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PROJECT 140

THE RIGHT TO KNOW ONE’S OWN BIOLOGICAL ORIGINS

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INTRODUCTION


The members of the SALRC are –

Judge Narandran (Jody) Kollapen (Chairperson)
Judge Thina Siwendu
Attorney Irvin Lawrence
Advocate Mahlape Sello
Professor Marita Carnelley
Professor Vinodh Jaichand
Professor Annet Wanyana Oguttu

The Secretary of the SALRC is Mr Nelson Matibe. The project leader responsible for this investigation is Judge Thina Siwendu. The SALRC researcher assigned to this investigation is Miss Veruksha Bhana.

Correspondence should be addressed to:

Post: The Secretary: SA Law Reform Commission, Private Bag X668, Pretoria, 0001
E-mail: VBhana@justice.gov.za
Fax: 086 216 7313 or 012 622 6362/6261
Tel: 012 622 6332
Website: http://www.justice.gov.za/salrc/index.htm

Issue Paper 32 will be made available on the internet at http://salawreform.justice.gov.za/ipapers.htm. A hardcopy may be obtained free of charge upon request to Mr Jacob Kabini on telephone 012 662 6327 or via email on JaKabini@justice.gov.za.
PREFACE

This issue paper was prepared to stimulate debate and to elicit responses which will serve as basis for the SALRC’s deliberations in an investigation into the rights of a child to know his or her own biological origins.

The SALRC seeks the comment of any person on any question contained in this issue paper or in respect of a related topic which may need inclusion in the debate. Such comment is of vital importance to the Commission and respondents are requested to respond comprehensively.

The SALRC will assume that respondents agree to the Commission quoting from or referring to comments and attributing comments to respondents unless representations are marked confidential. Respondents should be aware that the SALRC may be required to release information contained in representations under the Promotion of Access to Information Act, 2000 (Act 2 of 2000).

Respondents are requested to submit written comment, representations or requests to the SALRC (citing reference to Issue Paper 32) by no later than 31 August 2017 at the address appearing on the previous page.

Following the issue paper, the SALRC will publish a discussion paper setting out preliminary proposals and draft legislation, if necessary. The discussion paper will take the public response on the issue paper into account and will test public opinion on solutions identified by the SALRC. On the strength of responses on the discussion paper, a report will be prepared which will contain the SALRC’s final recommendations. The report (which may include draft legislation, if necessary) will be submitted to the Minister of Justice and Correctional Services for his consideration and onward transmission to the Minister of Social Development, Minister of Home Affairs and Minister of Health.

This issue paper is available on the internet at http://www.justice.gov.za/salrc/ipapers.htm

Enquiries should be addressed to the Secretary of the SALRC or to the SALRC researcher assigned to this investigation, Miss Veruksha Bhana on telephone 012 622 6332 or via e-mail at VBhana@justice.gov.za.
SUMMARY OF ISSUE PAPER

In 2016, the SALRC commenced an investigation into the The Right to Know One’s Own Biological Origins (Project 140). The object of the investigation is to perform research to ascertain whether a child should have legal right to know his or her biological origins.

This investigation is important in an age of cutting-edge and ever advancing science in the field of assisted reproduction. Assisted reproduction is used to treat infertility and entails the use of fertility medications and medical techniques to bring about the conception and birth of a child. Children are conceived using donor gametes in techniques such as in vitro fertilization, mitochondrial replacement therapy and genetic surrogacy.

Assisted reproduction in South Africa is regulated by the National Health Act 61 of 2003 and the Regulations Relating to Artificial Fertilization of Persons, 2012 as well as the Children’s Act 38 of 2005 and the regulations thereto. The legal position in South Africa is that gamete donors and surrogate mothers must be anonymous and it is an offence to reveal the identity of a gamete donor or surrogate mother. Further, gamete donation and surrogate motherhood should be altruistic and not for commercial purposes.

South Africa is State Party to the United Nations Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child, however; clauses in the Conventions are open to interpretation in deciding whether or not a child has a legal right to know his or her biological origins.

When heterosexual infertile persons and homosexual couples have children, obvious questions arise as to how these children were conceived and their biological origins. Innovations in genetic testing also means that the chances of donor-conceived children discovering that they are not biologically related to one or both of their parents are higher than before and this raises the question as to whether donor anonymity should remain the legal position as is the case in South Africa currently.

Mitochondrial replacement therapy is sometimes called three-parent IVF. It is a form of in vitro fertilization in which the future baby's mitochondrial DNA comes from a donor. This technique is used in cases when mothers carry genes for mitochondrial diseases. Therefore, mitochondrial DNA from a healthy donor egg is used to attempt to prevent the transmission
of mitochondrial disease from one generation to the next. Mitochondrial replacement therapy involves the introduction of foreign mitochondrial DNA into the germ line that will be inherited by all children in downstream generations. Ethical concerns relate to the alteration of germ line genetics and the dilemma of children inheriting DNA material from three instead of two parents. Mitochondrial transfer has also been closely associated with reproductive cloning which is regulated differently worldwide. Children born from these techniques might experience an identity crisis. The use of donors also raises the question of what information should be available about them to the children born from their eggs and vice versa. In light of Chapter 8 of the National Health Act 61 of 2003, questions are asked as to whether the legislative framework in South Africa allows for the use of mitochondrial replacement therapy in South Africa.

Practical considerations come into play in deciding whether or not to disclose information to a child regarding his or her conception. It is clear that one cannot simply emphasize a child’s right to know but there must also be consideration of broader social issues such as the relationship with the wider family, the community, financial issues and the ability of the donor-conceived child to deal with information regarding his or her biological origins.

In the case of AB and Surrogacy Advocacy Group v the Minister of Social Development (CCT155/15) [2016] ZACC 43; 2017 (3) BCLR 267 (CC), AB who is both conception and pregnancy infertile, challenged the constitutionality of S294 of the Children’s Act 38 of 2005. Section 294 requires that a child contemplated in terms of a valid surrogate motherhood agreement must be genetically related to both the commissioning parents or, if this is impossible as a result of medical or biological or other valid reasons, related to at least one of the commissioning parents. Where the commissioning parent is a single person, the child must be genetically related to the commissioning single parent.

On 29 November 2016, the Constitutional Court held that a genetic link is required between the intended parent and the child. The Constitutional Court adopted a more impartial approach in deciding the matter. Rather than focussing only on the rights of the intended parent, the Court considered the best interests of the intended child.

In light of the judgment of the Constitutional Court one could argue that a more balanced approach is necessary when weighing the rights of a person or couple who wish to have a child via assisted reproduction and that of the intended child. The Court held that clarity regarding the origin of a child is important to the self-identity and self-respect of the child.
Given this Constitutional Court decision, it is clear that South Africa needs to reconsider anonymous gamete donation in surrogacy and in other types of assisted reproduction.

The question of the right to know one’s own biological origins is also applicable as regards adoption, registration of birth, disputed paternity and child abandonment and all of these topics are dealt with in this issue paper.

Birth registration is necessary to concretize a child’s rights to a name and nationality. A birth certificate is a vital record that documents the birth of a child and is the means by which the State recognizes the existence and status of a child. A birth certificate provides a child with an identity of their own and allows a child to access key social services such as education, health care and social grants. Issues related to registration of birth and disputed paternity affects all children and not just donor-conceived children.

Section 10 of the Births and Deaths Registration Act 51 of 1992 deals with how a child is to be registered when the parents are not married each other. Where the parents are not married, the mother must register the child under her surname or, the child may be registered under the surname of the biological father provided that the father acknowledges paternity and both the father and the mother consent to the registration of the child under the father’s surname in the presence of a Home Affairs official.

Questions of equality can be raised in that an unmarried mother must register the birth of her child under her surname whereas the unmarried father must first acknowledge paternity and he has the option of whether or not his details appear on the birth certificate.

Questions are asked as to whether Courts should still use legal presumptions to determine paternity in the case of disputed paternity or whether a scientific approach should be adopted given the certainty that scientific tests provide.

Regarding abandoned children, questions are asked as to whether baby hatches should be established and whether safe haven laws (as in the United States of America) and confidential birth laws (as in Germany) should be enacted in South Africa.

This issue paper also deals with the ethics and regulation of inter-country medically assisted reproduction. Over the past decade, there has been a steady growth in a new global market of cross-border medical travel for repro-genetic purposes (medical tourism). Many practices of inter-country medically assisted reproduction involve ‘third-party’ individuals acting as
surrogate mothers and gamete providers in reproductive collaborations for the benefit of other individuals and couples who wish to have children. Arrangements between intended parents and third-party reproductive collaborators create a special kind of agreement that needs regulation so as to protect the interests of all the involved persons: the intended parents, the third-party collaborators and the children. In inter-country settings, under conditions of geographical distance, cultural differences and economic disparity, the for-profit motivation of medical entrepreneurs and intermediary agents exacerbates the potential commodification and abuse of women and children.

Human relationships are complex and, while the law does regulate various areas of life, the general consensus is that the law should not intrude too deeply into family relationships. However, where the State plays an active role either by way of public funding, research (legal or scientific), provision of health care services, legal regulation of service providers and the administration of registration of birth and nationality, one could confidently argue that the State is obliged to be proactive in order to protect the interests of children who, by their disposition, are dependent on the State to protect their interests.

This investigation cuts across law (the right to reproductive health care, the right to privacy in respect of one’s health or family life, the right to know one’s biological origins and the right to economic activity), sociology and science. In each chapter of this issue paper questions are asked regarding the content of the chapter in order to assess whether a child should have a legal right to know his or her biological origins and how such a right could be enforced and whether the law in this regard should be amended in light of prevailing and anticipated circumstances and contemporary mores and thinking.

The SALRC seeks answers to the questions raised in this issue paper and welcomes the comment of any person on any matter contained in this issue paper or in respect of a related topic which may need inclusion in the debate. Such comment is of vital importance to the Commission and respondents are requested to respond comprehensively as comments will serve as the basis for the SALRC’s deliberations on this investigation.
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CHAPTER 1
THE QUESTION OF THE RIGHT TO KNOW ONE’S OWN BIOLOGICAL ORIGINS

1.1 Introduction

1.1 In the past parents of children conceived using donated eggs, sperm, or embryos were encouraged to keep the donation a secret. This was because infertility was seen as an embarrassing, distressing problem and carried social stigma, to protect the legal status of the child conceived using donor gametes, to sever the link between the donor and the child in order to ensure that the parents are able to raise the child ‘as their own’ without any interference from the donor, to establish the rights and duties of the social parents and to ensure that the donor had no financial responsibility towards the donor-conceived child. The increasing using of assisted reproductive technology and the existence of legislation regulating this arena has led to a shift in attitude.

1.2 Increasing numbers of children are conceived through donor-assisted conception utilizing donated gametes. The unabated advance of medical science is altering the tradition of secrecy surrounding donor-conceived children’s conception. The relative ease with which it is now possible to discover the identity of a person’s genetic parents, the open identification policy with regard to adoption and the development of genetic testing for disorders have all dramatically influenced the development of human rights law in favour of the child’s right to know the truth about his or her biological origins.

1.3 Novel technologies such as mitochondrial replacement and even gene editing raise new concerns in this area and may expand the scope of a right to know one’s genetic origins.

1.4 Attitudes toward donor conception have changed dramatically since the use of donor gametes became a common medical approach to infertility in the last quarter of the 20th

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1 The information contained in Chapter 1 Paragraph 1.1 was extracted from article by Brigette Clark titled A Balancing Act? The Rights of Donor Conceived Children to Know their Biological Origins, Georgia Journal of International and Comparative Law, 2012 Volume 40 619 – 661 at 621-624. Accessed from http://digitalcommons.law.uga.edu/cgi/viewcontent.cgi?article=1001&context=gjicl
century. What was once usually kept a secret by heterosexual couples who conceived via sperm donation has become more public. Indeed, disclosure of donor conception to the children is now recommended by many psychologists and social workers who advise parents about these issues. Moreover, as family diversity became more accepted, single women and lesbian and gay couples could more easily acquire gametes, which they required for reproduction. These intended parents, who are not necessarily medically infertile, make it less likely that the reliance on donor gametes can be totally concealed either inside or outside the family.

1.5 A growing body of research, largely conducted in the adoption field, supports the argument that knowledge of one’s genetic background is crucial to the development of a sense of identity or self. Despite the fact that the analogy of donor conception to adoption is somewhat controversial, the use of rights-based arguments to endorse the position that children conceived by donor gametes should have access to identifying information about their gamete donor has gained credence and is now a commonly expressed argument.

1.6 The ability of donor-conceived children to access information about their genetic origins initially depends on their awareness of the nature of their conception. Without this knowledge, such children will assume that their “social” parent is their biological parent.

1.7 Hence the onus of revealing the manner of conception rests on the social parents, unless such information is disclosed by the state, such as through a birth certificate or it is obvious that the child cannot be the biological child of both social parents.

1.8 Concerns have been expressed about low levels of parental disclosure. A study conducted in 2002 indicated that as few as 5% of parents of donor-conceived children had told their near-adolescent children about their conception origins. Even that number may be high as reported disclosure rates are likely to be overestimated because some non-respondents do not participate due to privacy issues and fears of revealing their use of donor conception.

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2 Katherine O’Donovan, Interpretations of Children’s Identity Rights, in REVISITING CHILDREN’S RIGHTS 73, 75 (Deirdre Fottrell ed., 2000) (reporting on a study of Aboriginal children and the negative effects of policies that ignored their identity); see also Geraldine Hewitt, Missing Links: Identity Issues of Donor-Conceived People, J. FERTILITY COUNSELING, Autumn 2002, at 14, 19 (noting that “of the 47 donor-conceived people who took part in this study, only 3 had not experienced identity issues” and the other forty-four persons indicated that their identity issues related to “their conception through anonymous donor sperm”).
1.9 The low rate of disclosure may change as the United Nations Committee on the Rights of the Child puts increasing pressure on national systems that withhold information about the identities of donors from children born by donor conception. Although legislative changes removing donor anonymity may play a part in facilitating parental disclosure, a parental decision not to reveal the truth to a donor-conceived child is a complex family matter and therefore very difficult to regulate by law. Furthermore, in Europe, such intervention could arguably be construed as a violation of Article 8 of the European Convention on Human Rights (ECHR), which guarantees the right to privacy and family life, inter alia, subject to justifiable state intervention.

1.10 McRae argues that children who are deprived of knowing a biological parent or having a relationship with such a parent could grieve that parent’s loss even if he/she has never met or been in contact with such parent. There are several potential consequences that could arise in respect of children who go through this process and such a child could become angry, argumentative, oppositional, and exhibit disruptive and disturbing behaviour. She further states that until such a child is able to at least identify his/her biological parent(s), he/she will be unable to complete the grieving process and will continue to display these symptoms. These children may also experience genealogical bewilderment, which is regarded as the feeling of being deprived of one’s heritage, religious background, culture and/or race. Thus, knowing one’s biological history would enable children to build their self-identities.

1.2 South African Legal Framework

1.11 When a State first signs a treaty, it indicates an intention to become a party to the treaty. Signature does not legally bind the State but the State is obliged to refrain from acts that would defeat the object and purpose of such a treaty. When a State ratifies a treaty, it is

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3 Right to respect for private and family life
1. Everyone has the right to respect for his private and family life, his home and his correspondence.
2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others

formally ‘a State Party’ to the treaty and is bound under international law to respect the rights and carry out the duties in that treaty.


1.14 When interpreting and developing South African law, regard must be had to the CRC and ACRWC as South Africa is a State Party to both these instruments and is obliged to respect the rights and carry out the duties in that treaty. Articles in both these instruments are discussed further in other chapters of this paper.

1.15 Assisted reproduction in South Africa is regulated by the National Health Act 61 of 2003 (NHA) and the regulations thereto as well as the Children’s Act 38 of 2005 (Children’s Act) and its regulations.

1.16 According to the Regulations Relating to Artificial Fertilisation of Persons, GN R175 in GG 35099 of 2 March 2012 - hereinafter referred to as Regulations Relating to Artificial Fertilisation, 2012):

*artificial fertilisation* means the introduction by other than natural means of a male gamete or gametes into the internal reproductive organs of a female person for the purpose of human reproduction and includes artificial insemination, in vitro fertilisation, gamete intrafallopian tube transfer, embryo intrafallopian transfer or intracytoplasmic sperm injection;

*artificial insemination* means the placing of male gametes (sperm) into the female reproductive tract by means other than copulation;

*in vitro fertilisation* is the process of spontaneous fertilisation of an ovum with a male sperm outside the body in an authorised institution;
1.17 Draft regulations relating to artificial fertilisation of persons dated 15 August 2016 were published for comment. See GN 1165 in GG 40312 of 30 September 2016.

1.18 Section 28 of the Constitution reads as follows:

28. Children
(1) Every child has the right -
(a) to a name and a nationality from birth;
(b) to family care or parental care, or to appropriate alternative care when removed from the family environment;
(c) to basic nutrition, shelter, basic health care services and social services;
(d) to be protected from maltreatment, neglect, abuse or degradation;
(e) to be protected from exploitative labour practices;
(f) not to be required or permitted to perform work or provide services that -
   (i) are inappropriate for a person of that child’s age; or
   (ii) place at risk the child’s well-being, education, physical or mental health or spiritual, moral or social development;
(g) not to be detained except as a measure of last resort, in which case, in addition to the rights a child enjoys under sections 12 and 35, the child may be detained only for the shortest appropriate period of time, and has the right to be -
   (i) kept separately from detained persons over the age of 18 years; and
   (ii) treated in a manner, and kept in conditions, that take account of the child’s age;
(h) to have a legal practitioner assigned to the child by the state, and at state expense, in civil proceedings affecting the child, if substantial injustice would otherwise result; and
(i) not to be used directly in armed conflict, and to be protected in times of armed conflict.
(2) A child’s best interests are of paramount importance in every matter concerning the child.
(3) In this section “child” means a person under the age of 18 years.

1.19 The Constitution stipulates that a child is a person under the age of 18 years. Section 28(1)(b) says that a child has a right to family care or parental care. A parent could be a biological, social or legal parent. It is also not expressly stated that a child has a right to know his or her biological parent or biological origins.
1.2.1 Question

Does a right to parental care encompass a right to know one’s own genetic parent or parents and the does the right to family care encompass the right to know and have a relationship with one’s own genetic parent or parents and genetic family or siblings who may also have been conceived using assisted reproductive technology?

1.3 Anonymity of Gamete Donors and Surrogate Mothers

1.20 Section 41(2)\(^5\) of the Children’s Act prohibits the identity of a gamete donor or surrogate mother from being disclosed to a child or the child’s guardian.

1.21 Regulation 19 of the Regulations Relating to Artificial Fertilisation of Persons, 2012 states that no person shall disclose the identity of any person who donated a gamete or received a gamete, or any matter related to the artificial fertilisation of such gametes, or reproduction resulting from such artificial fertilisation except where a law provides otherwise or a court so orders\(^6\).

1.22 Regulation 21 of the Regulations Relating to Artificial Fertilisation of Persons, 2012 says that any person who contravenes or fails to comply with any provision of the regulations commits an offence and is liable on conviction to a fine or imprisonment for a period not exceeding 10 years, or to both such fine and imprisonment\(^7\).

\(^5\) Access to biographical and medical information concerning genetic parents
(1) A child born as a result of artificial fertilisation or surrogacy or the guardian of such child is entitled to have access to:
   (a) any medical information concerning that child's genetic parents; and
   (b) any other information concerning that child's genetic parents but not before the child reaches the age of 18 years.
(2) Information disclosed in terms of subsection (1) may not reveal the identity of the person whose gamete was or gametes were used for such artificial fertilisation or the identity of the surrogate mother.
(3) The Director-General: Health or any other person specified by regulation may require a person to receive counselling before any information is disclosed in terms of subsection (1).

\(^6\) Regulation 19 of the 2016 draft regulations proposes that no person may disclose the identity of any person who donated a gamete or received a gamete, or any matter related to the artificial fertilisation of such gametes, or reproduction resulting from such artificial fertilisation except where a law provides otherwise or a court so orders.

\(^7\) Regulation 21 of the 2016 draft regulations proposes that any person who contravenes or fails to comply with any provision of these regulations commits an offence and is liable on conviction to a fine or imprisonment for a period not exceeding 10 years, or to both such fine and imprisonment.
1.23 Section 26(1) of the Children’s Act states that a biological father claiming paternity may apply for an amendment to be effected to the registration of birth of the child in terms of s11(4) of the Births and Deaths Registration Act, 1992, identifying him as the father of the child, if the mother consents to such amendment. Section 26(2)(b) prevents any person who is biologically related to a child by reason only of being a gamete donor for purposes of artificial fertilisation from making such an application.

1.24 It is clear that the legal position in South Africa is that the identity of a gamete donor or surrogate mother may not be disclosed.

1.4 Altruistic Donation and Surrogacy

1.25 Section 60(4) of the National Health Act 61 of 2003 prohibition on the sale or trade of gametes and it is a criminal offence to contravene the section.\(^8\)

1.26 Regulation 4 of the Regulations Relating to Artificial Fertilisation of Persons, 2012 says that a person from whose body a gamete has been removed or withdrawn may be reimbursed for any reasonable expenses incurred by him or her in order to donate a gamete as contemplated in section 60(4)(a) of the Act.\(^9\) Conversely commercial trade is prohibited.

1.27 Regulation 21 of the Regulations Relating to Artificial Fertilisation of Persons, 2012 says that any person who contravenes or fails to comply with any provision of the regulations commits an offence and is liable on conviction to a fine or imprisonment for a period not exceeding 10 years, or to both such fine and imprisonment.\(^10\)

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\(^8\) 60 Payment in connection with the importation, acquisition or supply of tissue, blood, blood products or gametes (4) It is an offence for a person—
(a) who has donated tissue, a gamete, blood or a blood product to receive any form of financial or other reward for such donation, except for the reimbursement of reasonable costs incurred by him or her to provide such donation; and
(b) to sell or trade in tissue, gametes, blood or blood products, except as provided for in this Chapter.
(5) Any person convicted of an offence in terms of subsection (4) is liable on conviction to a fine or to imprisonment for a period not exceeding five years or to both a fine and such imprisonment.

\(^9\) Regulation 5 of the 2016 draft regulations proposes that a person from whose body a gamete has been removed or withdrawn may be reimbursed for any reasonable expenses incurred by him or her in order to donate a gamete as contemplated in section 60(4)(a) of the Act.

\(^10\) Regulation 21 of the 2016 draft regulations proposes that any person who contravenes or fails to comply with any provision of these regulations commits an offence and is liable on conviction to a fine or imprisonment for a period not exceeding 10 years, or to both such fine and imprisonment.
1.28 Section 303(2) of the Children’s Act says that no person may in any way for or with a
view to compensation make known that any person is or might possibly be willing to enter
into a surrogate motherhood agreement. This section makes it clear that commercial
surrogacy is unlawful by preventing anyone from facilitating surrogate motherhood
agreements in return for compensation. S305(1)(b) says that any contravention of sections
301, 302 and 303 of the Children’s Act is an offence.11

1.29 In the South African legal scheme, gamete donation and surrogate motherhood should
be altruistic and not for commercial purposes.

1.5 Analysis of the Convention on the Rights of the Child

1.30 In her article titled A Balancing Act? The Rights of Donor Conceived Children to Know
their Biological Origins, Brigette Clark12 analysed the CRC as follows:

1.31 In 1989, the CRC was drafted as the first legally binding international instrument to
incorporate the full range of human rights — civil, cultural, economic, political, and social—to
protect children defined as persons under the age of eighteen). By ratifying the CRC, States
Parties commit themselves to protecting and ensuring children’s rights and developing
actions and policies to promote the best interests of the child. However, none of the articles
in the CRC specifically promote a child’s right to knowledge of his or her origins.

1.32 The United Nations established the Committee on the Rights of the Child (CROC) to
monitor the rights granted by the CRC, but failed to provide the Committee with enforcement
powers and, further, there is no mechanism for individual petition under the CRC.

1.33 The CROC is concerned with producing guidelines and enforcing international laws
regarding children’s rights. CROC is in charge of monitoring the enforcement of the CRC.

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11 In Ex Parte WH 2011 (6) SA 514 GNP at paragraphs 64-67 on pages 528-529, the court reiterated that
commercial surrogacy is prohibited.

12 Brigette Clark, A Balancing Act? The Rights of Donor Conceived Children to Know their Biological Origins,
from http://digitalcommons.law.uga.edu/cgi/viewcontent.cgi?article=1001&context=gjicl
1.34 Article 7 of the CRC states:

1. The child shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and, as far as possible, the right to know and be cared for by his or her parents.
2. States Parties shall ensure the implementation of these rights in accordance with their national law and their obligations under the relevant international instruments in this field, in particular where the child would otherwise be stateless.

1.35 The Committee has interpreted Article 7 as granting a child’s right to knowledge of his or her origins. Further, it has consistently criticized nations that do not allow for such a right or that allow mothers to give birth anonymously, as in France, and made recommendations to contracting States Parties regarding incomplete national enforcement of the child’s right to know his or her origins. However, national authorities have a degree of discretion, provided they do not give higher priority to parental rights than children’s rights and do not “diverge in their interpretations of the scope and degree of the duties imposed by the CRC.

1.36 In the context of the right to know, the reference to parents could indicate a right to know one’s biological parents since it is possible to interpret Article 7 broadly so that the term “parents” includes not only social or legal parents but also biological and gestational parents.

1.37 Furthermore, if Article 7 is read in the light of the rest of the CRC, in particular Articles 9 and 18, it would appear to guarantee the child’s right to have a relationship with his or her parents.

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13 UN CROC Concluding Observations of the Committee on the Rights of the Child: Denmark, UN Doc. CRC/C/15/Add.33 (Feb. 15, 1995); UN CROC, Concluding Observations of the Committee on the Rights of the Child: Norway, UN Doc. CRC/C/15/Add.23 (Apr. 25, 1994); UN CROC, Concluding Observations of the Committee on the Rights of the Child: United Kingdom of Great Britain and Northern Ireland, CRC/C/15/Add.188 (Oct. 9, 2002)

14 Article 9

1. States Parties shall ensure that a child shall not be separated from his or her parents against their will, except when competent authorities subject to judicial review determine, in accordance with applicable law and procedures, that such separation is necessary for the best interests of the child. Such determination may be necessary in a particular case such as one involving abuse or neglect of the child by the parents, or one where the parents are living separately and a decision must be made as to the child’s place of residence.
2. In any proceedings pursuant to paragraph 1 of the present article, all interested parties shall be given an opportunity to participate in the proceedings and make their views known.
3. States Parties shall respect the right of the child who is separated from one or both parents to maintain personal relations and direct contact with both parents on a regular basis, except if it is contrary to the child’s best interests.
4. Where such separation results from any action initiated by a State Party, such as the detention, imprisonment, exile, deportation or death (including death arising from any cause while the person is in the custody of the State) of one or both parents or of the child, that State Party shall, upon request, provide the parents, the child or, if appropriate, another member of the family with the essential information concerning the whereabouts of the absent member(s) of the family unless the provision of the information would be detrimental to the well-being of
her parents but it is not entirely clear what the right to know and be cared for by one's parents would entail. It might imply the right to contact them as well as knowledge of their identity.

1.38 On the one hand, it might be argued that there should be legislation imposing this obligation on family relationships and that such an obligation should be based on a model of scientifically derived genetic truth. On the other hand, it could be maintained that the right to know one's origins is simply a fashionable notion fuelled by advances in biomedical sciences. Clearly the biological model of parenthood cannot rank as highly as other types of parenthood, such as those arising from active caring, nurturing, and love. Like the right to know, the right to be cared for by one's biological parents, besides one's social parents, is always qualified by the words “as far as possible”\textsuperscript{16}.

1.39 Article 8 states:

1. States Parties undertake to respect the right of the child to preserve his or her identity, including nationality, name and family relations as recognized by law without unlawful interference.
2. Where a child is illegally deprived of some or all of the elements of his or her identity, States Parties shall provide appropriate assistance and protection, with a view to re-establishing speedily his or her identity.

1.40 Article 8 was originally proposed in order to deal with the abuses committed by the military regime in Argentina in the 1970s and 1980s, which abducted infants from their mothers before their births had been registered and illegally gave them to couples associated with the armed forces and the police. However, during the drafting process of the CRC, many the child. States Parties shall further ensure that the submission of such a request shall of itself entail no adverse consequences for the person(s) concerned.

\textsuperscript{15} Article 18
1. States Parties shall use their best efforts to ensure recognition of the principle that both parents have common responsibilities for the upbringing and development of the child. Parents or, as the case may be, legal guardians, have the primary responsibility for the upbringing and development of the child. The best interests of the child will be their basic concern.
2. For the purpose of guaranteeing and promoting the rights set forth in the present Convention, States Parties shall render appropriate assistance to parents and legal guardians in the performance of their child-rearing responsibilities and shall ensure the development of institutions, facilities and services for the care of children.
3. States Parties shall take all appropriate measures to ensure that children of working parents have the right to benefit from child-care services and facilities for which they are eligible.

\textsuperscript{16} Article 7(1) of the CRC
1. The child shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and, \textit{as far as possible}, the right to know and be cared for by his or her parents.
countries opposed Article 8’s emphasis on the child’s identity and its inconsistency with secret adoption and protecting the identity of gamete donors. As a result, a political compromise was reached. The provision was retained with the addition of a few provisos, such as “without unlawful interference”, “illegally”, or “as recognized by law.”

1.41 “Lawful” is understood to encompass national as well as international legal norms, so that national legal restrictions will not be permitted to contradict international obligations. Article 8 does not define the concept of identity. Instead, it gives three examples of what identity includes: nationality, name, and family relations. Knowledge of one’s family relations is usually interpreted as going beyond knowing one’s legal parents and extending to biological and birth parents.

1.42 Article 8 implies duties to register and preserve data regarding a child’s identity and to make that data accessible to the child. It emphasizes positive duties of assistance by referring to states “undertaking to preserve” the child’s identity and calling for appropriate measures to re-establish the child’s identity.

1.43 Another guiding principle may be found in Article 3 of the CRC, which makes the child’s best interest a primary consideration, imposing limits on the right to know in cases where the information would be blatantly contrary to the child’s best interests.

1.44 The CROC appears to interpret the CRC as bestowing a clear right to donor-conceived children to knowledge of their genetic identity. However, no convincing research been done to indicate that the enforcement of such a right is as beneficial for donor-conceived children.

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18 Article 3

1. 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.
2. States Parties undertake to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her, and, to this end, shall take all appropriate legislative and administrative measures.
3. States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision.

19 UN CROC Concluding Observations of the Committee on the Rights of the Child: Denmark, UN Doc. CRC/C/15/Add.33 (Feb. 15, 1995); UN CROC, Concluding Observations of the Committee on the Rights of the Child: Norway, UN Doc. CRC/C/15/Add.23 (Apr. 25, 1994); UN CROC, Concluding Observations of the Committee on the Rights of the Child: United Kingdom of Great Britain and Northern Ireland, CRC/C/15/Add.188 (Oct. 9, 2002)
as it is for adopted children\textsuperscript{20}. Additionally, if children have a right to know their genetic origins, then from a Hohfeldian perspective, a corresponding duty should rest on the parent or the state to inform the child\textsuperscript{21}. That specific right appears to be lacking in the framework of the CRC.

1.45 Neither Article 7 nor Article 8 settles the issue of which among the child’s interests should prevail in case of conflict between the child’s interest to know his or her origins and his or her other interests. Nor do they provide any criteria as to how to balance the child’s interests with those of others in case of conflict.

1.46 Thus the provisions of the CRC relating explicitly to the child’s identity do not directly offer any protection to the child’s individual identity.

1.47 Moreover, the preamble to the CRC appears to envisage a social family, which succours the inner psychological sense of well-being of a donor-conceived child. It refers to the fact that countries that have ratified the CRC have accepted the obligations that the CRC imposes on States to take account of the significance of traditional and cultural family values “for the protection and harmonious development of the child”\textsuperscript{22}. The well-being of the child would thus appear to be the main object of the CRC, rather than a bald focus on the child’s right to identity, although the two concepts are clearly linked. Furthermore, Article 20\textsuperscript{23} states that, when children are deprived of their family environment, whether or not it be for their own best interest, “due regard shall be paid to the desirability of continuity in a child’s upbringing and to the child’s ethnic, religious, cultural and linguistic background.”\textsuperscript{24}

\textsuperscript{20} Ilke Turkmendag et al., The Removal of Donor Anonymity in the UK: The Silencing of Claims by Would-Be Parents, 22 INT’L J.L. POL’Y & FAM. (2008). At 290 they say that most studies are in the context of adopted children and that the ones that are specific to donor offspring are methodologically flawed.

\textsuperscript{21} See generally Wesley Newcomb Hohfeld, Fundamental Legal Conceptions As Applied In Judicial Reasoning And other Legal Essays (Walter Wheeler Cook ed., 1919) (presenting Hohfeld’s perspective that every right should have a correlative duty, a perspective that has dominated much of the jurisprudential discussion of rights).

\textsuperscript{22} CRC article 43(1), 20 November 1989, 1577, UNTS 3 and article 18(2) of the CRC

\textsuperscript{23} Article 20

1. A child temporarily or permanently deprived of his or her family environment, or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the State.

2. States Parties shall in accordance with their national laws ensure alternative care for such a child.

3. Such care could include, inter alia, foster placement, kafalah of Islamic law, adoption or if necessary placement in suitable institutions for the care of children. When considering solutions, due regard shall be paid to the desirability of continuity in a child’s upbringing and to the child’s ethnic, religious, cultural and linguistic background.

\textsuperscript{24} CRC article 43(1), 20 November 1989, 1577, UNTS 3 and article 20. Children who cannot be looked after by their own family have a right to special care and must be looked after properly by people who respect their ethnic group, religion, culture, and language.
1.48 Finally, Article 5 of the CRC states that States Parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the CRC.\textsuperscript{25}

1.49 Overall it would appear that, despite the interpretation of the CROC, the formulation of the CRC is in fact open-ended and can accommodate interpretations such as a child’s socio-legal parentage, religious, and cultural identities. Other human rights documents in the United Nations framework and substantive provisions of the CRC further that interpretation\textsuperscript{26}.

\textsuperscript{25} Article 5
States Parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention.

Brigette Clark says that Article 5 of the CRC provides that governments should respect the rights and responsibilities of families to direct and guide their children so that, as they grow, they learn to use their rights properly. Helping children to understand their rights does not mean pushing them to make choices with consequences that they are too young to handle. Article 5 encourages parents to deal with rights issues "in a manner consistent with the evolving capacities of the child." The CRC does not take responsibility for children away from their parents and give more authority to governments. It does, however, place on governments the responsibility to protect and assist families in fulfilling their essential role as nurturers of children.

\textsuperscript{26} Council of Eur. Comm. of Experts on Family Law, Report on Principles Concerning the Establishment and Legal Consequences of Parentage – “The White Paper,” at 7 (Nov. 15, 2006), available at http://www.coe.int/t/dghl/standardsetting/family/CJ-FA_2006_4e%20Revised%20White%20Paper.pdf. This White Paper “reflect[s] a balance between ‘the biological truth’, reflecting primarily biological and genetic parentage, and ‘the social parenthood’, reflecting . . . with whom the child is living and who is taking care of him or her.” The commentary specifically states that, in certain situations, the child’s best interests may justify withholding information regarding his or her origins. The Council of Europe Ad Hoc Committee of Experts on Progress in the Biomedical Sciences affirms that donor anonymity should be maintained more generally, but certain exceptions should permit the child access to donor information. Council of Eur. Ad Hoc Comm. of Experts on Progress in the Biomedical Sci., Report on Human Artificial Procreation (1989), available at http://www.coe.int/t/dg3/healthbioethic/source/PMAprinciplesCAHBI1989_en.doc (affirming Principle 28 of the White Paper that donor anonymity should be maintained). The health of the child is mentioned as a factor that could require a waiver of donor anonymity, but there is no indication of who should disclose the identifying information to the child in these circumstances.
CHAPTER 2
ASSISTED REPRODUCTIVE TECHNOLOGY

2.1 What is Assisted Reproductive Technology

2.1 In 2009, the World Health Organization (WHO) joined with the International Committee for Monitoring Assisted Reproductive Technologies (ICMART) and other partners to develop a Glossary of definitions for infertility and fertility care. This Glossary included the clinical definition for infertility as “a disease of the reproductive system defined by the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse.” This is in keeping with WHO definition of male and female infertility in the International Classification of Diseases (ICD 10). Infertility in women was ranked the 5th highest serious global disability (among populations under the age of 60).

2.2 Assisted Reproductive Technology (ART) involves several types of medical treatment designed to result in pregnancy. Types of ART include in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), embryo cryopreservation, egg or embryo donation, and gestational carriers.

2.3 In vitro fertilization is a highly sophisticated, meticulously timed procedure, which involves removing a ripened egg or eggs from the female's ovary, fertilizing it with semen, incubating the dividing cells in a laboratory dish and then replacing the developing embryo in the uterus at the appropriate time. The success and availability of IVF has raised the hopes of many infertile couples who have not been able to conceive because of infertility associated with not only blocked or absent fallopian tubes but also male infertility and many other causes.

2.4 Preparing for an IVF Cycle

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Before the first cycle a physician will do a semen analysis on the male and a trial or mock embryo transfer. This involves passing a catheter through the cervix into the uterus to determine its path through the cervix and to measure the distance to the top of the uterine cavity. IVF is generally preceded by the use of ovulation-stimulating drugs to increase the number of mature eggs that can be retrieved. The process of IVF usually includes ovulation induction, egg retrieval and embryo transfer.

**After an IVF Cycle**

2.5 Gamete Intrafallopian Transfer (GIFT)

In this ART procedure fertilization takes place in the fallopian tube. GIFT should only be performed when sperm level is adequate and at least one fallopian tube is open and functional. The steps involved in GIFT are similar to IVF up to the point of egg retrieval. Egg retrieval is usually performed under general anaesthesia, and the eggs and sperm are immediately transferred into a catheter that is used to place the eggs and sperm into the fallopian tube during a laparoscopy. Unlike IVF, there is no ability to document fertilization or to evaluate embryo quality in a GIFT procedure.

2.6 Zygote Intrafallopian Transfer (ZIFT)

ZIFT is a combination of IVF and GIFT: A fertilized egg is transferred into the fallopian tubes. Fertilization takes place in a laboratory, and the zygotes (newly fertilized eggs) are transferred into the fallopian tubes at the time of laparoscopy. With ZIFT, fertilization is documented, but evaluation of the dividing embryo is not possible.

2.1.1 Who uses Assisted Reproductive Technology

2.7 ARTs sometimes require the use of reproductive resources (sperm, eggs or wombs) from third parties who are not expected to play a role in raising the resulting child. ARTs are increasingly sought by those who cannot reproduce using only their own genetic and biological capacities. Heterosexual and same-sex couples and single women and men who seek to have biologically connected children frequently turn to clinics and agencies for donors who provide sperm, eggs or gestational services. Medically assisted reproduction using third parties (‘collaborative’ reproduction) is widely accepted in many countries. While
collaborative reproduction mostly involves individuals unknown by the recipients, some couples prefer the use of a known third party. This party may be either unrelated (e.g. a friend) or related (a family member). This latter strategy, termed intrafamilial medically assisted reproduction, raises various ethical issues and is especially controversial. Most intra-family donation involves intra-generational donation between siblings or cousins, most commonly egg donation between sisters or sisters-in-law. Less frequently there is intergenerational donation: usually father to son, daughter to mother or niece to aunt. There is little data on the prevalence of intra-family donation.

2.8 Gestational surrogacy is typically employed by heterosexual couples in which the woman can produce her own eggs but cannot carry a pregnancy to term. The couple contract with a woman to carry the foetus formed from their gametes. In traditional surrogacy, some heterosexual couples, single men or gay male couples achieve parenthood using the services of a woman who provides both genes and gestation and then surrenders the baby upon birth to those who intend to raise the child. A traditional surrogate is the child’s biological mother because it was her egg that was fertilized by the father’s sperm.

2.1.2 South African Law Prohibits Disclosure

2.9 In South Africa, the National Health Act 61 of 2003 and the Regulations Relating to Artificial Fertilisation of Persons, 2012 govern artificial fertilization. The law prohibits disclosure of donor and recipient identities. The identity of the donor shall remain anonymous and the commissioning person or parents have no right to learn the identity of the donor or solicit donor-identifying information from any other source. The donor shall also be free from any responsibility to the biological offspring produced by his or her gamete. Section 60 of the National Health Act 61 of 2003 prohibits donors from selling organs or tissue and therefore the donor is only entitled to have his or her expenses covered.

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31 According to the Regulations ‘artificial fertilisation’ means the introduction by other than natural means of a male gamete or gametes into the internal reproductive organs of a female person for the purpose of human reproduction and includes artificial insemination, in vitro fertilisation, gamete intrallopian tube transfer, embryo intrafallopian transfer or intracytoplasmic sperm injection.
32 Regulation 19 provides: Prohibition of Disclosure of certain facts
   No person shall disclose the identity of any person who donated a gamete or received a gamete, or any matter related to the artificial fertilisation of such gametes, or reproduction resulting from such artificial fertilisation except where a law provides otherwise or a court so orders.
33 60 Payment in connection with the importation, acquisition or supply of tissue, blood, blood products or gametes
   (1) No person, except-
2.2 Questioning the Ethical Justifications that May Ground a Right to Know

2.10 Inmaculada de Melo-Martin (Melo-Martín) is a professor of medical ethics in the Division of Medical Ethics, Weill Cornell Medical College and she wrote as follows:

The demand for gametes, and especially for eggs, has been increasing worldwide, in part because of delayed childbearing in the developed world. In 2009, donor eggs or embryos were used in approximately 12 percent of all ART cycles performed. Gamete donation can be useful for men and women with a variety of fertility problems, such as low sperm count, premature ovarian failure, or ovarian failure due to cancer treatment. It is also helpful for couples who are at risk of passing on a serious genetic disorder if they conceive using their own gametes.

Currently, the vast majority of gamete donations worldwide are done anonymously, and in some countries, including Spain, France, and Denmark, the anonymity of donors is explicitly protected by law. Nonetheless, a growing number of countries


35 Gametes are an organism’s reproductive cells. They are also referred to as sex cells. Female gametes are called ova or egg cells, and male gametes are called sperm. Gametes are haploid cells, and each cell carries only one copy of each chromosome. Accessed from http://www.nature.com/scitable/definition/gamete-gametes-311

have called into question the morality of such practices and are enacting laws allowing children access to identifying information about their gamete donor.\(^{37}\)

Sweden, Austria, the Australian State of Victoria, Switzerland, The Netherlands, Norway, The United Kingdom, New Zealand, and Finland now mandate that donors be identifiable to their genetic offspring. Non-anonymous gamete donation is also taking hold in some jurisdictions in North America. In 2011, the Supreme Court of British Columbia banned anonymous gamete donation,\(^{38}\) and Washington State recently passed legislation allowing donor-conceived children to have access to a donor's identifying information unless the donor explicitly elects not to disclose the information.\(^{39}\)

A significant reason for the growing legislative support for non-anonymous gamete donations is the belief that donor-conceived children have a fundamental moral right to know their genetic origins and that the right should be legally protected by policies that prohibit anonymous donations.\(^{40}\) Often, however, this right is assumed rather than explicitly justified. Of course, the presumed right to know one's genetic origin is not new. It has been used as grounds to promote openness in adoption records.

Nonetheless, a variety of factors, such as the increasing number of children born by means of gamete donation, advances in genetic science and technology that make it easy to discover the identity of a person's genetic parents, and the widespread belief that genetic information is important for protecting people's health, have made this alleged right quite salient, even leading some to challenge the ethical appropriateness of gamete donation practices altogether.\(^{41}\)


\(^{40}\) M. Cowden, “‘No Harm, No Foul’: A Child’s Right to Know Their Genetic Parents,” *International Journal of Law, Policy and the Family* 26 (2012): 102-26; N. R. Cahn, Test Tube Families: Why the Fertility Market Needs Legal Regulation (New York: New York University Press, 2009); J. D. Velleman, “Family History,” *Philosophical Papers* 34 (2005): 357-78. My concern here is with a moral right, rather than a legal one. I take recent legislative changes in several countries and states prohibiting anonymous gamete donations as legal attempts to protect this moral right. I will not discuss here, however, whether such attempts are successful. Rather, my concern is with the ethical grounds for such a moral right. In what follows, I will simply use “right” to refer to the moral right to know one's genetic origins.

2.11 Professor de Melo-Martín states that her concern is with a moral right rather than a legal one. She takes recent legislative changes in several countries prohibiting anonymous gamete donations as legal attempts to protect a moral right and her concern is with the ethical grounds for such a moral right. In what follows, “right” will refer to the moral right to know one’s genetic origins.

2.12 Professor de Melo-Martín calls into question the ethical justifications that are often thought to ground a right to know one’s genetic origins and states that different ethical theories lead to different justifications for rights nonetheless many would agree that at least one important function of rights is to protect some weighty human interest which makes an important contribution to well-being or flourishing.

2.13 She refers to proponents of a right to know one’s genetic origins as rights proponents and says that they usually argue that such a right protects at least three vital interests: the interest of donor-conceived people in having strong family relationships, their health interests, and their interest in forming a healthy identity.

2.14 These different interests might be protected by different aspects of the right to know one’s genetic origins: knowing one’s mode of conception, accessing medically relevant information and accessing identifying information about one’s genetic parents.

2.15 Professor de Melo-Martín discusses each of these interests and explores whether and how these interests might be set back by an individual's lack of access to information about his or her genetic parentage. She also evaluates whether donor anonymity policies are, as many of their opponents argue, morally impermissible because they fail to protect these important interests.

### 2.2.1 An Interest in Strong Family Relationships

2.16 Proponents of a right to know one’s genetic origins argue that donor conceived individuals have a vital interest in strong family relationships and that this interest is set back by the secrecy that often accompanies donor conception.

2.17 In one study, evidence about rates of disclosure in families that conceived a child with a gamete donation show that despite a shift in professional attitudes toward openness, at age
seven, about half of the children conceived by egg donation and nearly three-quarters of those conceived by donor insemination had not been told about their mode of conception\textsuperscript{42}.

Single and lesbian mothers have been found to have higher rates of disclosure than heterosexual couples because of the need to explain the absence of a father in the home\textsuperscript{43}.

2.18 Strong family relationships are necessary for the psychological and social development that allows children to become independent adults. Rights proponents contend that withholding the truth about donor-conceived children’s mode of conception is likely to have negative consequences on family relationships\textsuperscript{44}.

2.19 They argue that this nondisclosure and related secrecy can produce family tensions, anxiety, loneliness, stress-related symptoms, and self-doubt. Secrecy about a child’s origin, rights proponents insist, hinders active parent-child communication, undermines trust, creates unnecessary estrangements and promotes distance and suspicion\textsuperscript{45}.

2.20 Evidence suggests that those who use gamete donation usually tell a family member or friend\textsuperscript{46}, and rights proponents claim that it could be traumatic for a child to learn about the gamete donation from someone other than his or her parent.

2.21 They argue that discovering the existence of accidentally discovering about the gamete donation can cause irreparable damage to trust within the family. Few would deny that people have a vital interest in strong family relationships. It is not clear, however, that disclosing an individual’s mode of conception is necessary to protect this interest. The evidence is ambiguous.

2.22 Some studies have found that families that had disclosed show lower levels of parent-child conflict than families that had not\textsuperscript{47}. Others have found that secrecy can affect family relationships in various ways, for example, conflict, cohesion, or emotional expressiveness\textsuperscript{48}.


2.23 Other studies have suggested a correlation between accidental disclosures and strained relationships or mistrust within rearing families.\textsuperscript{49}

2.24 Nonetheless, other studies have shown that lack of disclosure seems to have no negative effects on children’s psychological well-being or on family relationships in general.\textsuperscript{50}

2.25 Of those studies that have found some differences in the level of conflict between disclosing and non-disclosing families, for instance, the evidence showed that such differences represented especially positive ratings in the disclosing group rather than dysfunctional relationships in the non-disclosing families.\textsuperscript{51}

2.26 Even in those studies in which secrecy negatively affected family relationships, donor-conceived children rated family functioning as moderately high.\textsuperscript{52}

2.27 And some studies found, contrary to expectations, that children who knew the circumstances of their birth show greater adjustment difficulties.\textsuperscript{53}

2.28 Moreover, some studies indicate that the conceptualization of family secrets that is typical of literature on donor conception may offer an impoverished image of the complexity of what happens in families that fail to tell their children that they are donor conceived.\textsuperscript{54}

2.29 Literature by rights proponents often depicts the keeping of family secrets as a categorically problematic activity that has negative effects on family relationships. However, some auto-ethnographical studies present a more empathic and compassionate view of


\textsuperscript{52} M. S. Paul and R. Berger, “Topic Avoidance.”

\textsuperscript{53} S. Golombk et al., “Children Born through Reproductive Donation.”

secret holders, one that is more attuned to people's vulnerability and that reveals understanding and acceptance of those who have kept secrets\textsuperscript{55}.

2.30 Indeed, some evidence suggests that the categories of “secrecy” and “openness” might be inadequate when considering families with gamete-conceived children, as many parents engage in different levels of openness about their child’s conception, both with their child and with family and friends\textsuperscript{56}.

2.31 In this more complex picture of how secrecy functions in the context of donor conception, disclosure is not obviously necessary to protect donor-conceived individuals’ interest in strong family relationships. Rights proponents might still argue that secrecy is impermissible on deontological grounds, but this claim, too, needs defence. It is not clear that secrets are prima facie wrong or even that all secrets are in need of justification\textsuperscript{57}.

2.32 Secrets can protect important aspects of human life, even when they can also invite abuse. Indeed, rights proponents are not proposing an end to all family secrets, or even to all secrets that relate to mode of conception. For instance, there has been little effort to argue that people born through in vitro fertilization or other reproductive technologies have a right to know how they were conceived. And this is the case in spite of the fact that parents who use IVF often do not disclose the mode of conception to their children and have concerns about disclosure\textsuperscript{58}, which suggests that they would have some anxiety and other stress-related symptoms that could negatively affect family relationships. Similarly, it would be implausible to suggest that parents have a duty to reveal all personal information about their relationships that might have affected their children’s coming into being.

2.33 If secrecy about gamete donation is wrong, then, it has to be wrong because of something particular to this context. But that argument is hard to make, especially when one considers the importance normally given to parental autonomy in making decisions that affect children’s welfare. If it is not clear that nondisclosure harms children’s interests in strong family relationships and if secret-keeping in general has not been shown to be prima facie


wrong, then giving parents the power to decide whether and when to disclose the use of a donor seems consistent with the value that we assign to parental autonomy.

2.34 Professor de Melo-Martín states that the arguments presented should in no way be taken to endorse nondisclosure or secrecy but that these arguments simply show that failing to disclose does not seem to affect people’s interests in strong family relationships and thus promoting such interests does not necessitate disclosure. There might be many other reasons why parents should be encouraged to disclose.

2.35 Anonymity policies do not mandate nondisclosure and many parents who have used anonymous gamete donations do disclose this fact to their children. Thus, even if donor-conceived children have a right to know this information, anonymous gamete donations are not inconsistent with disclosure. Furthermore, some evidence suggests that there are no differences in plans to inform a child based on the use of a known or an anonymous donor\textsuperscript{59}, and the rates of disclosure do not seem to be different in countries with and without anonymity\textsuperscript{60}.

2.36 Anonymity policies might still pose a threat to donor-conceived individuals’ interest in strong family relationships. If and when they learn of the donation, they might want to know the donor’s identity and anonymity policies create barriers to access such information. But there are problems with this objection.

2.37 First, it seems that if disclosing the mode of conception in the context of anonymity seriously disrupts family relationships, then that fact might be an argument against disclosure rather than against anonymity policies. This would be the case particularly if lack of disclosure does not negatively affect family relationships.

2.38 Second, there is no evidence that family functioning has been damaged when disclosure has occurred but anonymity remains\textsuperscript{61}.


2.2.2 Health Interests

2.39 Rights proponents have also argued that the access of donor-conceived individuals to health information about their donors is necessary to protect their vital interests. Genetic, environmental, and lifestyle factors influence the development of most common diseases affecting human beings. Since these factors are often shared by family members, a family medical history has the potential to provide information that illuminates a person’s risk of getting common diseases such as diabetes, stroke, cancer, and heart disease.

2.40 Arguably, therefore, having knowledge of one’s family medical history is important for making informed decisions about one’s health. Similarly, appropriate information about family medical history can lead to the use of adequate screening measures and to early treatment\textsuperscript{62}. Evidence also suggests that health advice tailored to an individual’s familial risk can motivate healthy behaviours\textsuperscript{63}.

2.41 Rights proponents contend that donor-conceived individuals who do not have access to genetic information about their donors are denied the benefits of a more complete family medical history and, thus, of information necessary to make informed decisions about their health. But even though donor-conceived people do not share their genetic make-up with both of the rearing parents, they certainly can share cultural and behavioural factors, such as lifestyle and nutritional habits. Thus, even when donor-conceived individuals might lack access to the donor’s genetic information, to the extent that the clinical utility of family medical history is grounded on environmental factors, their health interests are in no way set back, as they can obviously access information about their family’s culture and behaviour.

2.42 Notwithstanding the relevance of cultural and behavioural factors in health, family medical history can offer crucial information related to genetic factors. For instance, it can play an important role in identifying patients who may benefit from predictive genetic testing\textsuperscript{64}. And information about highly penetrant genetic mutations, such as those responsible for Huntington’s disease and some forms of breast cancer, can be crucial to a person’s health interests. Knowledge of family medical history can also be central to


determining who might benefit from genetic testing or how to properly interpret genetic test results.

2.43 Studies have shown the clinical utility of family history for identifying persons with particular genetic syndromes or illnesses, such as hereditary breast and ovarian cancers.65

2.44 Some evidence suggests that information about family medical history also seems useful for the assessment of risk for some common diseases in which genetic factors play a less clear role, such as most cases of diabetes, cardiovascular disease and mental health disorders.66

2.45 Nonetheless, there are several problems with the claim that access to a donor’s medical history is necessary to safeguard the person’s interest in health.

2.46 First, the role that knowledge about heritable factors plays in promoting health might be overstated. Even if people had accurate information about their genetic relatives, there is not sufficient evidence to conclude that access to family-history improves risk prediction, changes people’s risk perceptions and leads to better health outcomes.67

2.47 Risk perceptions appear to be relatively resistant to change even when individuals have detailed information about elevated disease risk based on family history.68 Indeed, knowledge of genetic risk, even if the knowledge is the result of genetic testing and not just of hearing a family history, seems to have little effect on people’s health-related behaviours.69

2.48 Moreover, if knowledge of genetic risks were important for health outcomes, the so-called revolution in personalized or precision medicine aims to give individuals the ability to have their own genome sequenced and analysed, thus providing them information about

relevant genetic risks without the need for access to genetic information about their progenitors\textsuperscript{70}.

2.49 Second, clearly many parents either lack or fail to disclose relevant health information to their genetically related children. People generally believe that their family history is important, but few collect health information from their relatives to develop a family history\textsuperscript{71}.

2.50 People often lack relevant details about their relatives’ health history or fail to recall pertinent information. Moreover, because some diseases have stigmatizing consequences, parents might choose not to disclose information about them to their genetic children. Furthermore, although primary care providers often report high rates of collecting family medical histories, evidence from practice suggests that a thorough exploration of a family history may be more the exception than the rule in adult primary care\textsuperscript{72}. And when that history is collected, studies show that it is not collected appropriately\textsuperscript{73}.

2.51 This is not to argue that because people often are misinformed or lack sufficient information about their family history, failing to disclose relevant health information to donor-conceived individuals would be acceptable. Rather, it is to point out the apparent dearth of strong evidence indicating that people who are uninformed or even misinformed about their family medical history are adversely affected by their lack of knowledge.

2.52 Of course, that dearth might be the result of inadequate collection practices or insufficient scientific knowledge. If at some point the evidence indicates that having accurate information about a family medical history is necessary to protect one’s health interests, then this would count as an important reason to ensure that donor-conceived individuals have access to it.

2.53 However, donor-conceived individuals might be negatively affected not simply because they lack access to genetic information from a progenitor but because they mistakenly


believe that their rearing parents are also their biological parents and so are mistaken about their own medical history.

2.54 This mistake can lead to misdiagnoses and can cause donor-conceived people to fail to take steps that might promote their health or not to seek medical help when they should. Nevertheless, as mentioned earlier, anonymity policies do not mandate nondisclosure and seem to have no effect on whether parents disclose.

2.55 Additionally, although current practices are variable, gamete donors usually undergo genetic screening for a significant number of heritable diseases and are also routinely asked to provide extensive information about their family medical history.

2.56 Even when anonymity is enforced, parents of donor-conceived children are given access to this information when selecting a donor, and they are free to give that information to their children.

2.57 It might be that better methods need to be implemented to ensure updated donor medical information that might be relevant to donor-conceived individuals. But such strategies can be implemented in ways that maintain anonymity without necessarily hindering donor-conceived children’s health interests.

2.58 Thus, anonymity polices do not seem to thwart the health interests of donor-conceived persons.

2.2.3 An Interest in Forging an Identity

2.59 Those who defend a right to know one’s genetic origins have also argued that donor-conceived people have a vital interest in forging healthy identities and that access to the identity of the donor is necessary to protect their interest. In this view, knowing one’s genetic origins is necessary to appropriately understand oneself.

2.60 Access to the identity of the genetic Progenitors is also thought to be necessary to help make sense of one’s talents, interests, or physical characteristics. It gives context to

questions about family resemblance. It also can help foster a sense of belonging and a connection with the past, a sense of continuity. Thus, lacking information about where certain traits come from, and lacking access to a context that provides evidence of or helps clarify family resemblance, is said to hinder donor-conceived children’s project of self-understanding.\(^7\)

2.61 According to these rights proponents, to the extent that personal identity requires at least some degree of self-understanding, a lack of access to genetic relatedness information will contribute to donor-conceived individuals having a defective sense of identity.

2.62 Rights proponents often use reports by donor-conceived or adopted persons who do not have identifying information about their genetic parents to support claims about the difficulties donor-conceived people face in their project of self-understanding and identity formation.\(^6\) These reports indicate that at least some donor-conceived individuals have feelings of a loss of identity, a sense that they lack understanding of who they really are and how they fit in the world. Indeed, some commentators have argued that donor-conceived people who do not know their genetic parents suffer from “genealogical bewilderment.”\(^7\)

2.63 Having access to the elements necessary for forging a healthy identity is quite clearly a vital human interest. If access to identifying information about one’s genetic parents is indeed necessary for healthy identity formation, then this would constitute a strong reason against both nondisclosure and anonymous donations and in favour of giving donor-conceived individuals access to information about their genetic origins. There are, however, several problems with these claims.

2.64 First, the role of genetics in constituting personal identity is highly contested.\(^7\) Professor de Melo-Martín says that she think that we can acknowledge that genetic relatedness, in one way or another, informs most people’s self-understanding and sense of identity. It is also true that the emphasis culture places on family resemblances (normally


\(^{77}\) N. R. Cahn, “Test Tube Families.”

understood as holding among genetically related family members) can make the process of self-understanding more challenging for individuals who lack information about their genetic progenitors. But many people who lack access to this information still have perfectly healthy identities. Indeed, as work on relational theories of the self illustrates, personal identity cannot be disentangled from contingent facts about the social, historical, and physical circumstances of the self and from the interrelatedness between the self and various others.  

2.65 In this theoretical approach, many kinds of relational properties will be important aspects of self-understanding and identity formation. Self-knowledge and the development of personal identity are dependent on interpersonal relations with others. Genetic relatedness can play a role in the construction of the self, but the role that it plays can be different for different people and at different times.

2.66 Second, although some anecdotal evidence indicates that at least some donor-conceived individuals are distressed by the lack of identifying information about their genetic parents, there is no robust empirical evidence showing that donor-conceived children on the whole suffer "genealogical bewilderment." On the contrary, several studies investigating donor-conceived children's social and emotional development have shown no significant differences in socio-emotional adjustment between donor-conceived children and those naturally conceived. This is not to say that no donor-conceived child suffers from a lack of access to identifying information about the donors. It is simply to point out that the evidence does not support the claim that such information is necessary for forging healthy identities.

2.67 Third, even if many donor-conceived people had a very strong interest in knowing their genetic origin and suffered when they lack that knowledge, depriving children of such information would still not be shown wrong. People have all kinds of interests that we would be reluctant to say must be satisfied. Unless one presupposes—problematically—that knowledge about genetic parentage is necessary to develop healthy identities, then it does not seem that the legitimate interest of donor-conceived people in identity formation is thwarted by lacking such knowledge.


2.68 Arguably, that interest depends chiefly on social conditions—such as education, opportunities for meaningful work, love, and civic participation—and there are no reasons to believe that donor-conceived individuals who lack information about their genetic parents are deprived of these conditions.  

2.69 The interest that rights proponents want to protect is not an interest in developing a healthy identity but an interest in developing a particular kind of identity, one that conforms to culturally dominant narratives. But, it is not at all obvious that we ought to satisfy one’s interest in a particular identity.

2.70 One must presuppose the importance of genetics in order to argue that any identity-related distress suffered by donor-conceived people is caused by a lack of information about their genetic origins. If this presupposition is called into question, the cause might be, not the lack of information, but the fact that lacking such information is thought to be a problem in the first place.

2.71 In a social context where information about genetic parentage is presumed necessary for identity formation, those who lack such knowledge might indeed have serious difficulties forging a healthy sense of self. It might then certainly be true that access to information could relieve the suffering of donor-conceived individuals. But deemphasizing the value of genetic information could also accomplish this.

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81 S. Haslanger, “Family, Ancestry and Self.”
83 K. Leighton, “Addressing the Harms of Not Knowing One’s Heredity.”
2.2.4 The Special Significance of Genetic Information

2.72 If the arguments here are correct, knowledge about one’s genetic origins has not been shown necessary for protecting donor-conceived people’s interests in thriving family relationships, health, and the forging of an appropriate sense of self. Thus, insofar as a right to know one’s genetic parentage is grounded on the need to safeguard such interests, the extant defences of this right are problematic.

2.73 A further challenge for rights proponents, however, is that the arguments offered on behalf of the right might actually contribute to some of the harms that the right is intended to prevent. Whether or not those who defend this right presuppose a belief in genetic essentialism (that is, the tendency to reduce the self in all of its complexity to genes), the defence of a right to know one’s genetic origins imbue genetic information with a very special significance. To argue that this right is simply a way to ensure that donor-conceived individuals have a chance to assess the importance of this information for themselves does not counter this.

2.74 There are all kinds of information that people might benefit from being able to assess, but which no one argues has to be given to them, as a matter of moral or legal right. It is precisely because genetic information is thought to be of particular relevance that one might believe that access to this information is of fundamental value. A defence of a right to know one’s genetic parentage thus presupposes the particular significance of genetic information for people’s lives. Given the increasing emphasis on the idea that genetics can explain all kinds of things about human beings, stressing the importance of genetic information might well promote problematic beliefs about genetic essentialism.

2.75 Emphasizing the importance of genetic information might also have the effect of pathologizing individuals who lack access to information about their genetic parentage. Because they seem to lack something presumed essential to advance weighty benefits, they could be stigmatized and considered in need of some psychological attention. And if they have no interest in finding this information, they might be thought of as suffering from some pathological deviation, insofar as they fail to conform to the going views about what is important for their well-being. Indeed, the question that is often presented as evidence for the

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importance of access to information about the donors—“who would not want to know their biological origins?”—betrays this pathologizing effect.

2.76 Emphasizing the importance of genetic relationships might also encourage problematic beliefs about the superiority of biological families. Presumably, these are the families where children’s interests in nurturing relationships, health, and identity formation are best protected. After all, children in these families know who their genetic parents are, have access to more information that allows them to acquire self-understanding, and can easily gain at least some knowledge about their risks for diseases with genetic bases. If emphasizing the importance of genetic information has the effect of idealizing the biological family, then it may actually undermine the interests of donor-conceived individuals. Even when information about the donors is available, families that depend on gamete donation are unlikely ever to measure up to the biological family.

2.77 An uncritical, even if implicit, support of the biological family as the ideal makes any family that does not conform to this ideal into a pathological deviation that requires adjustment. Insofar as proponents of this right fail to question the moral value of heredity, they are at least complicit in supporting a normative ideological framework that calls for critical evaluation.

2.78 Of course, donor anonymity and secrecy might be morally problematic for reasons other than those discussed here, which are the usual grounds for defending a right to know one’s genetic origins. The arguments presented here have attempted to problematize that presumed right. Some of the interests that this right is intended to protect—strong family relationships and health—can be recognized as weighty ones, but there is no evidence that they are set back by anonymous gamete donations.

2.79 Anonymous donations do not prevent parents from disclosing the mode of conception to donor-conceived offspring. Similarly, allowing for anonymous donation is not inconsistent with giving those individuals access to relevant health information. Furthermore, the evidence that failing to disclose one’s mode of conception adversely affects these interests is at best ambiguous and at worst non-existent.

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2.80 Anonymous donations prevent donor-conceived individuals from gaining access to identifying information about their donors. This constraint does not thwart a vital interest in forming a healthy identity; it might threaten an interest in developing a particular identity, but the moral weightiness of an interest in forging a particular identity is questionable. Because of the privileging of genetic relationships presupposed by a defence of a right to know one’s genetic origins, the defence could have negative effects on the well-being of donor-conceived people and their families.

2.81 Overemphasizing genetic connections might not be the best way to ensure the well-being of non-biological families. Indeed, if genetic connections were not imbued with such significance, then perhaps parents would be less reluctant to disclose that gametes were donated and to reveal whatever information was available about the donor.

### 2.2.5 Summary

2.82 Professor de Melo-Martín believes that the case for a right to know one’s genetic origins requires more substantiation than has so far been provided and questions the argument for this alleged right but also provides a counterargument. She argues that claiming the existence of such a right can actually contribute to the harms that the right is intended to prevent.

2.83 Vardit Ravitsky\(^7\) writes that Professor Melo-Martín deconstructs the interests the right to know one’s genetic origins is supposed to protect and argues that these interests are not set back or thwarted when one has no access to one’s genetic origins and that the basis of Melo-Martín’s argument is that we lack robust empirical evidence that donor-conceived individuals suffer certain alleged harms and, that even when such harms are present, they do not provide strong enough justification to ground the right.

2.84 Ravitsky is of the opinion that the research on the needs, preferences, and well-being of donor-conceived individuals is scant and that we lack robust empirical evidence regarding all aspects of donor conception. Ravitsky argues, however, that the right to know one’s genetic origins does not rest on empirical evidence. Some donor-conceived individuals who are unable to know their genetic origins may suffer great harms. Others may suffer no harm at all. For some, being donor-conceived may be an important element in the formation of

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their identities, narratives, and relationships. Others may find it irrelevant or insignificant. But Ravitsky states that all are treated wrongly when they are deprived of the ability to access information about their genetic origins.

2.3 Arguments in favour of Non-Anonymous Gamete Donation

2.85 In her article titled *No Harm, No Foul: A Child's Right to Know their Genetic Parents*\(^\text{88}\), Mhairi Cowden\(^\text{89}\) discusses the findings of the 2011 Australian Senate, Legal, and Constitutional Affairs References Committee report on donor conception practices in Australia (hereinafter Senate Inquiry Report), which recommended that there be separate but uniform legislation across Australia in this regard. The Senate Committee's recommendations, taken with the respective legislation of the States and Territories of Australia, indicate strong support for non-anonymous donation throughout Australia, based on a child's right to know their genetic parents.

2.86 Cowden motivates why a child has a right to know his or her genetic parents. In order to explain why a child has a right to know their genetic parents, Cowden argues that one must not only show why it is important that a child, once knowing they are donor-conceived, has access to information regarding their donor, but also why it is important that children are told of the nature of their conception in the first place.

2.87 Cowden considers the three main reasons cited in support of a child's right to know their genetic parents: the importance of genetic and medical history, the risk of consanguinity, and psychological harm.

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\(^\text{89}\) Dr Mhairi Cowden is an Assistant Principal Policy Officer in the Department of Premier and Cabinet of Western Australia. She was awarded her doctorate entitled ‘Do Children Have Rights? Five theoretical perspectives on children's rights’ from the Australian National University in 2012. She is interested in how children's rights can be constructed and the way in which they can assist us when approaching new policy problems such as the rights of children conceived using new reproductive technologies. She is a National Committee member of the Australian chapter of Defence for Children International and an Associate of the Children's Policy Centre in the Crawford School of Public Policy, Australian National University
2.3.1 Genetic and Medical History

2.88 People have an interest in accessing genetic and medical information about their genetic parents. It is in a child's interests to have knowledge of congenital diseases or traits that run in his or her genetic family. This is important for diagnosing and treating diseases, and also for making fully informed family-planning decisions. False assumptions regarding one's medical history can lead to an individual being misdiagnosed, unknowingly forgoing important care or undergoing unnecessary treatment. This concern seems to constitute an interest worthy of protection.

2.89 However, even if this interest is of sufficient importance to ground a right, the duty it produces would not necessarily entail knowing one's donor. This interest can be protected without revealing identifying information about the donor. Indeed, information about the donor's medical and genetic history is already released to the families of most donor-conceived individuals before the treatment begins. Clinicians often consider that they have met reasonable demands about genetic histories by the careful screening of potential donors for a great variety of heritable diseases and characteristics. For example, the Californian Cryobank provides a quarterly catalogue of donors detailing information from blood type, medical history to hair colour and the highest education level attained. In Australia, the social parents are allowed access to the medical and genetic history of the donor, while still being denied identifying information (NHMRC Guidelines)\(^{90}\). Even if this non-identifying information had not been previously provided or an unexpected situation arose whereby genetic testing of the donor was needed, this could be done without revealing the donor's identity.

2.90 One's interest in genetic and medical history can ground a right to non-identifying information, but it is not clear why this interest would be sufficient to allow children access to identifying information and to know their genetic parents. This interest would be most appropriately protected by building more detailed donor profiles rather than revealing the donor's identity. The comprehensive genetic screening undertaken by clinics is usually far more detailed than an individual's own knowledge of their family health history. Therefore, the child's claim to the genetic and medical history of their genetic parents cannot alone be the basis for identifying information about one's genetic parents.

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2.3.2 Consanguinity

2.91 Many donor-conceived children are concerned about the risk of unknowingly forming a sexual relationship with their genetic half-sibling. Consanguineous relationships can increase the risk of serious genetic disease in resultant children. If consanguineous couples do have children, they should undertake genetic counselling and screening, a process that most couples will only undertake if they are aware they are consanguineous. In addition, consanguinity may have adverse legal consequences. In Australia, the Marriage Act 1961 (Cth) states that marriage is void when it is between a half-brother and -sister (Commonwealth of Australia, Subsection 23(2)). However, the chances of a consanguineous relationship occurring seems to be very low yet this remains a real concern for donor-conceived individuals as noted by another witness:

[i]t is not just the issue of consanguineous relationships, which are statistically unlikely; it is the psychological impact on the child who, for a fellow, will be wondering about every girl he sees, "Is she my half-sister?"

2.92 Yet if we take this as a legitimate interest, albeit one based in being psychologically secure rather than statistical importance, again there exist many ways to address this concern without providing donor-conceived children with the identity of their donor.

2.93 There are limits to the number of families that may receive gametes from a single donor. This restriction is designed to reduce the statistical possibility of individuals forming consanguineous relationships, although there has been some criticism about inconsistent enforcement of these limits. Yet even if limits on the number of families to whom donors can donate prove ineffective, other steps can be taken to address these concerns. In the UK, long before the removal of anonymity, donor-conceived individuals could contact the Human Fertilisation and Embryology Authority and request information about whether their prospective partner is a genetic relation. The Authority would then check the register and let the donor-conceived individual know without revealing the identity of the donor.

2.94 Given the statistical rarity of consanguineous relationships and the fact that they can be prevented by revealing non-identifying information regarding the relation between two donor-conceived individuals, this interest does not seem sufficient to ground a right to access identifying information about one’s genetic parents. It cannot ground a child’s right to know their genetic parents.
2.3.3 Psychological Harm

2.95 The most persuasive basis for a child's right to know their genetic parents is that lack of access to identifying information about an individual's donor can lead to psychological harm. Most donor-conceived children report a feeling of loss of identity, and what has been termed 'genealogical bewilderment' when they are not allowed access to identifying information regarding their genetic parents.

2.96 'Who we are is partly inherited -- it is the beginning of our life story, knowing our history helps to understand who we are' (Parentlink91, 2011).

2.97 For many donor-conceived children, the importance of knowing their donor does not lie in issues of medical history or consanguinity, but rather in a deeper understanding of who they are and where they sit in the world in relation to others. One witness told the Australian senate inquiry:

   I cannot begin to describe how dehumanizing and powerless I am to know that the name and details about my biological father and my entire paternal family sit somewhere in a filing cabinet ... with no means to access it. Information about own family, my roots, my identity. (Senate Inquiry Report, 2011, 77)

2.98 Another man, conceived by donated gametes in the 1970's, described the feelings and trauma he had lived with his whole life:

   After having children of my own and holding them in my arms, I came to realize what my conception had truly deprived me of. I had lost kinship, my heritage, my identity and my health history. This realization was crushing, depressing and immensely painful ... the consequences of my conception had profound implications and affected me deeply without my even knowing it, and it is something that will negatively impact on me for the rest of my life. Every day I have to get up and look at a face in the mirror that I do not know. As a teenager, I struggled constantly with my sense of self and identity. (Senate Hansard, November 2010)

2.99 The first study of adult donor-conceived individuals found a diversity of negative experience resulting from not knowing their genetic parents. Participants reported feelings of 'genetic discontinuity', shock, deceit, mistrust of family, abandonment by donor and practitioners, frustration, and loss due to lack of information. The evidence is growing that

91 www.parentlink.act.gov.au
access to identifying information regarding one's genetic parents is essential to a child's mental health.

2.100 Cowden states that unlike concerns about medical and genetic history or consanguinity, one's interest in being free from psychological harm cannot be remedied by non-identifying information about the donor. The very harm arises from a lack of knowledge about the donor's identity. Providing identifying information will allow donor-conceived individuals the opportunity to place a name, a face, and a person in a space that was once empty. It allows individuals the opportunity to contact and know their donor, to complete their family history, and to fulfil their own sense of identity. Many donor-conceived individuals, having been presented with the opportunity to contact their donor, have reported a sense of fulfilment, contentedness, and even enrichment in the new family relationships they have formed (Senate Inquiry Report, 2011: 78-80). It seems, therefore, that for these donor offspring, 'non-identifying' information might not be sufficient to meet their identity needs.

2.101 Therefore, the interest in being free from psychological harm seems to present the most convincing argument that an individual has a right not only to information about their donor's medical and genetic history or about who they might be related to but also to information about who their donor actually is.

a. No Harm, No Foul

2.102 If the child is never told that they were donor-conceived, then they are saved from any psychological damage, or 'genealogical bewilderment', that may arise from the knowledge that the people who have raised them are not their genetic relations. 'No harm, no foul'!

2.103 Why does a child have a right to know they are donor-conceived if such knowledge will cause them harm and being unaware of this knowledge will protect them from such harm? It seems that the no harm, no foul rule presents a strong argument against openness in cases such as these.

2.104 If the right to know one's genetic parents is grounded solely in one's interest in being free from psychological harm, then the availability of the total non-disclosure option seems to render the right nugatory. Social parents may point to the no harm, no foul principle, and argue that they can protect the child by keeping the nature of their conception a secret,
rather than disclosing the donor's identity. Even though a child may have a legal right to access identifying information about their donor, they will not know that this information even exists unless they are first told by their parents that they are donor-conceived.

2.105 Therefore, in order to continue to support the notion that donor-conceived children have a right to know their genetic parents, Cowden argues that we must find some way to overcome the no harm, no foul principle and show that children also have a claim to be told the nature of their conception.

2.106 Cowden presents two arguments that may support the right to know, independently of traditional notions of harming. First is the argument that children have a claim to be told the truth because they have an interest in not being exposed to the risk of harm in non-disclosure, and second that disclosing the truth about the nature of the child's conception is a form of respectful behaviour towards the child, and that the child has an interest in being treated with respect.

2.107 The risk of harm, as opposed to harm itself, may offer a credible grounding for a child's interest in being told the truth about their genetic origins. The risk of a donor-conceived child finding out about their conception from someone else is quite high. Not only is the risk of harm high but also the gravity of the potential harm increases as the child becomes older and is not told of their genetic origins. Children who are told early have neutral or positive responses. In order to reduce the risk of harm, children should not need to be 'told' of their conception; rather they should simply always have known and should grow up with this knowledge rather than be told in a way that makes it seem unusual. Individuals who are told later in life are far more likely to report feelings of stress and psychological trauma.

2.108 Similarly, we may say that non-disclosure is likely to cause harm later if the donor-conceived individual discovers the truth; therefore, we should prohibit non-disclosure. This may give us good reasons to engage in truth-telling behaviour, but it does not explain why the donor-conceived individual has a right to know of the nature of their conception.

2.109 While the risk of harm argument may provide strong moral imperatives to tell the truth, it seems insufficient to explain why an individual has a valid claim to know the nature of their conception. And, perhaps most importantly, the risk of harm does not seem to properly capture what donor-conceived individuals themselves are expressing. Many people have
said that even if they never found out, they still think they had a right to know and that somehow they would have been wronged. In order to properly establish an individual's right to know the nature of their conception, we need a claim that exists even when there is no risk of the child being told.

b. Truth and Respect

2.110 The stories told by donor-conceived children place considerable emphasis on the element of deceit and lack of respect associated with non-disclosure. This seems to more closely reflect the wrong that donor-conceived individuals believe has been done even if they would never discover the deception. Children, therefore, may have a right to be told about their genetic origins not because of the potential harm of not telling, or the preventing of harm in not telling, but because deception of this nature constitutes a wrong in that it violates the respect owed to that child.

2.111 Consider the example of 'pure' rape (Gardner and Shute, 2000)92. Pure rape is a case where a victim is raped but is not aware that it has happened: she may have been drugged at the time, is left with no physical injuries and because of her lack of knowledge of the act, suffers no psychological harm. In this case is the act of rape wrong? Gardner and Shute argue that this case in fact isolates the core wrong of rape, stripping it of the associated harms that usually accompany it. Rape is wrong, according to them, because it involves treating the woman as something other than a person; it constitutes treating her as a thing. Therefore, harmless acts can still be seen as wrongs.

2.112 Cowden believes the same is true for the donor conception. By focusing on the case where the child does not know she is donor-conceived, we can isolate the wrong without the distractions of collateral harms.

2.113 'Respect' captures this sense of 'wrongness' that is independent of the consequences of the individual finding out about the nature of their conception. Respect is a mark of status owed to someone. Recognition of this value is expressed through behaviour towards the subject of respect. Darwall93 identifies two types of respect: the first is 'recognition respect' that is owed to members of a class simply and solely in virtue of their possession of some qualifying feature. This kind of respect is of a fixed and determinate kind. The other form of

respect, 'appraisal respect', is respect that derives from a positive evaluation of persons or things by some standard. Importantly for our purposes, recognition respect restricts the type of morally permissible actions one can take towards the object of respect.

2.114 It is recognition respect that is relevant to this argument; we owe the child respect not because of their life achievements but because of their status as a subject worthy of respect. Truth telling is a form of respectful behaviour and therefore the individual child has a claim, based in respect, to know the truth about their conception. Eekelaar\textsuperscript{94} too has argued that disclosure consists of respect as it empowers children with information that is incapable of manipulation by adults. Some commentators have pointed out that children may not be due the same type of respect as adults. This is because often the property that gives an individual the relevant status is that of autonomy or rational decision making. Children, it is argued, do not have this property. In this sense, they are unable to form rational preferences and pursue them. Without this essential element of autonomy, children are not due recognition respect.

2.115 There are a number of responses to this objection. First, it may be that we owe respect not to the child, but to the adult that child will become. Feinberg\textsuperscript{95} constructs a category of rights called 'rights-in-trust' whereby the child holds rights in trust for the future adult, who will be a rational, autonomous agent. Therefore, we owe a duty to tell the truth of the nature of the conception to the child because this is a form of behaviour respectful towards the autonomy of the adult the child will develop into.

2.116 There are a number of problems with constructing rights in trust, including metaphysical concerns regarding predictions of the autonomy of the future adult. However, one way to demonstrate that respect is owed to the child now vis-à-vis the adult they will become is to consider the case of a terminally ill-child\textsuperscript{96}. Does a child who is going to die in 5 years have the same claim to be told the nature of their conception? It seems that a 5-year-old child who is not told of their true genetic origins and who dies not knowing (and who was always going to die before becoming a fully autonomous agent) has been wronged in the same way as we think adult donor-conceived individuals have.

2.117 The wrong seems caught up somehow in the individual's identity. We need not insist that the essential property of respect is autonomy. Although recognition respect is binary


rather than scalar (unlike appraisal respect), the concept may admit different bases for recognition. For example, one can have recognition respect for the law by virtue of it being the law, or recognition respect for nature. Recognition respect could also encompass respect for persons who hold their own identity. Children certainly form a sense of identity from a very early age. Children can understand that their social parents are important to them and who they are -- how they sit in relation to the rest of the world. Children in their middle childhood become increasingly aware of biology as an underlying characteristic of family relations, and also rapidly begin to express greater curiosity about their origins. For these reasons, children are due the same kind of respect as adults -- as persons with a sense of identity. Failing to tell the truth about a child's genetic origins is therefore a morally impermissible action as it fails to respect that child's status as an identity-holding entity.

2.118 Cowden states it is worth noting that just as the second right bolsters the strength of the first, the reverse is also true. If the second right, to know identifying information about one's donor, is based purely on harm, then does it cover a child's right to know the 'true' identity of the donor? For example, a child may be told they are donor-conceived, and their donor may in fact be a famous mass-murderer. At the time he donated his sperm, the donor seemed a respectable young man but a few years later he was uncovered and sentenced to a life in prison in a very public trial. Clearly, telling the child the truth would harm them; is it therefore permissible in this case to lie? Cowden argues not, because a child's right to be told the truth regarding the nature of their conception (grounded in respect) encompasses a right to be told the truth about the identity of their donor. So even though the right to identifying information regarding one's donor is primarily based in harm, it too is bolstered by the claim to be treated with respect.

2.119 From the above analysis, it is clear that the child's right to know their genetic parents must be comprised of two distinct claims:

1) a child's right to be told about the nature of their conception based on their interest in being treated with respect and
2) a child's right to access identifying information regarding their donor based on their interest in being free from psychological harm.

c. Legal Prohibition on Non-disclosure

2.120 Cowden examines whether these claims create only moral duties, or whether they are sufficient to support legal prohibition on non-disclosure and legal entitlement to access identifying information. She argues that the claim regarding donor conception can move from a weak moral claim into a strong legal right in three distinct ways.

2.121 Firstly, the first claim to disclosure is necessary in order to protect and enable the second stronger claim to access of identifying information. One cannot know that one has a right to access identifying information about one's genetic parents unless one is first told that one was donor-conceived. Therefore, the first weaker claim becomes a necessary part of the stronger second claim, for if we want to enable individuals to access their legislated right to identifying information then we must ensure that they are aware of the relevant facts.

2.122 Second, the first claim is also necessary to protect the concerns regarding medical and genetic history and consanguinity. Although these two concerns are inadequate to ground a right to identifying information, they may very well stand on their own, producing duties to gain access to genetic and medical non-identifying information and non-identifying information about one's siblings. Disclosure regarding the nature of one's conception is necessary to realise these additional interests. These additional interests of the child support a claim that donor-conceived children have a right to be told the truth regarding the nature of their conception.

2.123 Finally, and perhaps most importantly, the claim is distinct and of greater significance than other children's claims to disclosure, because of the involvement of the state. Unlike private individuals who conceive a child and then conceal its paternity, the state is involved in the creation and conception of donor-conceived children.

2.124 State intervention can exist through legislation, regulation, and funding. This is may be due to the state funding research into ART, providing reproductive health care treatment including ART, medical aid schemes cover reproductive health care treatment, regulation clinics and physicians, legislation existing which covers ART.

2.125 Therefore, it may be that the state is complicit in the deception of children conceived using donated gametes through state-funded medical procedures and conducted at state-regulated clinics, if it does not take steps to ensure disclosure. This would arguably constitute unconscionable action by the state.
2.126 The state's involvement in the conception of donor-conceived children causes it to acquire duties towards them that it does not hold to children at large.

d. Decrease in Donors

2.127 In legislating a right, governments must also consider wider public policy considerations. Turkmendag\textsuperscript{98} argue that legislating a child's rights to know fails to take into account the rights of the would-be-parents. The removal of anonymity, it is argued, causes a drastic drop in the rate of gamete donation therefore infringing the would-be-parent's right to conceive. This argument seems to have much resonance throughout the debate; however, it is unclear that there is any evidence supporting it. Donation rates initially slumped in Sweden but have risen again and in Victoria, Australia but furthermore there is clear evidence that the rate of donations has not dropped in the UK since removing anonymity, in fact the number of first-time donors has actually increased (Human Fertilisation and Embryology Authority, 2011). Even if there was a shortage in gamete donations, there is a strong argument that this outcome is more acceptable than knowingly creating individuals who will never be able to know their genetic parents and therefore be subject to the psychological harm especially when it is unclear on what basis would-be-parents claim a right to procreate that creates a duty to assist in the process, rather than a duty simply not to interfere.

2.3.4 Summary

2.128 Cowden states that these combined arguments, but especially that of state involvement, demonstrates that a child's right to disclosure not only creates moral duties in their social parents but also imposes two distinct duties on the state to use its legislative power. First, the state should ensure that donor-conceived children are aware of their status and nature of their conception; and secondly it should allow donor-conceived children access to identifying information regarding their donor. These would correspond to legal rights in each donor-conceived individual. However, it is important to recognise that the framing the legal rights in this way does not mean that the state has a duty to ensure that the donor forms a relationship with the donor-conceived child. Once the child has access to the

information, the state cannot force the donor to interact with the child. The law 'may be able to destroy human relationships; but it does not have the power to compel them to develop’

2.129 Cowden argues that in order for a child to have a right to know their genetic parents, we must first overcome the principle of no harm, no foul. The no harm, no foul principle cannot be easily overcome by reference to traditional ideas of harm. However, she argues that children should be informed of the nature of their conception, based on their right to be treated with respect. Truth telling is a form of respectful behaviour related to the importance of identity to an individual. Once we have shown that no harm, no foul does not apply, it follows that the child's right to know their genetic parents is comprised of two distinct claims:

(i) the right to access identifying information regarding one's donor based on one's claim to be free from psychological harm arising from lack of access to identifying information; and
(ii) the right to be told about the nature of one's conception based on one's claim to respect as an identity-holding individual.

2.130 The existence of this additional and separate claim to disclosure regarding the nature of one's conception produces new duties within the state as unlike the case of other naturally conceived children, governments are directly involved in the process of donor conception through legislation, regulation, and funding.

2.131 Cowden argues that there are ways in which the counties can ensure disclosure, such as annotating birth certificates, notifying the child directly or mandating counselling to couples who receive state assistance. She does not examine which approach would be best and indicates that this is a project for future research, however she states that it is clear that a child's right to know their biological parents must encompass a right to be told about their genetic origins because a harmless action may yet still constitute a foul.

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2.4 Other Views

2.132 Cahn and Kramer, assert that it is quite simply not ‘fair to deny children the knowledge of their genetic origins.

2.133 Many worry about accidental incest between offspring who do not know that they are genetically related to each other, an issue raised as early as 1984 by the Warnock Committee in the United Kingdom.

2.134 In opposition to arguments about mandatory identification systems for sperm donors (such as that suggested by Cahn), Cohen argues that a market system, where intending parents can select the type of donor they want and donors can decide what kind of donor they want to be, allows both stake holders more options, maximizes ‘their own welfare and life plans’ and furthers the interest of both parties.

2.135 Further, Cohen argues that if a central organizing principle of family law is children's welfare or best interests, a ‘prohibition on sperm-donor anonymity cannot be justified simply by concerns of “harm” to children because the regulation would “protect” these particular children out of existence. In effect, Cohen argues that regulations would constrain the range of possibilities for reproduction by limiting who provides gametes and excluding intending parents who might not be willing to reproduce if donor identity were mandated.


103 I. Glenn Cohen, Rethinking Sperm-Donor Anonymity: Of Changed Selves, Non-Identity, and One-Night Stands, 100 GEORGETOWN LAW J. 431 (2012)

104 In addition to donors who are known by the recipients from conception, the two options offered are identity-release when the offspring turn 18 and anonymous. For a description of identity-release, see Joanna E. Scheib, Maura Riordan & Susan Rubin, Choosing Identity-Release Sperm Donors: The Parents’ Perspective 13–18 Years Later, 18 HUM. REPROD. 1115 (2003).

105 Cohen, supra 64 at 434

106 Cohen, supra 64 at 436

107 See also Gaia Bernstein, Regulating Reproductive Technologies: Timing, Uncertainty and Donor Anonymity, 90 BOSTON UNIV. LAW REV. 1189 (2010). Bernstein cautions that banning anonymous donors leads to increased inequalities and furthers commodification.
2.136 Finally, Cohen argues that if donor-conceived children have the right to know their genetic origins, all children should be extended the same right rather than creating a ‘reproductive-technology exceptionalism’.108

2.137 Those who support anonymity make additional arguments as well. They express concern about the donors’ rights to privacy, the donors’ status as ‘non-parents’, and the human right of intended parents to form a family without excessive state intervention; they also express concern about whether there will be a sufficient number of donors if donors are required to register as is the case in the United Kingdom.109 110

2.138 Further, they argue that the law adequately covers reproductive technology, for example, in the United States, through federal and state provisions which focus on safety and other aspects of consumer protection such as the screening of donors for diseases such as HIV and genetic anomalies is routine practice.111 In addition, fertility providers are required to report to the health authority which publishes a yearly report about every clinic and their IVF success rates.112

2.139 Regulation 7 of the Regulations Relating to Artificial Fertilisation, 2012 details the prerequisites for removal or withdrawal of gametes113 and regulation 16 provides that all births

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108 Cohen, supra 64 at 445
110 To date the arguments for and against mandatory registries for donors rarely discuss these issues as they relate to egg- or embryo-conceived families and it is not clear whether these arguments can be extended to include these other gamete users or whether stakeholders feel the same way about egg and embryo donation as they do sperm donation. Virginia Bolton et al., A Comparative Study of Attitudes Towards Donor Insemination and Egg Donation in Recipients, Potential Donors and the Public, 12 J. PSYCHOSOM. OBSTET. GYNECOL. 217 (1991).
112 ERTMAN, supra note 70 at 39.
113 7 Prerequisites for removal or withdrawal of gametes

A competent person who intends to remove or withdraw a gamete, or cause a gamete to be removed or withdrawn from the body of a gamete donor, shall, before such removal or withdrawal-
delivered as a result of artificial fertilisation shall be recorded by the person in charge of the facility where such delivery has taken place, into the central data bank within 3 months of such birth.\textsuperscript{114}

2.140 In the United States, about two-thirds of states have adopted the Uniform Parentage Act (UPA), which establishes paternity and maternity of minor children born to married and unmarried couples. The 1973 version provided protection to sperm donors in cases where a mother sued them for child support by stating that any man that ‘gives his sperm to a physician for purposes of artificially inseminating someone other than his wife is not the legal father of the child borne out of that insemination.’\textsuperscript{115} Some states have tailored the UPA to

\hspace{1cm}(a) ensure that if a gamete donor file has not previously been opened in respect of that gamete donor, open such a file, to which a unique identification number shall be allocated in respect of the gamete donor;

\hspace{1cm}(b) ensure that the information obtained in paragraph (a) is submitted to the central data bank;

\hspace{1cm}(c) in the case of a known donor, ascertain from the central data bank that not more than six children have been conceived through the artificial fertilisation of a person with the gametes of that gamete donor;

\hspace{1cm}(d) obtain a signed statement from the gamete donor stating whether the gamete donor has previously made a donation of gametes and, if so, where and when that donation of gametes took place;

\hspace{1cm}(e) obtain informed consent from the gamete donor relating to-

\hspace{1.5cm}(i) physical examination and questioning by a competent person;

\hspace{1.5cm}(ii) the removal or withdrawal a gamete for testing, analysing or other processing as the competent person may deem necessary;

\hspace{1.5cm}(iii) particulars contemplated in regulation 8(1)(a)(ii), (iii) and (iv), (b), (c) and (f) being made available to the recipient and the competent person who is to perform the artificial fertilisation;

\hspace{1.5cm}(iv) to particulars contemplated in regulation 8(2)(c) being made available to the Director-General; and

\hspace{1.5cm}(v) to particulars contemplated in regulation 8(2)(c) being submitted to the central data bank;

\hspace{1cm}(f) ascertain the age of the gamete donor;

\hspace{1cm}(g) ascertain that the gamete donor has on two occasions, not more than three months apart and one month prior to that donation of gametes, undergone-

\hspace{2cm}(i) medical tests for sexually transmissible diseases; and

\hspace{2cm}(ii) a semen analysis, in the case of a male gamete donor;

\hspace{1cm}(h) ascertain that in the case of a female gamete donor, the donor has undergone a gynaecological examination prior to stimulation for the withdrawal of gametes;

\hspace{1cm}(i) question such gamete donor concerning her or his family history, especially with regard to any possible genetic condition or carrier status and mental illness in respect of any child, brother, sister, parent or grandparent of such gamete donor; and

\hspace{1cm}(j) shall, in the event of a request in respect of which the donor and recipient are known to each other, ensure that there is-

\hspace{2cm}(i) written confirmation by both parties that they known [sic] each other;

\hspace{2cm}(ii) psychological evaluation of both parties.

\textsuperscript{116} 16 Reporting of births

\hspace{1cm}(1)(a) All births delivered as a result of artificial fertilisation shall be recorded by the person in charge of the facility where such delivery has taken place, into the central data bank within 3 months of such birth.

\hspace{1cm}(b) The mother who gives birth shall ensure that the competent person who effected the artificial fertilisation of or embryo transfer is informed of such birth and recording of the information referred to in subregulation (2), within 30 days of such birth.

\hspace{1cm}(2) The information recorded in terms of subregulation (1) shall include, but not be limited to:

\hspace{2cm}(a) confirmation of birth;

\hspace{2cm}(b) the unique identification number referred to in regulation 11(a); and

\hspace{2cm}(c) any genetic disorder or birth defect in the child.

remove the requirement of physician involvement and to extend protection to women who are not married.

2.141 Ertman\textsuperscript{116} argues that case law generally recognizes freedom of contract for alternative insemination unless the genetic parents conceive through coitus or the genetic father is brought into the picture through some social practice. In short, those opposed to bans on anonymity argue from the position that sufficient regulations are in place to protect all three stakeholders.

### 2.4.1 Studies

2.142 Research on donor-conceived offspring has suggested that those who come from heterosexual families are less comfortable altogether with the idea of donor conception than are those who come from lesbian families; other research suggests that there is not a single idea about, or attitude toward, anonymity even for those from lesbian families.

2.143 Studies do suggest that offspring who find out late in life about their donor conception are particularly disturbed by that knowledge. Recent research on offspring views them as key stakeholders who want to end anonymity.

2.144 The research on parents who are raising children conceived with the use of donated gametes is even more diverse. VanFraussen \textit{et al} found that the majority of lesbian parents wanted the donor to remain anonymous and that they felt this way more strongly than did their children.

2.145 In a study of 144 couples who received counselling about oocyte donation in Brussels, more than two-thirds preferred known donation, a response motivated by fears of the unknown origin of genetic material and the trust recipients had in the donor they had selected.

2.146 An interest in preserving sharp boundaries between the donors and the recipients was a primary motivation for wanting to maintain anonymity among those who preferred anonymity. One study has found that parents who have relied on sperm donations are more in favour of anonymity than are those who have relied on egg donations.

\textsuperscript{116} Ertman, supra note 70, at 48, 59.
2.4.2 Attitude of Gamete Donors

2.147 Studies have also explored the attitudes of gamete donors. One study found that, although sperm donors generally support sharing non-identifying information, the majority of sperm donors would resist having their identity known to the recipient and, eventually, the child.

2.148 A study in Australia found that donors who were under 26 or over 46 years of age and who were either single or living in a same-sex relationship were most likely to be willing to be identified to their children.117

2.4.3 Methodology

2.149 In spite of these indications of attitudes, no research has asked the same questions (at essentially the same time) of all three stakeholders in order to provide a precise comparison of their orientations toward the issue of anonymity and the issue of limits on number of offspring who can be born from a single donor.

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117 Riggs & Laura Russell, Characteristics of Men Willing to Act as Sperm Donors In the Context of Identity-Release Legislation, 26 HUM. REPROD. 266 (2011)
2.5 How Existing Relationships and Practical Considerations Influence Decisions on Disclosure

2.150 In her article titled *The Drive for Openness in Donor Conception: Disclosure and The Trouble with Real Life*¹¹⁸, Petra Nordqvist¹¹⁹ discusses how existing relationships impact on parents' decision of whether or not to disclose donor conception.

2.151 She writes that the implementation on 1 April 2005, in the United Kingdom, of the Human Fertilisation and Embryology Authority (Disclosure of Donor Information) Regulations 2004 was an important marker of the shift from secrecy of donor conception towards the removal of donor anonymity. Children conceived in clinics after this date are able to access identifying details about their donor when reaching maturity. The shift has been further consolidated through the Human Fertilisation and Embryology Authority's *Code of Practice*, which now states that parents should be encouraged to be open with their children about their genetic background (Human Fertilisation and Embryology Authority, 2012). The UK policy is thus now similar to that of other countries which support openness, such as Sweden, Norway, Austria, and New Zealand¹²⁰.

2.152 Whereas openness is now supported in policy, the issue might be less of a 'done deal' for parents themselves as evidence suggests that many still hesitate to disclose. This has caused concern among policy-makers and campaigners, putting parents under increasing pressure to tell. In this context it is important to seek to better understand parents' experiences, and why it is that some might feel uncertain about openness.

2.153 In 2009 in the UK, it was found that 43 per cent of mothers and 56 per cent of fathers of embryo conceived children were intending to keep the facts around the embryo donation a

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¹¹⁹ Dr Petra Nordqvist joined the Sociology and the Morgan Centre for the Study of Relationships and Personal Life at the University of Manchester in the 2009. She had previously studied both Sociology and Gender Studies as an undergraduate and postgraduate student at the University of Lund, Sweden, and also at the University of York, UK. She completed her PhD at the Centre for Women's Studies, University of York in 2009, and in this she explored lesbian couples' experiences of becoming and being parents using donor insemination. She joined the University of Manchester in 2009 and, in March 2013, she completed the Economic and Social Research Council funded research project 'Relative Strangers: Negotiating Non-genetic Kinship in the Context of Assisted Conception' together with Prof Carol Smart. Since April 2013, she holds hold a lectureship in Sociology at the University.

In 2003 comparable findings were made in the context of egg donation. Similar findings have been made in Sweden, where donor identity release has existed since 1985. In a study from 1998 Gottlieb and Lindblad found that 52 per cent of parents had informed, or where intending to tell, their children about their conception. The figures were slightly higher in a follow up study from 2004. Although small, these studies indicate that a significant proportion of parents do not make, or intend to make, their children aware of being donor conceived, which means in turn that they later on are not able to benefit from information being made available about their donor through the new policy.

The policy focus on openness, at least in the UK, is situated in a broader social context in which the role of openness or secrecy in family life has become the subject of heated discussions where secrecy has become associated with preventing children from ‘knowing who they are’ and from ‘having an identity’.

In 2013, the Nuffield Council on Bioethics launched their report *Donor conception: ethical aspects of information disclosure*, which highlighted the importance of relationships in the context of donor conception and spoke of ‘interests’ rather than children’s ‘rights’ to know. This message was perceived as deeply problematic in some camps as there is a powerful moral sentiment building around the need for donor-conceived children to know their genetic origin, underpinned by the idea that they might otherwise suffer harm.

Among policy-makers and campaigners, in the UK and elsewhere, there is thus a growing anxiety about children being ‘kept in the dark’ about their origins, unable to exercise

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their ‘right to know’. This adds up to a situation in which parents are now under considerable pressure to share information with their children, which, as will clear from what follows below, means sharing information more broadly as well.

2.157 Parents who choose not to disclose may be seen as problematic or out of step with modern and ethical thinking. In this context, it is very important to seek to better understand the context in which parents operate and why it is that they may hesitate to share information.

2.158 One way to explore this question would of be to interview those parents who are more secretive, but some answers might be found by looking at the experiences of parents who seek to be open.

2.159 Nordqvist draws on evidence from a sociological study into the impact of donor conception on family relationships conducted at the University of Manchester, which involved both lesbian and heterosexual parents, as well as grandparents, of donor conceived children, and in which the majority of the parents believed in openness. She shows that these parents however soon found that translating the idea of openness into practice was not as straightforward as they might have thought. Rather, it was discovered that openness could lead to a series of dilemmas in personal life.

2.160 She explores four areas which raised difficult quandaries: decisions about disclosure and the issue of family boundaries; sharing information with the child; sharing information with the wider family; and moral dimensions embedded in the idea of disclosure and so how to share information in the ‘right way’.

2.5.1 Genetic Relationships and Family Relationships in Broader Context

2.161 The gene and the perceived implication of genetic connections for the formation of personal identity are central to the contemporary emphasis on disclosure. This is part of a broader cultural and social ‘turn’ in which genetic thinking is gaining currency more widely (and in which genetics have become a major way of understanding human life. Human behaviour and characteristics are increasingly perceived to be ‘explained’ by a person’s ‘genetic makeup’. This way of thinking is giving way to a deterministic view of human life, where ‘who we are’ and ‘what we become’ is perceived as explained by our genes. The idea
that our genes are of vital importance for who we are is now embedded in cultural notions about what shapes human identity. This is where we find the notion that a person ‘needs to know’ his or her genetic background in order to know ‘who they are’ which has become central to debates in the field of both adoption and donor conception.

2.162 Genetic thinking has also greatly impacted on cultural perceptions of meaningful family relationships. Millbank\textsuperscript{129} indicates that a pervasive shift has taken place in policy and family law towards prioritizing biological links. The development of DNA testing is of importance here because the ease with which such tests can be conducted has radically altered the management of disputes in families because DNA tests are perceived to offer the irrefutable truth about the ‘real’ family relationships. This is significant because DNA testing technology operates in a framework in which the revelation of genetic truths is perceived to benefit any child whose genetic parentage might be in question, and children are also perceived to have the ‘right’ to know about their genetic parentage. Revealing the genetic truth in families and ensuring that social family relationships map onto genetic ones is perceived as necessarily a positive thing for family relationships. Similar developments have taken place in the context of lesbian motherhood legal disputes and Millbank shows that biological parentage is deemed to trump the social relationship between a non-biological mother and a child, despite the non-birth mother’s involvement in planning and caring for a child previously. Thus, biological or genetic parenthood has become a guiding principle for assessing worthwhile family relationships in courts.

2.163 However, real life experiences of family life calls into question the overriding assumption that genetic relationships trump social ones. Smart\textsuperscript{130} discusses the issue with reference to the British case \textit{Re H}\textsuperscript{131}. An 11-year-old boy lived with his (presumed) paternal grandmother, a brother and a cousin. Along came a stranger, who presented himself as the boy’s (true) genetic father. The man applied to the court for residence and contact orders and he wanted to perform a DNA test to prove his paternity with the intent of removing the boy from his de facto family and raise him as his son. The boy expressed with utmost clarity that he did not want any testing to take place; the truth might jeopardize the relationships he had with his grandmother, brother and cousin.


\textsuperscript{131} [1996] 3 FCR 201
2.164 Smart argues that:

The tendency for public policy, with its enthusiasm for DNA testing, to assume that (genetic) truth is better than (relational) fiction means that the addition of more genetic kin through these means is inevitably seen as producing a positive outcome for children (and possibly for adults). Yet children live in relationships that are delicately interconnected and adding more relatives may disrupt or even break some of these links (Smart, 2010: 409).

2.165 This example indicates that any genetic discoveries need to be balanced against the social aspects embedded in ‘being’ and ‘doing’ family life. If we prioritize genetic relations over social ones, we also risk squeezing the practice of relating out of the picture. This is not to say that genetic connections are of no consequence to family life, but rather that they need to be balanced alongside other meaningful dimensions that impact on how family relationships are conducted.

2.166 The concept ‘relationality’ is useful here because it offers a view on family relationships that highlights the need to take into account the subtle, intricate, and interlinked worlds in which families operate and analyse the reasoning, actions, and experiences of the actors of these worlds. It allows us to see that family relationships are imbued with subtle layers of meaning which take shape over time, through the ongoing (explicit and implicit) negotiations of family members.

2.5.2 The Study

2.167 Nordqvist undertook conducted a study together with Carol Smart132, ‘Relative strangers: Negotiating non-genetic kinship in the context of assisted conception’ which was funded by the UK Economic and Social Research Council 2010–2013 (RES 062 23 2810). This study considered donor conception and non-genetic kinship within the context of wider

132 See www.manchester.ac.uk/research/Carol.Smart. Carol Smart studied sociology at Portsmouth Polytechnic (now University) before going on to get her MA in Criminology at Sheffield University and her PhD in Socio-Legal Studies also at Sheffield in 1983. Before coming to Manchester in 2005 she was Professor of Sociology at the University of Leeds (from 1992) and before that she was Lecturer and then Senior Lecturer in Sociology at the University of Warwick (1985–92). At Manchester she was Co-Director of the Morgan Centre for Research into Everyday Life until she retired in 2014. In 2009 Carol was awarded an honorary doctorate of Law from the University of Kent and in 2011 she was elected as Fellow to the Academy of Social Science.
family relationships. It was based on interviews with 22 heterosexual parents and 22 lesbian parents of donor conceived children and additionally 30 interviews with grandparents.

2.168 In total they collected data from interviews with 74 families, with a total of 119 individuals taking part in couple or individual interviews. They conducted 34 couple interviews and 10 individual interviews with parents (total number of parents 78) and 11 couple interviews and 19 individual interviews with grandparents (total number 41). In order not to risk inadvertently conveying sensitive information to family members, they interviewed parents and grandparents from different families. All names, places, and identifying details were anonymized.

2.169 Recruitment and fieldwork took place in England and Wales in 2011. They recruited parents who conceived using donor conception around or after 1995 when the shift towards openness started to gain momentum in the UK, but also included some outliers for comparison. Most of their recruits came through the Donor Conception Network and local Lesbian Mums groups. The grandparents, who were a particularly hard-to-reach sample, were recruited through parents of donor-conceived children (who were not themselves taking part) and through our own networks.

2.170 Among the 74 families represented, 54 had children through sperm donation, 16 egg donation, 3 embryo donation and 1 through both sperm and embryo donation (a lesbian couple who had one child through sperm donation and who were expecting a sibling through embryo donation). The total number of donor-conceived children amounted to 111 (including five pregnancies at the time of data collection due in 2011). The majority of the children had been conceived using licensed UK clinics (69 per cent), but couples had also used clinics abroad, self-arranged sperm donation and accessed Internet company providers of donor sperm available for a while during the 2000s. The median age of the donor conceived children at the time of the interview was 3 years old, the median age of the parents was 41 and of the grandparents 68.

2.171 The interviewees lived in both rural and urban locations in England and Wales, with particular concentration in Greater London and Manchester. Ninety of the 119 participants were women. About 99 (83 per cent) identified as White British and 13 identified as White European, American or Australian; four as mixed British and three as Asian. Over half of the

133 Since 2007 Internet sperm providers can no longer operate in the UK without a licence from the Human Fertilisation and Embryology Authority
interviewees (53 per cent) identified as atheist or agnostic; 40 per cent were of Christian faiths and 5 per cent were Jewish while no one of Muslim faith came forward to be interviewed. About 78 per cent of the parent generation had gone on to higher education which compared with the general population of women giving birth in Britain gives a broad indication that the parent group that we interviewed were disproportionately middle class. The demographic constitution of the sample is likely to have shaped the data in significant ways, not least because religion and ethnicity are important factors shaping perceptions of infertility and donation\textsuperscript{134}.

2.5.3 Decisions about Openness and Family Boundaries

2.172 Who makes decisions about openness and how that is shaped by the perceived boundaries of the family. In and of itself, gamete donation creates links between the parents, the child, and the donor, in other words a family constellation that goes beyond cultural understandings of what a family looks like. When couples access donor sperm or eggs from unknown donors, or donors with identity release (usually through reproductive health clinics), the link to the donor is severed in order to ensure that the parents are able to raise the child ‘as their own’ without any interference from the donor. This means that the unusual network of relations that donor conception gives rise to is to a significant degree circumvented; and on the surface, the family can ‘pass’ as a conventional one. This is the kind of family by donation that features predominantly in the debates about disclosure, a debate which focuses on parents as those making decisions about disclosure.

2.173 It is of particular importance to consider how known donor relationships alter the framework within which families operate. One illustrative example of a family from the study with a known donor was that of Melissa and David who needed donor eggs. They found the waiting lists for donor eggs in the UK too long (the current waiting time is on average 2.5 years (National Gamete Donation Trust, 2014)), and so when female friends of theirs offered to help, the couple decided to accept an offer from ‘Jane’. Melissa explains why they choose to go with Jane, rather than someone else:

Well we’d decided that we’d rather go with Jane, because of all sorts of politics like, other people had offered but … their husbands would [not] really be on board, or the family dynamics, my niece was too young really. [Jane] offered and we felt

comfortable that her husband’s on board and she’d discussed it with all her family before as well, so kind of felt comfortable that everyone knew and everyone was on board with it (Melissa).

2.174 Another example in our study was Bridget and Lori, who wanted children but as a lesbian couple needed to access donated sperm. The cost of clinical donor insemination was simply unaffordable to them as they were both on a low income.

We always knew that we wanted kids, like I always said I wanted kids but realistically how would it ever happen…. And two of our friends called us over, a married couple and just asked us if you know if we want to use their sperm kind of thing. … [Our donor] and his wife have got two kids of their own and … we talk about [the donation] openly, because we don’t want it to be a secret (Bridget).

2.175 These short quotes signal that a very different set of parameters come into play for families formed through known donor arrangements because at the very heart of these arrangements is the ongoing relationship between the parents and the donor. The donor also brings with him or her family connections of their own (a husband or wife, children, sometimes also parents), and these connections are equally important to consider.

2.176 Melissa’s account indicates that the donor’s connections are so important that a connection deemed not to be favourable, such as a husband who is not supportive, can tip the balance towards rejecting a given donor. The accounts suggest that donation in families such as these is not considered to be the private concern of the intended parents, the donor and the donor conceived child, but is a concern for several whole family networks.

2.177 This means that known donation arrangements alter family relationships in important ways because it is not necessarily easy to define the boundaries of the family of the donor-conceived child. Donation broadens the circle of the family and as well as being a child of the family of the intended parents, the donor-conceived child could also, in some way, be perceived to be linked to the family of the donor. This means that decisions about how to manage knowledge about a link-by-donation between families joined through known donation are the outcome of delicate negotiations not just between the parents, but between a whole network of people. Decisions need to be made about the extent to which the connection is made known, and it was felt to be of paramount importance that people agree.
Melissa and David felt that it was vital that everyone in the donor's family knew about the connection, and also felt comfortable about it. Equally, in the case of Lori and Bridget, the donor and his wife spoke openly about the donation, and they also told (all) the children.

There were cases in the study where the donor refused openness, in which case the parents felt they had little choice but not to name the donor because of how that would alter relationships. Moreover, there were cases where the parents felt that the donor wanted ‘too much’ openness and ‘too much’ connection.

The example of known donation and how it shapes relationships is important for debates about disclosure because it highlights that decisions about openness can be taken in a context of very complex family relationships where the boundaries of ‘the family are not clear. It highlights the need to understand that openness or secrecy can be the outcome of delicate and sensitive processes where many people's feelings are taken into account, not just the parents. In contrast to popular assumption they can concern a whole network of relations and span several families.

### 2.5.4 Sharing Information with Children

Translating the idea of openness into practice was also complicated because it meant working out how to talk to the children about donor conception. Telling stories is a central part of family life and in order to translate the idea of openness into practice, donor conception has to be made into a story that parents tell their children as they grow up. But donor conception requires that parents tell a story that goes beyond the stories usually told to children about their birth. This means that parents have to invent strategies about how to manage the process. Delhia explains her thinking about how to manage this dilemma:

> You know how you get baby books that say this is the date you were born and this is when you lost your first tooth and all this sort of thing? And I've got a scrapbook and I wanted to almost do the same but do it from even prior to that. So, for instance, we've got scans of her when she was an egg … . It's because, those baby books that are

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tracking, you know, from birth – and generally it starts from birth – and actually, her story starts way before birth. And that's the bit that I think she needs to be aware of [that] the birth stage was way down the journey (Delhia, with James).

2.182 As with Dehlia, some of the parents created their own books when an appropriate format could not be purchased. Others turned to the Donor Conception Network\(^\text{138}\) (DCN) and used their children's books entitled 'My Story', the aim of which is to convey the story about donor conception in a child-friendly way.

2.183 The parents also had to take decisions about when to tell the child. The now received wisdom is to start telling the child from a very young age. This means speaking to children of 2, 3, and 4-years old about 'the facts of life: sperm, eggs, men, women, sex, genetics, the role of the donor, and what it meant to be lesbian or heterosexual. Trying to follow this advice, the parents in their study told their very young children (sometimes as young as 6 months). But this meant that the adults found themselves negotiating unusual situations because their children would use words and ask questions that were unusual for their age. Brian and Fiona recalls:


*Fiona:* She asks friends of ours when they've been getting pregnant, the women, so where did you get your eggs from then? And how about the daddy? Was that okay? Which does disconcert people.

2.184 Nordqvist and Smart discovered that parents who tell their children about being donor conceived need to live with and navigate their children's unusual knowledge about conception as part of their everyday lives. This could mean, as with Brian and Fiona, that parents could be 'exposed' by their child, who could indiscriminately and inadvertently convey intimate, and often painful information about the family publicly.

2.185 Nordqvist and Smart also discovered that, although the parents did tell their children from a young age, this did not mean that the children understood the implications of what they had been told, at least not in the way that the parents expected.

They've got the information, but they don't relate it to real life (Matthew with Zoe, children aged 10, 8 and 6).

\(^\text{138}\) The UK Donor Conception Network (DCN) was initiated by parents of donor conceived children in the 1990s and campaigns for increased openness
I don’t think he’s put two and two together (Christine with Jared, children aged six and three).

They’re [our son and the donor’s children] all little and you know, it just seems natural to them, [but] they haven’t actually put anything together (Lori, son four years old).

2.186 Many also found that the children showed very little interest in the story. Vanessa talks about how her 10-year-old twins engage with the facts of their conception:

I mean they’re not that interested in [the story] in fairness, I mean I think people imagine children conceived that way it [is] going to be this great [thing] in their life and it’s really not. They’re more interested in you know are we going to get another hamster now that [ours has] died (Laughter) (Vanessa, single).

2.187 The parents soon realized that telling the children was not a one-off occasion. Instead, it emerged as a process that parents needed to revisit again and again. This meant that the parents became ‘gatekeepers’ of the information, and they carried with them a sense of having a continuous responsibility for the children ‘understanding’ the implications of the story, despite already having imparted the information. Cathryn had two girls conceived using eggs donated from two different women, one anonymous and one identifiable. Cathryn felt that although she had told the girls, she remained responsible for talking about the donation and potential problems caused by having different donors:

Cathryn: I feel quite anxious about [the donors] sometimes. I think what I’m finding out is that as long as I’m the one who’s holding it all still, I feel really anxious. And then when I start to have the conversations with the girls it gets easier (Children six and three years old).

2.188 These insights complicate the abstract idea of disclosure as information sharing and points to the importance of relationships, care, children’s development and the passing of time. What is particularly striking about the data about telling children is that information sharing cannot be understood as a one-off event but as a process that the parents needed to attend to gradually and over time in order for their children to know about their donor background, and to understand its implications.
Regarding the child age and maturity, articles 12\textsuperscript{139} and 13\textsuperscript{140} of the CRC must be considered.

**2.5.5 Telling the Wider Family**

Families of donor-conceived children quickly realized that, having disclosed information to the child, they also needed to tell significant others. The family of origin was a particularly important audience. The study data indicated, however, that doing so was not always straightforward. The cases of Monica and Trevor, and Sheryl usefully illustrate the complexities that could be involved in telling the wider family. Monica and Trevor's account of telling their own parents and extended families echoes the experiences of many:

*Monica:* With my family I found it very easy to tell them and well certainly my mum, you know is someone that I do talk to about it and I'm close with and you know my dad I'm close with but he's not someone who will talk about those kind of things but he'd do it kind of vicariously through my mum anyway.

*Trevor:* He hovers around.

*Monica:* He would hover around (laughter) and let her do the talking … . And then I would say about Trevor's family it was difficult to tell them. It was difficult [because] once they knew and then they ignored it … . And it was never spoken about again by anyone.

Monica’s experience of telling her parents reflects a common pattern. She remembers telling her parents as an easy process, but that her father did not seem able to engage in the conversation. We cannot of course know how her father felt about the situation, but it

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\textsuperscript{139} Article 12
1. States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.
2. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.

\textsuperscript{140} Article 13
1. The child shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of the child’s choice.
2. The exercise of this right may be subject to certain restrictions, but these shall only be such as are provided by law and are necessary:
   (a) For respect of the rights or reputations of others; or
   (b) For the protection of national security or of public order (ordre public), or of public health or morals.
appears from Monica’s account that, while he is generally supportive, he is not the sort of man who engages actively in the intimate and emotional aspects of relating to his daughter; it appears that falls to his wife to manage. This appears unsurprising to Monica who seems unperturbed by her father’s distance and passivity and we can assume that the nature of this relationship has been established over many years. Her account reflects the more general findings we made that grandmothers took the active role in supporting their daughters, or daughters-in-law, through the process of fertility treatment, whilst grandfathers were expected to remain more inactive; the notion of ‘hovering’ usefully depicting the passive but supportive stance of many grandfathers.

2.192 Trevor’s experience was also common in the general sample, and one that was often experienced as far more difficult. Both Trevor’s parents had greeted his disclosure with silence and we must assume that this family would normally manage potentially intimate and sensitive topics through non-discussion; a way of relating that came into play as Trevor told his family about his infertility. Finch and Mason note how silence can be a prominent strategy that families use to manage potentially controversial topics.

2.193 The outcome of these initial moments of disclosure to the wider family is very important because they set the scene for subsequent conversations. Whereas it was a topic that Monica was able to discuss with her mother from time to time, Trevor’s family remained completely silent on the issue years later. Consequently Trevor, who had struggled greatly with the realization of being infertile and the subsequent use of a donor, felt that he could not broach the topic with his family. But he could also not ‘undo’ the telling in the first place because, once said, the information cannot be taken back again, and so he lived with a continuous sense of upset about the situation that had developed in his family. Moreover, the couple felt uneasy thinking about how Trevor’s family might respond to their daughter talking about the issue in years to come. It was typical that couples found the process of disclosure complex in these ways. This was not because most parents were outright unsupportive or judgemental about the situation, although that could happen (see below). Instead the

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144 Nordqvist P. Smart C. (2014c) ‘Troubling the family: ongoing problems of coming out as lesbian or gay to families of origin’, Families, Relationships and Societies 3(1), 97–112
complexity was linked to the fact that disclosure meant taking well established ways of relating in families into new territories, and family members were not always willing to follow.

2.194 When considering disclosure to wider family networks, it is important to understand how little control parents have over how the process unfolds, and also how vulnerable they can feel at the thought of relatives’ disapproving of their method of conception. Many parents found themselves in a situation where they were quite content to tell the child, and yet they found disclosure a very fraught process because of how grandparents or wider family would react. Whereas some grandparents were supportive, others responded with silence or denial. In some families, they even ‘blocked’ any subsequent sharing of information with the wider family.

An example of this emerged in our interview with Sheryl, who had a child through donor insemination with her former partner Penny. When Sheryl came out as gay, her parents distanced themselves from her for many years and they became quite estranged. As she became a mother, her parents got back in touch but still disapproved of her being gay. According to Sheryl they found the idea of having a child in the context of a lesbian relationship unpalatable. When Sheryl had her baby, the grandparents managed the situation by telling the wider family that the child was the outcome of a heterosexual alliance (which they were able to do because Sheryl and her partner lived far away), thus constructing a lie that rendered Sheryl’s sexuality, Penny, as well as the donor conception invisible. Sheryl described her parents as ‘very traditional’ and perhaps we can assume that the idea of a daughter of theirs being gay and having a child through donation would be an unacceptable blemish on the whole family, and could not be incorporated in the family story and so needed to be kept secret.

2.195 To suppose that a parent in Sheryl’s situation could simply disregard her parents’ desire for secrecy when taking decisions about openness is to underestimate the power and complexity of family relationships. In circumstances such as Sheryl’s, it is difficult to envisage how openness can be realized without significant damage being caused to those vital relationships. Despite her parents’ disapproval, they were meaningful people in Sheryl’s personal life, and her daughter’s. On becoming a mother herself, she was keen to create connections for herself and her daughter with the wider family. She was also on a low income and single, and her mother offered indispensable help with child care. A tacit agreement not

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to discuss the donor conception appeared to her the only option to enable family relationships to continue despite the underlying conflict, and to support herself and her daughter. This example illustrates how openness can cut at the heart of family life and that sometimes, openness can threaten vital relationships with family.

2.196 Sheryl's experience also highlights that disclosure can have significant consequences because it interlinks with economic and social vulnerability. Sheryl's account shows how life circumstances such as relationship breakdown, single parenthood, lesbianism in the context of homophobia, poverty and being dependent on the good will of family members for support, can add up to a situation in which a person is vulnerable and needs their family for survival\(^\text{148}\). Such a person cannot easily afford to put vital relationships at risk if that means potentially loosing vital support.

2.197 These findings indicate that wider family have a significant role to play in donor conception and that relationships with grandparents and other family members shape decisions about disclosure in fundamental ways. It also shows that disclosure is a process embedded in relationships formed over time that are delicate and that do not easily change.

2.5.6 Sharing Information in the ‘Right’ Way

2.198 Negotiating openness could also be complicated as an idea because of underlying doctrines about how information should be shared. One particularly powerful idea that parents navigated was that children need to be told about being donor conceived because it is information about them, and so the idea of disclosure is framed as a matter of personal identity. The parents were encouraged by clinical staff to think of the information about donor conception as something that ‘belonged’ to the child and this was taken to mean that the child should be in charge of the process of sharing.

2.199 Carrie spoke of her experience of being confronted with this belief. She and her partner Paul underwent a series of difficult and time consuming medical investigations before it became clear that they needed to use sperm donation. This was a horribly difficult time for them, and Carrie sought the support of her friends in the process, telling them about the situation that she and her husband found themselves in. When Carrie fell pregnant, the

fertility counsellor at the reproductive health centre told her that she should not have told her friends:

I felt terrible because [the counsellor] said ‘Well you don’t realise kind of what you’ve let out of the bag [by telling people]’ …

Carrie went on to explain:
At this point [when we went through treatment, children] seemed like a sort of minor miracle if they were going to happen at all to us. You don’t tend to think that far ahead that it’s about their origin, it’s then their information to share. But you’ve already shared it. But then you know [the children] didn’t even exist at that point. So it takes a stretch to think about being confidential about your child’s information, the child you haven’t even got yet.

2.200 Parents were charged with the moral responsibility of ‘doing the right thing’ by their child, constructed as allowing him or her to decide about whether to be open and with whom. However, they soon found that this idea that sounded easy enough in the abstract did not necessarily fit with their life experience. Carrie’s account points to a fundamental understanding of parents who undergo the treatment of donor conception, which is that they do not know if they will ever be able to conceive a child and that they are trying against the odds.

2.201 Statistically speaking, success rates are still relatively low and the national average for women under the age of 35 (who have the highest predicted chance of success) is 32.6 per cent likelihood of a live birth following IVF treatment.\(^\text{149}\) This means that through the cycles of treatment the parents have to manage the hopes that it will be successful, whilst also being realistic about their (slim) chances of success.\(^\text{150}\) Fertility treatment is known to be extremely stressful, partly because it means being on an emotional rollercoaster of hope and despair. Understandably, Carrie felt the need to talk to her friends. However, the clinic counsellor is charging Carrie, and parents like her, with the moral responsibility of keeping that very difficult process private and secret in case it results in a child, the idea being that it then becomes the information of that child.

2.202 The problem of which Carrie speaks is the discord between the idea that information belongs to the child, and the real life experience of how relational lives work. Carrie’s account


indicates that donor conception in fact touched the lives of a number of people in her family – herself, her partner and her children and that these different people had different needs in relation to that information at different times.

2.203 Parents and their children, and wider kin, live interconnected lives, and boundaries could not easily be drawn between events in the parent’s lives and matters that concern the child. It would be more accurate to view information about donor conception as something that morphs into different shapes over time, so that it is simultaneously a difficult process that the parents went through and meaningful for the child. Thus, the contemporary notion of what it means to ‘do the right thing’ does not fit easily with how families operate.

2.204 Another example of how parents tried to get a handle on this irresolvable moral dilemma transpired in our interview with Jonathan and Abigail, who had a son through known egg donation:

On one hand … my vision about [the egg donation] is that it’s nothing to hide. And it’s something to be celebrated and embraced and isn’t it a wonderful thing? And so it’s really important that [our son] understands that from us. On the other hand the tension is then between [that and] him to be in control of that information as well.

(Jonathan)

2.205 Jonathan’s quote suggests that he and his wife found it hard to know what ‘doing the right thing’ meant and that there were in fact competing moral parameters that came into play when decisions were made about openness. They were extremely pleased and proud about the way that they had been able to have a child against all odds, and they wanted to communicate this sense of amazement to their son. However, celebrating the egg donation openly was in tension with the idea that he should be in control over sharing the information. Adding to their sense of bewilderment was the fact that at 3 years old, their son could not be in control of the information and so Jonathan and Abigail had to make decisions about who to tell. Jonathan went on to say:

While he’s a child he can’t be in control of who knows and who doesn’t. [We then have to make the decision for him] so you end up with these sort of like record knowledge. But who falls within which circle [of who should know]? And I find that, out of all of it I find that bit … confusing.
Jonathan refers to information about donor conception as ‘record knowledge’, by which we must assume that he means a kind of knowledge that is shared with much thought and consideration only to ‘the closest circle’.

Jonathan’s feeling of being confused is significant because it is suggestive of the difficulty of bringing together the abstract moral idea that information about the donor conceived child ‘belongs’ to the child, with the idea that a child should be told from a very young age when he or she is too young to make an informed decision about who to tell. These two doctrines cannot possibly both be fulfilled at the same time. A child cannot both know from a young age about his or her donor origins and yet make informed decisions about if they want to be open and with whom. And yet the parents tried to bring the two together and understandably struggled to make sense of the right course of action. The parents also of course knew the crucial impact of kinship information of this kind: that it does in fact affect a whole network of relationships and that information about biogenetic connections is in itself constitutive in its consequences and will always alter relationships\(^\text{151}\). Once the information is shared, it cannot be taken back.

The accounts also signal that the moral discourse has a significant impact on parents’ lives. Carrie said she felt ‘awful’ about having done the ‘wrong thing’ and it is evident from Jonathan’s account that he and Abigail have thought hard about how to do the ‘right thing’. We may understand the potency of these decisions through a notion of being ‘good’ parents, and so what is at stake by doing the right thing by their child, is the moral identities of parents\(^\text{152}\).

In debates on disclosure this adds important insights that parents work quite hard to ‘do the right thing’ and be open ‘in the right way’ but that what this means as far from clear. Contemporary moralities introduce competing parameters in the lives of parents, who find that they do not easily translate into practice and that knowing how to navigate between competing doctrines is not straightforward.


2.5.7 Summary

2.210 The sociological findings introduced in the study by Nordqvist and Smart highlight the importance of everyday family life experiences in shaping decisions about openness and secrecy. This is the world in which parents operate, and this is the context in which openness with children about their genetic origins is processed and turned into practice.

2.211 Seeking to practice openness raises a series of dilemmas for parents of donor-conceived children in areas in which problems can arise namely: decision-making in the context of porous family boundaries; telling children; telling the wider family and also navigating making decisions in the context of contradictory moral doctrines.

2.212 What unfolds through these different angles is the central role of relationships and relating for decisions about transparency. Information sharing needs to be understood as both relational and as a process that unfolds along the lines of already established ways of relating and in accordance with existing family biographies.

2.213 There is an important difference between information being transmitted and communication being established; it is more relevant to talk about openness as a process of establishing open lines of communication, rather than it being an event, and that these lines are shaped by existing family relationships.

2.214 A focus on relationships also brings into view that donor conception is not only the concern of the donor conceived, but also of their parents and wider families; the idea that the information about donor conception belongs to the child exclusively fails to take into account the relational nature of family life.

2.215 Parents and donor-conceived children are embedded in family networks, networks of family of origin or networks of the donor, and these networks are vital in personal life. These networks are also ‘sticky’ in the sense that they are not easy to shed\textsuperscript{153}, and so if a set of grandparents is unsupportive, this is significant because they are still vital in parents and children’s lives.

2.216 Family relationships are imbued with a sense of being in the world, security and history and are hugely significant in personal life. It is important to realize that family

relationships are all interconnected and that they are also delicate and need to be managed with care. Parents and children are embedded in networks with one another as well as with wider family, and their experience and choices around openness will, crucially, be shaped by them.

2.217 This also means that whereas it is important to consider the child’s ‘need to know’ about being donor conceived and her or him being able to make decisions about disclosure, such needs must be balanced against other needs of that child as well as the needs of other members of the family. It is possible to imagine a situation where a child might have a need for privacy which is opposed to a mother or father’s need for openness about their own history of having endured fertility treatment. Or, it may be that the need to be open needs to be balanced against the need to preserve existing relationships with wider family. Rather than understanding family members as making decisions as autonomous individuals, it is more useful to think of these experiences and decisions as structured by people connected in family relationships because their lives are interlinked, even co-constituted.

2.218 Nordqvist argues for a change in direction in the debate on openness and suggest that it is vital to the policy debate to appreciate the importance of relationships in shaping the decision-making process. It is not her argument that openness should be abandoned and secrecy should be reinstated in the world of donor conception but rather that the desire for openness amongst policy-makers and the importance attached to openness need to be brought into conversation and balanced against other factors which greatly influence children’s and adult’s personal lives.

2.219 A more nuanced understanding of openness is needed, which acknowledges, for example, the important relationships with wider family, especially grandparents, socio-economic status and material restraints, that family relationships are complex and can be at once supportive and less than perfect, and also that parents make decisions in a context which is not of their own choosing and may be less than ideal. In driving the agenda of openness, it is crucially important to be mindful of the complex nature of family relationships.

2.220 It is Nordqvist’s argument that it is timely to bring into the debate on openness and the ‘child’s need to know’ the important role of relationships in shaping personal life and parents decision-making processes about disclosure and she argues that it is of vital importance to seek to better understand and take account of how openness impact of family relationships.
and everyday life when developing policy and engaging with parents relative ‘unwillingness’ to be open with their children.

2.21 Nordqvist mentions that in a more recent study conducted 2005–2008 Isaksson\textsuperscript{154} found what seems to be more positive attitudes to disclosure, with 90% of the sample stating that parents should be open with their offspring. However, this data were gathered with couples at the time of treatment rather than with parents of donor conceived offspring. Therefore we don't know the extent to which these couples went on to become parents, or indeed, if they chose to actually disclose information to their children.

2.6 Questions

1. Do donor-conceived children have a moral right to know their own biological origin or should donors be anonymous or have the right to remain anonymous?

2. Is it beneficial to donor-conceived children to know their own biological origins?

3. What factors should be taken into account in deciding whether or not it is in the best interests of the child to know his or her biological origins? Does it make any difference if the donor is related to the parent (intrafamilial medically assisted reproduction) or unrelated to the parent or known to the parent or unknown to the parent?

4. Should legislation provide for donor-conceived children to have a legal right to know their own biological origins?

4.2 A donor-conceived child will likely also have a his or her own genetically-related child. Does a child born to a donor-conceived person have a right to know his or her true genetic heritage? What are the rights of future generations?

5. When and how should a child be told about his or her biological origins, if at all?

5.2 Should a child be told about his or her biological origins when he or she is sufficiently mature?

5.3 Who will decide when a child is sufficiently mature? What mechanisms can be established to ensure that a donor-conceived child is sufficiently mature (mature minor) to deal with information about his or her donor conception?

5.4 Who assesses whether a child has the maturity to make their own decisions and to understand the implications of those decisions?

6.1 Should a donor be given a choice as to whether or not he or she wishes to have his or identity disclosed to the child or parents? In this instance, the law will not provide for an express right to now one’s genetic origins but persons/intended parents who use ART can elect to use a donor who has no objection to his or her identity being disclosed. In this instance it is expected that the intended parents will reveal the child’s biological origins to the child.

6.2 Will this lead to an argument that such a position violates the equality clause in the Constitution (in that donor-conceived children will be treated differently depending on what the donor elects) or, is this a more flexible approach given the complexity of this matter and that each child and each family is different?

7. If a child (or adult child) is made aware of the identity of the donor, to what extent can or should the child (or adult child) interact with the donor or the donor's family, for instance the biological children of the donor who are also genetically related to the child (if for instance the donor is deceased)?

8. In the event that a donor elects to have his or her identity disclosed to the child (or adult donor-conceived person) or social parents, should the donor stipulate to what extent the child (or adult donor-conceived person) can interact with him or her? In other words, can the child contact the donor or meet the donor and develop a relationship with the donor and or the donor’s family?

9. Will it be of any benefit to the child (or adult donor-conceived person) to know the identity of the donor but to be barred from or unable to communicate with or interact with the donor and or the donor’s family?

10. The ability of donor-conceived children to access information about their genetic origins initially depends on their awareness of the nature of their conception. In other words the child must know that he or she was conceived via ART. Without this knowledge, such children will assume that their “social” parent is their biological parent. Hence, the onus of revealing the manner of conception rests on the social parents, unless such information is disclosed by the
state or, it is obvious that the child cannot be the biological child of the social parents. Although legislative changes removing donor anonymity may play a part in facilitating parental disclosure, a parental decision not to reveal the truth to a donor-conceived child is a complex family matter and therefore very difficult to regulate by law.

10.1 Who is responsible to tell a child about his or her biological origins, the social parent or the State?

10.2 How should a child be told about his or her biological origins?

10.3 Should the information appear on the birth certificate? Would this be feasible because a minor child would hardly ever see his or her birth certificate because an important document would be kept safely stored or be in the possession of the parent? Further a minor child may not understand the significance of the document.

10.4 Should the State reveal information about the child’s biological origins to the child when he or she applies for an identity document? Does such an approach take into account the emotional and psychological well-being of the child?

10.5 Will State disclosure on a birth certificate or identity document encourage disclosure or cause upheaval in the family? In other words, should a more individual approach be adopted depending on the circumstances of the family and the disposition of the donor-conceived child?

11.1 Should the State maintain a donor register or should an independent organization maintain such a register?

11.2 Who should have access to a donor register and when?

11.3 For how long should donor records be kept?

11.4 Should there be any costs involved in accessing donor information?

11.5 If South African law is amended to remove donor anonymity, should a voluntary donor register be established to mitigate the impact of the current legal position which allows for anonymity?
2.7 Limits on the Number of Offspring

2.222 The debates about limits on the number of offspring who can be conceived or born from a single donor's gametes centre around issues concerning the spread of genetic malformations, inadvertent incest and the emotional distress for all parties (parents, donors, and offspring) of knowing that there are numerous people with shared genes (i.e. donor siblings or half siblings). This knowledge has become more common with the rise of informal registries that allow for contact among those individuals with the same donor.\textsuperscript{155}

2.223 Media attention to the issue of large numbers of offspring from a single donor suggests that the public at large is fascinated with and even appalled by the idea of a vast number of genetically related individuals.\textsuperscript{156}

2.224 As is the case for anonymity, regulations vary by country. A number of countries including parts of Austria, Australia, Belgium, Canada, Denmark, France, Germany, Hong Kong, the Netherlands, New Zealand, Norway, Spain, Sweden, Switzerland, and the United Kingdom have limits that range from a low of 3 in Hong Kong to as many as 25 in the Netherlands.

2.225 In The Netherlands, a limit of 25 children is used based on the principle that children from sperm donors may have, at most, a similar risk to children in the general population of having a relationship with a naturally conceived unknown half-sibling. This calculation was based on specific population data in the country and included figures on the chance of having an unknown half-sibling, the average number of children parents have, the chance of donor-conceived children having children themselves, age and geographical factors determining the likelihood of meeting a partner in the district of a donor bank, and the size of the population being served by a donor bank.

\textsuperscript{155} Jenni Millbank, Numerical Limits In Donor Conception Regimes: Genetic Links And ‘Extended Family’ In The Era Of Identity Disclosure, 22 med. law rev. 325 (2014).
2.226 The American Society of Reproductive Medicine recommends that the limit should be based on the population from which a donor is selected and the catchment area that may be served by a particular donor. Using this recommendation, it came up with a figure of not more than 25 pregnancies for a population of 800,000 to avoid the risk of unintentional relationships between two genetically linked individuals.

2.227 With respect to the issue of limits, a study in Sweden found that half of both oocyte and sperm donors thought the number of offspring should be limited to no more than 10. The study also found that oocyte donors were four times more likely than were sperm donors to support an even lower upper limit of five offspring.

2.228 The limit, while being set to minimise the possibility of two children from the same donor having a consanguineous relationship without knowing that they are genetically related, should ideally apply to sperm donations only, as sperm cells can be donated more easily and in larger quantities than eggs, and donation of eggs involves a complex medical intervention that could give rise to complications.

2.229 The fertility industry is a big business\(^\text{157}\) and it has a stake in both of these issues. Because of the profit they gain from providing gametes, the fertility industry will undoubtedly also have view in this regard\(^\text{158}\). In addition, three parties have an ongoing interest in the regulations concerning issues of gamete donations: donor-conceived offspring, parents who rely on donated gametes to conceive a child, and gamete donors themselves.

### 2.7.1 Limits on the Number of Offspring in South Africa

2.230 \(^\text{159}\)Regulation 6\(^\text{160}\) of the Regulations Relating to Artificial Fertilisation, 2012 stipulate that no further gametes can be removed or withdrawn from the body of a donor once six

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160 6 Restriction on donation of gametes

A competent person-

(a) shall not remove or withdraw a gamete, or cause a gamete to be removed or withdrawn, from the body of a gamete donor if the competent person has information or suspects that a maximum of six children have been conceived through the artificial fertilisation using the gametes of that gamete donor;

(b) shall, where the gamete donor has conceived six children as contemplated in paragraph (a), inform
children have been conceived through artificial fertilisation using the gametes of that donor. If a competent person involved in this aspect of reproductive medicine is informed or suspects that the maximum number of conceptions have occurred, he or she must make the donor aware of this and in addition must inform the donor that he or she may not make any further donation of gametes. This information must also be relayed to the central databank.

2.231 Currently there is no information on what informed the limitation to six live births in the Regulations Relating to Artificial Fertilisation or how this figure was arrived at. In addition, there appears to be no information from valid population genetics in the country indicating that if the number of donor offspring was not limited to fewer than six, the possibility of inbreeding would increase.

2.232 What the Regulations Relating to Artificial Fertilisation, 2012 have also not taken into consideration is that a conception is not the same as a live birth, that pregnancy losses do occur and that there is a definite attrition rate during pregnancies from conception to birth.

2.233 The limit, while being set to minimise the possibility of two children from the same donor having a consanguineous relationship without knowing that they are genetically related, should ideally apply to sperm donations only as sperm cells can be donated more easily and in larger quantities than eggs and donation of eggs involves a complex medical intervention that could give rise to complications.

2.234 Regulation 8(2)(e)(iii)\textsuperscript{161} of Regulations Relating to Artificial Fertilisation, 2012 states that once six conceptions have occurred, all gametes donated by the gamete donor and in
storage must be destroyed unless the Minister of Health consents to the practitioner keeping those gametes. Regulation 8(2)(e)(iii) does not stipulate the purpose of keeping the gametes and is open-ended and ambiguous. One can therefore only speculate as to the reasons for keeping the gametes and ask whether those who drew up the Regulations Relating to Artificial Fertilisation, 2012 foresaw the possibility of requests that would necessitate more than six conceptions per donor being allowed, e.g. in situations of donor siblings? Perhaps this should be a common sense approach to use when interpreting this aspect of the Regulations Relating to Artificial Fertilisation, 2012 which needs to be read together with s3(1)\(^\text{162}\) of the NHA.

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\(^{(f)}\) results of the tests and the analysis or examination contemplated in regulation 7(e) to (g); and

\(^{(g)}\) any other relevant document or information that the competent person may request.

(2) The competent person-

(a) shall retain the gamete donor file in safe-keeping and shall not destroy the file, except with the written permission of the Director-General;

(b) shall make the particulars set out in subregulation (1)(a)(ii), (iii) and (iv), (b), (c) and (f), together with the identification number referred to in regulation 7(a), available to the recipient and the competent person who is to effect the artificial fertilisation of the recipient;

(c) shall furnish the central data bank before 31 January of each year with the following particulars regarding the preceding year in respect of the gamete donor:

(i) the identification number of the gamete donor file;

(ii) the number of donations of gametes, with the dates on which the donations were made; and

(iii) the number of children conceived through the artificial fertilisation of a person that have been born alive from the gametes of the gamete donor;

(d) shall not make the gamete donor file, or information therefrom, available to any person other than a person acting under her or his supervision, except in terms of legislation or a court order;

(e) shall immediately, after, if it has come to her or his attention that a maximum of six children conceived through the artificial fertilisation have been born alive from the gametes of a specific gamete donor-

(i) make a conspicuous note to that effect in the gamete donor file;

(ii) make available this information to the Central Data Bank;

(iii) destroy all gametes donated by such gamete donor and any gametes that the competent person has in storage, unless the Minister consents to the competent person keeping those gametes; and

(iv) inform the donor of the actions taken as in terms of subparagraph (iii).

(f) who wants to keep the gametes referred to in paragraph (e)(iii)-

(i) shall forthwith address a substantiated request including the informed consent document from the gamete donor to the Minister for her or his consent to keep the gametes; and

(ii) may refrain from destroying the gametes until the Minister notifies the competent person of her or his decision.

\(^{162}\) 3 Responsibility for health

(1) The Minister must, within the limits of available resources-

(a) endeavour to protect, promote, improve and maintain the health of the population;

(b) promote the inclusion of health services in the socio-economic development plan of the Republic;

(c) determine the policies and measures necessary to protect, promote, improve and maintain the health and well-being of the population;

(d) ensure the provision of such essential health services, which must at least include primary health care services, to the population of the Republic as may be prescribed after consultation with the National Health Council; and

(e) equitably prioritise the health services that the State can provide.

(2) The national department, every provincial department and every municipality must establish such health services as are required in terms of this Act, and all health establishments and health care providers in the public sector must equitably provide health services within the limits of available resources.
2.235 In addition, the Regulations Relating to Artificial Fertilisation, 2012 are silent on donor siblings and leave very little room for consideration of family desires. An appraisal of the international situation reveals that in order to decrease the chance of offspring intermarrying, donor gametes will not normally be used once the number of children believed to have been born from them has reached a certain number.

2.236 The Regulations Relating to Artificial Fertilisation have been reviewed and in September 2016 draft regulations were published for comment. The draft regulation proposes that a competent person may not remove or withdraw a gamete, or cause a gamete to be removed or withdrawn, from the body of a gamete donor for a new recipient if the competent person has information or suspects that a maximum of 12 live births have been reached through the artificial fertilisation using the gametes of that gamete donor and inform that gamete donor that he or she may not make any further donation of gametes to a new recipient except where the Minister allows a family to use the gametes from that donor to have an additional sibling.

2.7.2 Questions

1. Should there be a limit on the number of children conceived or born from a donor’s gametes? Would a limit be in the best interests of donor-conceived children as it would reduce the chances of such consanguineous relationship between donor-conceived children?

2. Do you agree with the limit of 12 as proposed in the draft regulations?

163 See GN 1165 in GG 40312 of 30 September 2016
164 Restriction on donation of gametes

7. (1) A competent person -
(a) may not remove or withdraw a gamete, or cause a gamete to be removed or withdrawn, from the body of a gamete donor for a new recipient if the competent person has information or suspects that a maximum of 12 live births have been reached through the artificial fertilisation using the gametes of that gamete donor;
(b) must, where the gamete donor has been used and resulted in 12 live births as contemplated in paragraph (a), inform that gamete donor that he or she may not make any further donation of gametes to a new recipient unless the provisions of sub-regulation (2) apply; and
(c) must, immediately relay all the information relating to such gamete donor, the removal or withdrawal of a gamete and the artificial fertilisation, to the central data bank contemplated in regulation 6;
(2) Where the maximum number of 12 live births have been reached using the gametes of a specific donor, the Minister may allow a family to use the gametes from that donor to have an additional sibling.
(3) The competent person and the central data bank must ensure that gametes from a single donor are not used for more than 12 live births.
4. Should there be different limits for sperm and egg donors?

4. What factors should be considered when establishing what the maximum number should be – race, ethnicity of the donor and recipient, population dynamics, locality?
CHAPTER 3
SURROGACY

3.1 What is Surrogacy

3.1 The word “surrogate”, from Latin surrogatus (substituted), means “appointed to act in the place of”165.

3.2 Surrogacy is an agreement whereby a woman agrees to carry a pregnancy for another person or persons, who will become the newborn child's parent or parents after birth.

3.3 Having another woman bear a child for a couple to raise is has been known for hundreds of years166. Babylonian law and custom allowed this practice and infertile woman could use the practice to avoid a divorce, which would otherwise be inevitable167. The existence of the concept of one woman bearing a child for another dates back to the Old Testament, when Hagar, the maidservant of Sarah, lies with Abraham to bear a child for her infertile mistress:

Sarai, Abram’s wife, had not been able to bear children for him. But she had an Egyptian servant named Hagar. So Sarai said to Abram, ‘The Lord has prevented me from having children. Go and sleep with my servant. Perhaps I can have children through her.”168

3.4 Surrogacy arrangements have also existed for some time in African customary law169. In other less enlightened times, African American slaves often acted as surrogate mothers for

165 Online Etymology Dictionary accessed on 29 March 2017
166 Paragraph 35 of the minority judgment of Khampepe J in AB and Another v Minister of Social Development (CCT155/15) [2016] ZACC 43; 2017 (3) BCLR 267 (CC) (29 November 2016)
168 Genesis 16:1-2 and Genesis 30:3.
169 Bekker Seymour's Customary Law in Southern Africa 5 ed (Juta & Co Limited, Cape Town 1989) at 279
their owners\textsuperscript{170}. However, the first formal surrogacy agreement was not arranged until 1976, in the United States\textsuperscript{171}.

3.5 There are two main types of surrogacy namely, traditional surrogacy and gestational surrogacy.

3.6 Traditional surrogacy (also known as partial, genetic, or straight surrogacy), occurs when the surrogate mother’s own ovum is fertilized using the sperm of the intended father or of a donor. Fertilization is usually done by artificial insemination or intrauterine insemination. The resulting child is genetically related to the surrogate.

3.7 Gestational surrogacy (also known as host or full surrogacy) takes place when an embryo created by \textit{in vitro} fertilization is implanted in a surrogate, sometimes called a gestational carrier. Gestational surrogacy may take a number of forms, but in each form the resulting child is not genetically related to the surrogate:

- the embryo is created using the intended father’s sperm and the intended mother’s eggs. The resulting child is genetically related to both intended parents.
- the embryo is created using the intended father’s sperm and a donor egg where the donor is not the surrogate. The resulting child is genetically related to the intended father.
- the embryo is created using the intended mother’s egg and donor sperm. The resulting child is genetically related to the intended mother.
- a donor embryo is implanted in a surrogate. Such an embryo may be available when others undergoing IVF have embryos left over, which they donate to others. The resulting child is genetically unrelated to the intended parent or parents.

3.8 Surrogacy has become a viable option for the increasing number of infertile couples and individuals who wish to have children of their own and may be used for the following reasons:

- A woman does not have a uterus. This can be because the woman was born without a uterus or she needed her uterus removed to treat a medical condition such as cancer, tumours, uterine injury and uncontrollable bleeding. Since there


\textsuperscript{171} http://www.newworldencyclopedia.org/entry/Surrogacy accessed on 29 March 2017
is no uterus, a child cannot be carried. Therefore a surrogate is one option for having a baby if a woman has had a hysterectomy.

- The woman has a structural abnormality to her uterus, or has fibroids or scar tissue inside the uterus. These conditions can make it harder for women to become pregnant or carry a pregnancy to term.
- The woman has a medical condition that would make pregnancy dangerous. Such conditions may include serve heart disease, severe kidney disease, severe diabetes, severe preeclampsia or a history of breast cancer.
- Older women may be more likely than younger women to need a gestational carrier because some of the risk related to some conditions, such as uterine fibroids, that affect the ability to carry a pregnancy, increase with age. Older women may also be more likely to have chronic conditions that would make pregnancy risky, such as heart, lung or thyroid conditions.
- Some women, who have reached an older gestational age, choose surrogacy because pregnancy and the health of the child become a higher risk at this stage. They may also find it difficult to conceive or carry a baby to term.
- The woman has experienced repeated in vitro fertilisation implantation failures or miscarriages.
- The woman has no eggs or unhealthy eggs.
- To avoid passing on heredity diseases to the child.
- Couples who have experienced multiple miscarriages or difficulty conceiving.
- Single men who want to have a child use the services of either a traditional or gestational surrogate.
- Gay men use surrogacy to fulfil the desire to become parents. By doing so, at least one of the intended parents can have a biological connection to the child by providing their sperm.

### 3.2 Legal Regulation of Surrogacy in South Africa

3.9 The laws governing surrogacy in South Africa are set out in Chapter 19 of the Children's Act which Act came in to operation on 1 April 2010. Before the enactment of Chapter 19 of the Children's Act, surrogacy was not expressly regulated in South Africa by any legislation.
3.10 The South African Law Commission (as it was known then - SALC) had investigated Surrogate Motherhood and, in its report, it had concluded that the “practical application of existing legislation leaves much to be desired” as it “does not provide adequate protection for the parties involved”. In the same year, the SALC sought to fill this lacuna and drafted a Surrogacy Bill and proposed that Parliament adopt the bill as an Act. The bill was never passed. In 2002, the SALC suggested that an amended version of the Surrogacy Bill be made a chapter of the intended Children’s Act. The legislature then set up an Ad hoc Select Committee to make recommendations regarding the SALC’s proposal. The Ad hoc Select Committee subsequently compiled its own report. Based on this, the legislature enacted Chapter 19 of the Children’s Act 38 of 2005, which presently regulates surrogacy in South African law.

3.11 Section 1(1) of the Children’s Act defines a:

'surrogate motherhood agreement' as an agreement between a surrogate mother and a commissioning parent in which it is agreed that the surrogate mother will be artificially fertilised for the purpose of bearing a child for the commissioning parent and in which the surrogate mother undertakes to hand over such child to the commissioning parent upon its birth, or within reasonable time thereafter, with the intention that the child concerned becomes the legitimate child of the commissioning parent.

"surrogate mother" as an adult woman who enters into a surrogate motherhood agreement with the commissioning parent

"commissioning parent" as a person who enters into a surrogate motherhood agreement with a surrogate mother.

3.12 Stemming from the definition of 'surrogate motherhood agreement' (SMA), it is clear that only an adult woman can agree to be surrogate mother, fertilization must take place by artificial means (conception of the child by means other than natural sexual intercourse) and the surrogate mother must intend to handover the child to the commissioning parent after

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173 Paragraphs 34 and 37-38 of the minority judgment of Khampepe J in AB and Another v Minister of Social Development (CCT155/15) [2016] ZACC 43; 2017 (3) BCLR 267 (CC) (29 November 2016)
birth with the intention that the child becomes the legitimate child of the commissioning parent.

### 3.2.1 Brief Overview of the Requirements for a Valid Surrogacy Agreement

3.13 The requirements for a valid SMA are set out in Chapter 19 of the Children’s Act in sections 292 to 303. The information below is a brief overview of the requirements for a valid surrogate motherhood agreement.

3.14 SMA must be in writing and confirmed by the High Court. This specific requirement makes it clear that a written contract between the surrogate mother and commissioning parents will be invalid if not confirmed by the High Court.

3.15 In addition, a SMA will also be invalid unless:

- the agreement is signed by all the parties thereto (including the partner or spouse of the surrogate mother, if applicable)
- the agreement is concluded in South Africa
- at least one of the commissioning parents, or in the case of only one commissioning parent, this person, is domiciled in South Africa at the time that the agreement is entered into
- the surrogate mother (and her husband or partner, if relevant) are domiciled in South Africa at the time of entering into the contract. If good cause is shown, the court may dispense with the requirement that the surrogate mother and her spouse, civil union partner or permanent partner must be domiciled in South Africa
- the agreement is confirmed by the High Court within whose jurisdiction the commissioning parent(s) are domiciled or habitually resident.

3.16 No agreement will be confirmed by the High Court if the partner or spouse of the surrogate mother, as well as the partner or spouse of the commissioning parent, is not a party to the agreement and has not provided his/her consent to the arrangement in writing. However, the court may confirm the agreement if a spouse or partner of the surrogate mother (who is not genetically related to the child to be born) unreasonably withholds the relevant consent.
3.17 A SMA must be confirmed by the court before the surrogate mother is artificially inseminated. Artificial insemination may not be performed on the surrogate mother after the lapse of 18 months after the date of confirmation of the agreement by the court. The artificial insemination of the surrogate mother must also be specifically authorised by the court which validates or confirms the surrogate motherhood agreement.

3.18 The SMA is terminated by a termination of pregnancy that may be carried out in terms of the Choice on Termination of Pregnancy Act 92 of 1996. The decision to terminate lies with the surrogate mother, but she must inform the commissioning parents of her decision prior to the termination and consult with the commissioning parents before the termination is carried out. The surrogate mother incurs no liability to the commissioning parents for exercising her right to terminate a pregnancy except for compensation for any payments made by the commissioning parents in terms of s301 where the decision to terminate is taken for any reason other than on medical grounds.

3.19 A court may also not confirm the agreement if the agreement does not make adequate provision for the contact, care, upbringing and general welfare of the child, who is entitled to be born in a stable environment. The child’s position in the event of the death of one or both of the commissioning parents, or their divorce or separation before the birth of the child must be considered.

3.20 A court may not confirm a SMA unless the agreement includes adequate provisions for the contact, care, upbringing and general welfare of the child that is to be born in a stable home environment, including the child's position in the event of the death of the commissioning parents or one of them, or their divorce or separation before the birth of the child and, in general, having regard to the personal circumstances and family situations of all the parties concerned but, above all, the interests of the child that is to be born should the agreement be confirmed.

3.21 The commissioning parent or parents must be unable to give birth to a child and this condition must be permanent and irreversible. The must be a genetic link between the commissioning parent or parents and the child.

3.22 Section 301(1) of the Children’s Act prohibits a person from giving or promising to give to any person, or from receiving from any person, a reward or compensation in cash or in kind in connection with a SMA.
3.23 Section 301(2) of the Children’s Act allows for payments for:

(a) compensation for expenses that relate directly to the artificial fertilisation and pregnancy of the surrogate mother, the birth of the child and the confirmation of the surrogate motherhood agreement;
(b) loss of earnings suffered by the surrogate mother as a result of the surrogate motherhood agreement; or
(c) insurance to cover the surrogate mother for anything that may lead to death or disability brought about by the pregnancy.

3.24 Section 301(3) provides that any person who renders a *bona fide* professional legal or medical service with a view to the confirmation of a SMA is entitled to reasonable compensation therefor.

3.25 Section 303(2) says that no person may in any way for or with a view to compensation make known that any person is or might possibly be willing to enter into a SMA. This section makes it clear that commercial surrogacy is unlawful by preventing anyone from facilitating surrogate motherhood agreements in return for compensation.

3.26 S305(1)(b) says that any contravention of sections 301, 302 and 303 of the Children’s Act is an offence.\(^{174}\)

3.27 Various authors have discussed the requirements for a valid SMA including the role of the judiciary when assessing SMA, the prohibition on commercial surrogacy and the phenomenon of cross border surrogacy.\(^{175}\) The legislature may need to amend the legislation and or enact regulations to provide certainty on how role players in a SMA can ensure compliance with the legislation.\(^{176}\)

\(^{174}\) In *Ex Parte WH 2011 (6) SA 514 GNP* at paragraphs 64-67 on pages 528-529, the court reiterated that commercial surrogacy is prohibited.


3.3 Legal Requirement for a Genetic Link

3.28 Section 294 of the Children’s Act reads as follows:

No surrogate motherhood agreement is valid unless the conception of the child contemplated in the agreement is to be effected by the use of the gametes of both commissioning parents or, if that is not possible due to biological, medical or other valid reasons, the gamete of at least one of the commissioning parents or, where the commissioning parent is a single person, the gamete of that person.

3.29 Section 294 clearly requires that a child contemplated in terms of a valid SMA must be genetically related to both the commissioning parents or, if this is impossible as a result of medical or biological or other valid reasons, related to at least one of the commissioning parents. Where the commissioning parent is a single person, the child must be genetically related to the commissioning single parent.

3.30 In the SALC’s report, it had specifically recommended that surrogate motherhood should only be available for a legally married husband and wife and that the child contemplated in a valid surrogacy agreement should be genetically related to both the husband and wife or to either the husband or wife where the other spouse is unable to conceive.\(^{177}\)

3.31 Subsequent to the SALC’s report, a parliamentary ad hoc Committee was established in 1994 and their deliberations culminated in a further Report “The Ad Hoc Committee Report” in 1999. The Ad Hoc Committee Report recommended the retention of the requirement that the gametes of at least one of the commission parents be used towards conception or in the case of a single person, the gametes of that single parent. The rationale for this recommendation was as follows:

In the instance where both the male and the female gametes used in the creation of the embryo are donor gametes, it would result in a similar situation to adoption, as the child or children would not be genetically linked to the commissioning parent or parents. This would obviate the need for surrogacy as the couple could adopt a child. This type of surrogacy was not preferred by most commentators. It was felt that in

\(^{177}\) South African Law Commission Report on Surrogate Motherhood (Project 65, November 1992) at paras 8.2.2 and 8.2.6.1-8.2.6.3
both partial and full surrogacy it should be a pre-condition that the child or children should always be genetically linked to the commissioning parent or parents.

3.32 This provision is deemed harsh and discriminatory by practising reproductive specialists, as it is possible that both the commissioning parents may suffer from (male or female) infertility. An ordinary adoption for these persons is not always possible, as there may be long waiting lists for new-born babies or the person or couple may be too old to qualify as an adoptive parent(s). Such a provision may also infringe an infertile person’s right to make decisions regarding reproduction, entrenched in section 12(2)(a) of the Constitution, including his or her rights to dignity and privacy. Some legal scholars, however, argue that to allow surrogacy where the commissioning parent is or both are infertile would amount to a ‘commissioned adoption’ and would hence be unacceptable. Others argue that the genetic link requirement would prevent the practice of commissioning parents ‘shopping around’ with the intention to create children with specific characteristics.\(^\text{178}\)

3.33 Metz\(^\text{179}\) objects to the genetic link requirement and writes:

In this article I have mostly argued against a variety of ethical rationales for SA’s current approach to surrogacy, which requires a genetic link between the commissioning parents and the created child. These rationales have appealed to: the prospect of harm to the child; a slippery slope towards systematic eugenics; a principle of respect for human nature; and a principle of developing one’s humanness. In each case I argued that these considerations fail to provide a sound defence for the law. Furthermore, I contended that in the absence of a strong, or even widely held, ethical rationale for it, the law should be revoked out of respect for people’s privacy and their ability to create loving and intimate relationships. Such a position, which would accord more liberty than a religious traditionalism, is not necessarily motivated by a radical transhumanism, and also need not lead to that in practice. Instead, SA’s Constitution and its attendant values can chart a safe course.


3.34 Van Niekerk writes\textsuperscript{180}:

Roots do matter, as a right to know one’s genetic origins plays a pivotal role in informing one’s identity. However, they do not matter so much as to require genetic material from at least one commissioning parent to facilitate a surrogacy arrangement. What is or should be important is the commissioning parent(s) suitability to parent, which can be gathered from, amongst other evidence, their intention to parent. Biology/genetics provides no guarantee for the welfare of the child. In fact, it has been suggested that the absence of a genetic link may provide a better guarantee of the child’s welfare.

### 3.3.1 Constitutional Court: AB and Surrogacy Advisory Group v Minister of Social Development

**A: BACKGROUND**

3.35 On 29 November 2016, the Constitutional Court\textsuperscript{181} handed down judgment in an application for confirmation of a High Court\textsuperscript{182} order that declared section 294 of the Children’s Act unconstitutional.

3.36 The first applicant, AB, has a medical condition which is permanent and irreversible and prevents her from conceiving and carrying a pregnancy and is unable to give birth to a child. She is medically unable to fall pregnant using her own gametes or with the assistance of donated gametes by way of IVF. AB is also unable to donate her own gametes in order for surrogacy to take place. AB is thus both conception-infertile and pregnancy-infertile. She was not in a sexual relationship with someone who could make a gamete donation.

3.37 Between 2001 and 2011, she underwent 18 IVF cycles which were all unsuccessful in helping her fall pregnant. AB considered a SMA; however, she was informed that as a single woman incapable of donating a gamete, she could not legally enter into a surrogacy agreement as s294 of the Children’s Act requires the gametes of at least one commissioning parent to be used in the conception of the child contemplated by the surrogacy agreement.

\textsuperscript{180} C Van Niekerk, Section 294 of the Children’s Act: Do roots really matter? PELJ 2015 Vol 18 No 2 398 at 421

\textsuperscript{181} AB and Another v Minister of Social Development (CCT155/15) [2016] ZACC 43; 2017 (3) BCLR 267 (CC) (29 November 2016)

\textsuperscript{182} AB and Another v Minister of Social Development As Amicus Curiae: Centre for Child Law (40658/13) [2015] ZAGPPHC 580; [2015] 4 All SA 24 (GP); 2015 (10) BCLR 1228 (GP); 2016 (2) SA 27 (GP) (12 August 2015)
3.38 The second applicant, Surrogacy Advisory Group (SAG) is a voluntary association of medico-legal practitioners and other professionals experienced in the field of infertility that offer education, advice and support, free of charge, to persons considering entering into surrogacy agreements in order to become parents. With the assistance of the SAG, AB challenged the constitutionality of s294. In their view, families without a parent-child genetic link are just as valuable as families with such a link.

3.39 The High Court held that the section unjustifiably limits AB’s rights to equality, dignity, autonomy, privacy and reproductive healthcare. For this reason, it declared the section unconstitutional and invalid.

3.40 In accordance with section 172(2)(a) of the Constitution, the applicants approached the Constitutional Court for confirmation of the order of invalidity made by the High Court.

3.41 The applicants accept that one of the purposes of s294 of the Children’s Act is to guarantee that a child to be born as a consequence of a surrogate motherhood agreement is genetically related to at least one of her commissioning parents. The SAG argued, however, that this purpose does not immunise the provision from constitutional scrutiny and referred to what it calls a “threshold requirement”. This is defined as “the requirement found in s295(a) of the Children’s Act, namely that the commissioning parent or parents must not be able to give birth to a child and that such condition must be permanent and irreversible”.

3.42 The SAG also drew a distinction in its written submissions between what it terms, the “Class” and the “Subclass” and argued that s294 of the Children’s Act separately infringes the rights of members of the Class to equal protection before the law, human dignity, “reproductive autonomy” and privacy. Additionally, as members of the Subclass, persons like AB are unfairly discriminated against and are denied access to reproductive healthcare. The applicants further assert that none of the justifications offered by the respondent, Minister of Social Development, for the limitation of rights have merit and the purpose of s294 contended for by the state cannot qualify as a “legitimate government purpose” in the South African constitutional dispensation.

3.43 The Minister opposed the confirmation of constitutional invalidity. She submitted that none of the rights enumerated by the applicants are limited by s294. The Minister argued that even if the rights are limited, the limitations are justifiable in an open and democratic society based on human dignity, equality and freedom. She asserted that s294 exists for the
protection of the best interests of children and prevents commercial surrogacy and the commodification of children.

3.44 The Centre for Child Law was admitted as amicus curiae (friend of the Court) and submitted that the “genetic origin” is something that belongs to the prospective child. Further, it insisted that the risk to children’s self-identity and self-respect – their dignity and best interests – is all-important. S294 is accordingly rationally connected to the purpose of ensuring that children know their genetic origin, an approach that is supported by international law.

B: MAJORITY JUDGMENT

3.45 In the majority judgment written by Nkabinde J (Mogoeng CJ, Moseneke DCJ, Bosielo AJ, Jafta J, Mhlantla J and Zondo J concurring), it was acknowledged at the outset that the case was complex and required sensitivity. The majority highlighted that, at its core, the matter concerned the power of the state to regulate the assistive reproductive opportunities available to those who are conception and pregnancy infertile, to have children of their own.

3.46 The majority judgment held that this matter was not about whether the statutory requirement of a genetic link in that section had relevance to the legal conception of family.

3.47 At paragraph 263-264 Nkabinde J referred to the High Court judgment and said:

In declaring section 294 of the Children’s Act to be inconsistent with the Constitution and invalid, the High Court approached the matter by analysing the legal conception of what constitutes family. It remarked that the Legislature should take cognisance of the advances in fertility and reproductive technology and the obligation to redefine the traditional view of the family. The High Court held that the genetic link requirement—

(a) is irrational in terms of section 9(1) of the Constitution. It referred to the differentiation in the procedures between IVF in terms of the Regulations Relating to Artificial Fertilisation of Persons (IVF regulations) and surrogacy. The High Court concluded that there is no rational connection between the differentiation and the legitimate government purpose that differentiation is designed to achieve;

(b) infringes AB’s or the Subclass’s right—
(i) not to be unfairly discriminated on the basis of infertility whereas under the IVF regulations parents are free to use double-donor gametes in terms of section 9(3) of the Constitution;
(ii) to human dignity in terms of section 10 of the Constitution;
(iii) to reproductive autonomy in terms of section 12(2)(a) of the Constitution.

The High Court remarked that in making decisions to use donor gametes towards conception of the prospective child commissioning parents exercise their autonomy – a vital part of human dignity. The genetic link requirement, it held, thus infringes human dignity and the right to bodily and psychological integrity, which includes the right “to make decisions concerning reproduction”; and
(iv) to access to health care services in terms of section 27 of the Constitution.

While the High Court accepted that “mere differentiation” does not necessarily violate the right to equality, it said that the factual differentiation does not justify a legal differentiation. The Court said that this is so “[i]f regard is had to the IVF regime where parents are free to use double-donor gametes”. It held that differentiation based on the genetic link requirement constitutes discrimination because it has the effect of excluding members of the Subclass “from accessing surrogate motherhood as a reproductive avenue”. That exclusion, it said, reinforces the profound negative psychological effects that infertility has on a person.

3.48 In deciding the confirmation application regard must be had to the text of the impugned provision, to determine its legislative objects. It held that the regulatory scheme in chapter 19 must be considered in the context of the Children’s Act as a whole and specifically referred to the long title, preamble, objects as set out in s2, sections 4, 6, 7 (best interests of the child), 9, 41, 292-297, 301 and 303.

3.49 At paragraphs 279-282 Nkabinde J said:

The regulatory scheme in Chapter 19 must be considered in the context of the Children’s Act, as a whole. While the Children’s Act seeks to protect other rights in the Constitution its main objective, as set out in section 2, is to give effect to the constitutional rights of children: this is plain from the name of the statute itself. Its long title and preamble also bear that out. The legislative scheme under Chapter 19, especially the impugned provision, also protects the child by ensuring that a genetic link exists when that child is conceived.
Section 295(e), read with section 9, of the Children's Act also affirms the paramountcy of the best interests of the child contemplated in the surrogate motherhood agreement. This does not mean that the child's rights assume dominance over other constitutional rights. In terms of section 295(e), the personal circumstances and family situations of “all the parties concerned” have to be considered when confirming the agreement.

Section 28(2) of the Constitution avows the paramountcy of the best interests of the child in every matter concerning the child. The fact that this provision gives paramountcy to the best interests of the child in matters concerning the child does not mean that other rights should not be taken into account. Moreover, as this Court remarked in De Reuck, “constitutional rights are mutually interrelated and interdependent and form a single constitutional value system.” The Court said that section 28(2), like the other rights in the Bill of Rights, is subject to limitations that are reasonable and justifiable in compliance with section 36 of the Constitution. It follows that children's rights do not trump other rights.

With this prelude, the alleged limitation of AB’s rights needs to be examined with a view to determining whether the challenged provision passes muster. These rights include, broadly, the rights to equality, human dignity, freedom and security of the person, privacy and health care.

i. Rationality of Section 294

3.50 At paragraphs 286-290 Nkabinde J said:

The respondent accepted that there is a differentiation between the surrogacy legislation and the IVF regulations. This is correct because IVF is regulated by the Regulations Relating to Artificial Fertilisation of Persons. The Regulations are enacted in terms of the National Health Act. Surrogacy is regulated in terms of the Children’s Act even though the artificial fertilisation procedures have to be carried out in terms of the Regulations. Needless to say, the objectives of the Children’s Act and the National Health Act are different, hence the obvious differences between IVF and surrogacy. It then follows that a statutory provision cannot be measured against regulations under different legislation to decide whether it is rational or consistent with the Constitution. It is only when the regulatory measure does not serve a legitimate
government purpose that it can fall foul of section 9(1) of the Constitution. Otherwise, many statutes that are replete with measures that merely differentiate would run afoul of the Constitution.

Is there a rational connection between the differentiation in question and the legitimate governmental purpose that differentiation is designed to achieve? YES: The requirement of donor gamete(s) within the context of surrogacy indeed serves a rational purpose – the public good chosen by the lawgiver – of creating a bond between the child and the commissioning parents or parent. The creation of a bond is designed to protect the best interests of the child-to-be born so that the child has a genetic link with its parent(s). Therefore, a rational connection exists.

In any event, the disqualification of AB or of other people similarly placed is rational in that it safeguards the genetic origin of the child as contemplated in the surrogacy agreement, for the child's best interests. The disqualification is no different, for example, from the disqualification from obtaining or holding a learner's or driving licence in terms of section 15(1) the National Road Traffic Act. Those disqualified include people with biological disabilities or medical conditions: defective vision (blindness) or uncontrolled epilepsy and uncontrolled diabetes mellitus, respectively. Unquestionably, these disqualifying conditions, as those contained in the impugned provision, result in differentiation that serves legitimate government purposes. In this case, although AB is disqualified from concluding the surrogate motherhood agreement by reason of biological, medical or other reasons she is not left without any legal option. She could in theory bring herself within the ambit of section 294 by entering into a partnership relationship with someone whose gamete may be used for the conception of the child as contemplated in the agreement.

Besides, an IVF arrangement cannot be compared with the use of donor gamete within the surrogacy context. This is so because the procedures in respect of IVF and surrogacy differ substantially. In relation to the former, although the “host mother” may not necessarily be the genetic mother of the child she retains a gestational link to

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183 Boniface AE, The genetic link requirement for surrogacy: A family cannot be defined by Genetic Lineage 2017 TSAR 190. Boniface discusses the High Court judgment and writes that the “South African court does not appear to have focussed on the best interests of the child or the child’s origins but instead on the rights of the commissioning parents.”
the child as a result of carrying the child. In regard to surrogacy a genetic link is created between the child-to-be and the commissioning parents or parent.

It is correct that the IVF regulations allow for double-donor IVF. This is in the context of the National Health Act. Thus, a specific recipient can, in terms of regulation 10(2)(a)(ii), receive gametes from a male and female donor. But that cannot be a justification to strike down the challenged provision. The applicants did not dispute that the clarity of origin may be important to a self-identity and self-respect of the child. The High Court nonetheless considered that, because the same is not required in the context of IVF where double-donation of gametes is permitted, it should not be required in the context of surrogacy. Indeed, as the amicus correctly argued, the logic in the reasoning is difficult to follow. The risk to children’s self-identity and self-respect (their dignity and best interests) is, unquestionably, all important. The fact that these rights are placed at similar risk in another context is hardly a reason to find their protection irrelevant.

And further at 293-294 Nkabinde J said:

At the risk of repetition, it cannot be disputed that the conditions in section 294 are the means to establishing a genetic link between the commissioning parents and the child to be born as contemplated in the surrogacy agreement. Nor can it be questioned that establishing a genetic link is a legitimate government purpose. The High Court disregarded the object of the Children’s Act. It overemphasised the interests of the commissioning parent(s) and overlooked the purpose of the impugned provision and the best interests of children despite it being established that cases involving children are pre-eminently of the kind where one “must scratch the surface to get to the real substance below”.

Here, the substance below the surface is the need for a genetic link between a child and at least one parent. The importance of this genetic link is affirmed in the adage “ngwana ga se wa ga ka otlha ke wa ga katsala” (loosely translated the adage means “a child belongs not to the one who provides but to the one who gives birth to the child”). Hence clarity regarding the origin of a child is important to the self-identity and self-respect of the child. Unsurprisingly, this was correctly endorsed by the High Court. There is a rational nexus between the purpose of the legislative scheme, including section 294, that provides a framework within which individuals are able to have children and become parents in circumstances where they would
otherwise not have been. For all these reasons, I do not support the conclusion by the High Court that section 294 constitutes an irrational legal differentiation that violates section 9(1) of the Constitution. The rationality challenge must fail.

3.52 The majority found that the differentiation between the genetic link requirement in s294 of the Children's Act and the IVF regulations is rational. The requirement of donor gamete(s) within the context of surrogacy indeed served a rational purpose of creating a bond between the child and the commissioning parents or parent. The majority therefore did not endorse the conclusion of the High Court that s294 constituted an irrational legal differentiation that violated s9(1) of the Constitution.

3.53 Furthermore, the court held in terms of s9(3), that the impugned provision did not disqualify commissioning parents because they are infertile – it afforded infertile commissioning parents the opportunity to have children of their own by contributing gametes for the conception of the child. If the intended parent cannot contribute a gamete, the intended parent still had available options afforded by the law.

ii. Does section 294 limit AB’s right to equality?

3.54 At paragraph 295 Nkabinde J said:

Having concluded that the impugned provision is rationally connected to a legitimate government purpose, the next inquiry is whether the provision limits AB’s right to equality. Here, it is necessary to determine whether the impugned provision discriminates against AB and members of the Subclass in terms of section 9(2) of the Constitution and, if so, whether the discrimination is unfair in terms of section 9(3) of the Constitution.

3.55 At paragraphs 298-300 Nkabinde J said:

In this case, it is argued that the discrimination is based on infertility and the genetic link requirement. These grounds are not specified in section 9(3) of the Constitution. The differentiation will amount to discrimination if the impugned provision authorises unequal treatment of people based on certain attributes and characteristics attaching to them. As mentioned above, section 294 regulates the conclusion of valid surrogacy agreements. The section does not confer a right to conclude the agreement. The High Court correctly recognised that mere differentiation does not
necessarily violate the right to equality. However, it held that the differentiation based on the genetic link requirement constitutes discrimination because it has the effect of excluding members of the Subclass “from accessing surrogate motherhood as a reproductive avenue”.

It cannot be gainsaid that inherent human dignity is at the heart of individual rights, including the right to equality. It is true also that equality will mean nothing if it does not recognise a person’s equal worth as a human being. Undeniably, infertile people often feel socially isolated and marginalised. But, it cannot be safely said that all these negative effects of infertility are attributable to the legislative measures contemplated in section 294, specifically the genetic link requirement in that provision. It needs to be stressed that section 294 merely regulates the conclusion of a valid surrogate motherhood agreement. What disqualifies AB, and others similarly placed, is nothing but the biological, medical or other reasons as contemplated in section 294.

Notably, as evidenced by the history behind the legislative scheme, Chapter 19 favours the commissioning parents or parent. It has brought certainty regarding the status of the relationship between the commissioning parents or parent and the child-to-be as well as the surrogate mother. Moreover, given the object of the Children’s Act, it gives effect to the best interests of the child-to-be. Section 7 lists the needs for the child to maintain connection with his or her culture and tradition and the need to protect the child from psychological harm. In our diverse society keeping the connection with extended family, culture and tradition is indeed part of the factors showing where the best interests of the child lie.

3.56 Further at paragraphs 301-305 Nkabinde J said:

In my view, the alleged ground of discrimination is not based on the attributes and characteristics of AB or of the Subclass. As a result, unless the applicants can show that the object of the legislative scheme is arbitrary, capricious or manifests naked preferences, the “personal choice” of AB or the Subclass is of no relevance to the inquiry. Section 294 neither creates nor compounds infertility, as submitted by AB.

The impugned provision does not disqualify commissioning parents because they are infertile. It affords infertile commissioning parents the opportunity to have children of their own by contributing gametes for the conception of the child contemplated in the surrogate motherhood agreement. In the case where the commissioning parent is
single, the impugned provision provides for that parent, where a gamete of that parent can be used in the creation of the child. But if that parent cannot contribute a gamete, the parent still has available options afforded by the law: a single parent has the choice to enter into a permanent relationship with a fertile parent, thereby qualifying the parent for surrogacy. If the infertile commissioning parents, or parent, decide not to use the available legal options, they have to live with the choices they make.

As a matter of fact, AB made several attempts to fall pregnant by undergoing the IVF treatment, using her own ova and the sperm of her husband at the time. When this failed she repeatedly used anonymous donor ova and the sperm of her husband at the time by using the IVF option because of her infertility. At some stage, after switching fertility clinics and getting divorced, she underwent further unsuccessful IVF treatment cycles – using anonymous donor ova as well as donor sperm but miscarried. As a single person, who is conception and pregnancy infertile, AB sought to resort to surrogacy but the donor gamete requirement disqualified her. But, as mentioned above, the Legislature affords her an option. It is her personal choice and not her attributes of being infertile or the challenged provision that place her outside of the ambit of section 294. This being the case, it cannot be said that the impugned provision discriminates against her or members of the Subclass.

To that end, it is not necessary to proceed to the final leg of the inquiry – to determine whether the discrimination is unfair. In any event, assuming that the differentiation in section 294 amounts to discrimination, which I do not find, it does not necessarily follow that it is unfair. It can only be so if the differentiation results in AB or the Subclass being treated differently in a way which impairs their fundamental dignity as human beings, or which affect them adversely in a comparably serious manner.

For these reasons, I do not agree with the first judgment that section 294 of the Children’s Act discriminates against AB and the members of the Subclass and that the discrimination is unfair. Therefore, the challenge based on section 9(2) and (3) of the Constitution must also fail.

3.57 The Court held that the disqualification in terms of s294 arose from AB’s biological and medical conditions. AB could still, in theory, bring herself within the ambit of s294 by entering into a partnership relationship with someone whose gamete may be used for the conception of the child as contemplated in the Act.
Does section 294 limit AB's right to reproductive autonomy?

3.58 The applicants It is submitted that AB’s right to dignity and “reproductive autonomy as guaranteed by section 12(2)(a) of the Constitution” is limited by the genetic link requirement in section 294.

3.59 Section 12 of the Constitution deals with “freedom and security of the person” and Section 12(2) reads:

“(2) Everyone has the right to bodily and psychological integrity, which includes the right—
(a) to make decisions concerning reproduction;
(b) to security in and control over their body; and
(c) not to be subjected to medical or scientific experiments without their informed consent.”

3.60 At paragraphs 313-315 Nkabinde J said:

The right relating to reproductive autonomy in section 12(2)(a) confronts directly the fact that many women do not enjoy security in and control over their own bodies. To that end, the focus is on the individual woman’s own body and not a body of another woman. This view finds support in the context of scholarly writings that have analysed section 12(2) to date, generally within the confines of the issue of abortion and the subject’s own body.

Jurisprudence in comparable jurisdictions also shows that security of the person encompasses personal autonomy involving control over a person’s bodily integrity. The applicants’ argument that the “donor gametes decision” entails a decision regarding AB’s reproduction is thus misconceived. Surrogacy, in its most basic sense is the situation where one woman bears a child for another. As a result, an interpretation that the text of section 12(2)(a) affords reproductive autonomy protection to the commissioning parent in the context of the surrogate motherhood agreement is unduly strained.

I acknowledge the need to respect the autonomy of commissioning parents in relation to the choices they make, for purposes of concluding surrogacy agreements. However, section 12(2)(a) does not give anyone the right to bodily integrity in respect
of someone else’s body. If this were so, that begs the question, how then does section 294 of the Children’s Act impair the right to bodily integrity of someone who is unable to produce gamete? In my view, while the donor gamete decision is an important exercise of a prospective parent’s autonomy, it does not entail a decision regarding the commissioning parent’s bodily integrity. It entails the body of a surrogate “host” mother.

3.61 The majority traced the scope of the right in s12(2)(a) of the Constitution and held that the focus of the right to reproductive autonomy is on the individual woman’s own body and not the body of another woman. It therefore found that the interpretation contended for by the applicants was unduly strained and therefore, the attack on section 294 based on section 12(2)(a) had to fail.

iii. Does section 294 limit AB’s right to reproductive health care?

3.62 At paragraph 319 Nkabinde J said:

The High Court held that surrogacy is a form of “reproductive health care” guaranteed in terms of section 27(1)(a) of the Constitution. This section entitles everyone to have access to health care services including reproductive health care. Section 27(2) obliges the state to “take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation” of these rights.

3.63 Nkabinde J said that it is difficult to understand the applicants’ constitutional challenge based on the right to have access to reproductive health care in terms of s27(1) because the applicants did not elaborate on the content of the right to health care under section 27.

3.64 Nkabinde J said that the High Court reached its conclusion regarding s27(1) without analysing the nature of the right. On the facts of this case and based on what the Court decided regarding s294 in relation to the position of the infertile commissioning parent(s), the majority held that the genetic link requirement does not prevent AB and members of the Subclass from enjoying the right to have access to health care services, including reproductive health care in terms of section 27(1) of the Constitution.
iv. Does section 294 limit AB’s right to privacy?

3.65 At paragraph 323 Nkabinde J said:

The applicants’ challenge based on AB’s privacy right in terms of section 14 of the Constitution must also fail because this right is not limited by the genetic link requirement in section 294 of the Children’s Act. Section 14 of the Constitution provides that “[e]veryone has the right to privacy, which includes the right not to have: (a) their person or home searched; (b) their property searched; (c) their possessions seized; (d) or the privacy of their communications infringed”. In Jordan this Court remarked that the right to make autonomous decisions in respect of “intensely significant aspects of one’s personal life” falls into the right to privacy but it declined to posit an independent right to autonomy. As with the position in relation to the other rights dealt with earlier, the impugned provision does not limit AB’s right to privacy.

3.66 The Court held that the provision does not limit AB’s right to privacy as contended for by the applicants.

3.67 Accordingly, the majority judgment upheld the Minister’s appeal and declined to confirm the declaration of constitutional invalidity in respect of section 294 of the Children’s Act.

C: MINORITY JUDGMENT

3.68 The minority judgment of Khampepe J (Cameron J, Froneman J and Madlanga J concurring), found that section 294 violated the right to make decisions concerning reproduction and the right to equality. It determined that by preventing those who are both conception and pregnancy infertile from ameliorating the negative effects of their infertility through surrogacy, the provision harms their psychological integrity. It held that the provision unfairly discriminates on the basis of both pregnancy and conception infertility.

3.69 The minority held that the limitation was not reasonable and justifiable. It found that the provision did not prevent the proliferation of “designer babies”, nor did it guard against the commercialisation of surrogacy as contended for by the Minister.
3.70 The minority judgment said that it is s41 of the Children’s Act that prevented children born of surrogacy from knowing their “genetic origin”, rather than s294. The minority judgment also found that as the best interests of the child was a flexible standard, it cannot always be the case that it was better for a child to have never been born, than to be born without a “genetic link” to one of its parents.

3.71 It further held that surrogacy and adoption were not sufficiently similar processes to justify the limitation of constitutional rights. It emphasised that it is inappropriate to entrench any particular form of family and that AB should not be compelled to seek a partner to have a child, as a multitude of family formations are woven through South African society.

3.72 The minority judgment would have confirmed the declaration of invalidity and suspended it for 18 months to enable the legislature to remedy the unlawful position.

### 3.4 Surrogacy and Anonymous Donors

3.73 As stated above, gestational surrogacy takes place when an embryo created by *in vitro* fertilization is implanted in a surrogate. Gestational surrogacy may take a number of forms, but in each form listed below the resulting child is not genetically related to the surrogate:

A. the embryo is created using the intended father's sperm and the intended mother's eggs. The resulting child is genetically related to both intended parents.

B. the embryo is created using the intended father's sperm and a donor egg where the donor is not the surrogate. The resulting child is genetically related to the intended father and the biological mother is a donor.

C. the embryo is created using the intended mother's egg and donor sperm. The resulting child is genetically related to the intended mother and the biological father is a donor.

D. a donor embryo is implanted in a surrogate. Such an embryo may be available when others undergoing IVF have embryos left over, which they donate to others. The resulting child is genetically unrelated to the intended parent or parents. The biological mother and the biological father may both have been donors.
3.74 In South Africa, it is not possible for the commissioning parents to use a donor embryo which has no genetic link to the commissioning parent because s294 of the Children’s Act requires that a child contemplated in terms of a valid SMA must be genetically related to both the commissioning parents or, if this is impossible as a result of medical or biological or other valid reasons, related to at least one of the commissioning parents. Where the commissioning parent is a single person, the child must be genetically related to the commissioning single parent.

3.75 Section 41\(^\text{184}\) of the Children’s Act entitles a child or the guardian of a child who was born as a result of artificial fertilisation or surrogacy to have access to certain information about the child's genetic parents.

3.76 In the instance where the embryo is created using the intended father's sperm and the intended mother's eggs, the resulting child is genetically related to both intended parents and will be raised by and will know the intended parents and will know his or her genetic origins on both the paternal and maternal side. However, in terms of s41(2), the child or the guardian/commissioning parent of such child cannot know the identity of the surrogate mother who gave birth to him or her.

3.77 It is clear that in the case of gestational surrogacy, there will be instances (such as B and C above) where either donor eggs or donor sperm will be used. In the case of surrogacy where either donor sperm or donor eggs are used, s41(1)(a) entitles the child or the guardian/commissioning parent of such child to have access to any medical information concerning that child's other genetic parent. In terms of s41(1)(b), the child or the guardian/commissioning parent of such child may access any other information about the child's other genetic parent but not before the child reaches the age of 18 years.

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\(^{184}\) Section 41 of the Children’s Act read as follows:
Access to biographical and medical information concerning genetic parents
(1) A child born as a result of artificial fertilisation or surrogacy or the guardian of such child is entitled to have access to-
(a) any medical information concerning that child's genetic parents; and
(b) any other information concerning that child's genetic parents but not before the child reaches the age of 18 years.
(2) Information disclosed in terms of subsection (1) may not reveal the identity of the person whose gamete was or gametes were used for such artificial fertilisation or the identity of the surrogate mother.
(3) The Director-General: Health or any other person specified by regulation may require a person to receive counselling before any information is disclosed in terms of subsection (1).
3.78 Section 41(2) stipulates that information disclosed in terms of s41(1) may not reveal the identity of the person whose gamete was or gametes were used for such artificial fertilisation or the identity of the surrogate mother.

3.79 Thus where donor sperm or donor eggs are used in a surrogate motherhood agreement, the child will not know the identity of one of his or her parents and will not know his or her own genetic origin related to that parent. Further the child will not know the identity of the surrogate mother who gave birth to him or her.

3.80 Section 41(1)(a) and (b) speak of information related to the child’s genetic parent and is silent on access to information (other than identifying information) related to the surrogate mother. It is therefore unclear as to whether the child can access information regarding the surrogate mother whether this is medical information or any other non-identifying information.

3.81 In the constitutional court judgment in AB and Another v Minister of Social Development the court held that the creation of a bond between the child and commissioning parents by way of a genetic link was in the best interests of the child.

3.82 The court said:

[Paragraph 288] In any event, the disqualification (in terms of s294) of AB or of other people similarly placed is rational in that it safeguards the genetic origin of the child as contemplated in the surrogacy agreement, for the child’s best interests.

[Paragraph 290] The risk to children’s self-identity and self-respect (their dignity and best interests) is, unquestionably, all important.

[294] Hence clarity regarding the origin of a child is important to the self-identity and self-respect of the child.

3.83 The “origin” of a child relates to how the child was conceived and by whom and who gave birth to the child. “Clarity” could mean that the child is entitled to know his or her genetic origins not only as it relates to the commissioning parent, but also of the donor and surrogate mother.

185 AB and Another v Minister of Social Development (CCT155/15) [2016] ZACC 43; 2017 (3) BCLR 267 (CC) (29 November 2016)
3.84 Further, the Constitutional Court said

[300] Moreover, given the object of the Children’s Act, it gives effect to the best interests of the child-to-be. Section 7 lists the needs for the child to maintain connection with his or her culture and tradition and the need to protect the child from psychological harm. In our diverse society keeping the connection with extended family, culture and tradition is indeed part of the factors showing where the best interests of the child lie.

3.85 The Constitutional Court found that the High Court had disregarded the object of the Children’s Act by overemphasising the interests of the commissioning parent(s) and overlooked the purpose of the s294 and the best interests of children\textsuperscript{186}.

3.86 In light of the judgment of the Constitutional Court one could argue that a more balanced approach is necessary when weighing the rights of a person or couples who wish to have a child via ART and that of the intended child.

3.87 A 2015 decision of Israel’s Supreme Court ruled that a genetic connection between the child and at least one of the intending parents is needed in order to rule out child trafficking. The case concerned a single woman who arranged for the fertilization of embryos with the sperm of an acquaintance and the egg cell of an anonymous provider from South Africa. The woman’s niece carried the pregnancy for her after undergoing embryo implantation in India, and gave birth to the child in Israel. The woman then petitioned the court for a parenting order, which she was denied. The court reasoned that the law does not recognize parentage that is purely contractual and making babies cannot be left to simple agreement for the creation of a product\textsuperscript{187}.

\textsuperscript{186} Paragraph 293 on page 112
\textsuperscript{187} Ba’am (Administrative Appeal Motion) 1118/14 Anonymous v. Ministry of Welfare and Social Services (1 April 2015)
3.5 Questions

1. Does a child contemplated in terms of a valid surrogate motherhood agreement have a right to know his or her genetic origin?

2. Should a child born as a result of a surrogacy motherhood agreement where a donor gamete is used have the right to know the identity of the gamete donor?

3. Should a child born as a result of a surrogacy motherhood agreement have a right to know the identity of the surrogate mother?

4. The constitutional court in AB and Another v Minister of Social Development held that clarity regarding the origin of a child is important to the self-identity and self-respect of the child. Given this decision should South Africa reconsider anonymous gamete donation in surrogacy and in other types of assisted reproduction?

3.6 Womb Transplants and Growing of Wombs

3.88 People may resort to surrogacy because the intended mother either does not have a uterus. Since there is no uterus, a child cannot be carried. Also the intended mother may have a structural abnormality to her uterus or has fibroids or scar tissue inside the uterus. These conditions can make it harder for women to become pregnant or carry a pregnancy to term. For woman in this predicament, using a surrogate is an option.

3.89 Surgeon Mats Brännström and his team made history by carrying out the world’s first successful womb transplant from a living donor in October 2013 in Sweden which resulted in the birth of baby Vincent in 2014.

3.90 Days after the birth of Vincent, Brännström, who is a professor at Gothenburg University, announced that he is working on growing wombs from scratch a lab within a decade. The project is still in its infancy, however Professor Brännström envisages taking wombs from dead donors and stripping them of their cells, to leave little more than a living framework. This would then be coated with stem cells – ‘master cells’ – taken from the woman’s body. It would then be grown in the lab, before being given to her as a new womb. Using the woman’s own cells would mean it would be an exact match for her own body –
removing the need for powerful and potentially dangerous immunosuppressant drugs. Brännström successfully made a rat’s womb, however, it will be decade before he has a womb ready to put into woman.\footnote{http://www.dailymail.co.uk/health/article-2788193/surgeon-history-womb-transplant-aims-grow-one-scratch-decade.html accessed in July 2016}

3.91 While progress with uterus transplant depends on medical factors, there are also important ethical and legal concerns. Uterus transplant is essential for women without access to surrogacy. It may also be sought by infertile women who dislike surrogacy. John Robertson examines medical, ethical, legal, and policy issues that arise with womb transplant, including the role of surrogacy policies that make them necessary. His conclusion is that there is a clear ethical path for either surrogacy or uterus transplant to be used by women with uterine insufficiency\footnote{John A Robertson, Other women’s wombs: uterus transplants and gestational surrogacy J Law Biosci. 2016 Apr; 3(1): 68–86. Published online 2016 Mar 21. doi: 10.1093/jlb/lsw011 PMCID: PMC5033439, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5033439/ accessed 3 March 2017}.

3.92 The law needs to keep up with the ever advancing science. In years to come womb transplants or custom-made wombs may become the norm and surrogacy may only be used by gay men - unless a womb can be transplanted into a man and he can carry a successful pregnancy.
CHAPTER 4
ADOPTION

4.1 Effect of Adoption

4.1 Adoption is the statutory process of terminating a parent’s legal rights and duties towards its biological children and substituting similar rights and responsibilities with its adoptive parents. An adoption thus severs parental responsibilities and rights of the biological parent or parents and transfers those responsibilities and rights to the adoptive parent or parents. A legal parent-child relationship is created between individuals who are not biologically parent and child. Biological parents are also referred by terms such as original parents, natural parents or birth parents\(^{190}\).

4.2 In terms of s242 of the Children’s Act, an adoption order terminates all the parental ties that any person, including a parent, step-parent or partner in a domestic relationship had in respect of the child prior to the adoption and confers full parental responsibilities and rights in respect of the child, unless the adoption order or a post-adoption agreement confirmed by the court provides otherwise\(^{191}\).

\(^{190}\) Accessed from https://adoption.uslegal.com/adopted-childs-right-to-access-information-about-biological-parents/

\(^{191}\) 242 Effect of adoption order

(1) Except when provided otherwise in the order or in a post-adoption agreement confirmed by the court an adoption order terminates—

(a) all parental responsibilities and rights any person, including a parent, step-parent or partner in a domestic life partnership, had in respect of the child immediately before the adoption;

(b) all claims to contact with the child by any family member of a person referred to in paragraph (a);

(c) all rights and responsibilities the child had in respect of a person referred to in paragraph (a) or (b) immediately before the adoption; and

(d) any previous order made in respect of the placement of the child.

(2) An adoption order—

(a) confers full parental responsibilities and rights in respect of the adopted child upon the adoptive parent;

(b) confers the surname of the adoptive parent on the adopted child, except when otherwise provided in the order;

(c) does not permit any marriage or sexual intercourse between the child and any other person which would have been prohibited had the child not been adopted; and

(d) does not affect any rights to property the child acquired before the adoption.

(3) An adopted child must for all purposes be regarded as the child of the adoptive parent and an adoptive parent must for all purposes be regarded as the parent of the adopted child.
4.2 Access to Information

4.3 In recent decades, both in South Africa and internationally, there has been an ongoing movement towards greater openness with regard to adoption. From being an area which was long surrounded by great secrecy, arising in large measure from the stigma often associated with extramarital pregnancy and infertility, South African adoption practice has followed the international trend towards promoting a climate in which there would be an optimum level of sharing of information with adoptees about their origins.

4.4 The Child Care Act, 1983, reflected the early stages of this shift by allowing for a regulated process whereby adult adoptees and other interested parties could obtain access to adoption records. Adult adoptees could then, if they wished, make contact with biological parents and family members.

4.5 The necessary tracing and intermediary processes and the counselling of all concerned have become an integral part of adoption social work practice, and a substantial body of experience and practice wisdom has developed in this regard.

4.6 Section 248 of the Children’s Act reads as follows:

Access to adoption register
(1) The information contained in the adoption register may not be disclosed to any person, except–
(a) to an adopted child after the child has reached the age of 18 years;
(b) to the adoptive parent of an adopted child after the child has reached the age of 18 years;
(c) to the biological parent or a previous adoptive parent of an adopted child after the child has reached the age of 18 years, but only if the adoptive parent and the adopted child give their consent in writing;
(d) for any official purposes subject to conditions determined by the Director-General;
(e) by an order of court, if the court finds that such disclosure is in the best interests of the adopted child; or
(f) for purposes of research: Provided that no information that would reveal the identity of an adopted child or his or her adoptive or biological parent is revealed.
(2) The Director-General may require a person to receive counselling before disclosing any information contained in the adoption register to that person in terms of subsection (1)(a), (b), (c) or (e).

(3) Notwithstanding subsection (1), an adopted child or an adoptive parent is entitled to have access to any medical information concerning –

(a) the adopted child; or

(b) the biological parents of the adopted child, if such information relates directly to the health of the adopted child.

(4) Notwithstanding subsection (1), parties to a post-adoption agreement as contemplated in section 234 are entitled to have access to such information about the child as has been stipulated in the agreement.

4.7 The current Act extends allows for court-ordered disclosure of information held in the adoption register, for access by the child or the adoptive parent to essential medical information, and for access to any information which may be specified in a post-adoption agreement in terms of s234192.

4.8 Regarding inter-country adoptions, s272193 of the Children’s Act provides for access to information and states that, subject to the provisions of s248 with regard to access to the adoption register, read with such changes as the context may require, the Central Authority194 may disclose to a person older than 18 years who, as a child, was adopted in accordance with the Hague Convention on Inter-country Adoption, any information in the records of the Central Authority concerning that person’s origin.

193 272 Access to information
Subject to the provisions of section 248 with regard to access to the adoption register, read with such changes as the context may require, the Central Authority may disclose to a person older than 18 years who, as a child, was adopted in accordance with the Hague Convention on Inter-country Adoption, any information in the records of the Central Authority concerning that person’s origin.
194 S257 of the Children’s Act titled Central Authority provides as follows:
(1) For the purposes of the Hague Convention on Inter-country Adoption, ‘Central Authority’-
   (a) in relation to the Republic, means the Director-General; or
   (b) in relation to a convention country, means a person or office designated by such convention country under Article 6 of the Hague Convention on Inter-country Adoption.
(2) The Director-General, after consultation with the Director-General: Justice and Constitutional Development, must perform the functions assigned by the Convention to Central Authorities.
4.3 LGBTI, Ethnicity and Cross Culture

4.9 In September 2002 in *Du Toit v Minister for Welfare and Population Development* the Constitutional Court held that the law must allow for joint adoption and guardianship of children by permanent same-sex life partners. The Court held further that excluding partners in same-sex life partnerships from adopting children jointly where they would otherwise be suitable to do so was in conflict with the principle enshrined in s 28(2) of the Constitution, i.e. that ‘a child's best interests are of paramount importance in every matter concerning the child’.

4.10 Subsequently S231 of the Children's Act, 2005 was enacted and allows for adoption by spouses and by partners in a permanent domestic life-partnership and by other persons sharing a common household and forming a permanent family unit.

4.11 S231(3) states that a social worker may take into account the cultural and community differences of the adoptable child and prospective adoptive parent. S231(3) does not exclude a person from adopting on the basis of race or culture but relates to the matching of the prospective adoptive parent and the child.

4.12 Shannon Finlay (Finlay, November 2006) undertook an empirical study to conduct applied, exploratory and descriptive research to establish challenges specific to cross racial

\[^{195}\text{2003 (2) SA 198 (CC) }\]
\[^{196}\text{Paragraph 22 at 208B }\]
\[^{197}\text{231 Persons who may adopt a child }\]
\[^{198}\text{(1) A child may be adopted— }\]
\[^{199}\text{(a) jointly by— }\]
\[^{200}\text{(ii) partners in a permanent domestic life-partnership; or }\]
\[^{201}\text{(iii) other persons sharing a common household and forming a permanent family unit; }\]
\[^{202}\text{(b) by a widower, widow, divorced or unmarried person; }\]
\[^{203}\text{(c) by a married person whose spouse is the parent of the child or by a person whose permanent domestic life-partner is the parent of the child; }\]
\[^{204}\text{(d) by the biological father of a child born out of wedlock; or }\]
\[^{205}\text{(e) by the foster parent of the child. }\]
\[^{206}\text{(3) In the assessment of a prospective adoptive parent, an adoption social worker may take the cultural and community diversity of the adoptable child and prospective adoptive parent into consideration. }\]
adoption in Gauteng as part of her Master’s studies. She interviewed adoptive parents who took part in the focus groups and wrote in her thesis as follows:

All respondents were in agreement that their cross racially adopted children have a right to seek out their biological parents and that they would support them in doing so. One respondent said: “We would support our children in finding their parents because they will do it with or without us if they really want to do it”.

However, respondents are also adamant that they would like to maintain clear boundaries between their family units and that of the birth family. One respondent stated: “I wouldn’t want our lives getting tangled up.”

Respondents were in full agreement that in the case of seeking out biological parents that the same elements of honesty and openness that apply to all other areas of making a cross racial adoption successful, apply here equally. In the words of one respondent: “The happy adoptees are the ones who have support, honesty and closure and the unhappy ones are the ones who have lies and deceit”.

In this regard Palacios and Sandoval (in Brodzinsky & Palacios, 2005:140) point out that secrets and lies surrounding adoption have been shown to have a negative effect on the adopted child. In his novel Thomas Brooks (2006:5) said that because he knew nothing about his biological parents or heritage he felt that his own human identity was partially lacking. Literature indicates that although seeking biological parents is often difficult, it is an important process for the adoptee. (Compare Melina, 2002:199-206 and Schooler, 1993:199-210.)

Melina (2002:200) says adoptive parents may question what the search for birth parents represents and what it fulfils but research has shown that the reasons adopted children search for birth parents are vast and varied. Some adopted children want a link to ancestors, some want to fill in missing parts, some to know what parts of their self are inherited and some require closure, among many reasons.

The challenge for the adoptive parent, in the researcher’s view, will be being able to accept and support the individual adoptee’s reasoning for searching, regardless of whether it makes sense to them. It is, in the researcher’s view, the responsibility of adoptive parents to educate adoptees that not all reunions are successful or pleasant
and they should be prepared for a number of possible outcomes. Cross racially adopted child may wish to seek out their biological parents or link with their birth history and culture.

4.13 The empirical study demonstrated that parents who cross racially adopt do experience challenges and there are challenges specific to cross racial adoption. A number of the challenges experienced by parents who cross racially adopt are directly linked to a lack of support throughout the adoption process. A need exists for a comprehensive model of support for parents who cross racially adopt

4.4 Questions

According to s248 and s272 of the Children’s Act, an adopted child has the right to access information contained in the Adoption Register (other than medical information) at 18 years of age.

1. Should adopted an adopted child have access to information related to his or her biological parent or parents when younger than 18 years of age?
   If so, why?
   If not, why not?

2. Would an adopted child having access to information related to his or biological parent or parents when younger than 18 years of age have the effect of destabilising the adoption family arrangement?

3. Would an adopted child having access to information related to his or her biological parent or parents when younger than 18 years of age have the effect of causing the adopted child psychological or emotional harm or would such information be beneficial to the child depending on the circumstances and the maturity of the adopted child?

4. In instances where it is clear that the adopted child is not the biological child of the adoptive parents (such as a black child adopted by a white couple) or where there could certainly be questions about the biological origins of an adopted child (such as a white child adopted by a white gay couple), should the adopted child have access to information about his or her biological parents sooner rather than at 18 years of age in the interests of the
adopted child learning about his or her culture or to answer obvious questions about the adopted child’s paternity or maternity?

5. Is it to the donor-conceive person’s benefit to have knowledge of who his or her parents are, if he or she cannot have a relationship with his or her genetic parents?
CHAPTER 5
REGISTRATION OF BIRTH AND DISPUTED PATERNITY

5.1 The Right of a Child to a Name, Registration of Birth and Identity

5.1 The Constitution provides that “every child has the right to a name and a nationality from birth”.

5.2 The Department of Home Affairs (DHA) administers the Birth and Death Registration Act, 1992 (BDRA) and the Regulations on the Registration of Births and Deaths (BD Regulations) thereto which provides for the birth registration of children born in South Africa.

5.3 Birth registration is necessary to concretize a child’s rights to a name and nationality. A birth certificate is a vital record that documents the birth of a child and is the means by which the State recognizes the existence and status of a child. A birth certificate provides a child with an identity of their own and allows a child to access key social services such as education, health care and social grants.

5.4 The register of births allows the State to obtain statistics regarding births and mortality and to develop social structures to cater for all children.

5.5 The CRC and the ACRWC protect the right of all children to be registered immediately after birth, to be given a name, and to acquire a nationality. Article 8(1) of the CRC obliges States Parties to respect the right of the child to preserve his or her identity,
including nationality, name and family relations. The identity of the child’s parents is relevant to establish the child’s identity, including nationality\textsuperscript{205}, name and family relations.

5.6 The CRC\textsuperscript{206} and the ACRWC\textsuperscript{207} both also contain a sub-article requiring the State to ensure that its laws and systems in relation to birth registration do not result in foreign children becoming stateless.

5.7 The CROC has commented as follows\textsuperscript{208}:

25. Birth registration. Comprehensive services for early childhood begin at birth. The Committee notes that provision for registration of all children at birth is still a major challenge for many countries and regions. This can impact negatively on a child’s sense of personal identity and children may be denied entitlements to basic health, education and social welfare. As a first step in ensuring the rights to survival, development and access to quality services for CRC/C/GC/7/Rev.1 page 12 all children (art. 6), the Committee recommends that States parties take all necessary measures to ensure that all children are registered at birth. This can be achieved through a universal, well-managed registration system that is accessible to all and free of charge. An effective system must be flexible and responsive to the circumstances of families, for example by providing mobile registration units where appropriate. The Committee notes that children who are sick or disabled are less likely to be registered in some regions and emphasizes that all children should be registered at birth, without discrimination of any kind (art. 2). The Committee also reminds States parties of the importance of facilitating late registration of birth, and

\textsuperscript{205} Citizenship by birth

(1) Any person-
(a) who immediately prior to the date of commencement of the South African Citizenship Amendment Act, 2010, was a South African citizen by birth; or
(b) who is born in or outside the Republic, one of his or her parents, at the time of his or her birth, being a South African citizen,

shall be a South African citizen by birth.

\textsuperscript{206} Article 7(2) of the CRC: States Parties shall ensure the implementation of these rights in accordance with their national law and their obligations under the relevant international instruments in this field, in particular where the child would otherwise be stateless.

\textsuperscript{207} Article 6(4) of the ACRWC: States Parties to the present Charter shall undertake to ensure that their Constitutional legislation recognize the principles according to which a child shall acquire the nationality of the State in the territory of which he has been born if, at the time of the child’s birth, he is not granted nationality by any other State in accordance with its laws.

ensuring that children who have not been registered have equal access to health care, protection, education and other social services.

5.8 On 26 March 2014, Deputy Minister Fatima Chohan said the following regarding the BD Regulations at a DHA media briefing:

You will recall that we gazetted the Births and Deaths Amendment Act, 2010 on 7 December 2010. We published the Regulations on the Registration of Births and Deaths on 26 February 2014 as required by our statutory procedures.

The Amendment Act and the new Regulations came into operation on 1 March 2014 during an important month in our country dedicated to human rights. Home Affairs plays a pivotal role in ensuring every individual’s human rights are protected. We see updating and strengthening legislation on births registration as a fundamental step in protecting our national population register, citizenship, identity and human rights.

You would know that recently we have been doing much work also in improving and strengthening our immigration laws.

In our continued efforts to secure the integrity of our national population register, we have effected the following changes:

Firstly we have tightened up processes for birth registration in that, among others, we now require the notification of birth to be made by both parents whose fingerprints we will verify as part of the process of registering children. We also now require the palm, foot or fingerprint of the child whose birth is sought to be registered to be taken and archived.

These measures are being introduced in an attempt to eliminate fraud relating to parentage as well as one child being used to register multiple birth certificates. If the parents are deceased we require notice of birth to be given by the legal guardian or next of kin of the child.

The birth notification must be submitted within 30 days of birth. We have begun to see a shift in the behaviour of South African parents in that the trend is showing that most
births are registered within the first year of birth. This has got to change if we are to have a secure and reliable National Population Register.

We therefore will be introducing a registration fee for those parents who register their children’s birth within the first year but after the 30 day period provided by the law. We hope this will incentivise compliance on the part of parents who have to take seriously the responsibility of parenthood. This entails exercising their civic duty toward their children who have a right to nationality and citizenship. We also have introduced a larger administrative fee for those persons who register the birth of their children after the first year of birth.

We reiterate the call made by the President when he launched the National Registration Campaign in 2010 to ensure that all children are registered within 30 days of birth.

In many countries the law states that children are to be registered immediately after birth. In our country the law provides a leeway of 30 days. In addition we have a footprint in over 300 hospitals both public and private around the country all in an effort to make it easier for parents to access our services.

All birth notifications will be subject to verification and may also be subject to screening through interview processes where there is need to do so.

Birth registration processes have been put in place for various categories of children including:

- Two categories of children born to non-South African citizens (permanent and non-permanent)
- Abandoned and orphaned children may be registered by a social worker designated by the Children’s court
- Adopted children
- South African children born outside of the Republic
- Children born out of wedlock

This last category poses numerous challenges for the department as there are many permutations relating to these types of family relations.
There is the situation where the father is not forthcoming and the birth certificate reflects only the mother of the child. If the father later wishes to acknowledge paternity, in this instance we have difference requirements for fathers who are South African citizens and those that are not.

In this regard we have been aware that single mothers who get involved in relationships with non-South African men come to our offices to record these persons as fathers of their children even if they not the biological fathers.

This is then used by such persons to address our department for permanent status in the country due to the right that children have to be cared for by their parents. In this regard where such a circumstance arises we now require the results of paternity tests. This is applicable to non-South Africans.

Where there is an application by a third party to substitute his particulars as the father of a child and to effectively remove the recorded father’s name in the birth certificate, the regulations now provide that a paternity test must be submitted by the applicant. The other scenario which transpires is where the parents of a child born out of wedlock are both recorded as parents but their status is unmarried and recorded as such. They subsequently marry and with to change their marital status on the child’s profile, the law provides that this may be done.

The regulations also provide for the different scenarios relating to name-change. One notable insertion into the law is that where an adult person requires a name-change, the application shall be published in the Government Gazette for general public edification, also in this instance, the law provides that no change of birth date may be accepted and consequently no change may be effected to the ID number of the person who changes any part of his/her name.

These are some of the ways through which we hope to restore identity and dignity to all our people in every part of the country, urban and rural, while fostering and promoting social cohesion, nation-building and unity in the state. We have made great strides notwithstanding formidable challenges including fraudulent acquisition of citizenship and fear of excluding some from enjoying benefits of democracy due to gaps in legislation.
5.9  It could be said that the BD Regulations are in line with the CRC and the ACRWC. From the Deputy Minister's briefing it is clear that the DHA is trying to encourage early birth registration within 30 days of birth and to discourage late registration by imposing fees for late registration. In order to facilitate early registration of the birth of a child, the DHA has enabled registration in both public and private hospitals. Further the DHA has sought to eliminate fraud and to protect the identity of the child by imposing stringent registration requirements.

5.10  Where a child's parents are married to each other, the birth may be registered by either parent under the surname of the mother or father or under both of their surnames joined together\(^{209}\).

5.11  It is clear that there are problems regarding the registration of children who are born out of wedlock or where paternity is in dispute and this may affect the rights of a child to know his or her biological origins.

### 5.2 Registration of Birth of Children Born Out of Wedlock

5.12  Section 10 of the BDRA states:

10.  Notice of birth of child born out of wedlock

(1)  Notice of birth of a child born out of wedlock shall be given

(a)  under the surname of the mother; or

(b)  at the joint request of the mother and of the person who in the presence of the person to whom the notice of birth was given acknowledges himself in writing to be the father of the child and enters the prescribed particulars regarding himself upon the notice of birth, under the surname of the person who has so acknowledged.

(2)  Notwithstanding the provisions of subsection (1), the notice of birth may be given under the surname of the mother if the person mentioned in subsection (1)(b), with the consent of the mother, acknowledges himself in writing to be the father of the child and enters particulars regarding himself upon the notice of birth.

\(^{209}\) s9(1) and (2) of the Births and Deaths Registration Act
Where the parents are not married, the mother must register the child under her surname or, the child may be registered under the surname of the biological father provided that the father acknowledges paternity and both the father and the mother consent to the registration of the child under the father’s surname in the presence of a Home Affairs official.

Notwithstanding the provisions of s10(1)(a) and (b), the child may still be registered under the surname of the unmarried mother’s even though a man with her consent acknowledges himself to be the father and completes his particulars on the notice of birth.

When mothers and fathers want the unmarried father's particulars to be added to the birth notice form, the father will need to fill out an affidavit acknowledging paternity of the child. If the unmarried father is not a South African citizen, permanent resident or refugee (with a s24 refugee permit or a refugee identity document) he will also need to submit a paternity test, obtained at his own cost, confirming paternity (Proudlock, 2014).

Unmarried fathers, who want to add their particulars to the birth register of their child but who are unable to get consent from the mother due to, the mother refusing or being unable to consent or deceased, currently have to approach the High Court for relief.

Proudlock is of the opinion that applications to the High Court are prohibitively expensive and not accessible to the majority of unmarried fathers and recommends that the BDRA should therefore be amended to allow unmarried fathers to also approach the children’s court and not just the High Court as the children’s court is more accessible being at magistrates court level, less costly, and well-practiced in making decisions based on children’s best interests.

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210 s10(1)(a) of the Births and Deaths Registration Act
211 s10(1)(b) of the Births and Deaths Registration Act and http://www.home-affairs.gov.za/index.php/civic-services/birth-certificates
212 s10(2) of the Births and Deaths Registration Act
213 s24 of the Refugees Act 130 of 1998
215 s11(5)(a) of the Births and Deaths Registration Act
216 Proudlock P
217 Proudlock P at 32
5.2(a) Question

1. Should the Act be amended to allow unmarried fathers to approach the children’s court or the High Court when seeking to amend birth registration particulars?

5.2.1 Section 10(1)(a) of the Births and Deaths Registration Act, 1992

5.18 Where the parents are not married, the mother must register the child. She can do so under her own surname without including the father’s particulars or, with the father’s particulars if the father consents and acknowledges he is the father in writing on the birth notice form.

5.19 Section 10(1)(a) does not compel an unmarried mother to disclose the identity of the biological father. An unmarried mother can give birth to a child and simply register the child under her name no questions asked. It is conceivable that the unmarried mother may therefore also never disclose the identity of the biological father to the child thus depriving the child of knowledge of his or her paternal relations and of getting to know and forming a bond with his or her biological father and paternal family.

5.20 It is also possible that the mother may deceive the child by telling the child that another man is his or her biological father either knowing that this is untrue or in circumstances where she is not certain as to whom the biological father is.

5.21 There are various reasons why an unmarried mother may not know the identity of the biological father or why she may not want to disclose the identity of the biological father such as:

a. the pregnancy is a result of rape and the identity of the perpetrator is unknown;

b. the pregnancy is a result of rape and the identity of the perpetrator is known but she wants no association or contact with the him;

c. the pregnancy is a result of incest or sexual abuse;

218 According to an article at http://www.iol.co.za/news/south-africa/western-cape/single-moms-head-most-sa-households-1909488 by Sipokazi Fokazi dated 2 September 2015, the statistician general, Pali Lehohla presented a report to parliament on recorded “live births” in 2014 and said that “of the 886 202 babies born last year, more than 50 percent were to single mothers and 61.3 percent of births had no information about the fathers of the babies”
d. she is a teenager and the pregnancy is the result of a relationship with an older or married man (a blesser or sugar daddy);
e. family pressure not to disclose the identity of the biological father possibly in circumstances where the family does not approve of the relationship;
f. she does not know who the father is due to the fact that she had sexual relations with more than one man at the time of conception (the mother is promiscuous or she is a prostitute and the sex was contractual);
g. the relationship between the mother and father has ended and she has not revealed to him that she is pregnant with his child;
h. the biological father denies paternity; and
i. the biological father acknowledges paternity but refuses to be identified on the birth certificate.

5.22 Section 31(1)(b) of the BDRA states:

31. Offences, penalties and evidence
   (1) Any person who -
   (b) makes or causes to be made any false statement relating to any of the particulars required by this Act to be made known and registered;
   shall be guilty of an offence and on conviction liable to a fine or to imprisonment for a period not exceeding 15 years or to both such fine and such imprisonment.

Further Article 8(2)219 of the CRC state that where a child is illegally deprived of some or all of the elements of his or her identity, States Parties shall provide appropriate assistance and protection, with a view to re-establishing speedily his or her identity.

5.23 Section 26 of the Children’s Act states:

26 Person claiming paternity
   (1) A person who is not married to the mother of a child and who is or claims to be the biological father of the child may-
   (a) apply for an amendment to be effected to the registration of birth of the child in terms of section 11 (4) of the Births and Deaths Registration Act, 1992

219 CRC Article 8(2)
2. Where a child is illegally deprived of some or all of the elements of his or her identity, States Parties shall provide appropriate assistance and protection, with a view to re-establishing speedily his or her identity.
(Act 51 of 1992), identifying him as the father of the child, if the mother consents to such amendment; or

(b) apply to a court for an order confirming his paternity of the child, if the mother-

(i) refuses to consent to such amendment;

(ii) is incompetent to give consent due to mental illness;

(iii) cannot be located; or

(iv) is deceased.

(2) This section does not apply to-

(a) the biological father of a child conceived through the rape of or incest with the child’s mother; or

(b) any person who is biologically related to a child by reason only of being a gamete donor for purposes of artificial fertilisation.

5.24 Article 8(1) of the CRC\(^{220}\) obliges States Parties to respect the right of the child to preserve his or her identity, including nationality, name and family relations. The identity of the child’s father is relevant to establish the child’s complete identity, including nationality, name and family relations.

5.25 Section 11(4) of the BDRA allows a biological father who wishes to acknowledge himself as the father of a child born out of wedlock, to apply, with the consent of the mother, to the Director-General of DHA to amend the registration of the birth of such child by recording such acknowledgement and by entering the prescribed particulars of such person in the registration of the birth of such child. In terms of s11(4A), such an application must be supported by prescribed conclusive proof of that person being the father of the child\(^{221}\). The applicant may apply to the High Court should the mother refuse to consent\(^{222}\). The biological

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\(^{220}\) CRC Article 8(1)

1. States Parties undertake to respect the right of the child to preserve his or her identity, including nationality, name and family relations as recognized by law without unlawful interference.

\(^{221}\) 11. Amendment of birth registration of child born out of wedlock

(4) A person who wishes to acknowledge himself to be the father of a child born out of wedlock, may, in the prescribed manner, with the consent of the mother of the child, apply to the Director-General, who shall amend the registration of the birth of such child by recording such acknowledgement and by entering the prescribed particulars of such person in the registration of the birth of such child.

(4A) An amendment of the particulars of a person who has acknowledged himself as a father of a child as contemplated in subsection (4) and section 10(1)(b) of the Act shall be supported by the prescribed conclusive proof of that person being the father of the child.

\(^{222}\) 11. Amendment of birth registration of child born out of wedlock

(5) Where the mother of a child has not given her consent to the amendment of the registration of the birth of her child in terms of subsection (4), the father of such a child shall apply to the High Court of competent jurisdiction for a declaratory order which confirms his or her paternity of the child and dispenses with the requirement of consent of the mother contemplated in subsection (4).
father will likely only take steps to ascertain paternity if, in the first place, he has reason to believe that he might be the biological father of the child.

5.2(b) Questions

1. Does a child born to an unwed mother have a right to know his or her paternal biological origins?

2. Should an unwed mother be compelled by law to disclose the identity of the biological father when registering the birth of a child?

3. Will an unwed mother be guilty of an offence in terms of s31(1)(b) in instances where she fails to disclose the identity of the biological father even though she knows who he is in circumstances described in paragraph 5.19, in particular 5.19 d-g?

4. Does a child have the right to know the identity of his or her father in circumstances described in paragraph 5.19 d-g?

5. Should a mother be compelled by law to disclose the identity of the biological father in circumstances described in paragraph 5.19d-g? Is it desirable to legislate in these circumstances or will the law be stretching too far in to social issues and be dictating how people should conduct their relationships?

6. In instances, where the mother is unsure of who the father is, should she be compelled to disclose the identity of the men who she had sexual relations with around the time of conception so that paternity tests can be done in order to establish the identity of the biological father so that his name can appear on the birth records?

7. If so, should such men be compelled in law to submit to such paternity tests?

8. If so, who should bear the costs of such paternity tests (especially in the case of multiple sexual partners: the State (taxpayer), the mother, the man established to be the biological father, the mother and the biological father equally or the costs should be shared equally between the mother and all the men tested?

(6) When the court considers the application contemplated in subsection (5) the provisions of section 26(b) of the Children's Act shall apply.
9. Whose responsibility is it to use contraception? Can a man say that he should not be liable for the cost of such paternity tests because the mother was responsible for using contraception or that she led him to believe that she was using contraception or that he believed that they were in a monogamous relationship?

10. Would compelling a mother to disclose the identity of the biological father or men who she thinks may be the biological father have the effect of:

   a. Preventing or reducing unwanted pregnancies (on the assumption that men behave recklessly and fail to use contraception because they can simply walk away from a pregnancy leaving the woman to deal with the consequences. Knowing that they will be discovered and that they will have to support the child may cause men to be more responsibly sexually and either use contraception themselves or ensure that the woman uses contraception)?

   b. Preventing or reducing rape and sexual abuse?

   c. Would such a law be a deterrent to reckless sexual behaviour?

   d. Changing the gender bias which favours men and give woman a stronger footing to assert themselves socially and legally? If a woman is not encumbered by a pregnancy and caring for a child, she could pursue her studies or a career. She would have legal basis to claim maintenance from the father for the child.

   e. Changing the sexual dynamic which favours men and give woman a stronger footing to assert themselves sexually? In many instances men refuse to use condoms. Woman could use such a law or persuade men to use condoms. In turn, the more frequent use of condoms to prevent pregnancy may also have the effect of reducing HIV infection.

   f. Making it possible for children to know their fathers and extended family resulting in children having a healthier upbringing because fathers are compelled to acknowledge their children and take responsibility for their children? Would this in turn create a more stable society?

   g. Would this in turn have a positive effect on the fiscus because less money would have to be spent on social welfare grants because fathers would have to support their children?
11. What should an unwed mother tell her child regarding his or her biological origins in the instances of rape or incest\footnote{The Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 (also referred to as the Sexual Offences Act) reformed and codified the law relating to sex offences and, in terms of s12 of this Act, incest is illegal:}

12. What are the child’s rights to know his or her genetic origins in the case of incest?

13. Would it be in the best interests of the child to know his or her genetic origins in the case of incest?

14. Should the law have any say in this regard or should it be the biological mother’s decision entirely?

15. Would the mother disclose an incestuous relationship bearing in mind that incest is illegal? Could there be criminal proceedings against the biological father stemming from such disclosure? In answering this question it should be borne in mind that s26(2)(a) specifically prohibits a biological father from applying to be identified as the father of a child in circumstances where the child was conceived through the rape of or incest with the child’s mother.
5.2.2 Section 10(1)(b) of the Births and Deaths Registration Act, 1992

5.26 The BDRA effectively allows a father of a child born out of wedlock to decide whether he can be identified on the birth certificate and whether his child can carry his surname.

5.27 A person who wishes to be registered as the father of a child born out of wedlock must apply to do so jointly with the mother of the child and must appear physically before a DHA official and must acknowledge in writing that he wishes to be identified as the child’s father.

5.28 A child cannot be registered with a surname of the unmarried father unless he consents to the child carrying his surname.

5.29 In the absence of the unmarried father’s acknowledgement and consent, the father will be documented as unknown in the birth register and on the birth certificate.

5.30 On the one hand it makes practical sense that in the case of a child born out of wedlock, the consent of the father is required before he is registered as the father on the birth register and birth certificate. This prevents an unmarried mother from registering a man as the father of her child when in fact he may not be the father.

5.31 However, the section is also open to abuse by men who can simply elect not to be identified as a father.

5.32 The section may be challenged on the basis of equality as enshrined in s9224 of the Constitution in that unmarried mothers are treated differently from unmarried fathers. Unmarried mothers have no choice but to register the child in their name whereas unmarried fathers have a choice in this regard and must consent to being registered as the father of the child225.

224 Section 9(3) of the Constitution reads: “The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.”

225 In the unreported Western Cape High Court judgment in South African Human Rights Commission and Others v Minister of Home Affairs and Others Case no: 17283/2014 Heard: 5 February 2015 and 14 April 2015 Date of Judgment: 7 July 2015, the applicants challenged the constitutionality of s10 of the Births and Deaths Registrations Act, 1992 in so far as the unmarried father must consent to registration of his child’s birth in his
5.33 Further, section 28(1)(a) of the Constitution provides that every child has the right to a name and a nationality from birth. Usually, a child carries a first and a surname, either the father’s surname or the mother’s surname or a double-barrelled surname of both the mother and father. One could argue that in allowing a father to decide whether or not he wants to be identified on the registration of birth and whether the child can be registered with his surname, the child cannot exercise his or her right to a name fully.

5.34 Also it could be argued that the Act impugns the dignity of the mother be reflecting the father as unknown when in fact the father is known to the mother but he refuses to be registered as the child’s father. It could also that this would have a detrimental effect on the child’s self-esteem and be a source of embarrassment to him or her.226

5.35 Article 8(1) of the CRC227 obliges States Parties to respect the right of the child to preserve his or her identity, including nationality, name and family relations. The identity of both of the child’s parents is relevant to establish the child’s complete identity, including nationality, name and family relations.

5.36 The BDRA does not compel a biological father to identify himself on the birth certificate and there is no provision which gives the mother the right to bring an application to the Director-General of the DHA to amend the birth records where the mother has conclusive proof that the father is indeed the biological father and that paternity has been established.

5.37 On the hand, the Act does allow a father to bring an application in terms of s11(4) to be recorded as the father where conclusive proof is available. It is preferable that there be an express provision in the BDRA in this regard together with applicable regulations as this would clearly set out the rights of the unmarried mother and would avoid any perception of inequality in the treatment of unmarried mothers and unmarried fathers.

5.38 Some may argue that that an unmarried mother could bring an application to have the biological father recorded as the father in terms of s7(4)228. However, s7(4) deals with the

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226 https://mg.co.za/article/2014-10-31-00-dad-must-acknowledge-me-right accessed on 14 December 2016

227 CRC Article 8

1. States Parties undertake to respect the right of the child to preserve his or her identity, including nationality, name and family relations as recognized by law without unlawful interference.

2. Where a child is illegally deprived of some or all of the elements of his or her identity, States Parties shall provide appropriate assistance and protection, with a view to re-establishing speedily his or her identity.

228 7. Verification, supplementation and rectification of particulars
amendment or rectification of particulars already furnished in terms of the BDRA (as one can only amend or rectify information already provided) and it is submitted that s7(4) does not cover an instance where an unmarried father’s particulars were never recorded in the first place because he refused to give consent for his details to be recorded. Further, one would question what regulation would apply if s7(4) were to be used for such an application.

5.2(c) Questions

1. Does a child born to unwed parents have a right to know his or her biological origins and have the biological father registered on the birth register and on his or her birth certificate?

2. Should s10 amended or repealed?

3. Should the BDRA be amended to allow the DHA to register the unmarried father when there is proof of paternity even where he does not consent to be registered as the father?

4. Why do certain fathers refuse to be registered on the birth register? Is it because they are unsure about whether they are actually the biological father of the child?

5. Should paternity tests be mandatory in order to ensure correct birth registration reflecting both the mother and father of the child?

6. Should paternity tests take place before or after the birth of the child?

7. Would it be in the best interest of the child to have the birth registered with both the mother’s and father’s information detailed?

8. Would having both parents legally identified protect the child’s dignity and provide a child with an established complete identity and the potential to form stable family relations with both mother and father?

9. Would having both parents legally identified provide a child with legal certainty from the time of registration of birth regarding claims for maintenance and succession?

(4) Any person may apply, in the prescribed manner, to the Director-General to request the amendment or rectification of his or her particulars furnished in terms of this Act.
5.3 Presumptions regarding Paternity

5.3.1 Common Law Presumptions

5.39 In order to determine who a child’s father is, the common law distinguishes between married and unmarried mothers and different presumptions operate in these different cases.

5.40 If a married woman gives birth to a child, her spouse is deemed to be the father of the child and the maxim *pater est quem nuptiae demonstrant* applies. The meaning of the maxim is that the father is he who is married to the mother. The law presumes that the woman’s husband is the father of the child. The operation of this maxim presupposes a valid marriage.

5.41 The presumption may be rebutted by evidence which proves, on a balance of probabilities, that the woman’s husband is not in fact the child’s father. The evidence can take the form of non-access to his wife during the period of conception, sterility or impotence, blood tests or the more accurate HLA system of tissue typing or DNA fingerprinting test (Family Law Service, October 2016)\(^229\).

5.42 The defence of *exceptio plurium concubentium* entails the denial of paternity because the mother had sex with another man or men at the time of conception. In S v Swart the Court left open the question of whether the *exceptio plurium concubentium* defence can be used to rebut the presumption of paternity; however, there are later cases which held that it cannot. It would seem that the reason is that the presumption impugns the dignity of a woman and casts aspersions on her character.

5.43 If an unmarried mother alleges that a certain man has fathered her child she must adduce conclusive evidence to prove her allegations. In civil cases, including enquiries under the Maintenance Act, paternity is proved on a balance of probabilities but in criminal cases proof beyond reasonable doubt is required.

5.44 Previously, the courts required corroboration of the woman’s allegations. This was overruled by the Appellate Division in Mayer v Williams\(^230\). This case substituted the

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\(^229\) Family Law Service, Clark, Brigitte Publisher: LexisNexis South Africa, October 2016, Service Issue 66, J70

\(^230\) 1981 (3) SA 348 (A) at 350-351
requirement of corroboration with a flexible cautionary rule in terms of which the plaintiff female’s evidence must be carefully scrutinised and weighed.

5.45 On the other hand, as soon as sexual intercourse between the female plaintiff and the alleged father is proved or if he admits to coitus having taken place at any time when the child could have been conceived, it shall be presumed that he is the father of that child unless evidence to the contrary is led. This presumption may be rebutted by any admissible evidence; for example, sterility or non-access, which proves on a balance of probabilities that he is not the child’s father. The exceptio plurium concubentium is not sufficient evidence to rebut the onus resting on the alleged father.231

5.3.2 Presumptions in the Children’s Act

5.46 Section 36 of the Children’s Act States:

36 Presumption of paternity in respect of child born out of wedlock
If in any legal proceedings in which it is necessary to prove that any particular person is the father of a child born out of wedlock it is proved that that person had sexual intercourse with the mother of the child at any time when that child could have been conceived, that person is, in the absence of evidence to the contrary which raises a reasonable doubt, presumed to be the biological father of the child.

5.47 Section 36 creates a rebuttable presumption that the unmarried man is the child’s biological father and operates ‘in the absence of evidence to the contrary which raises a reasonable doubt’. The Children's Act does not define the word 'evidence'. The word therefore bears its usual, wide meaning. Thus any acceptable evidence suffices, regardless of whether it is direct or circumstantial, provided that it is sufficient to raise a reasonable doubt (Commentary on the Children’s Act, May 2015).232

5.48 Further, section 37 of the Children’s Act provides that any party who refuses to submit himself or herself, or the child, to the taking of a blood sample in order to carry out scientific tests relating to the paternity of the child, must be warned by the court of the effect which such refusal might have on the credibility of that party.

231 Family Law Service, Clark, Brigitte Publisher: LexisNexis South Africa, October 2016, Service Issue 66, J71
232 Commentary on the Children's Act, CJ Deval and AM Skelton (editors), May 2015
5.3.2.1 Question

1. In an age of highly advanced medical technology, is there a need to apply legal presumptions or should scientific means by used to ascertain paternity?

5.3.3 South African Case Law - LB v YD

5.49 In South Africa there is no legislation regarding the use of scientific paternity tests and whether a court can compel an adult or child to submit to blood tests. Case law in this regard has been inconsistent and the courts have had to balance rights to privacy, dignity and the best interests of the child^{233} (Albertus, June 2014)

5.50 In LB v YD 2009 (5) SA 463 (T), the applicant and respondent were involved in an intimate relationship which terminated and the respondent resumed a relationship with her previous partner whom she married while pregnant. Initially, it seemed that the applicant accepted the child as his but he later questioned the paternity of the child.

5.51 The respondent decided that she would accept the applicant's denial of paternity and exclude him from the child's life especially by the willingness of her husband to assume paternity. The applicant requested the respondent and the child to submit to DNA tests. The respondent advised that she was not prepared to subject herself to a DNA test and stated further that it was not in the best interests of the child to do so either.

5.52 As a result the applicant launched an application seeking an order directing the respondent and her minor daughter (Y) to subject themselves to DNA tests for the purpose of determining whether the applicant is the biological father of the minor daughter. In the event that the DNA tests establish that the applicant is the biological father then in terms of prayer 2 of the notice of motion he sought a declaration that he is entitled to full parental rights and responsibilities. Similarly, in the event of a positive result, he asked for an order directing the parties to proceed to prepare a parenting plan as provided for in s34 of the Children's Act. At the commencement of the hearing, counsel for the applicant asked for postponement sine die of the relief sought in prayers 2 and 3 pending the outcome of any test done in terms of

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prayer 1, should such be ordered. The respondent opposed the application in its entirety, including the application to separate the order for testing from any consequential relief.

5.53 Regarding case law in this regard the court said:

The law on the topic of compulsory blood or DNA testing in parental disputes is not satisfactory. There is no legislation which specifically regulates the position in civil cases. Judicial pronouncements on the topic have not been unanimous in their approach to the issues and have differed on the proper legal basis for ordering tests. In relation to the child the courts have relied on their inherent jurisdiction as upper guardian, while in relation to the non-consenting adult some judges have invoked the inherent jurisdiction of a court to regulate its own procedures while others have refused to do so. In all cases the courts have been mindful of the need on the one hand to protect the privacy and bodily integrity of those to be subjected to tests, but on the other hand have asserted the court's role to discover the truth whenever possible and to make use of scientific methods for that purpose234.

5.54 Regarding subjecting minors to blood tests the court said:

The most significant cases dealing with this thorny topic date to before our adoption of a fundamental Constitution in 1994 and the enactment of the Children's Act 38 of 2005. The preponderance of authority favours the proposition that a court, in the exercise of its power as an upper guardian of all minors, is entitled to authorise a blood test on a minor, despite objections by a custodian parent. In deciding whether it should do so the court must act in what it considers to be the best interests of the child235.

5.55 Regarding truth, administration of justice and identity, the court said:

Truth is a primary value in the administration of justice and should be pursued, if not for its own sake, then at least because it invariably is the best means of doing justice in most controversies. While estoppel and waiver might find equitable justification in commercial causes, they, or principles like them, have less value in cases requiring a determination of status or identity. Where we come from and who we are, for most people, are questions within the realm of the sacred.

234 at 469
235 at 469 D
5.56 The court aligned itself with the sentiment expressed by Campbell J of the Supreme Court of South Dakota in *State of South Dakota v Damm* (1936) 266 NW 667 at 670 - 671 (cited by Didcott J in *Seetal*236 at 841C - E)237:

‘The primary function of the judiciary is the administration of justice, and justice can never be rightly administered unless the truth be first ascertained, as nearly as may be . . . . The citizen holds his citizenship subject to the duty to furnish to the Courts, from time to time and within reasonable limits (which are for the Courts to determine), such assistance as the Courts may demand of him in their efforts to ascertain the truth in controversies before them . . . . We perceive no valid reason why Courts of record may not require of any person within their jurisdiction the furnishing of a few drops of blood for test purposes when, in the opinion of the Court, so to do will or may materially assist in administering justice in a pending matter.’

The court said that there should be no overriding reason in principle or policy impeding the exercise of the Courts inherent power and authority, as upper guardian or otherwise, to order scientific tests in the interests of discovering the truth and doing complete justice to all parties involved in a suit.

The Court found that, as a general rule the more correct approach is that the discovery of truth should prevail over the idea that the rights of privacy and bodily integrity should be respected and that it will most often be in the best interests of a child to have any doubts about true paternity resolved and put beyond doubt by the best available evidence.

5.57 Regarding the Children's Act the court said:

I turn now to consider the relevant provisions of the Children's Act, 2005. The Act was enacted to effect changes to existing laws relating to children in order to bring them into line with the constitutional rights and values. Chapter 3 of the Act deals with parental responsibilities and rights. Section 18 provides generally that a person may have either full or specific parental responsibilities and rights in respect of a child, which may include the responsibility and the right to care for the child, to maintain contact with the child, to act as guardian of the child and to contribute to the

236 *Seetal v Pravitha and Another NO* 1983 (3) SA 827 (D)
237 at 470 D-G
maintenance of the child. These elements correspond broadly with the key components of parental authority, namely: custody, access and guardianship.

However, the Act envisages greater flexibility, in that it is now possible to award different aspects of care and contact to different parents. This is accomplished either by agreement, court orders or parenting plans (ss 22, 23 and 33). Section 30 provides that more than one person may hold parental responsibilities and rights in respect of the same child. Section 31(2) further provides that, before a person holding parental responsibilities and rights in respect of a child takes any decision significantly affecting the co-holder of parental rights and responsibilities, that person must give due consideration to any views and wishes expressed by the co-holder.

Section 19 of the Act gives the biological mother of a child full parental responsibilities and rights in respect of the child; while s 20 confers similar full rights and responsibilities on the biological father, but only if he is married to the child's mother, or if he was married to the child's mother at the time of conception, the time of birth or any time between conception and birth.

Section 21 deals with the parental responsibilities and rights of unmarried fathers, and has obvious relevance to the present application on account of it being common cause that the parties have never been married at any time. In terms of this provision the unmarried biological father acquires the same parental responsibilities and rights as the child's mother, provided he meets certain requirements, namely if at the time of birth he is living with the mother in a permanent life-partnership, or, regardless of whether or not he is living with the mother, he consents to being identified as the father, or applies under s 26 of the Act for an order confirming his paternity, and contributes or attempts to contribute to the child's upbringing and maintenance for a reasonable period. This provision is a significant advance upon the common law and the provisions of the Natural Fathers of Children Born out of Wedlock Act 86 of 1997 (which the Act repeals), neither of which afforded an unmarried father any automatic rights in respect of the child. Under the previous dispensation an unmarried father could obtain parental responsibilities and rights, only if a court determined that it was in the best interests of the child. That has now changed. The unmarried father has automatic rights, provided he meets the requirements of s 21(1)(a) or (b). If there is a dispute regarding the fulfilment of the requirements the matter must be referred to mediation in terms of s 21(3) and the outcome of such mediation may be reviewed by a court.
This significant change in policy towards the rights and responsibilities of unmarried biological fathers brings added importance to the need for scientific determinations of paternity. In the past a court in its discretion would grant aspects of parental authority to an unmarried biological father only if it considered it to be in the child's best interests. It could accordingly rule that the father had no rights or responsibilities beyond a duty to pay maintenance. Now, once paternity is established, the rights and responsibilities are automatic, with the precise nature and content being subject to mediation, review and ultimately a parenting plan. Once paternity is established the parties become co-holders of parental responsibilities and rights on an equal footing.

The court held that s36 and s37 of the Children's Act do not add or detract much from the fact that the court is possessed inherently and constitutionally of a jurisdiction to order parties to have blood tests where it concludes that the competing rights and interests at play require the truthful verification of paternity by scientific means…The adverse inference will not provide positive confirmation to the extent required in this case. The applicant seeks verification of whether or not he is the father. Reliance by the court on an adverse inference will produce a finding that he is the father, as the respondent says he is, when in fact he wants to eliminate the possibility that he is not the father. If he is not the father then he will not be a co-holder of parental responsibilities.

Given the extended rights and obligations of unmarried fathers, it seems only right that the truth be established, as it can be, in the interests of justice, before burdening a party with responsibilities that might not be his to bear.

5.58 Regarding the best interests of the child, the court said:

I am not inclined to place much store in the expedient that concealing the truth from a child might have the supposed advantage of not 'bastardising' the child or cutting it off from an established source of maintenance. With regard to the latter there is in my view an inherent and inescapable injustice in compelling a person to assume obligations not rightfully his or hers. As for the former, I agree with the position of Asche SJ in the Australian case *Lamb v Lamb* (1977) FLC 90-225 (cited in *Seetal* at 838H) when he said:
'Although . . . it might not always be conducive to the welfare of a child for such tests to be carried out, there must be many cases where the determination of paternity (or, more correctly, non-paternity) by blood tests would set at rest nagging doubts and festering resentments by one party which must be detrimental to a child's welfare. Even when doubts proved justified, many children would be at least in no worse position than before, and a clearing of the air might be for their ultimate welfare. The stigma of illegitimacy, though still with us, is fading . . . . Knowledge of biological parentage is becoming an increasingly important factor in the treatment or amelioration of genetic weaknesses.'

The child is barely 1 year old and thus there is no established relationship that might be unduly disturbed or harmed by a determination of non-paternity. If the applicant is established to be the father, the child will benefit in time from knowing the truth and from the applicant's commitment to her financial wellbeing. And, furthermore, legislative safeguards exist for the assignment and monitoring of appropriate parental rights and responsibilities to the applicant, should that prove permissible. I accordingly consider that it will be in the best interests of the child that paternity be scientifically determined and resolved at this early stage.

5.59 The respondent was ordered to submit herself and her minor child to DNA tests for the purpose of determining whether the applicant is the biological father of the child.

5.60 It is clear that the court considered ascertaining the truth regarding paternity as taking precedence over the rights to privacy and dignity and as being necessary in determining where parental rights and duties actually lie. In establishing paternity, the possible stigma of a disputed paternity will also be removed. Importantly the Court said: Where we come from and who we are, for most people, are questions within the realm of the sacred.
5.3.4 The Appeal - YM v LB

5.61 The mother (respondent in the court a quo) appealed the decision in LB v YD\textsuperscript{238} in the Supreme Court of Appeal\textsuperscript{239} (SCA) and was successful in this regard.

5.62 The court held that paternity was not actually in dispute and was determinable on a balance of probabilities as the mother was certain that the applicant in the court a quo was the father and, further, he never actually denied paternity. The SCA held that the High Court should not have ordered the mother and her child to undergo DNA testing.

5.63 In particular, there was no reason to order the mother to be tested as her maternity could not have been in doubt.

5.64 The court held that what the applicant sought was scientific proof that he was the biological father of the child which is something he was not entitled to.

5.65 The court said that there are cases where there is genuine uncertainty as to paternity and a DNA test should be ordered for the child in question as it is within the inherent power of a court, as the upper guardian of children, to order scientific tests if this is in the best interests of a child and, further, s37 of the Children's Act does anticipate the use of scientific tests to determine paternity. However, the court held that this is not a case in which that inherent power needed to be invoked given that paternity was not disputed.

5.66 The court was of the firm view that rights to privacy and bodily integrity may be infringed (by a procedure ordered by a court in the exercise of its inherent jurisdiction) if it is in the best interests of a child to do so. These rights, like others enshrined in the Constitution, may be limited where it is reasonable and justifiable, applying the criteria in s36(1) of the Constitution. However, held that it is not the case in this matter but in others it might well be, justifiable to order blood or DNA tests.

5.67 The court said that whether the discovery of truth should prevail over the rights to privacy and bodily integrity is a matter that should not be generalised and said that it is not necessarily always in an individual's interest to know the truth. In each case the court, faced with a request for an order for a blood test or a DNA test, must consider the particular position of the child and make the determination for that child only. The role of a court, and

\textsuperscript{238} LB v YD 2009 (5) SA 463 (T)
\textsuperscript{239} YM v LB 2010 (6) SA 338 (SCA)
its duty, is to determine disputes in civil matters on a balance of probabilities. It is not a
court's function to ascertain scientific proof of the truth.\textsuperscript{240}

### 5.3.5 The Need for a Scientific Approach

5.68 Michael Buthelezi\textsuperscript{241} wrote that this judgment should have been ground-breaking for
two main reasons. First, this was the first SCA judgment dealing with the use of scientific
tests in paternity disputes. Until then, different provincial divisions had reached different
conclusions on the court's power to compel either a minor or an adult to submit to the tests.
Thus, this case was an ideal opportunity for the SCA to bring certainty about the law
regarding DNA testing for paternity disputes. Second, the decision was delivered in the
constitutional era and at a time when the s37 of the Children's Act was operational hence this
was an opportunity for the SCA to put section 37, which had not been tested before in a court
of law, into perspective. However, the court missed this golden opportunity.

5.69 Latiefa Albertus\textsuperscript{242} wrote that:

Although the SCA stated that the matter did not involve a dispute regarding paternity,
there was indeed such dispute as the \textit{pater est quem nuptiae demonstrant}
preservation came into play. By virtue of the marital presumption the appellant's
husband is deemed the father of the child. It is uncertain why the SCA did not
address this issue as in this instance there were two possible fathers. According to
Nicholson\textsuperscript{243}, the High Court was correct in ordering the DNA tests as reliance on the
presumption would have bestowed parental responsibilities and rights on the
appellant's husband as a consequence of the marriage. Whether the High Court was
correct in not relying on the presumption is a matter that had to be clarified by the
SCA, especially in light of the automatic responsibilities and rights that an unmarried
father is afforded if the requirements in section 21 of the Children's Act are met.\textsuperscript{244}

\textsuperscript{240} 2010 (6) SA p342 A-B
\textsuperscript{241} Buthelezi, Michael 2011 Obiter Volume 32 Issue 2 480-488
\textsuperscript{244} Bonthuys E, What you don’t know can’t hurt you: the Supreme Court of Appeal and the presumptions of
paternity, “South African Law Journal” 2011, p. 431 argues that the Children's Act does not govern the situation
where an unmarried father acquires automatic rights and responsibilities but another man is afforded these
responsibilities and rights by virtue of marriage, which was the scenario in this case
One would have expected a comprehensive analysis of paternity by the SCA, yet one finds that the Court’s decision was limited to a statement that the matter at hand was not a paternity dispute. However, the Court does not elaborate on what would constitute a ‘genuine’ disagreement regarding paternity.

According to the SCA the application merely amounted to a ‘request for scientific proof of certainty’. The Court did not acknowledge that this so-called ‘request’ was the result of doubt, regardless of the fact that the respondent had admitted paternity after also having denied it. What the court failed to consider as a factor in its decision was that there was a denial of paternity on the part of the appellant as well, regardless of the reasons she gave for making the statement. Furthermore, if ‘uncertainty’ regarding fatherhood does not result in a paternity dispute, it is unclear what does and required the SCA’s clarification.

5.70 The fact that a man had sexual intercourse with a woman during the conception period does not mean that he is necessarily the child’s father as illustrated in Ranjith v Sheela. Although there is a marital presumption which results in fatherhood, it does not always mean that the woman’s spouse is indeed the father. In this case, the Court found that although it was possible that the first defendant could be the father of the child as a result of the parties having sexual intercourse at the relevant time of conception, the results of the blood tests proved otherwise. Thus, the presumption that operates once sexual intercourse is admitted or proved, adds nothing to the question of paternity; in fact, all it does is place the presumed father in a vulnerable position. Similarly, the marital presumption points to the mother’s spouse and if the spouse cannot prove sterility or absence of sexual intercourse, it is unclear how else he can disprove paternity without relying on DNA/blood tests.

5.71 A mother could easily identify a particular man as the father, being aware that she had intercourse with more than one man during the conception period. However, if the alleged father admits to having intercourse with her during the relevant time, it is difficult to conceive how he could disprove paternity unless he is sterile. Albertus is of the view that our

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246 1965 3 SA 103 (D).
247 Although the exceptio plurium concubentium no longer forms part of our law, it has been argued that a woman having the right to ‘choose’ the father is unconstitutional as it infringes the rights of the true father. Furthermore, it could also be in contravention of the best interests of the child principle as well as the right of the child to parental care: H. Kruger, et al The law of persons in South Africa, Southern Africa 2010, p. 98.
courts should reconsider the position of the *exceptio plurium concubentium* especially in light of the constitutional dispensation\(^\text{249}\).

5.72 It is impossible for a woman to not know that she had intercourse with more than one man at the possible time of conception\(^\text{250}\) whether married or unmarried. Paternity fraud is a reality, and is especially risky for husbands who have been cheated on as well as wealthy and famous men\(^\text{251}\).

5.73 There is also the possibility of a maternity dispute arising. Such dispute can arise in the context of assisted fertilisation. There are cases where the incorrect eggs are implanted in the birth mother, who then believes that the child is biologically hers, when in reality the child is biologically that of another couple. Similarly, maternity will also be in dispute if a baby is switched in hospital\(^\text{252}\). The question that arises is whether a mother who disputes maternity will find herself in the same difficulty as a father who disputes paternity?

5.74 The SCA held that what the applicant sought was scientific proof that he was the biological father of the child and this is something he was not entitled to. Even further, the court said that it is not a court's function to ascertain scientific proof of the truth. This means that a man in similar circumstances would not have certainty regarding whether or not he is the biological father of a child nor would he have absolute certainty that the duties that he has or may be encumbered with towards the child are in fact his to bear.

5.75 Surely, the fact that the parties are litigating over paternity means that there is in fact a “dispute” and, an age of advanced and ever advancing scientific technology requires that courts adopt a scientific approach to such matters and should resolve same precisely given the fact that accuracy regarding paternity and maternity is possible. Reliance on legal presumptions is unsatisfactory.

5.76 The High Court touched on the question of the right of a child to know his or her biological origins by stating “Where we come from and who we are, for most people, are

\(^{249}\) Although the *exceptio plurium concubentium* no longer forms part of our law, it has been argued that a woman having the right to ‘choose’ the father is unconstitutional as it infringes the rights of the true father. Furthermore, it could also be in contravention of the best interests of the child principle as well as the right of the child to parental care: H. Kruger, et al The law of persons in South Africa, Southern Africa 2010, p. 98


\(^{252}\) A.M. Noble-Allgire, Switched at the fertility clinic: determining maternal rights when a child is born from stolen of misdelivered genetic material, “Missouri Law Review” 1999 64:3, p.517
questions within the realm of the sacred whereas the SCA did not consider a child's right to know his or her genetic origin, other than providing that it is not always in the best interests of a person to know the truth.

5.77 There are medical why it is in the best interests of a child to know his or her biological origins. A child can learn of his or her biological parent’s medical history and a can be aware his or her predisposition to genetic diseases and can take preventative or cautionary measures in this regard. Further, in instances where a child requires an organ transplant or bone marrow for example, biological relatives may be the best donors and knowledge of the child’s biological origins would this be crucial. Further, not knowing one’s biological relatives can lead to incestuous relationships. Or, one could simply live in doubt as to one's true identity and long for the truth which may lead to behavioural or emotional problems.

5.78 Albertus concludes that:

One has to consider the SCA’s statement that knowing the truth is not always beneficial to individuals and/or children. It is not always in one’s interest to find out the truth, but how is not knowing any better? DNA/blood tests should not be regarded as the 'ends' which the administration of justice seeks. Instead, it should serve as the 'means' to attain the ‘end’, the end not only being truth and justice but a decision which will be in the best interests of the particular child. The truth will reveal that the alleged father is or is not the biological father of the child and provide the child with certainty regarding his or her genetic origin. Justice would be served by ensuring that a particular relationship is not built between a child and a man that may not be his or her biological parent and fulfilling duties that are not his. Furthermore, the best interests of a child cannot be served by perpetuating a possible fraud. Instead, the best interests of a child in establishing paternity should only lie in finding such child’s biological parent.

5.3.6 Questions

1. Does a child have a right to know his or her biological origins in instances of disputed paternity?
2. If so, should a child’s right to know his or her genetic origin be considered in determining paternity?

3. Duties and rights may be conferred on an alleged father in respect of a child that could possibly not be his. Would a man who is uncertain about whether a child is his biological child really do right by that child? Would he, for example, ensure that maintenance is paid timely or at all or that he builds and maintain a good father-child emotional relationship with the child? Will a man who is presumed to be a father and who grudgingly maintains the child, really be serving the best interests of that child?

4. Duties may be conferred on an alleged father in respect of a child that could possibly not be his. Is this fair to such a man simply because a child may benefit by receiving maintenance?

5. Does it serve the best interests of the child to impose a relationship between that child and a man that may or may not be his or her father especially in light of the fact that the child may at stage discover the truth about his or her biological origins?

6. What is in the best interests of a child: knowing the truth about his or her parentage or believing that a particular man is such a child’s father when there is a possibility that this may not be so?

7. Should civil courts still decide paternity disputes on a balance of probabilities in an era of advanced scientific technology?

8. Should paternity be determined by the courts by the use of presumptions or scientifically?

9. When and on what grounds can one approach the court for an order compelling blood tests for purposes of determining paternity or maternity?

10. Should the legislation be enacted to provide for the resolution of paternity and maternity disputes? If so, should the Children’s Act be amended in this regard or should stand alone legislation be enacted?

11. Should paternity be determined at the earliest and scientifically? Children grow into adults. What would an adult who learns that he or she was the centre of a paternity dispute which was settled by means of presumptions do? Would such an adult be
inclined to want to ascertain his or her paternity scientifically? Would such actions have the effect of destabilizing the family *status quo*? Will establishing paternity at the earliest, avoid the possibility of a dispute later which may lead to serious upheaval in the child’s life especially if the child has grown up in circumstances that the child believes are reality?

12. Regard being had to s129 and s130 of the Children’s Act, should a child be able to consent to paternity tests?

13. Should the Children’s Act be amended to provide for compulsory paternity and maternity testing especially in light of assisted reproductive techniques?

14. Will it be in the best interests of the child if paternity is determined scientifically and accurately and resolved at the earliest?

15. How should a child at the centre of a paternity dispute be registered?

### 5.4 Temporary residents, Asylum-seekers and Parents with Work Permits

5.79 In South Africa’s Progress in Realising Children’s Rights: A Law Review253 the following information appears:

The regulations require the parents to submit a copy of their passport and visa, work permit or asylum-seeker permit254. In the case of a child born to a non-South African mother and South Africa father, if the parents want to register the child as a South African citizen, the DHA requires that the father must apply to register the birth of the child under his surname with the mother present.

The new requirement of having to submit a valid passport and a visa or permit has been criticised by Lawyers for Human Rights as it is likely to prevent many children born to foreigners in South Africa from being registered, thereby putting such children at a high risk of growing up stateless.

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254 Regulation 8(3)(c) of the 2014 Regulations
There are many migrants in South Africa without proof of legal residence. There are also many asylum-seekers with valid asylum-seeker permits but without passports, who will be unable to obtain their passports from their country of origin.

Many asylum-seekers' permits regularly expire as they endure the long delays in the refugee status application process. The result of the imposition of this requirement will be that many children born in South Africa to migrant parents (lawfully and unlawfully in the country) will be unregistered.

This may result in them being denied access to a range of socio-economic services such as education and health care while living in South Africa. As mentioned, it will also put them at greater risk of remaining stateless as they may struggle to obtain birth registration in their parent's country of origin.

5.80 Proudlock recommends that the onerous requirement in the B&D Regulations that foreign national parents produce both proof of lawful residence in South Africa and a copy of their passports should be amended to require only one document proving identity and to allow for the use of alternative forms of recognizing their identity where none of the documents are available\(^\text{255}\).

5.4.1 Question

1. Should Regulation 8(3)(c) of the B&D Regulations be amended to require either proof of lawful residence in South Africa or a passport and to allow for the use of alternative forms of recognizing a foreign national’s identity where none of the documents are available?

5.5 Gamete Donors and Registration of Birth

5.81 Section 26(1) of the Children's Act states that a biological father claiming paternity may apply for an amendment to be effected to the registration of birth of the child in terms of s11(4) of the Births and Deaths Registration Act, 1992, identifying him as the father of the child, if the mother consents to such amendment. Section 26(2)(b) prevents any person who

is biologically related to a child by reason only of being a gamete donor for purposes of
artificial fertilisation from making such an application\textsuperscript{256}.

5.82 Section 41(2) of the Children’s Act prohibits the identity of a gamete donor from being
disclosed to a child or the child’s guardian.

5.83 Regulation 19 of the Regulations Relating to Artificial Fertilisation of Persons (GN
R1165 in GG 40312 of 30 September 2016) states that no person may disclose the identity
of any person who donated a gamete or received a gamete, or any matter related to the
artificial fertilisation of such gametes, or reproduction resulting from such artificial fertilisation
except where a law provides otherwise or a court so orders.

5.84 Further Regulation 21 of the provides that any person who contravenes or fails to
comply with any provision of these regulations commits an offence and is liable on conviction
to a fine or imprisonment for a period not exceeding 10 years, or to both such fine and
imprisonment.

5.85 It is clear that the identity of the gamete donor may not be disclosed.

5.5.1 Questions

1. Donor gametes would have to have been used where a single person or a gay couple
or a lesbian couple conceive and have a child. How would or should the birth of such
a child be registered?

\textsuperscript{256} Person claiming paternity

(1) A person who is not married to the mother of a child and who is or claims to be the biological father of the child may-
(a) apply for an amendment to be effected to the registration of birth of the child in terms of section 11 (4) of the
Births and Deaths Registration Act, 1992 (Act 51 of 1992), identifying him as the father of the child, if the mother
consents to such amendment; or
(b) apply to a court for an order confirming his paternity of the child, if the mother-
   (i) refuses to consent to such amendment;
   (ii) is incompetent to give consent due to mental illness;
   (iii) cannot be located; or
   (iv) is deceased.

(2) This section does not apply to-
(a) the biological father of a child conceived through the rape of or incest with the child’s mother; or
(b) any person who is biologically related to a child by reason only of being a gamete donor for purposes of
artificial fertilisation.
2. Where a heterosexual couple conceive and have a child using donor gametes, how would or should the birth of such a child be registered?

3. Who is responsible to tell a child about his or her biological origins, the social parent or the State?

4. How and when should a child be told about his or her biological origins?

5. Should the information appear on the birth certificate? Would this be feasible because a minor child would hardly ever see his or her birth certificate because an important document would be kept safely stored or be in the possession of the parent? Further a minor child may not understand the significance of the document.

6. Should the State reveal information about the child’s biological origins to the child when he or she applies for an identity document? Does such an approach take into account the emotional and psychological well-being of the donor-conceived person?
CHAPTER 6
ABANDONED CHILDREN

6.1 Registration of Birth of Abandoned and Orphaned Children

6.1 Section 28(1)(b) of the Constitution states:

28. (1) Every child has the right—
(b) to family care or parental care, or to appropriate alternative care when removed from the family environment;

6.2 The preamble of the CRC reads as follows:

Recognizing that the child, for the full and harmonious development of his or her personality, should grow up in a family environment, in an atmosphere of happiness, love and understanding.\(^\text{257}\)

6.3 Article 7(1) of the CRC states:

The child shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and, as far as possible, the right to know and be cared for by his or her parents.\(^\text{258}\)

6.4 Article 18(1) of the CRC states:

States Parties shall use their best efforts to ensure recognition of the principle that both parents have common responsibilities for the upbringing and development of the

\(^{257}\) The preamble of the ACRWC reads as follows “Recognizing that the child occupies a unique and privileged position in the African society and that for the full and harmonious development of his personality, the child should grow up in a family environment in an atmosphere of happiness, love and understanding.”

\(^{258}\) Article 19(1) of ACRWC reads as follows: “Every child shall be entitled to the enjoyment of parental care and protection and shall, whenever possible, have the right to reside with his or her parents. No child shall be separated from his parents against his will, except when a judicial authority determines in accordance with the appropriate law, that such separation is in the best interest of the child.”
child. Parents or, as the case may be, legal guardians, have the primary responsibility for the upbringing and development of the child. The best interests of the child will be their basic concern.\textsuperscript{259}

6.5 It should be clear from the above that the family is regarded as the foundation of society and that parents have the primary responsibility for the care and upbringing of their children. More particularly every child has the right to parental care and family care or to appropriate alternative care when removed from the family environment.

6.6 However, the realities of the South African landscape paint a dark picture as far as the child’s the right to know and be cared for by his or her parents. Based on research conducted from March 2013 to February 2014 by Dee Blackie, a consultant to NACSA (Blackie, 2014),\textsuperscript{260} the statistics appear as follows:

Statistics on Child Abandonment in South Africa

- Child Welfare South Africa estimated that more than 3500 babies were abandoned in 2010
- There are no current statistics detailing the number of children who are abandoned in South Africa on an annual basis, but most child protection organizations believe that the numbers have increased significantly over the past decade

Statistics on Children in South Africa

- There are 18.5 million children in South Africa, of these children 4.5 million live with neither of their parents.
- Orphans have increased by 30% over the decade to approximately 5.2 million children
- Over this same period, foster care grants have increased by over 70% whilst adoption has decreased by more than 50%
- An estimated 150,000 children live in child headed households

\textsuperscript{259}Article 18(1) of ARCWC reads as follows: “The family shall be the natural unit and basis of society, it shall enjoy the protection and support of the State for its establishment and development.” Further, Article 20(1) of ACRWC reads as follows: “Parents or other persons responsible for the child shall have the primary responsibility of the upbringing and development the child and shall have the duty...”

\textsuperscript{260}Child Abandonment and Adoption in the context of African Ancestral Beliefs in Contemporary Urban South Africa, Dee Blackie, 2014 for the National Adoption Coalition of South Africa
• Over 13 000 children live in residential care facilities
• An estimated 10 000 children live on the streets of South Africa
• In 2013 over 11 million children were registered for child support grants and over half a million children for foster care grants

6.7 Chapter 9 of the Children’s Act deals with children in need of care and protection. Section 150(1)(a) reads as follows:

(1) A child is in need of care and protection if, the child-
   (a) has been abandoned or orphaned and is without any visible means of support;

6.8 The section does not distinguish between abandoned and orphaned children. The key difference being that, in the case of abandoned children the parents are alive but fail to take care of the children whereas in the case of orphaned children the parents are deceased and therefore the child is in need of alternative care.

6.9 Section 1 of the Children’s Act defines an abandoned child as a child who-

(a) has obviously been deserted by the parent, guardian or care-giver; or
(b) has, for no apparent reason, had no contact with the parent, guardian, or care-giver for a period of at least three months;

6.10 There are many reasons why parents abandon their children and these include:

- The birth of a baby outside marriage and not accepted in a culture leaves the mother feeling that she cannot keep the baby for fear of being rejected by her family.
- Depression, in particular, post-natal depression. Mothers not bonding with the baby after birth. An inability to communicate with family members and a feeling of being overwhelmed by the pregnancy.
- Abortion is frowned upon as a child is seen as a gift from the ancestors.
- A review of African ancestral beliefs indicates that adoption where children are incorporated into families that they are not related to is viewed as problematic.263

262 Child Abandonment and Adoption in the context of African Ancestral Beliefs in Contemporary Urban South Africa, Dee Blackie, 2014 for the National Adoption Coalition of South Africa
263 Child Abandonment and Adoption in the context of African Ancestral Beliefs in Contemporary Urban South Africa, Dee Blackie, 2014 for the National Adoption Coalition of South Africa
- Personal circumstances of the mother, poverty, alcohol and substance abuse
- Mass urbanization and diminished family support
- HIV and Aids, most young women who are affected by Aids are also in the grips of poverty and do not possess the emotional, mental or financial capacity to support a child.
- Mothers feel isolated and do not know where to turn especially since anonymous abandonment is not allowed in South Africa.
- Pregnancy as a result of rape is also seen as a possible reason for infanticide and abandonment. The foetus growing inside the woman is seen as a violation, an invader of her body. When the baby is born, all the woman feels is anger and revulsion, resulting in her actions against the baby.
- Gender inequality as men or boys father babies and then leave the responsibility of raising the child to the mother.
- The phenomenon of sugar daddies and blessers who impregnate young girls and then abdicate their responsibility for the baby.
- Baby abandonment might be an extreme form of the maternal instinct. Some young mothers feel that the baby would be better off without them and place their babies in a spot where they intend them to be discovered\textsuperscript{264}.
- Babies born with mental or physical health defects or diseases.
- Relinquishing one’s parental rights so that a child can be adopted, can only be done without a legal guardian’s consent from the age of 18 years, making this option inaccessible to teenage mothers.

6.11 Section 12 of the Births and Deaths Registration Act 51 of 1992 provides for the registration of abandoned or orphaned children as follows:

12. **Notice of birth of abandoned or orphaned child**

(1) The notice of birth of an abandoned child which has not yet been given, shall be given, after an enquiry in respect of the child concerned in terms of the Children's Act, by the social worker concerned: Provided that in the event of any parent of the child being traced after the registration of the birth and the particulars in any document or record in respect of the child not being reflected correctly, the Director-

\textsuperscript{264} http://www.parent24.com/Baby/Babycare/care_nutrition/Why-do-moms-abandon-their-babies-20101115
General may on application, in the prescribed manner, amplify and correct the said particulars.

(2) The notice of birth of an orphaned child which does not list any of the persons contemplated in terms of section 9(1), shall be given by a social worker, after conclusion of an enquiry in respect of such child concerned in terms of the Children's Act.

6.12 The following information appears in South Africa’s progress in Realising Children’s Rights: a Law Review by Paula Proudlock\(^\text{265}\) (Proudlock, 2014):

In the case of abandoned children, who have never been registered with the DHA, the Births and Deaths Registration Act provides that their births must be registered by a social worker after the conclusion of an inquiry in terms of the Children’s Act.

While the law did not impose such a requirement for orphaned children in the past, as of 1 March 2014 the law now requires the first time notice of the birth of orphaned children, in cases where a family member or legal guardian is not available to do so, to be submitted by a social worker.

Where a social worker identifies an abandoned child (or orphaned child without a family member to register them), the process for the registration of the child’s birth is as outlined below:

- After the initial court appearance for the temporary removal of the child in terms of section 151(1) of the Children’s Act, the social worker concerned must approach a district surgeon for an age estimation of the child.
- The age estimation is then presented to the court with the social worker’s report, and the children’s court will then issue an order to the DHA to register the birth of the child and issue a birth certificate.
- The social worker then submits the children’s court order to the DHA and applies for the birth certificate. At this stage of the process the child is likely to be older than 30 days, which means the social worker will need to follow the stricter requirements for late registration of births.

Only once the birth certificate has been issued by the DHA can the children’s court inquiry be heard and the final order as to the placement of the child be handed down.

Delays within the children’s court processes to obtain the initial order for the DHA and delays at the DHA in issuing the birth certificates (especially if it is a late birth registration) are challenges raised by social workers in the field. These in turn create further delay in the finalization of placement orders such as foster care and adoption, which tend to take a very long time in their own right already.

Where the abandoned child is not a South African citizen, the DHA is less inclined to issue a birth certificate for the child despite a children’s court order requesting it to do so. Lawyers for Human Rights have observed that late birth registration applications to the DHA for children born to foreign nationals or unaccompanied foreign children can take upwards of six months.

6.2 Safe Haven Laws

6.13 Many State legislatures in the United States have enacted legislation to address infant abandonment and infanticide in response to a reported increase in the abandonment of infants. Beginning in Texas in 1999, “Baby Moses laws” or infant safe haven laws have been enacted as an incentive for mothers in crisis to safely relinquish their babies to designated locations where the babies are protected and provided with medical care until a permanent home is found.266

6.14 Safe haven laws generally allow the parent, or an agent of the parent, to remain anonymous and to be shielded from prosecution for abandonment or neglect in exchange for surrendering the baby to a safe haven. “Safe-haven” laws typically let parents remain nameless to the court, often using a numbered bracelet system as the only means of linking the baby to the parent.

6.15 Some states treat safe-haven surrenders as child abandonment or child dependency (meaning that the parent is unable or unwilling to care for the child), with a complaint being filed for such in juvenile court. The parent either defaults or answers the complaint. Other states treat safe-haven surrenders as adoption surrenders and a waiver of parental rights.

266 https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/safehaven/
The laws have different names in different states and states have different age limits. Police stations, hospitals, rescue squads and fire stations are all typical locations to which the safe-haven law applies.

6.16 South Africa does not have safe haven laws. Child abandonment and orphanhood are dealt with together in s150 of the Children’s Act.


6.18 Vadivalu finds that despite the non-ratification of the CRC on the part of the United States, Californian law, as illustrated in legislative provisions and judicial decisions, is in keeping with many of the provisions of the CRC. Safe Haven laws in the United States are an innovative feature of their child abandonment laws. The aim of these laws is to protect and save the lives of newborns. This is done by designating specific locations as safe haven sites where parents may surrender their child with immunity from prosecution provided that the child has not been harmed. In essence, these laws provide for the legalisation of child abandonment.

6.19 He discusses the main weaknesses in South African law as well as the strengths in American law, having regard primarily to Californian abandonment law, and provides a list of recommendations for improving the current South African law on child abandonment which includes proposed amendments to sections 150(1)(a) and 1 of the Children’s Act.

6.20 He recommends the enactment of safe haven legislation and the consequent establishment of safe haven sites in South Africa where children, particularly infants, may be surrendered and immunity offered to the surrendering parent, provided the child is found unharmed. This proposed legislation is aimed at saving the lives of newborns who may otherwise be unlawfully abandoned potentially resulting in fatal consequences. Based on the positive experience in California, he opines that safe haven laws should be adopted in South Africa.

6.21 A further recommendation is for the criminalisation of child abandonment when it falls outside the scope of a safe haven. The enactment of such legislation serves as a deterrent against child abandonment and will encourage parents to make use of other available
options such as adoption or foster care in circumstances where parents are experiencing difficulty in caring for their child. Similar to safe haven laws, the criminalisation of abandonment is aimed at protecting the lives of children.

6.22 He concludes that the South African law on parental abandonment is inadequate and could be considerably improved through amendments to the Children’s Act and that such legislative change would be beneficial given the serious harm to both children and parents which results whenever an incorrect finding of abandonment is made by a court.

6.23 Despite the fact that South Africa has no safe haven laws, baby hatches are springing up around South Africa as a result of the high incidence of child abandonment.

6.3 Baby Hatches

6.24 A baby hatch or baby box is a place where people (typically mothers) can bring babies, usually newborn and abandon them anonymously in a safe place to be found and cared for.

6.25 This arrangement was common in the middle ages and in the 18th and 19th centuries when the apparatus was known as a foundling wheel. An abandoned child is called a foundling. Foundling wheels were taken out of use in the late 19th century but a modern form, the baby hatch began to be introduced again from 1952 and since 2000 has come into use in many countries. Economic pressures and social breakdown are often cited as the reason for the increase in baby hatches worldwide. The hatches are usually in hospitals, social centres, or churches, and consist of a door or flap in an outside wall which opens onto an insulated bed. In certain instances, sensors in the bed alert carers when a baby has been put in it so that they can come and take care of the child.267

6.26 The non-profit organisation, Door of Hope Children’s Mission set up a baby hatch in July 1999 at the Mission Church in Hillbrow, Johannesburg in 1999. After hearing about an abandoned baby in a rubbish bin, pastor, Cheryl Allen, thought about what could be done to save these unwanted babies. She thought of installing a ‘hole in the wall’ (bin) where mothers could leave there babies any time day or night and give them an alternative to dumping them. For a long time, it was known as ‘The Hole in the Wall’. By March 2013

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267 https://en.wikipedia.org/wiki/Baby_hatch
around 148 babies came through the hole in the wall while over 1300 babies came through their doors.

6.27 Various other counties have baby hatches including Austria, Canada, Czech Republic, Hungary, India, Japan, Philippines, Malaysia, Poland and Switzerland.

6.28 A two-year project was conducted by Kevin Browne of the Institute of Work, Health and Organisations, University of Nottingham that aimed to explore child abandonment and its prevention in Europe. It found that child abandonment is not been extensively dealt with in Europe. Few countries keep records regarding the number of children abandoned, abandonment is seldom legally defined in legislation, and very little research exists regarding the extent, causes and consequences of this phenomenon. There is growing evidence that it is frequently men or relatives abandoning the child and this raises the question as to whether babies are abandoned by angry fathers, relatives or even pimps. Staffs from 100 maternity units and 100 prevention programmes in ten countries were interviewed (Bulgaria, Czech Republic, Denmark, France, Hungary, Lithuania, Poland, Romania, Slovakia, and the United Kingdom). Government departments and non-governmental organisations in other European countries were contacted for information relating to child abandonment in their country.

6.29 The research found little information regarding the number of children abandoned outdoors or in public places. However, some countries do keep national records of children abandoned in maternity units. The approaches to addressing child abandonment vary. In some countries it is no longer illegal to abandon a child, provided that the child is left in a safe place. In terms of preventing child abandonment, despite a great deal of good work being done, considerably more effort is required in order to develop effective, evidence-based prevention programmes\textsuperscript{268}.

6.30 In the United Kingdom there are no baby hatches as they are illegal under section 27 of the Offences against the Person Act 1861 the law states that any mother who abandons a child less than two years of age is a criminal and can face up to five years' imprisonment.

\textsuperscript{268} Child Abandonment and its Prevention in Europe, Kevin Browne, Institute of Work, Health and Organisations, University of Nottingham, January 2012
6.3.1 Baby hatches in Germany

6.31 In November 2009, the German Ethics Council recommended that a statutory basis should be created for relinquishment of infants on a confidential basis and that the possibilities of anonymous birth and baby drops, which are unlawful but which till now have been tolerated, should be discontinued. Parallel to this, the availability of public information on the existing comprehensive legally sanctioned assistance facilities for pregnant women and mothers in situations of distress or conflict should be expanded. The reasons for this decision was that the council was not convinced that baby hatches do in fact prevent the death of newborns and because baby hatches do not address the root cause of the problem and the plight of the mother who has abandoned her child.

6.32 In 2013 German chancellor Angela Merkel put forward legislation to find an alternative to baby hatches (known as babyklappe in Germany). The draft laws provide that women will be allowed to give birth anonymously at hospitals in Germany. The personal information of the mother is recorded and kept in a sealed envelope by federal authorities. The information would be kept for 16 years which would allow children who have been abandoned to find out who their birth mother is when they are older. The child then has the right to find out the name of his or her mother unless the mother refuses. The mother can ask that her files not be given out in certain circumstances such as if she fears the reaction of her family or feels threatened. At that point, a family court decides. The law grants the mother temporary anonymity at least in her immediate social circle and makes a major contribution to the rights of the child who wants to know his or her origins on the other hand.

6.33 The Act Expanding Assistance for Pregnant Women and Regulating Births in Confidence of 28 August 2013 (Federal Law Gazette I, p. 3458), which came into force on 1 May 2014 creates the new option of a confidential birth as an alternative to the unregulated option of giving a child up anonymously. The law guarantees safe childbirth for pregnant women and the possibility for children unwanted by their biological mothers to learn their origin when they turn 16 years of age. The Act does not criminalize bay hatches.

6.4 Baby Hatches and the Right to Know One’s Own Biological Origins

6.34 The CROC objects to the establishment of baby hatches as they believe that these violate a child’s right to know the identity of his or her biological parents as provided for in Article 7(1) of the CRC which states that a child shall, as far as possible, have the right to know and be cared for by his or her parents.

6.35 The right Article 7(1) is further grounded by Article 8(1):

States Parties undertake to respect the right of the child to preserve his or her identity, including nationality, name and family relations as recognized by law without unlawful interference.

6.36 Professor of Philosophy at the University of New Hampshire, Charlotte Witt,270 says that baby hatches do not violate the human rights of an abandoned baby as the service provides mothers with an alternative to infanticide and unsafe abandonment and, in fact, promotes the child’s right to life as found in Article 6 of the CRC:

1. States Parties recognize that every child has the inherent right to life.
2. States Parties shall ensure to the maximum extent possible the survival and development of the child.

6.37 Safe–surrender programs sever the connection between a child and his or her parents and family of origin. Witt says that those who believe that baby hatches violate a child’s right believe that children have a right to know their family of origin because that knowledge is central to the healthy formation of their identity. She argues that this assumption is mistaken as family members do not need to be biological relatives to serve as the basis for identity formation. Therefore, the alleged need cannot ground a supposed right of the child to know his or her biological kin.

6.38 She says that there is no evidence of serious harm to children who don’t know their biological or genetic origins.

Witt says that the concept of identity that allegedly grounds a child's right to know his or her biological origins is a "fuzzy" one at best.

Witt makes her case as follows:

The relevant notion of identity is the psychological sense of self that normally develops in childhood. Two ideas connect a child's psychological identity to knowledge of her family of origin. First, one might think that a child's identity is determined to a substantial degree by her biogenetic inheritance, so to know herself she must know what that biogenetic heritage is. This claim might even seem self-evident in our era of the human genome and genetic medicine, but, in fact, this knowledge cannot be necessary for a child to develop an adequate sense of self. For most of human history (and in many cultures today) children have developed adequate identities or selves without access to biogenetic information.

To skirt this difficulty one might claim that what is important for developing a sense of self is the ability to observe family resemblances, which requires direct acquaintance with biologically related family members. The philosopher J. David Velleman makes this argument against anonymous donor vending, which he claims intentionally deprives children of an essential ingredient in the development of a healthy identity. Children conceived through anonymous donation lack a reservoir of family resemblances (including personality and character traits) with biological kin (including uncles, aunts, grandparents) from which to understand what it's like to be them and hence will be unable to develop an adequate sense of self.

Velleman writes: When adoptees go in search of their biological parents and siblings, there is a literal sense in which they are searching for themselves. They are searching for the closest thing to a mirror in which to catch an external and candid view of what they are like in more than mere appearance. Not knowing any biological relatives must be like wandering in a world without reflective surfaces, permanently self-blind.

Velleman's argument is contradicted by my own experience. Consider my daughter Anna, who identifies strongly with her grandmother, Jeannette, a lifelong resident of New York City. In a vignette she wrote in high school about Jeannette, Anna underlines their similarities, in particular their shared love of New York. Even though she has spent her life in Maine, Anna's adolescent identity draws on her feelings of
kinship with Jeannette, and Anna understands herself through the prism of that relationship. However, Anna is my adopted daughter and Jeannette is not her biological kin. So, Velleman may well be correct that family resemblances are one ingredient in a child’s identity formation, but he is wrong to argue that these resemblances must be with biological kin.

Neither the biogenetic argument nor the family-resemblances argument grounds a child’s right to know her family of origin. Granted, some individuals feel harmed by lack access to information about their origins.

In a landmark Canadian case concerning anonymous gamete vending, *Pratten v. British Columbia* (2011), Olivia Pratten described the psychological harm she experienced as a result of being conceived via anonymous sperm vending.

But for these psychological harms to ground a right they must be substantial and widely shared in the relevant class—namely children who for one reason or another do not have direct acquaintance with biological family members. However, a recent comparative survey of families formed via adoption and via anonymous gamete provision, conducted by the Centre for Family Research at Cambridge University, does not record widespread psychological harm to these children or a vast difference in psychological well-being between children in these families and children in standard families.

If knowledge of one’s biological and genetic origins, or direct acquaintance with bio-family members, were a necessary part of developing a healthy identity, the evidence would show widespread, serious psychological damage in children who lack such knowledge and acquaintance. That is not the case.

When we were growing up, my siblings and I had no idea that my father had a brother, a lifelong alcoholic. We learned of his existence from a photograph. Were my parents guilty of violating a basic right in not informing us? If a mother is estranged from her family of origin or does not know who her child’s father is, has she violated her child’s rights? Should the government try to craft regulations that would require full family identification and disclosure to children? If we are inclined to answer no to these questions, then it cannot be that children have a right to know their families of origin.
There is a hidden political dimension to the debate over children’s right to know. The debate presupposes a bionormative view of the family, which holds that families formed via biological reproduction are the gold standard or Platonic form of the family. The implicit bionormative assumption emerges in the thought experiments above.

When we ask about children placed in baby boxes (and subsequently adopted), our intuitions might favour the notion of a right to know. But when we consider families formed by biological reproduction, our intuitions do not line up to support such a right. Rather, we think that the mother who is estranged from her family of origin, or who does not know who or where the father is, has the right, and, indeed, the obligation, to determine what to tell her child about family and ancestry, and what not to tell her. It is a question of the child’s welfare, not the child’s rights. In the case of families that do not meet the bionormative standard, however, we are more likely to favour a child’s right to know. This indicates a tacit priority granted to biological or genetic ties.

There may be good reasons for society to support policies and procedures that facilitate contact between children and their families of origin or progenitors. At least in some contexts there is evidence that open adoptions are beneficial to children and families. At a minimum, children should be told the truth about their origins, and parents have a moral obligation to avoid deception. There is also an equality argument that supports access to original birth records for adult adoptees and for offspring of anonymous gamete vending or surrogacy. It is simply discriminatory to deny access to original birth records to one group of adults due to the circumstances of their birth, over which they had no control.

6.41 Witt concludes that:

In the face of these considerations it may be that safe surrender does not serve the best interests of children unless it includes mechanisms for preserving original birth records. But reaching this conclusion does not require positing a child’s right to know or reinforcing the bionormative prejudice inherent in that supposed right.

6.42 Witt’s conclusion suggests that, in the best interests of the child and not because a child has a right to know his or her biological origins, confidential birth is to be favoured rather than anonymous adoption.

6.43 Possible reasons for including mechanisms for preserving original birth records is to ensure equality in how different child are treated e.g. adult adoptees can access birth records
and the same should be the case for abandoned children; there may be benefit to a child in interacting with the family of origin and children should be told the truth about their origins and parents have a moral obligation to avoid deception.

6.5 Objections to the Establishment of Baby Hatches

6.44 Academics at the Department of Bioethics, Kumamoto University, Japan, Atsushi Asai and Hiroko Ishimoto critically assessed various objections to baby hatches in their 2013 article titled “Should we maintain baby hatches in our society?” For the purposes of this paper, we look only at the objection to baby hatches on the basis that these violate a child’s right to know the identity of his or her biological parents by allowing anonymous birth.

6.45 Abandoned children may suffer disadvantages due to not knowing their biological origins including that the lack of genetic information may infringe on the child’s right to health; the inability to exclude the possibility of a consanguineous marriage when the child marries; the child will lack information on his or her biological parents and his or her own birth, which are crucial to the establishment of independence and identity. Asai and Ishimoto say that some countries have started requiring a sperm donor to allow disclosure of his identity if a child born by artificial insemination requests it. In this case, those who do not desire disclosure of their identity are unlikely to become donors. Similarly, parents who wish to remain anonymous and women who wish to conceal their pregnancies may choose abortion, infanticide, or child abandonment if anonymous drop-offs are not allowed. Fixating exclusively on respecting the right of the child to know his or her parents without considering the circumstances will lead to violation of the right to life.

6.46 If the child cannot survive, then, the right to know his or her origins can neither be claimed nor protected. Discussions should thus consider the temporal sequential order of realizing rights. Baby hatches give children the right to life and, for newborns, survival is more important than the right to know and be cared for by their parents.

271 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3586365/, Atsushi Asai and Hiroko Ishimoto, article titled “Should we maintain baby hatches in our society?” published online on 22 February 2013, National Center for Biotechnology Information, US National Library of Medicine
Further, Asai and Ishimoto say that not all parents should be forced to disclose their identity. In principle, the right of a child to know his or her origins should be higher in priority than the parent’s right to anonymity based on the vulnerability of children and the importance of the outcome, however, in exceptional cases where the parent is mentally and economically desperate and the conditions are such that abortion, infanticide, or child abandonment may occur unless privacy is protected, the parent's right to anonymity should be upheld to protect both the child and parent. Therefore, even anonymous use of baby hatches should be allowed.

Asai and Ishimoto list the benefits of baby hatches as follows:

- Baby hatches can give children the right to life and they can be saved.
- Baby hatches can protect vulnerable pregnant women who are mentally and economically desperate.
- Baby hatches can uphold parent’s right to anonymity and both stigmatization and discrimination against them can be avoided.
- Baby hatches can have the societal function of serving as a last resort for desperate women and/or parents.
- Baby hatches can provide an alternative form of social childcare organizations with only limited function.
- Baby hatches can serve as the emergency shelter role temporarily which accepts the baby of the mother and/or parents who need time to think.
- Baby hatches can fulfil social responsibility to protect and raise children by realizing a principle of solidarity.
- Baby hatches can offer pregnant women and/or parents an opportunity to drop off their child at a safe place hoping that he or she survives.
- Baby hatches can serve as important local direct and upmost measures for women and/or parents in trouble, by offering 24-hour preventive consultation and support system.
- Baby hatches can be a symbol embodying human compassion which is a pure and natural feeling that it is unbearable and impossible to remain indifferent in the face of another’s misfortune.
- Baby hatches can urge society as a whole to deliberate current situation in which child-rearing is difficult.
6.49 They question whether a baby hatch is an activity to support the safety and independence of the mother and child by preventing child abandonment and child murder, or a device that encourages easy child abandonment.

6.50 They answer that, in fact, no one knows. Although there are arguments for and against baby hatches, clear and solid evidence for these arguments is unavailable at the present time. However, human beings die very easily. If we are to err, then it is better to make attempts that seem beneficial to life even in the slightest degree.

6.51 They say that not all human beings are capable of communicating well with others, being self-assertive or asking for help in a timely manner. If they were, then tens of thousands of people per country would not commit suicide each year, nor would people kill themselves out of desperation induced by bullying. Not all human beings are careful and responsible either. Some are weak-willed. There are thoughtless people as well as cowardly people. There are complete egoists. There are also cunning men, and women who have children despite knowing that their partners are such men. Some people are not blessed with partners or relatives. Some grandparents will be unsympathetic. Furthermore, in this world, there are no perfect systems or life-saving facilities. We should consider the continuation of baby hatches with such realities in mind. Baby hatches are necessary in our present society. Though it is best not to be used, it is a place of socially essential emergency refuge for babies and parents.

6.52 Asai and Ishimoto conclude that baby hatches should be supported if they are opened and operated with good intentions, the maximum possible efforts are made to protect the interests, rights and safety of children at the facility and there is no clear evidence of harm to the mother, child, or society. To prevent the baby hatches from losing their function, the ultimate decision of whether to drop off the child in anonymously should be left to the parents. They consider baby hatches to be an embodiment of human compassion which is a pure and natural feeling that it is unbearable and impossible to remain indifferent in the face of another's misfortune.
6.6 Questions

1. What are the solutions to child abandonment in South Africa?

2. Should South Africa enact safe haven laws similar to those in the United States?

3. Should South Africa enact confidential birth laws similar to that in Germany?

4. Should South Africa enact both safe haven and confidential birth laws?

5. Does an abandoned child have the right to know his or her biological origins?

6. Does ancestor worship play a role in child abandonment? If so, why?

7. Does ancestor worship influence the right a child to know his or her biological origins?
CHAPTER 7
MITOCHONDRIAL REPLACEMENT THERAPY

7.1 What is Mitochondrial Disease?

7.1 Mitochondria are small structures contained in the cytoplasm of a cell, producing energy in the form of adenosine triphosphate (ATP). Each cell contains hundreds to thousands of mitochondria, depending on the energy requirements of particular tissues. Mitochondrial DNA (mtDNA) is made up of 37 genes, which are primarily responsible for maintaining the function of the mitochondria, making up less than 0.1% of the human body's total DNA.

7.2 Mutations in the 37 genes housed inside mitochondria can lead to fatal inherited diseases that affect organs that need lots of energy, such as the brain and muscles. Although the genetic contribution of mitochondria is small, the impact when they fail to function is considerable. Mitochondria dysfunction can be due to mutations in either nuclear or mitochondrial DNA sequences. Diseases caused by mutations of mtDNA display a maternal inheritance pattern. Both sexes can inherit the disease but it is only

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272 Mitochondria are an organelle found in large numbers in most cells, in which the biochemical processes of respiration and energy production occur.
273 Cytoplasm is a clear, gel-like substance found in all cells. Everything contained within a cell is found suspended in cytoplasm, except the nucleus, which is separated from the cytoplasm by a membrane. Cytoplasm helps rid cells of waste material, aids in cell respiration and helps convert glucose into energy.
274 The cell (from Latin cella, meaning "small room") is the basic structural, functional, and biological unit of all known living organisms. A cell is the smallest unit of life that can replicate independently, and cells are often called the "building blocks of life".
275 DNA, or deoxyribonucleic acid, is the hereditary material in humans and almost all other organisms. Nearly every cell in a person's body has the same DNA. Most DNA is located in the cell nucleus (where it is called nuclear DNA) but a small amount of DNA can also be found in the mitochondria (where it is called mitochondrial DNA or mtDNA). DNA is a molecule that carries the genetic instructions used in the growth, development, functioning and reproduction of all known living organisms and many viruses.
276 A gene is the basic physical and functional unit of heredity. Genes, which are made up of DNA, act as instructions to make molecules called proteins.
277 A nucleus, in biology, is a specialized structure occurring in most cells (except bacteria and blue-green algae) and separated from the rest of the cell by a nuclear membrane. The nucleus controls and regulates the activities of the cell such as growth and metabolism and carries the genes (structures that contain the hereditary information).
women who are at risk of transmitting the disease to their children since all mitochondria are derived from oocyte278 cytoplasm.

7.3 Although it is difficult to identify disease prevalence, it is estimated that one in 400 people carries a disease causing mitochondrial mutation. Mitochondrial disease is extremely variable according to which organs are affected and to what extent and patients can be mildly, severely or fatally affected. Symptoms can include diabetes, epilepsy, digestive disorders, fatigue, cardiomyopathy, deafness, restricted sight and difficulties with mobility and balance. The term ‘mitochondrial disease’ was introduced in the late 1980s, but it encompasses a range of distinct disorders, including mitochondrial encephalomyopathy, lactic acidosis and stroke like episodes (MELAS), myoclonus epilepsy with RRF (MERRF), Leber’s hereditary optic atrophy (LHON) and Leigh syndrome279.

7.4 There is no cure for mitochondrial disease. Multiple organs are severely affected, no preventative treatments are available and most patients experience a poor quality of life or early death. The goal of medical intervention is to control symptoms and hinder progression of the disease as much as possible through a healthy lifestyle and in some cases medications. Diseases resulting from mutations in mtDNA are inherited by all offspring through the maternal lineage. Since treatment is limited, technologies that can prevent a child from inheriting the disease have been widely welcomed280.

7.2 What is Mitochondrial Replacement Therapy

7.5 Mitochondrial replacement therapy (MRT) is sometimes called mitochondrial donation or mitochondrial transfer or three-parent IVF.

7.6 It is a form of in vitro fertilisation in which the future baby's mitochondrial DNA comes from a third party. This technique is used in cases when mothers carry genes for mitochondrial diseases. Therefore mtDNA from a healthy donor is used to attempt to prevent the transmission of mitochondrial disease from one generation to the next.

278 An oocyte (also known as oocyte, ovocyte, or rarely oocye) is a female gametocyte or germ cell involved in reproduction. It is an immature ovum or egg cell. An oocyte is produced in the ovary during female gametogenesis.


280 United Mitochondrial Disease Foundation at http://www.umdf.org/faq-page-1/
7.7 Without the use of MRT, the only ways to both prevent the transmission of mitochondrial disease between generations and assist infertile women in having children are whole egg donation, embryo donation, and adoption. With whole egg donation, the intending parents use only an egg donor, whereas with embryo donation, the intending parents use both an egg donor and a sperm donor.

7.8 MRT can prevent transmission of mitochondrial diseases between generations and help infertile women have children while retaining the genetic link between intending parents and offspring. This is achieved because MRT transfers the nuclear DNA of the intending mother into a donor egg with healthy mitochondria, ensuring the resulting child will also have healthy mitochondria. It is hypothesized that MRT can also be used to treat infertility because the fertilized egg would have more mitochondria, assisting its normal development post-implantation.

7.9 MRT proposes to give women with mtDNA mutations an excellent chance of having a child that is over 99% genetically matched with her and her partner and, most importantly, is likely to be free of the mitochondrial disease.281

7.10 The two most common techniques in mitochondrial donation are pronuclear transfer and maternal spindle transfer.282

7.2.1 Pronuclear Transfer

7.11 The first mitochondrial replacement technique developed to stop mitochondrial diseases is called pronuclear transfer (PNT). It was first done in mouse embryos in 1983. Pronuclei are nuclei from the egg and sperm that are in the fertilized egg, called a zygote, but have not yet fused into a single nucleus.

7.12 In this technique, the mother’s egg and a donor egg are fertilized at the same time. The pronuclei are removed from the donor egg and discarded. Then the pronuclei are sucked out of the mother’s egg and transferred into the empty donor egg.

7.13 Shoukhrat Mitalipov283 says pronuclear transfer has a couple of drawbacks. Some people object to it on ethical grounds because it is seen as destroying two embryos.284

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281 United Mitochondrial Disease Foundation at http://www.umdf.org/mitochondrial-replacement-therapy/
Scientists worry because a bit of cytoplasm is usually transferred along with the pronuclei. That means that unacceptably high numbers of mitochondria including disease-carrying ones from the mother’s egg may be carried into the donor egg.

7.14 In June 2015 scientists reported that refinements in the technique produced embryos in which less than 2 percent of the mitochondria were carried from the mother’s egg into the donor egg but an earlier study suggested that even 1 percent carryover could be dangerous because mutant mitochondria may replicate, eventually taking over the cell and crippling its energy production. The process is called reversion and raises the potential that children born from MRT could still develop mitochondrial diseases. It is unclear why this happens, but one theory is that some mitochondria replicate faster than others, allowing them to dominate the healthy donor mitochondria.

### 7.2.2 Maternal Spindle transfer (MST)

7.15 When a dividing cell divides its chromosomes, they are attached to protein fibres called microtubules or spindles. The transplant technique starts with two unfertilized egg cells, one from the donor and one from the mother. In both cells, the membrane surrounding the nucleus has broken down, but the cell has not yet completely divided.

7.16 The spindle and its attached chromosomes are removed from the mother’s egg and inserted into the donor egg, which has been emptied of its spindle and chromosomes. Then a sperm cell is injected to the resulting egg to fertilize it.

7.17 Mitalipov pioneered the maternal spindle transfer (MST) technique, showing in 2009 that he could produce healthy monkeys however, the monkey experiments indicate that the technique has a lower level of carryover of mitochondria from the mother’s egg to the donor egg than pronuclear transfer, usually 1 percent or less but Mitalipov seeks to reduce.

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283 Shoukhrat Mitalipov is an American biologist who heads the Center for Embryonic Cell and Gene Therapy at the Oregon Health & Science University in Portland. He is known for discovering a controversial genetic therapy that may be a way to prevent mitochondrial diseases, as well as a new way of creating human stem cells from skin cells accessed at [https://en.wikipedia.org/wiki/Shoukhrat_Mitalipov](https://en.wikipedia.org/wiki/Shoukhrat_Mitalipov) on 27 December 2016.

284 Embryo is an organism in the early stages of growth and differentiation, from fertilization to the beginning of the third month of pregnancy in humans. After that point in time, an embryo is called a foetus.

285 Chromosome is a thread-like structure of nucleic acids and protein found in the nucleus of most living cells, carrying genetic information in the form of genes.
7.18 Spindle transfer has another possible downside in that chromosomes may fall off the spindle. That could result in an embryo with too few chromosomes or too many if some are left in the egg from the donor or extras are carried over from the mother’s egg. Both cases usually result in abnormal development.

7.19 Besides the risk of even trace levels of mitochondria ballooning, another study suggests that mismatches between the parents’ nuclear DNA and the donor mitochondrial DNA could affect aging.

7.20 This technique was used by John Zhang to produce a baby boy born in April 2016. The infant reportedly has 1 percent of mitochondrial DNA from his mother. At 3 months old, he was healthy. Long-term consequences are unknown. Some of the mitochondria in the baby boy’s mother’s cells have a mutation that causes Leigh syndrome, a fatal neurological disorder. Most of her mitochondria function properly and she doesn’t have the syndrome. However she can pass the disease on to her children. Two of her children have died of the disease and she has had four miscarriages. Her son’s caps nearly three decades of efforts to manipulate mitochondria and produce healthy eggs initially to overcome fertility problems and now to avoid passing on disease

7.3 Mitochondrial Replacement Therapy in the United Kingdom

7.21 In February 2015 the UK became the first country in the world to pass legislation to regulate MRT and regulations in this regard came into force on 29 October 2015. The UK parliament voted to allow mitochondrial replacement and this gave the country’s Human Fertilisation and Embryo Authority (HFEA) the power to approve the therapy.

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286 John Zhang is a medical scientist. He made news headline in September 2016 for successfully producing the world’s first three-parent baby using spindle transfer technique. Obtaining an M.D. from Zhejiang University School of Medicine, an M.Sc. from University of Birmingham, and a Ph.D. from University of Cambridge, he became the founder-director of New Hope Fertility Center in New York, USA. Accessed at https://en.wikipedia.org/wiki/John_Zhang_(scientist) on 27 December 2016


288 The Human Fertilisation and Embryology (Mitochondrial Donation) Regulations 2015 which can be accessed at http://www.legislation.gov.uk/ukdsi/2015/9780111125816/contents
7.22 On 15 December 2016, the HFEA approved the therapy after a scientific report concluded on 30 November 2016 recommended cautious approval.

7.23 The UK became the first country to formally allow children to be genetically altered to ensure they do not inherit disorders caused by mutations in mitochondria, a momentous decision that could eventually lead to other kinds of reproductive genetic engineering. The country’s HFEA has given a cautious go-ahead to the use of MRT to prevent mitochondrial disorders. Clinics that wish to carry out the procedure now have to convince the HFEA that they are competent. Thereafter, the HFEA will approve applications on a case by case basis.\(^{289}\)

7.24 Researchers at Newcastle University in the United Kingdom have been at the forefront of the work and they said they plan to apply for a license as soon as possible. Doug Turnbull, who has helped lead the research, said in a statement that he and his colleagues "will be aiming to treat up to 25 carefully selected patients a year with the mitochondrial donation technique as a clinical risk reduction treatment. We will also provide long-term follow up of any children born."\(^{290}\)

7.25 The potential use of mitochondrial donation as a means to enhance fertility or for lesbian couples wishing to have children related to both also seems to have played a role in the eligibility requirements of the UK regulations of 2015 as the regulations require proof that women are at risk of transmitting mitochondrial disease to their children, although such findings are not as clear cut as they might seem.\(^{291}\)

7.26 The possibility of ‘medical tourism’ to the UK has been heightened by current limitations on MRT clinical trials in the USA or the unavailability of MRT in other counties. Potential problems could arise because the solutions developed by UK law regarding parentage, consent and access to information would not apply to children born outside of the UK. Different countries of origin of prospective parents could have different and contradictory legal solutions to these questions. Further, medical tourism might limit research


and clinical follow-up of children born through the use of MRT and the eventual identification of any safety issues\textsuperscript{N}. 

7.4 Controversy over Mitochondrial Replacement Therapy

7.27 With developments in mitochondrial transfer techniques, hope for preventing transmission of mutated mtDNA onto offspring is emerging. However, ethical issues have been raised regarding such treatments, which involve transfer of nuclear material into donated oocytes with healthy mitochondria or the introduction of healthy donor mitochondria into affected oocytes.

7.28 In particular, ethical concerns relate to the alteration of germ line genetics and the dilemma of children inheriting DNA material from three instead of two parents.

7.29 Although three gametes are needed to produce a healthy embryo in this scenario, the child will inherit all nuclear DNA from the intending parents, while only inheriting mtDNA from the donor.

7.30 In contrast to gene therapy, where only the DNA of the treated individual is altered, these techniques involve the introduction of foreign mtDNA into the germ line that will be inherited by all children in downstream generations.

7.31 Mitochondrial transfer has also been closely associated with reproductive cloning, which is regulated differently worldwide. Children born from these techniques might experience an identity crisis.

7.4.1 Is Mitochondrial Replacement Therapy Genetic Modification?

7.32 MRT has been surrounded by a broader controversy about the modification of germ cells that would produce heritable changes, with many arguments grounded in the fear of eugenics. However, at least according to some experts, MRT should not give rise to this type of concern. First, mtDNA constitutes a very low fraction of the total DNA in a cell. Second, genetic traits that most people would associate with visible human characteristics

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293 Reproductive cloning is the production of a genetic duplicate of an existing organism. A human clone would be a genetic copy of an existing person.

294 Eugenics (from Greek eugenes "well-born" from "good, well" and genos, "race, stock, kin") is a set of beliefs and practices that aims at improving the genetic quality of the human population.
are contained in the nuclear DNA rather than in the mtDNA, which targets a limited number of proteins related to the function of mitochondria and a few other cell functions. Moreover, the purpose of MRTs to replace faulty mtDNA with healthy mtDNA rather than enhancing any genetic trait, which is what most people fear about eugenics and presumptive ‘designer babies’. Reports commissioned in the UK and the USA to examine the ethical aspects of MRT found significant distinctions between modifications to nuclear genes and those directed to mtDNA.

7.33 There is no universally agreed definition of ‘genetic modification’ in humans – people who have organ transplants, blood donations or even gene therapy are not generally regarded as being ‘genetically modified’. While there is no universally agreed definition, the UK government has decided to adopt a working definition for the purpose of taking forward these regulations that genetic modification involves the germ-line modification of nuclear DNA (in the chromosomes) that can be passed on to future generations.

7.34 The UK government has strongly defended its decision to use the ‘working definition’ of genetic modification which excludes mitochondrial DNA. The techniques are viewed as replacing faulty mitochondrial genes, while leaving both the nuclear DNA and mitochondrial DNA intact.

7.35 Leading scientists have questioned this position, accusing the government of dishonesty, misleading the public and acting by stealth. In anticipation of these concerns, the UK government and leading supporters have attempted to clearly demarcate the boundaries between mitochondrial donation and nuclear modification. Making clear that this is not genetic modification is politically prudent as it would have been unlikely that the public would accept attempts to approve the modification of the nuclear genome at this stage.

7.36 Additionally, the legislation specifies who are eligible to use the techniques (women at risk of transmitting mitochondrial disease to their offspring). This would mean that those wishing to use the techniques to enhance fertility and lesbian couples who wish to use the techniques so that the child has a genetic contribution from both (one would be mitochondria donor) would not be permitted.


7.4.2 Is ‘Three-Parent IVF’ a Sensationalised Term?

7.37 Relationships produced through donation, and the meanings we give them, are dependent on the legal, social and cultural context. We expect very different relationships between donor and recipient when the donation is blood, for example, to when it involves a living donation from a relative, or when it involves egg or sperm donation. Mitochondrial donation involves the transfer of genetic but not nuclear material, and this has led to uncertainty as to whether it should be regulated as egg donation or as tissue donation.

7.38 Mitochondria play an important role in many bodily processes and, therefore, the genetic contribution of the donor might be significant. There are complex interactions between nuclear DNA and mtDNA and organelles contained in the cytoplasm which might introduce epigenetic alterations in nuclear DNA.

7.39 The prevention of mtDNA disease transmission has been dubbed ‘three-parent IVF’. Headlines of ‘three-parent babies’ dominate the debate. Although there is a difference between a genetic parent and a social parent, focusing on biology alone suggests that all babies born through these techniques would be tri-parental.

7.40 The UK Department of Health took a different view. Based on the extent of the genetic contribution and the function of the genes involved, it did not accept that the child born through mitochondrial donation would have three parents. Genetically, the child will indeed have DNA from three individuals but all available scientific evidence indicates that the genes contributing to personal characteristics and traits come solely from the nuclear DNA, which will only come from the proposed child's mother and father. The donated mtDNA will not affect those characteristics.

7.41 The relationship between child and donor is now defined as one where there is no legal obligation towards each other. Whether or not the child feels a genetic kinship with the mitochondria donor, knowing something about the donor might still be important, for example, in providing a fuller picture about the context of their conception. The legislation provides for
this possibility, recommending the child has access to non-identifying information such as screening tests, family health and personal information provided by the donor.297

7.42 The crucial point is that the child will inherit all nuclear DNA from the intending parents, while only inheriting the mtDNA from the donor. Mitochondrial DNA possesses less than 30 genes, while nuclear DNA encodes approximately 25,000 genes. Furthermore, mtDNA is highly conserved among humans and, to an extent across species, as mitochondrial energy production is a universal function required by all living organisms. By scale of quantity (number of genes) and quality (gene function), it is misleading for a resultant child to be led to believe that its physical attributes are derived from three, not two, sets of parental DNA.298

7.43 MRT is unique in creating children with three genetic parents, but it is not unique as a “three-parent” ART. Rather, three-parent arrangements are particularly common in the context of ART. With the division of parentage roles into intending parents, genetic parents, and a gestational parent, the law has recognized multiple parties with particular parentage roles for decades. Even the Bible contains stories of men seeking surrogates to carry a child for themselves and their wives; as described in the Old Testament Abraham and Sarah were intending parents and Hagar, a surrogate, was the genetic and gestational parent—three parents in total.

7.44 ARTs have made three-party arrangements even more common. Artificial insemination allows women to have children using foreign-donor sperm. In this context, the woman and her husband are intending parents and the donor is a genetic parent—three parents in total. In gestational surrogacy arrangements, a woman and her husband might create an embryo using their own egg and sperm, but a different woman actually carries and gives birth to the child. In this context, the husband and wife are both the intending and genetic parents, but the second woman is the gestational parent—three parents in total.

7.45 Some arrangements could contain up to five different parents. For example, a husband and wife could use a donor egg and donor sperm to create an embryo, which is


then carried and birthed by a gestational surrogate. In that case, the resulting child’s intending parents are different from the genetic parents (donors), and they are all different from the gestational parent (surrogate).

7.46 As evidenced by the examples above, many ART arrangements result in a child having three or more parents. Labelling only the children of MRT, and not children of other ARTs, as “three-parent babies” has the unfortunate effect of sensationalizing MRT when, in reality, many ART procedures result in the birth of children with multiple parents. “Three-genetic-parent IVF”, “three-genetic-parent embryos”, “three-genetic-parent babies” would all be more appropriate terms to describe MRT. When “parent” has many potential definitions, it is unfair to describe MRT as the only ART that creates three-parent situations, at least without further clarifying the type of parent.

7.47 Although it takes three people to make a fertilized egg, some researchers take issue with the moniker “three-parent baby”. Pioneering clinical embryologist Jacques Cohen calls the term erroneous. Mitochondrial DNA doesn’t contribute to a person’s traits, so a mitochondrial donor hardly constitutes a parent, he says.

7.48 The use of donors also raises the question of what information should be available about them to the children born from their eggs and vice versa.


7.4.3 Implications for Identity

7.49 Alongside questions of parentage, the concept of identity has remained central within the debate. Once again, perspectives primarily differ according to the perceived significance of mitochondrial DNA. For example, if our character and physical appearance is considered to be solely determined by our nuclear genes then, as the UK Department of Health suggested, altering mitochondrial genes might not have a significant impact on the child. But many reject this kind of genetic essentialism.

7.50 Identity is difficult to define, but it is more than our character and physical traits. Reproductive medicine further complicates questions of identity. Being born without mitochondrial disease would, of course, have a significant impact on the child and a person without a mtDNA disease will have a different life experience, a different biography and perhaps also a different character. Through embryo selection or modification, many widely accepted reproductive technologies have the potential to alter an individuals' identity. Mitochondrial donation is therefore not necessarily a special case.

7.51 Other kinship forms that challenge the argument of loss of identity in children with ‘three’ parents include adoption, surrogacy and use of donor gametes (sperm or oocytes alike) or gestational carriers. Such children could experience the same psychosocial issues. While not possessing DNA from three parents, they have the potential to experience a crisis in terms of how they fit into their families, as in theory they have more than two biological and social parents.

7.52 Applying this sensationalism on a broader scale, would children born through embryo donation then have four parents? Nevertheless, researchers have suggested that if a paternal female relative is available and willing to donate oocytes for the mitochondrial transfer treatment, offspring will inherit paternal mtDNA and all nuclear DNA of the intending parents. Thereby the child will theoretically not possess any ‘foreign’ DNA from a third party. Additionally, excluding adoption, all cases have a genetic aspect involved.

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7.5 Genetic Manipulation in South Africa

7.53 Chapter 8 of the National Health Act 61 of 2003 (NHA) deals with the control of use of blood, blood products, tissue and gametes in humans.

7.54 Section 56 of the NHA states:

Use of tissue, blood, blood products or gametes removed or withdrawn from living persons
(1) A person may use tissue or gametes removed or blood or a blood product withdrawn from a living person only for such medical or dental purposes as may be prescribed.

7.55 Section 57 of the NHA states:

Prohibition of reproductive cloning of human beings
(1) A person may not-
(a) manipulate any genetic material, including genetic material of human gametes, zygotes or embryos; or
(b) engage in any activity, including nuclear transfer or embryo splitting, for the purpose of the reproductive cloning of a human being.

7.56 Section 57(6) states that for the purpose of this section-

(a) ‘reproductive cloning of a human being’ means the manipulation of genetic material in order to achieve the reproduction of a human being and includes nuclear transfer or embryo splitting for such purpose;

7.57 The NHA does not mention alteration of germ line genetics or reproductive embryo cloning. Transfer of mtDNA even in the form of blastomere nuclei (the technique which has been scrutinized the most by ethicists) is not ‘reproductive cloning of a human being’.

7.58 The NHA also does not specify that genetic material may not be manipulated for any other reasons. Germ line genetics and cloning (other than for purposes of reproducing

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304 Blastomere is a type of cell produced by cleavage (cell division) of the zygote after fertilization and is an essential part of blastula formation. After the cleavage has produced over 100 cells, the embryo is called a blastula
human beings) is not mentioned and it is not clear whether the lack laws and regulations on these techniques imply that they are not prohibited. It is likely that ministerial authorization will be required.\textsuperscript{305}

### 7.6 Questions

1. Does the legislative framework in South Africa allow for MRT or MRT research to be carried out in South Africa?

2. If not, should MRT or MRT research be carried out in South Africa?

3. Should laws be enacted regulate this area of science?

4. Does a child born via MRT have three parents?

5. Should lesbian couples be allowed to use MRT to create a biological link between both woman and the child?

6. Should a child conceived using MRT have the right to know his or her biological origins including the details of the donor?

CHAPTER 8
ETHICS AND REGULATION OF INTER-COUNTRY MEDICALLY ASSISTED REPRODUCTION

8.1 The information contained in this chapter was extracted from a paper by Carmel Shalev306

8.2 In Israel IMAR (inter-country medically assisted reproduction) practices have grown rapidly in recent years, mainly because of restrictions on access to domestic surrogacy for same sex couples and a chronically insufficient supply of egg cells for the treatment of couples and singles in need.

8.3 Drawing upon local expertise, Shalev’s paper307 describes documented practices that are harmful, suggests principles of good practice based on an ethic of care, and calls for action at the international, national and professional levels to establish a human rights based

306 See http://weblaw.haifa.ac.il/he/Events/techLawCont/Pages/Dr.-Carmel-Shalev.aspx
Dr. Carmel Shalev is a human rights lawyer and ethicist, who earned her doctoral degree from Yale Law School and pursued a public interest and academic career in health, human rights and bioethics. She teaches at academic institutions in Israel and abroad, including Haifa University Faculty of Law, and works as a consultant on health and research ethics for local and international public interest organizations such as WHO and UNAIDS. Between 1998 and 2004 Dr. Shalev established and directed the Unit for Health Rights and Ethics at the Gertner Institute for Health Policy Research, Israel. Previously she served as chief legal advisor to the Israel Ministry of Health. Between 1994 and 2000 Dr. Shalev served as an independent expert member on the United Nations Committee on the Elimination of All Forms of Discrimination Against Women (CEDAW), and between 1999 and 2005 she served on the Israel National Committee for Genetic Experiments in Human Beings. She has been a member of the Scientific and Ethical Review Group (SERG), of the WHO Special Programme of Research, Development and Research Training in Human Reproduction since 1997. Dr. Shalev has published extensively in her areas of expertise, including Birth Power: The Case for Surrogacy (Yale University Press, New Haven, 1989); and Health and Human Rights in Israeli Law (Ramot, Tel Aviv University Press, 2003). Her major current interest is in the ethics of repro-genetics. In 2009 she founded the Department for Reproduction and Society at the International Center for Health, Law and Ethics at Haifa University, Israel, which she continues to head.

system of international governance for IMAR based on three regulatory models: public health monitoring, inter-country adoption, and trafficking in human beings, organs and tissues.

8.4 Shalev’s paper is a summary of a project on the *Ethics and Regulation of Inter-country Medically Assisted Reproduction* (ERIMAR) that took place between 2014–2015 at the Department for Reproduction and Society (DRS), International Center for Health Law and Ethic, Haifa University, Israel. The DRS provides a multi-disciplinary forum for research and public debate on subjects related to the interface between science and society in medically assisted reproduction.

8.5 The aim of the ERIMAR project was to engage academics, professionals, governments and civil society so as to collaborate in gathering information on the global market of cross-border human embryo and stem cell transfers, egg cell and sperm donations, and surrogate mother arrangements, and to initiate a discussion on the adoption of an international code of ethics and the drafting of an international human rights convention to address failures in an unregulated market, with a focus on protecting the human dignity of women involved in transnational reproductive collaborations.

### 8.1 Emerging Global Market for Medically Assisted Reproduction

8.6 The proliferation of medically assisted reproduction (MAR) for the treatment of infertility has brought benefit to many individuals around the world, since the first birth of a child following in vitro fertilization (IVF) in 1978. By 2012 it was estimated that the number of babies born as a result of MAR reached a total of 5 million308.

8.7 Infertility is often a cause of suffering and of social harm, particularly to women, and the right to reproductive health can be understood to include a right to treatment of infertility. But women also carry the primary burden of treatment for others: IVF is used for the treatment of male infertility; IVF also serves as a platform technology for pre-implantation

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genetic diagnosis (PGD) of embryos, often with no medical cause and as a tool for elimination of female foetuses. All these, together with the spread of egg ‘provision’ practices and surrogacy arrangements, mean that more often than not otherwise healthy women undergo invasive medical interventions for the sake of their partners or for strangers who wish to become parents.

8.8 What is more, over the past decade, there has been a steady growth in a new global market of cross-border medical travel for repro-genetic purposes. Many practices of IMAR involve ‘third-party’ individuals acting as surrogate mothers and gamete providers in reproductive collaborations for the benefit of other individuals and couples who wish to have children.

8.9 IMAR involves various permutations of the cross-border movement of intended parents, third-party reproductive collaborators and new-born children, with transfers of human embryos, sperm and egg cells. Like transnational organ transplants, IMAR consists of shifting international networks. The chain of medical production starts from sperm and egg cell procurement, and continues through fertilization, embryo implantation and gestation, to culminate in birthing. Theoretically each of these six links could be performed in a different country, and the child then transported to the country of the intended parents. Some of the surrogacy practices currently marketed involve, in combination, three different provider countries. The intended parents from country A might transact with an egg provider from country B, who travels to a clinic in country C, where the egg is fertilised and implanted in a surrogate mother from provider country D.

8.10 The growth of the IMAR market in recent years is due to complex economic, legal and cultural conditions. A major driver of this multi-billion dollar business is the desire of individuals to parent children, and their inability to do so in their home countries due to legal restrictions or economic constraints on surrogacy or egg cell procurement. Moreover, there are signs of an emerging market of cross-border reproductive care for non-medical sex

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309 Pre-implantation genetic diagnosis is a procedure used prior to implantation to help identify genetic defects within embryos created through in vitro fertilization to prevent certain diseases or disorders from being passed on to the child.

selection of embryos by means of PGD, and similar practices for the selection of preferred embryonic traits are likely to grow further\textsuperscript{311}.

8.11 Since the IMAR market is not regulated, there is no official data and a dearth of information. At the same time, for-profit trade in IMAR services involves the commodification of human beings (women and children) and body parts (gametes and wombs). Indeed, there is evidence of violations of the human rights of children and women, and some cases of harmful and degrading practices have been documented\textsuperscript{312}.

8.12 Against this background, an interdisciplinary group of ethicists, researchers and practitioners convened in Israel to discuss the need for international governance of IMAR. Israel is a country in which MAR is practiced extensively with almost unlimited public funding, resulting in the highest per capita rates of usage worldwide\textsuperscript{313}. Courts recognize a constitutional right to parenthood, and the Knesset, Israel’s parliament, has enacted legislation that establishes a regulatory system of bureaucratic approvals for various third-party MAR practices, based on statutory criteria of eligibility. Israel’s Surrogate Mother Agreements Law (1996), was the first in the world to allow commercial surrogacy under the supervision of a statutory committee\textsuperscript{314}. The Egg Cell Donations Law, 2010 enacted a similar system\textsuperscript{315}.

8.13 Nonetheless, despite liberal domestic law, IMAR practices have grown rapidly in recent years, mainly because of restrictions on access to domestic surrogacy for same sex couples\textsuperscript{316} and a shortage of healthy women who are willing to provide their eggs for the treatment of couples and singles in need\textsuperscript{317}. Although the Egg Cell Donations Law allowed

\begin{thebibliography}{1}
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‘donations’ from healthy volunteers and compensation for their effort, it did not alleviate the ‘shortage’ of egg cells in the country.

8.14 Therefore, Israel, despite its relative small population size, has become an important site for gathering information regarding the complex mechanisms of IMAR usage, and indicates the urgent need for agreements and regulations that will ensure the health and well-being of all collaborators.

8.15 Shalev’s paper is based on collective experience and knowledge. Discussions revealed differences of opinion that reflect multiple perspectives on the complex issues of IMAR, even among professional researchers who are all committed to a human rights based approach. They discovered, inter alia, different concepts of autonomy, different views as to the degree to which the State should interfere in agreements between consenting adults, and different opinions as to the proper balancing of competing rights and values. But by all indications the issues are here to stay, and will likely grow as new business opportunities emerge to bring to the IMAR market controversial technological innovations, such as the recent developments of mitochondrial replacement therapy and whole genome sequencing or CRISPR-Cas9 (‘gene editing’) for embryos.

8.16 The purpose of Shalev’s paper is to call for a discussion of the need for IMAR international governance at multiple levels – the international community, nation states,

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318 See https://ghr.nlm.nih.gov/primer/hgp/genome. A genome is an organism’s complete set of DNA, including all of its genes. Each genome contains all of the information needed to build and maintain that organism. In humans, a copy of the entire genome—more than 3 billion DNA base pairs—is contained in all cells that have a nucleus.

319 See http://www.yourgenome.org/facts/what-is-crispr-cas9

What is CRISPR-Cas9?

CRISPR-Cas9 is a unique technology that enables geneticists and medical researchers to edit parts of the genome by removing, adding or altering sections of the DNA sequence. It is currently the simplest, most versatile and precise method of genetic manipulation and is therefore causing a buzz in the science world.

What are the applications and implications?

CRISPR-Cas9 has a lot of potential as a tool for treating a range of medical conditions that have a genetic component, including cancer, hepatitis B or even high cholesterol. Many of the proposed applications involve editing the genomes of somatic (non-reproductive) cells but there has been a lot of interest in and debate about the potential to edit germline (reproductive) cells. Because any changes made in germline cells will be passed on from generation to generation it has important ethical implications. Carrying out gene editing in germline cells is currently illegal in the UK and most other countries. By contrast, the use of CRISPR-Cas9 and other gene editing technologies in somatic cells is uncontroversial. Indeed they have already been used to treat human disease on a small number of exceptional and/or life-threatening cases.

professional organizations and civil society – as market forces lead the proliferation of reproductive technologies for individuals of means.

8.17 The subject matter is extremely controversial. Questions of children’s legal parentage and nationality in transnational surrogacy have been on the agenda of the Hague Conference on Private International Law for several years. A comprehensive document prepared by its Permanent Bureau in 2014 notes the diversity in states' domestic law regarding the establishment of legal parenthood, and emphasises the importance of focusing on building bridges between legal systems based on internationally established common principles, rather than the harmonisation of substantive laws concerning legal parentage. Yet discussions there have yet to resolve the divergent views on the legal status of children born in cross-border situations that circumvent legal prohibitions in the parents’ country of origin.

8.18 What is more, public international law aspects of IMAR practices that are similar to the field of organ transplant tourism, such as trafficking in human beings and body parts – are not within the mandate of the Hague Conference, and have not been addressed so far by any other relevant international forum.

8.19 The goal of Shalev’s paper is to set an agenda for discussion, to identify areas of concern, to suggest good practices that might alleviate some of the most grievous consequences of an unregulated IMAR market, and to describe points of disagreement that require further exploration.

8.20 Shalev’s paper concludes with a call for action at the international, national and professional levels within the framework of a feminist ethic of care for all involved individuals, including the children and the women who assist in bringing them into the world. We believe that continuing discussion and deliberation will eventually lead to clarity as to the promotion of fair practices, the prevention of human rights violations and the criminalization of extreme abuses.

8.2 Terminology

8.21 Much of the literature on the subject of IMAR refers to “cross-border reproductive care”. This reflects the viewpoint of individuals suffering from infertility who need and seek access to medical treatment which is either unavailable or unaffordable in their countries of origin. Shalev chose to use the term “inter-country MAR” because it accommodates the viewpoints of all involved individuals, including the third-party reproductive collaborators. Moreover, Shalev refrains from using the term ‘care’ which carries underlying assumptions of altruism and empathy, which is not necessarily present in the medical interventions involved in medically assisted reproduction, especially when involving third-party reproductive labourers.

8.22 Similarly, much of the literature addressing domestic issues refers to ART (“assisted reproductive technology”), rather than MAR (“medically assisted reproduction”). Shalev et al chose the latter, because it reflects the human activity of reproduction, whereas the former focuses on the technology.

8.23 Human reproduction by its very nature involves the collaboration of human beings, in particular women, whether or not medically assisted, and whether or not it involves third-party individuals. The notion of collaboration implies respect for all those assisting in the birth of the child. Because reproduction is essentially collaborative, Shalev et al use the term “third-party collaborators” to denote the genetic progenitors (gamete “providers”) and the women who carry pregnancies and give birth to children (“surrogate mothers”) for other individuals whom they call the “intended parents”.

8.24 The term “providers” is used for those whose gametes (egg cells and sperm) are used in the reproductive collaboration, so as to preserve the term “donors” for those who act altruistically in non-commercial relationships, and “procurement” rather than “donation” is used for the same reason.

8.3 Ethics and Human Rights

8.25 Shalev’s theoretical approach is a human rights based ethics of care and responsibility. As opposed to transnational transplant medicine, where professional self-
governance provided the basis for an emerging consensus in international law, IMAR remains an unregulated market driven by the desire of prospective parents for a family and a healthy child and the profit making interests of medical entrepreneurs and the biotechnology industry.\textsuperscript{324}

8.26 At the moment, there are no internationally accepted ethical principles or clinical standards for the quality and safety of MAR interventions. The distribution of scarce human bio-resources is done according to ability to pay rather than considerations of justice or solidarity.\textsuperscript{325}

8.27 There are no mechanisms in international law for transparency and accountability, nor for regulatory oversight in case of human rights violations. And lastly, there is no understanding of what differentiates legitimate cross-border medical travel from reproductive trafficking, and no criminal justice redress for instances of exploitation, deception and coercion.

8.28 MAR has brought many blessings to numerous individuals worldwide, but in some cases this has incurred harm to other individuals. The main approach of Shalev’s paper is to suggest good practices so as to avoid harm to children and third-party women and men. Shalev also acknowledges known cases of such harm and argues for the need to prohibit the most grievous harmful practices as tantamount to reproductive trafficking.

8.29 Shalev’s view comes from a commitment to an ethic of care and responsibility, respect and solidarity towards all the adults involved in IMAR collaborations, concern for the rights and well-being of the resultant children, and a commitment to inter-generational justice and responsibility for the heritage of humanity that we pass on to future generations.\textsuperscript{326} Shalev aligns the call with concerns brought to the fore by feminist scholars in recent decades,\textsuperscript{327} while also recognizing the agency of reproductive labourers and the need for


their involvement in the discussion, as suggested by ethnographies of the reproductive trade\textsuperscript{328}.

8.30 Shalev’s view is that the activity of reproduction is intrinsically dependent on collaboration with others, and the relational context of this activity should be acknowledged so as to avoid the objectification of third-party collaborators. Shalev believes that it is in the child’s best interests to be born from and into relationships, however short- or long-lived, that are based on respect, reciprocity, trust and integrity between intended parents and third-party collaborators\textsuperscript{329}.

8.31 The working group reaffirmed its commitment to values of fundamental human rights and the dignity and worth of the human person. These include the equal rights of men and women, regardless of race, class, marital status and sexual identity. Multiple instruments of international human rights law contain principles rules that are relevant to IMAR, including the right of adult men and women to found a family, the right of women to reproductive health, the right of persons to autonomy in medical decision making, and the right of children to identity, parentage and nationality\textsuperscript{330}.

8.32 However, none of those instruments address the potential for the exploitation, coercion and deception of women as providers of reproductive services and resources. There is a consensus that human beings and their body parts cannot be the subject of commercial transaction and financial gain\textsuperscript{331}. But issues of third-party IMAR practices are not addressed in the relevant instruments that prohibit servitude and trafficking in human beings and organs, while instruments on tissues and cells typically exclude the cross-border transportation of human sperm, egg-cells and embryos.


A common argument in defence of the MAR market derives from the principle of personal liberty and freedom of contract\(^{332}\). However, much as personal liberty is inalienable and cannot extend to the right of an individual to sell one self into slavery\(^{333}\), and much as freedom of contract is constrained by considerations of morality and public policy, the freedoms and rights of infertile persons to establish a family through IMAR may be subject to limitations for the purpose of meeting just requirements of morality and public order in the global marketplace. Such restrictions are necessary and justified out of respect for the rights and freedoms of both the children and the third-party women who provide their bodily services and resources to assist in bringing them into the world\(^{334}\).

### 8.4 Areas of Concern

IMAR is a particular form of medical tourism but it raises concerns beyond those which are typical to critiques of general medical tourism practices, such as quality of care, and the issues of affordability and accessibility which concern distributive justice in two-tier health systems\(^{335}\).

Unlike most situations of cross-border medical care, IMAR also involves the use of another (non-patient) person’s body as a means of medical “treatment”. In this it is similar to transnational organ transplant procedures. We therefore believe that our discussion aligns better with bioethical discussions of organ transplant medicine in cross-border settings. Furthermore, IMAR also involves the creation of a child, and thus aligns with inter-country adoption as well as the literature examining the commodification of human bodies and intimacies more broadly.

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\(^{334}\) Universal Declaration of Human Rights, 1948 – Article 29.

8.5 Intended Parents

8.36 Despite the many benefits of MAR in alleviating infertility, the proliferation of this technology has led to multiple new forms of associated suffering. Despite the many children born to otherwise infertile persons by means of MAR, infertility as such continues to be experienced as distressful and socially stigmatized. Childlessness may be remedied, but people want more than one child.

8.37 In addition, infertility treatment itself is physically and financially taxing and often entails multiple unsuccessful cycles. Emotional harms associated with infertility treatment include anxiety and grief, as well as stress and disruption of spousal relations, shame and blame, anger and depression, low self-esteem and stigma\textsuperscript{336}. The suffering of the thwarted desire for a child may be aggravated by limitations on access to treatment for couples and individuals in need due to the lack of available or affordable services. In 2011 only 48 out of 191 member States of the World Health Organization had IVF facilities. Among those that do, many do not have insurance schemes for reimbursement for MAR treatment\textsuperscript{337}.

8.38 At the same time, success rates remain relatively low: pregnancy rates per treatment cycle are around 35%, with around 25% chance of a live birth per treatment cycle\textsuperscript{338}. Risks to the health and well-being of women from preparatory hormonal treatment, egg retrieval and multiple embryo-pregnancies are well known\textsuperscript{339}.

8.39 Multiple-embryo pregnancies are also associated with premature delivery and low birth weight new-borns. Moreover, infertility patients seeking treatment outside their home countries might be at increased risk due to lack of control over quality and safety standards; the absence of counselling; inadequate information about possible health risks; and increased exposure to incompetence, negligence and recklessness\textsuperscript{340}.


8.40 In the case of third-party IMAR, intended parents are vulnerable to disinformation and exploitation by intermediaries in foreign countries. Added risks include uncertainty as to the source of gametes or embryos, and financial extortion by intermediaries who might also obstruct attempts to contact, deal directly and form a relationship with surrogate mothers. In addition there are numerous bureaucratic hurdles to establishing parentage and returning home with the children\(^\text{341}\).

8.41 Third-party collaborators As for egg cell providers and surrogate mothers, a major concern is the exacerbated risk of harm from medical interventions because of a double standard of care, that is, care that is centred towards the paying customer rather than the surrogate’s or egg donors’ medical needs, as well as emotional and financial harm due to unequal relations of power between third-party collaborators and commissioning parents, and the potential bias of mediators and professionals within the IMAR industry.

8.42 Physical risks to egg cell providers include the pain and discomfort of daily hormonal injections and harmful side effects, including anaesthesia complications, ovarian hyper-stimulation syndrome, damage to reproductive organs and post-retrieval complications of surgery\(^\text{342}\). Recruitment advertisements on university campuses do not mention these risks, and the women might undergo excessive repeat procurement cycles without being informed of the risks involved\(^\text{343}\). Although there has been no systematic medical tracking of the effects of egg cell procurement on otherwise healthy young women, there is no evidence base for the safety of the procedure in the medical literature, and there are controversies regarding longterm risks of breast and ovarian cancer\(^\text{344}\). Anecdotes abound of loss of fertility, stroke, cancer and premature death, while psychological risks of detachment from resultant children might arise years later\(^\text{345}\).

8.43 The potential for exploitation and deception of women who provide egg cells for others is illustrated by a case from Israel that came to light in 2000: a leading fertility expert confessed in professional disciplinary proceedings to having submitted patients to excessive


hormonal stimulation, retrieving dozens of eggs from single treatment cycles, and using these eggs in the treatment of large numbers of recipients, without the knowledge of the providers. In one case he retrieved 256 eggs from one woman and used 181 of them to treat 34 others.\textsuperscript{346}

8.44 Research from Israel on domestic surrogacy agreements reveals similar vulnerabilities of third party women to a double standard of medical care and disinformation, and also to emotional harms and violations of privacy and autonomy.

8.45 Israel provides a rich data source on commercial surrogacy, since the Surrogate Mothers Agreements Law (1996) requires approval of any surrogacy contract signed and performed within the country. It is therefore possible to know exactly how many surrogacy contracts were signed since 1996 and their outcomes. Data collected from official records of approved surrogacy agreements show a relatively high rate of multiple births. Notably, less than 40% of the agreements actually result in the birth of children, and commercial practices often do not pay women for unsuccessful treatment cycles, failed attempts to become pregnant or spontaneous miscarriage of a pregnancy, while the women report a heavy emotional toll of failure.\textsuperscript{347} Nor are the women remunerated fairly for the time and energy they invest in the process of applying for bureaucratic approval, including intrusive mental and physical diagnostic procedures. In the case of a successful pregnancy, agreements typically restrict the surrogate’s lifestyle and personal freedom, with obligations to refrain from sexual intercourse, not to smoke, not to eat certain foods, and a requirement to obtain permission from the intended parents to travel outside the country, thus limiting their personal autonomy beyond what would be expected in the case of women carrying their own child.

8.46 Surrogate mothers, like egg providers, appear to be motivated by both financial interests and noble altruistic sentiments, and report forming an emotional attachment with the intended parents during the pregnancy, often with a sense of self-worth as a result of this relationship, which allows them to experience the process as an act of heroism rather than exploitation.\textsuperscript{348} But once they deliver the child this relationship might be severed abruptly and surrogates report having little control over the process of separation after having given birth.

8.47 The vulnerability of third-party reproductive collaborators to harm is exacerbated in inter-country settings due to structural inequalities, geographical distance and cultural gaps. There is limited quantitative data, because IMAR takes place in a private market. But social science studies, human rights reports and documentary films – mostly about India – indicate patterns of exploitation, deception and coercion that might amount to human trafficking. Cases in which women have been recruited to travel and tricked or forced into working as surrogates have been documented in Guatemala, Poland, Myanmar and Thailand.349

8.48 In more routine cases, intended parents may set in course a process marketed and facilitated by intermediaries, that culminates in the birth of a child without having met or seen their third party collaborators. The relative invisibility of resource providers to those who purchase gametes or surrogacy services in these markets, due to language and cultural barriers as well as geographical and social distancing, is a factor that objectifies them and diminishes concern for their well-being.

8.49 Egg providers are typically recruited to be a racial match with intended parents, but do not receive any information about their identity. International surrogacy agencies working from Israel recruit women from countries such as the Ukraine and South Africa, offering them a “reproductive tourism” package that includes egg “donation” and a holiday in India, Thailand or Nepal. Women in India will provide eggs for intended parents who are Indian, whether residing in or outside the country. These women might also work as surrogates and as human subjects in clinical trials. One woman who provided eggs recounted that the hospital told her to get lost after the retrieval procedure and refused to give her any medical record of the intervention.350

8.50 Surrogacy practices in India incur impaired autonomy in decision making about the pregnancy: choices about the numbers of embryos implanted, termination of pregnancy, lifestyle during pregnancy, and interventions during labour and delivery such as c-section will be made by the intended parents and medical professionals. The literature describes deprivations of liberty (confinement in hostels for the duration of the pregnancy, with controlled nutrition and limited family visits), violations of patient autonomy and bodily integrity (non-consensual abortions, routine c-sections) and exploitation of maternal labour

350 SAMA Resource Group for Women and Health, India. Can we see the baby bump please? 2013. documentary film.
(multiple embryo implantations, and breast milk nursing pending the late arrival of intended parents). Social harms include stigmatization\textsuperscript{351}.

8.51 In many cases, surrogate women are required to leave their homes and live in dormitories or housing providing by the surrogacy clinics and agencies. These practices have been documented in India\textsuperscript{352}, Nepal\textsuperscript{353} and Russia\textsuperscript{354}. In such dormitories or housing arrangements, surrogates are fed and monitored around the clock by the clinic personnel and, in extreme cases, are not allowed to exit the site or engage in physical activity. One of the narratives is about a surrogate awaiting the arrival of the intended parents, an Indian couple from Canada, after giving birth to twins. After delivery, she expresses breast milk to feed the babies. Ten days after the birth the parents have still not come and she ventures into the infant unit to see the babies. As time goes by and the parents still do not come, she starts physically taking care of the infants and names them. The couple arrive only three weeks after the babies were born.

8.52 While the standard of care for MAR in developed countries now discourages the implantation of multiple embryos because of the risks to the health of the pregnant woman and to premature newborns, it is often practiced in IMAR. Surrogates are usually offered a bonus payment for carrying and giving birth to twins, but if more than two embryos develop they are expected to undergo a procedure of embryo reduction to abort the excess one\textsuperscript{355}.

8.53 Accounts of intended parents from Israel stranded in Katmandu with their newborns at the time of the earthquake there in May 2015 indicated relatively large numbers of twins and premature births. The clinic there had a 100% rate of c-sections, which the women were told was the “best way” to give birth – yet another instance of a double standard of medical care. Of course, c-section allows for control over the time of the birth of the child, so that intended parents can plan travel accordingly. According to the accounts of intended parents,

\textsuperscript{351} Saravanan S. An ethnomethodological approach to examine exploitation in the context of capacity, trust and experience of commercial surrogacy in India. Philos Ethics Humanit Med. 2013;8:10.
\textsuperscript{354} Weis C. Trajectories of labor and delivery: Surrogacy workers in Russia. Presentation given at: Gender, justice and the political economy of the cross-border fertility industry April 7–8, 2016 University of Vienna.
their expectation was that the children would be born at 36 weeks, rather than 40, which is the norm\textsuperscript{356}.

8.54 A business model that guarantees an end product and caters to the preferences of customers has also led to what is known as ‘twin’ or ‘twibling’ surrogacy, where two surrogate mothers are hired at the same time in order to maximize the chance of a live birth\textsuperscript{357}. At a ‘surrogacy fair’ in Israel, in February 2013, attended by 15 surrogacy agencies from Israel and the USA, one agency offered potential customers a track of ‘parallel pregnancies’ in which several women would carry pregnancies for a single prospective family, so as to increase the chance of producing a child within a certain time frame. It was implied that if the achieved pregnancies exceeded the planned number of children, the ‘excess’ pregnancies would be terminated. The women carrying the aborted pregnancies have no say in the decision. They might be deceived and told that there is a medical indication related to the health of the foetus. According to one surrogacy agent operating in Eastern Europe, under their contract surrogates might not be entitled to payment for their services if a live child is not produced.

8.6 Children

8.55 While the number of children conceived as a result of inter-country surrogacy and other IMAR arrangements has increased dramatically in recent years, there have been certain extreme cases of child trafficking in which the babies have become commodified as a marketable product of exchange. For example, the surrogacy industry in India has also produced ‘extra’ babies, either because excess pregnancies are carried to full term or because intended parents do not claim the children they ordered. At this point the abuse of surrogate mothers turns into baby selling. In a recent documentary, one journalist went undercover to meet a surrogacy agent who claimed there were ‘extra’ babies being sold on the black market, and there and then offered to sell her one on the spot\textsuperscript{358}.


8.56 In February 2012, Theresa Erickson, a USA attorney specializing in reproductive law was sent to prison for her role in an international baby selling scheme. In her guilty plea, Erickson admitted that she and her conspirators used surrogate mothers to create an inventory of unborn babies that they would sell for over $100,000 each. They accomplished this by paying women from the USA to travel to the Ukraine, to become implanted with ‘donated’ sperm and eggs.

8.57 If the women sustained their pregnancies into the second trimester, the conspirators offered the babies to prospective parents by falsely representing that the unborn babies were the result of legitimate surrogacy arrangements, but that the original intended parents had backed out\(^\text{359}\).

8.58 A recent decision of Israel’s Supreme Court ruled that a genetic connection between the child and at least one of the intending parents is needed in order to rule out child trafficking. The case concerned a single woman who arranged for the fertilization of embryos with the sperm of an acquaintance and the egg cell of an anonymous provider from South Africa. The woman’s niece carried the pregnancy for her after undergoing embryo implantation in India, and gave birth to the child in Israel. The woman then petitioned the court for a parenting order, which she was denied. The court reasoned that the law does not recognize parentage that is purely contractual, and making babies cannot be left to simple agreement for the creation of a product\(^\text{360}\).

8.59 In other cases children born of IMAR have been rendered parentless and stateless, in violation of the rights of the child to nationality and parentage under article 7 of the Convention on the Rights of the Child\(^\text{361}\).

8.60 The baby is born in one country on the basis of an agreement with the intended parents who live in another, and they need travel documents to bring the baby home. But conflicts of domestic law can arise between the two jurisdictions as regards the

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\(^{360}\) Ba’am (Administrative Appeal Motion) 1118/14 Anonymous v. Ministry of Welfare and Social Services (1 April 2015)

determination of legal parenthood. In one case, intended parents from the UK had a child from surrogacy in the Ukraine. Under the law in the UK the surrogate and her husband would be considered the legal parents, while under the law in the Ukraine the child’s legal parents were the intended parents, so they could not adopt the child to be recognized as her parents under UK law.

8.61 In another case, the European Court of Human Rights found that France had violated the right of children born of international surrogacy to respect for private family life under Article 8 of the European Convention on Human Rights by denying the parent–child relationship that had been legally established in the USA, where the children were born. The decision concerned two couples from France who had children biologically related to the male partner by means of a surrogacy agreement in the USA, where the legal parent–child relationship had been recognized. The French authorities refused to enter the birth certificates in the French register of births, because that might be seen as giving effect to a surrogacy agreement that was null and void under French law on grounds of public policy.

8.62 Other cases have involved abandonment of the children. For example, an infant was born in India in 2010 to a married couple from Japan, who had divorced during the course of the pregnancy. Neither the Indian birth mother nor the Japanese intended mother wanted the child. At the time Japanese law did not recognize surrogacy and the intended father could not adopt the child under Indian law because he was now single. The baby’s paternal grandmother took responsibility for the baby but they were stranded in India for six months while trying to overcome the legal hurdles to obtaining travel documents.

8.63 A more recent and much publicized case was that of Baby Gammy born as a twin in Thailand in 2014 to an Australian intended couple. Gammy had Down’s syndrome and a congenital heart condition, and the intended parents took his healthy twin sister home while abandoning him. The Thai surrogate mother took responsibility for Gammy, and succeeded eventually in obtaining Australian citizenship for the child and rights of access to health care in Australia.


8.64 Yet another crucial issue concerns the right of the child to identity, or the right to know the circumstances of one’s birth and origin. This has both psychological and health-related aspects. Medical documentation about genetic progenitors is obviously relevant to informed health care decision-making, but the right to know has more far-reaching meaning as is evident from the growing support for the moral right of donor-conceived children to know their genetic origins.

8.65 It is a key facet of the child’s sense of self-identity and his or her connectedness with heritage and kin, be they the genetic father and mother, the woman who gave birth, or part-siblings. But in IMAR no one has the legal obligation or responsibility to keep records of gamete providers and surrogate mothers. This erases the identity of the third-party collaborators while compromising the child’s ability to learn of his or her circumstances of birth later in life.

8.7 Discussion

8.66 Arrangements between intended parents and third-party reproductive collaborators create a special kind of agreement that needs regulation so as to protect the interests of all the involved persons: the intended parents, the third-party collaborators and the children. In inter-country settings, under conditions of geographical distance, cultural differences and economic disparity, the for-profit motivation of medical entrepreneurs and intermediary agents exacerbates the potential commodification and abuse of women and children.

8.67 The unregulated market of IMAR involves the commercialization of human reproduction and transforms the personal and intimate nature of reproductive relations into contractual and labour relations. Considering also foreseeable technological developments that would allow the genetic selection and modification of human embryos, there are profound concerns about the moral limits of markets and the impact of market-driven reprogentic technology on the future of humanity and the very nature of the human species.


366 See https://en.wikipedia.org/wiki/Reprogenetics

Reprogentic is the use of reproductive and genetic technologies to select and genetically modify embryos with germinal choice technology for the purpose of human enhancement. However, a report by the Hastings Center broadly defined reprogentic as any “creation, use, manipulation, or storage of gametes or embryos.”
8.68 In inter-country settings, the current lack of professional self-governance and the absence of internationally accepted clinical-ethical guidelines for MAR are conducive to potential abuse of third-party women who collaborate to fulfil the desire of others to have a child - throughout the process of egg cell extraction, fertilization, impregnation, implantation, gestation, miscarriage, labour, delivery and post-birth nursing and care. These women are often treated according to double standards of care for invasive medical interventions, ethical standards of consent to treatment are not observed, and decisions about the medical interventions they undergo are often made by others. At times they have no direct contact with intended parents and do not even know who they are. Intermediaries perform a necessary social function in mediating between individuals seeking MAR services outside their countries of residence.

8.69 However, the commercial nature and profit-seeking motivation of this function create conditions that are conducive to exploitation. There is evidence that unregulated IMAR can lead to grave violations of women’s dignity and human rights, as described above. In extreme circumstances, abuses might even amount to human trafficking, in the sense of the appropriation and control of women and children as commodities. Thus, there is an urgent need to conceive a governance regime for the unregulated IMAR market so as to ensure safe and fair practices, minimize harms and prohibit abuses.

8.70 IMAR need not necessarily be abusive or incur violations of human rights. Lessons learned from countries in which MAR is regulated indicate elements of a good practice model by which new forms of multi-parent families can be established on the basis of mutual respect, intimacy and relationship between intended parents and reproductive collaborators, with support and counselling for all the involved adults throughout the process. Most of the participants in the working group of Israeli experts thought that open relationships between third party collaborators and the children and their families could be encouraged, and the altruistic motivations of third-party collaborators could be acknowledged even if they are also paid for their work. Some thought that fully altruistic arrangements should be seen as best practice, i.e., where the egg donor or surrogate mother is a relative or friend of the intended parents. In such case, however, it would be necessary to ensure that the women are not induced to collaborate as a result of family or social pressure, and that they are fully informed.

The term was coined by Lee M. Silver, a professor of molecular biology at Princeton University, in his 1997 book Remaking Eden.
of the risks involved in the process and provided with compensation if these risks should materialize.

8.71 One view in the literature is that ideally countries might aim to adopt a policy of national self-sufficiency so as to meet domestic needs for MAR, including third party reproductive collaborations, and to minimize disincentives to local providers of gametes and surrogacy services such as lost wages, costs of travel and out-of-pocket expenditures. Nonetheless, international governance is needed since it is improbable to assume that the global market will disappear.

8.72 First and foremost, international bodies and nation states should recognize new forms of family and should guarantee the child’s right to parentage, nationality and identity. Some of the working group participants considered that responsibility for the welfare and best interests of children born of IMAR should be paramount. Therefore, in case of conflicts of law as regards the child’s parentage, the default presumption should be that the country of birth is parens patriae, in accordance with the principle of subsidiarity. Likewise, this view suggested that children born of IMAR should have a right to nationality in both the country in which the intended parents are nationals and the country of birth. This would prevent the child from being rendered stateless in case of dispute about the child’s parentage and make it the responsibility of both countries to care for children born of reproductive collaborations initiated by their nationals, or within their jurisdictions.

8.73 As for the right to identity of children born of IMAR, i.e., the right to know the origins of conception and circumstances of birth for both medical and psychological needs, the consensus among the working group was that the medical professionals who administer the procedures that result in the child’s birth should have a legal obligation to preserve identifying information about the third party collaborators.

8.74 However, there was disagreement about whether or not children have a right to know the identity of their genetic progenitors, as in adoption, and whether or not they have a right to know the identity of their gestational mother. One view was that the child has a medical interest in knowing the identity of the genetic mother, but does not have any interest in knowing the identity of the woman who carried the pregnancy and gave birth if there is no genetic relation between the two. Others considered this view – that genetic motherhood is of greater value than gestational motherhood – to be an expression of genetic essentialism and materialism, and to reflect a gender bias since genetic parenthood is the only form of
biological parenthood for the male of the human species, as opposed to the female form of biological parenthood which can be either genetic or gestational.

8.75 According to this point of view, epigenetics show that the gestational environment has significance for the child’s development, and female parenthood emphasizes the nurturing aspect of human relationship.

8.76 What is more, the third-party collaborators also have an interest in whether or not their identifying information is preserved and made accessible to the children. The issue of the anonymity of third-party collaborators is controversial. Its origin is in the practice of sperm ‘donation’. Recognition of the children’s interest in knowing the identity of their fathers has led some jurisdictions to legislate a right to disclosure for ‘donor’ offspring similar to the law of adoption. The members of the working group were divided as to whether a similar scheme should apply to egg cell procurement in inter-country settings. Some considered that anonymity was a compromise of parental responsibility and should be discouraged. Others considered that it would not be beneficial if disclosure of identifying information led to a decrease in egg cell provision, and that potential providers should be given the choice as to whether to be anonymous or identifiable when the child reached the age of majority.

8.77 In any event, most participants thought there was a difference between egg cell procurement and surrogacy, and there was widespread agreement that anonymous surrogacy should not be allowed because it violates human dignity. From the point of view of the woman who carries the pregnancy and births the child, anonymity and the erasure of any identifying information renders her invisible, and is a means of objectification, commodification and instrumentalization that dehumanises the person as a mere vessel. It is therefore important to make sure the gestational mothers are present as human beings, and they have a right to be acknowledged as having birthed the children and to choose whether and how to have ongoing contact with them.

8.78 There was also substantial agreement about drawing red lines of extremely harmful IMAR practices that should be prohibited as criminal offences under both domestic and international law. Drawing parallels from international documents on organ transplant trafficking these offences might include:

medical interventions in third-party collaborators without the free, informed and specific consent of the patient;
- the use, storage and transportation of illicitly procured human reproductive cells and embryos;
- the commercial brokerage of IMAR services, including solicitation, advertisement and recruitment of sperm and egg donors and surrogate mothers for financial gain (i.e., advertisement and brokerage involving payment);
- the implantation of human embryos outside of the framework of the domestic regulatory system;
- the solicitation of gamete donors and surrogates to cross national borders, for the purpose of evading local protective regulations or undermining the rights of reproductive labourers in their country of origin;
- the offer or receipt by health care professionals of any undue advantage in connection with illicit IMAR practices.

8.79 In general, countries of origin and destination should take responsibility to quell the cross-border abuses of women and children perpetrated by nationals in circumvention of domestic law. Ideally, they should not allow a double standard of intra- and extra-territorial legality, and would exercise extra-territorial jurisdiction over offences committed by or against nationals or other individuals who are resident within their jurisdiction, in contravention of domestic restrictions on access to MAR\textsuperscript{369}.

8.80 In this respect, the question whether intended parents should be penalized for circumventing domestic laws needs further consideration because it involves possible stigmatisation of children with “new illegitimacy”. However, intermediary agencies should be held responsible.

8.81 Many participants in the working group took the position that commercial intermediary agencies should be banned and replaced by non-profit organizations with the capacity to provide professional counselling, similar to the model of the Hague Convention on Inter-Country Adoption, 1993. The group was divided as to whether individuals representing IMAR agencies currently operating out of Israel should be invited to participate in the process of deliberation about the need for international governance. Some thought that their experience

and knowledge of the field would be a valuable contribution to the discussion, and that they too should adopt a code of business ethics, while others considered that commercial interests would skew the debate.

8.8 Call for Action

8.82 In light of all the above, it appears to be time for a system of international governance that addresses the challenges that IMAR presents. The system should be based on human rights and promote universal access to MAR for the treatment of infertility through the sharing of knowledge, transfer of technology and publicly funded services\(^\text{370}\), and be based on a combination of three existing models of regulation: (1) an international mechanism for monitoring IMAR practices; (2) inter-country adoption; and (3) trafficking in human beings, organs and tissues.

8.83 Existing mechanisms of international monitoring, such as those operating within the UN human rights treaty bodies, or for public health purposes within the WHO Framework Convention on Tobacco Control, 2003 might be adapted to the context of IMAR so as to guarantee the collection and reporting of transparent data as follows:

- To report on adverse events affecting the health and well-being of third-party women and children born of IMAR;
- To ensure the provision of post-procurement, post-implantation and post-birth clinical follow-up care for third-party women;
- To gather epidemiological data on IMAR and enable the conduct of longitudinal studies on the health and well-being of children and of third-party women;
- To collect information for the traceability of human reproductive cells and embryos at both national and international levels, so as to guarantee quality and safety in the interests of public health.

8.85 Regulatory measures drawn from the model of the Hague Convention on Inter-Country Adoption would require the accreditation of not-for-profit IMAR agencies, so that services involving women as third-party reproductive collaborators are provided equally and fairly with due transparency and accountability. Such measures might also establish designated central authorities for maintaining a national registry of IMAR children, gamete

\(^{370}\) UNESCO Universal Declaration on Bioethics and Human Rights, 2005 – Article 2.
providers and surrogates, in order to guarantee the right of the children to access information regarding their genetic origins and circumstances of birth.

8.86 A regulatory model based on international norms concerning trafficking in human beings, organs and tissues would likewise establish a transparent system of national oversight by means of competent not-for-profit national authorities with overall responsibility and accountability for IMAR practices involving nationals, including traceability. It would also ensure standards of provider and recipient safety through the accreditation of MAR centres for gamete procurement and embryo implantation, and establish rules of distributive justice that govern the transparent allocation of and equitable access to limited medical services and human resources, including human reproductive cells, according to evidence-based clinical guidelines. An anti-trafficking approach would call for cooperation between countries of origin, transit and destination to adopt necessary measures to prevent, protect and prosecute the exploitation, deception and coercion of third-party reproductive collaborators and the sale of children.

8.87 Shalev therefore calls upon the United Nations and other inter-governmental organizations and their agencies, international human rights bodies and international professional associations, nation states and civil society, and upon all concerned individuals – jointly and severally, to take all possible measures to respect, protect and fulfil the human rights of women and children involved in IMAR, including the following:

- To take appropriate measures, at both national and international levels, to prevent practices which lead to the commodification of children and women;
- To criminalise IMAR practices which involve the sale of human beings and their body parts and resources, including human reproductive cells and embryos;
- To prohibit IMAR practices that involve the exploitation, deception and coercion of third-party women and men, and other violations of equity, justice and respect for their human dignity and human rights, regardless of the victim's consent371;
- To provide medical, psychological and social care for the short- and long-term effects of MAR on the physical and emotional health and well-being of third-party women who provide their reproductive resources for the benefit of others, and for the

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recovery of victims of exploitation, deception and coercion, and reproductive trafficking\textsuperscript{372}.

8.88 Perhaps most importantly, the working group considered that medical professionals are key links in the IMAR industry, without whose involvement none of the harmful practices would be at all possible. As opposed to the field of organ transplantation, in the area of reproduction professional organizations have not laid down clinical standards of efficacy, quality and safety, and have not taken a leadership role in terms of ethical self-governance.

8.89 Shalev therefore call upon professional medical associations to take a leading role of self-governance in advancing the international regulation of IMAR, and to establish clinical and ethical guidelines that set universal standards of respect and care for women undergoing MAR treatment worldwide. The medical profession should also take responsibility to ensure the traceability of human gamete donations and embryo implantations, and to preserve information necessary to realize the right of the child to know his or her origins. And last but not least - to adopt standards of conduct that sanction health care professionals who are involved in illicit IMAR practices.

8.9 Overview

8.90 The growth of the IMAR market in recent years is due to complex economic, legal and cultural conditions. A major driver of this multi-billion dollar business is the desire of individuals to parent children, and their inability to do so in their home countries due to legal restrictions or economic constraints on surrogacy or egg cell procurement.

8.91 Moreover, there are signs of an emerging market of cross-border reproductive care for non-medical sex selection of embryos by means of PGD, and similar practices for the selection of preferred embryonic traits are likely to grow further.

8.92 IMAR is complicated by the fact that different counties have different laws. It should be obvious, that IMAR impacts not only on a child’s right to know his or her genetic origins but also on a child’s right to a nationality, registration of birth and parental care.

8.93 Since the IMAR market is not regulated, there is no official data and a dearth of information. At the same time, for-profit trade in IMAR services involves the commodification of human beings (women and children) and body parts (gametes and wombs).

8.94 There is evidence of violations of the human rights of children as babies born as a result of IMAR may simply be abandoned or sold on the black market.

8.95 IMAR can lead to human rights abuses and the exploitation of woman who collaborate in MAR in that they may be misled as to the nature and extent of their involvement in MAR, they may be subject biased health care advice and subject to harmful treatments and degrading practices. Further, they may have no say in what happens to their gametes or the embryos created with the gametes. In some instances they are not compensated for their services. There is an urgent need to establish clinical and ethical guidelines that set universal standards of respect and care for women undergoing MAR treatment worldwide.

8.96 There is a need for inter-governmental organizations and their agencies, international human rights bodies and international professional associations, nation states and civil society to take all possible measures to respect, protect and fulfil the human rights of women and children involved in IMAR.

8.10 Questions

1. Does a child conceived by way of IMAR have a right to know his or her biological origins?

2. Should South Africa prohibit IMAR or stipulate which countries may be suitable destinations for IMAR?

3. Should South Africa enter into bilateral agreements regarding IMAR with counties that are known to be regular IMAR destinations so as to regulate IMAR health care services and issues related to the nationality, adoption or the right of the donor-conceived child to know his or her biological origins?

4. Which country will be responsible to store information regarding the donor?
5. Which country will be responsible to ensure that a child is told about being conceived via donor gametes?

6. How can uniformity or international law regarding IMAR be established?

7. What can South Africa do to prevent illicit IMAR and the abuses that IMAR can result in?

8. What rules should health care professionals establish regarding IMAR?
GLOSSARY

ACRWC – African Charter on the Rights and Welfare of the Child

ART – Assisted Reproductive Technology

BDRA – Births and Deaths Registration Act 51 of 1992


Children’s Act - Children’s Act 38 of 2005


CROC – United Nations Committee on the Rights of the Child


DHA – Department of Home Affairs

Donation means the gifting of sperm, eggs or embryos for use in fertility treatment or research

Donor is a person who donates his or her gametes for use in fertility treatment or research

Embryo – an embryo is formed when a sperm fertilizes an ovum (egg). An embryo is a new organism in the earliest stage of development. In humans this is defined as the developing organism from the fourth day after fertilization to the end of the eighth week. After the eight week, it is usually referred to as the foetus.

Gametes are an organism’s reproductive cells. They are also referred to as sex cells. Female gametes are called ova or egg cells, and male gametes are called sperm. Gametes are haploid cells, and each cell carries only one copy of each chromosome.

HFEA - Human Fertilisation and Embryo Authority (United Kingdom)

IMAR – inter-country medically assisted reproduction
In vitro fertilization/IVF is the joining of a woman's egg and a man's sperm in a laboratory dish. In vitro means outside the body. Fertilization means the sperm has attached to and entered the egg.

MAR – medically assisted reproduction

MRT – Mitochondrial Replacement Therapy

mtDNA - Mitochondrial DNA

NHA – National Health Act 61 of 2003

Ovum or egg cell is the female reproductive cell/gamete

Reprogenetics is the use of reproductive and genetic technologies to select and genetically modify embryos with germinal choice technology for the purpose of human enhancement. However, a report by the Hastings Center broadly defined reprogenetics as any "creation, use, manipulation, or storage of gametes or embryos". The term was coined by Lee M. Silver, a professor of molecular biology at Princeton University; in his 1997 book Remaking Eden.


SMA - surrogate motherhood agreement

Sperm is the male reproductive cell/gamete

WHO – World Health Organization
STATUTES

International
European Convention on Human Rights (ECHR)

Germany
The Act Expanding Assistance for Pregnant Women and Regulating Births in Confidence of 28 August 2013 (Federal Law Gazette I, p. 3458)

Israel
Surrogate Mother Agreements Law, 1996
Egg Cell Donations Law, 2010

South Africa
Birth and Death Registration Act 51 of 1992
Children’s Act 38 of 2005
Choice on Termination of Pregnancy Act 92 of 1996
National Health Act 61 of 2003
South African Citizenship Act 88 of 1995
Refugees Act 130 of 1998
Regulations on the Registration of Births and Deaths (GN R128 in GG 37373 of 26 February 2014)
Regulations Relating to Artificial Fertilisation of Persons, GN R175 in GG 35099 of 2 March 2012. *Note that draft regulations relating to artificial fertilisation of persons dated 15 August 2016 were published for comment. See GN 1165 in GG 40312 of 30 September 2016
Regulations under the Children’s Act 38 of 2005

United Kingdom
Human Fertilisation and Embryology Authority (Disclosure of Donor Information) Regulations 2004
Human Fertilisation and Embryology (Mitochondrial Donation) Regulations 2015

United States of America
Baby Moses laws or Safe-haven laws
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