUMS

28 April 2004	Helen Szoke, Infertility Treatment Authority
30 April 2004	Felicity Martin
7 May 2004	Attorney-General's Advisory Committee on Gay, Lesbian, Bisexual, Transgender and Intersex issues
20 May 2004	Prospective Lesbian Parents
24 May 2004	Helen Trihas and Ian Bowler, Registry of Births, Deaths and Marriages
10 June 2004	Registry of Births, Deaths and Marriages
21 June 2004	Rainbow Parents Playgroup, Bentleigh
6 July 2004	Louis Waller Lecture, delivered by Dr Sally Cockburn
5 July 2004	VLRC Advisory Committee for ART & Adoption reference
26 August 2004	West of Docklands Lesbians
6 September 2004	Melbourne IVF, tour with Dr John McBain
25 October 2004	Infertility Treatment Authority, presentation by Angela McNab, CEO of Human Fertilisation and Embryology Authority (UK)
26 October 2004	Infertility Treatment Authority, presentation by Professor Ken Daniels
27 October 2004	Infertility Treatment Authority Symposium (Melbourne Museum)

Bibliography

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- Allen Consulting Group, *Protecting Children: The Child Protection Outcomes Project* (Victorian Department of Human Services, 2003).
- Almack, Kathryn, 'Seeking Sperm: Accounts of Lesbian Couples, Reproductive Decision-Making and Understandings of the Needs of the Child' (2006) 20(1) *International Journal of Law, Policy and the Family* 1.
- Assisted Human Reproduction Implementation Office, *Issues Related to the Regulation of Pre-Implantation Genetic Diagnosis under the Assisted Human Reproduction Act* (2005).
- Assisted Reproductive Technologies Review Committee, *Report of the Independent Review of the Assisted Reproductive Technologies* (February 2006).
- Australian Bureau of Statistics, *Year Book Australia 2005*, Catalogue No 1301.0 (2005).
- Australian Bureau of Statistics, *Women's Safety Australia*, Catalogue No 4128.0 (1996).
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