

Advisory Committee on Assisted Reproductive Technology



Import and Export of Gametes and Embryos:

Background paper for
stakeholder discussion

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Foreword

The Advisory Committee on Assisted Reproductive Technology (ACART) was established under the Human Assisted Reproductive Technology Act 2004 (the HART Act). ACART's functions include advising the Minister of Health on the import and export of human gametes and embryos ("import/export").

We first engaged with stakeholders on import/export in 2006 as part of consultation on human reproductive research. In 2007 our consultation on assisted reproductive procedures included questions about import/export. The former Chair of ACART met with medical directors in 2010 to discuss trends and concerns. More recently, staff members in some clinics have shared their observations and thoughts with me. An ACART hui in 2012 included discussion about import/export. Clinics have further assisted by providing ACART with data about import/export cases and inquiries.

As we have reflected on what we have heard, some things have become clear.

- Import and export of gametes and embryos is part of a much bigger picture. A growing number of New Zealanders are looking overseas for fertility treatment or gametes. Transborder reproduction by New Zealanders is part of an established and growing international phenomenon.
- New Zealand requirements for the use of gametes and embryos are often very different from requirements elsewhere. A key group affected by this lack of harmonisation is people who want to import gametes and embryos which have been sourced or created in circumstances which are not acceptable in New Zealand.
- There are significant ethical concerns to take into account when considering whether any New Zealand requirements should be more flexible in regard to import and export.

We have decided it would be useful to take a two stage approach to talking with stakeholders. In this stage we want to hear your views on some matters.

- If New Zealand's regulatory framework was amended to facilitate import and export of gametes and embryos, where might change or flexibility be justified?
- On the other hand, are there areas where there should be no flexibility in New Zealand requirements?

After reviewing the feedback received, we will undertake formal consultation on proposed advice. We will then finalise our advice to the Minister of Health.



John Angus

Chair, Advisory Committee on Assisted Reproductive Technology



How to have your say

Please take this opportunity to have your say. You may give feedback on your own behalf or as a member of an organisation. You can contribute your views in either of these ways:

- email a completed submission form or your comments to acart@moh.govt.nz, or
- post a completed submission form or your comments to:
ACART Secretariat
PO Box 5013
Wellington.

We will place all feedback on ACART's website as it is received, and therefore prefer that feedback is submitted electronically if possible. However, we will accept and consider all feedback regardless of how we receive it.

Where you give feedback on your own behalf, we will remove your contact details before placing the feedback on ACART's website. Alternatively, you may request that all or part of your feedback is withheld from publication for reasons of confidentiality.

The closing date for feedback is 31 May 2013.

After receiving and considering feedback, we will develop proposed advice to the Minister of Health on import and export of gametes and embryos. We will then undertake formal public consultation on our proposals. If you provide feedback to this background paper, we will send you a copy of the discussion document with our proposed advice. At the end of that consultation round we will finalise and give our advice to the Minister.

You can obtain additional copies of this paper and feedback form from the ACART website (www.acart.health.govt.nz). If you require a hard copy, please contact the ACART Secretariat (email acart@moh.govt.nz or telephone 04 816 3931).



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Executive summary

New Zealand, in common with many countries, is experiencing growth in the numbers of people accessing assisted reproductive procedures in other countries. In some cases, transborder reproduction involves sending, or wanting to send, gametes (sperm and eggs) or embryos between countries.

New Zealand requirements for the use of gametes and embryos are often very different from requirements elsewhere. A key group affected by this lack of harmonisation is people who want to import gametes and embryos which have been sourced or created in circumstances which are not acceptable in New Zealand.

The HART Act requires ACART to provide specific advice to the Minister of Health on:

- the import into, or export from, New Zealand of *in vitro* human gametes or *in vitro* human embryos, in respect of human reproductive research
- the import into, or export from, New Zealand of *in vitro* donated cells or *in vitro* embryos, in respect of human assisted reproductive technology.

We are taking a two stage approach to talking with stakeholders about the issues associated with import and export. In this first stage we present arguments about six key issues where there is potential for a significant clash between New Zealand requirements and those elsewhere:

- altruistic donation v. commercial supply
- right to access identifying information about donors v. no right to access identifying information about donors
- family size requirements
- use of sex selection
- scope of informed consent
- use of gametes and embryos overseas in procedures or research prohibited or precluded in New Zealand.

We are interested in views about where New Zealand's regulatory framework should be amended to facilitate import and export of gametes and embryos, and views about areas where there should be no flexibility in New Zealand requirements.

For each issue, we have identified ethical and policy arguments that can be made in support of and opposition to different positions. We have taken into account the Principles of the HART Act, other ethical principles, and public policy issues. Please note that the arguments presented should not be read as ACART's position on the matters discussed.

After receiving and considering feedback, we will develop proposed advice to the Minister of Health on import and export of gametes and embryos. We will then undertake formal public consultation on our proposals.



1 Background

1.1 Context

1. New Zealand, in common with many countries, is experiencing growth in the numbers of people accessing assisted reproductive procedures in other countries.¹ This phenomenon is sometimes called transborder reproduction or cross border reproductive care. The evidence suggests that key motivations for people to look overseas include to access treatments not possible in their home country, and to obtain donated eggs or sperm which are in short supply in their home country. In some cases, transborder reproduction involves sending, or wanting to send, gametes or embryos between countries.
2. The impacts of transborder reproduction include conflicts between standards and laws in different countries; concern about the potential exploitation of donors and surrogates in developing countries; and managing the entry of children born from overseas surrogacy arrangements into the home countries of intending parents.

A common situation in New Zealand is where a woman has had IVF treatment overseas with embryos created using commercially sourced donated eggs. The woman may be a New Zealander who has gone overseas for treatment. Alternatively, she may have been living overseas before coming to New Zealand as a migrant or as a returning expatriate.

Currently she would not be able to use the embryos in New Zealand because the embryos have been created in circumstances which are inconsistent with New Zealand requirements. The commercial supply of eggs, sperm and embryos is prohibited in this country. Such situations, say providers, result in some undesirable outcomes.

- She will need to return overseas for any further treatment using the stored embryos, with associated costs (eg, travel, disruption to family life).
- She may return to New Zealand with more than one embryo implanted, in order to avoid further travel and treatment. The health sector is concerned that in such cases, women and any resulting children incur the health risks of a multiple pregnancy and birth, and the New Zealand health system incurs any short term and long term costs.

¹ See: Dr Mary Birdsall's blog "Inside Fertility" and her posting on Fertility Tourism on 12 January 2012. <http://fertilityassociates.blogspot.co.nz/>; Grunwell, Rachel. 8 August 2010. Lured by fetal attraction. *New Zealand Herald* http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10664431; Johnston, Kirsty. 10 June 2012. Kiwis head overseas for fertility treatment. *Stuff*, <http://www.stuff.co.nz/dominion-post/news/7074636/Kiwis-head-overseas-for-fertility-treatment>

- If she decides to create further embryos in New Zealand for treatment in New Zealand, she must first find an egg donor. If she can find a donor, the donor will then be subject to the risks and discomfort associated with retrieving eggs. The embryos created overseas may never be used, yet might be better quality than new embryos created in New Zealand because the donor overseas was likely to be younger than a New Zealand donor.

3. Clinics have told us that numbers of import and export cases in New Zealand are low. This may be because people understand the current restrictions applying to the use of imported gametes and embryos (discussed on page 3). However, we know that there are increasing numbers of people in the situation described above, including as a result of links between New Zealand and overseas clinics. This means that there is a parallel increase in the numbers of people who might potentially wish to bring embryos back to New Zealand for treatment here, if this was possible.

1.2 Why is ACART developing advice to the Minister of Health on the import and export of gametes and embryos?

4. The HART Act requires ACART to provide specific advice to the Minister of Health on:
 - the import into, or export from, New Zealand of *in vitro*² human gametes or *in vitro* human embryos, in respect of human reproductive research
 - the import into, or export from, New Zealand of *in vitro* donated cells or *in vitro* embryos, in respect of human assisted reproductive technology.
5. ACART must provide the Minister with information, advice, and if it thinks fit, recommendations on these matters (s.37(1)(g) and s.38(f) of the HART Act).
6. ACART's role of advising the Minister is significantly different from ACART's role of developing and issuing guidelines. While ACART must consult with the Minister of Health before issuing guidelines, the responsibility for the guidelines lies with ACART. In contrast, where ACART advises the Minister, as it will about import/export matters, the Minister decides whether to accept any or all of the advice. Depending on the nature of advice that is accepted, any further work is likely to be the responsibility of the Ministry of Health (eg, development of regulations).

² *In vitro* means outside a living organism.

1.3 What are the current requirements for import and export of human gametes and embryos?

7. New Zealand's requirements associated with the import and export of human gametes and embryos are set out in:
 - the HART Act
 - Ministry of Health advice to clinics
 - the Fertility Services Standard.

1.3.1 *The HART Act*

8. The HART Act is the key law that regulates assisted reproductive technology and human reproductive research in New Zealand. The HART Act prohibits import and export of cloned and hybrid embryos and gives Customs Officers powers to detain any item or material if Customs has concerns that the item or matter may be prohibited.³
9. The HART Act is otherwise silent on rules for import and export of human gametes and embryos. Instead, the HART Act requires ACART to provide the Minister of Health with advice about import into, or export from, New Zealand. The HART Act also says that regulations may be made for the purpose of prescribing requirements for import and export, including requirements for the giving of informed consent by persons from whom gametes are obtained overseas.⁴ New Zealand has not made any such regulations.

1.3.2 *Ministry of Health advice to clinics and individuals*

10. In response to queries from individuals and clinics, the Ministry of Health has said that there are no legal barriers to gametes and embryos being imported into and exported out of New Zealand. However, any treatment in New Zealand using imported gametes or embryos must meet the same requirements for the use of gametes and embryos sourced/formed in New Zealand.
11. In addition, the Ministry of Health has advised clinics that if they are involved in importing or exporting gametes and embryos, the Ministry expects clinics to act ethically in relation to the following considerations:
 - HART Act principles
 - HART Act requirements (particularly requirements which describe prohibited actions including commercial supply and sex selection, and requirements about keeping information about donors and donor offspring)
 - legislation and regulations in countries of origin and their similarity to that in New Zealand
 - informed consent requirements as in the HART Act and the Code of Health and Disability Services Consumers' Rights.

³ See s.8(2) and s.73 of the HART Act 2004.

⁴ S.76 of the HART Act 2004.

1.3.3 Fertility Services Standard

12. Fertility clinics in New Zealand must operate in accord with the Fertility Services Standard which sets out the requirements for the safety and quality of fertility services in New Zealand. Clinics are audited and certified against the Standard.
13. The Standard contains only one requirement specific to import or export. Providers must have a written procedure outlining requirements for the safety and quality of embryo and gamete transport, including obtaining consent of consumers before transport.⁵ Our understanding is that the Standard applies to all treatment in New Zealand regardless of the origin of gametes or embryos.

1.4 What is the scope of ACART's work?

1.4.1 In scope

14. Import means to bring or carry *in vitro* gametes (eggs, sperm or reproductive tissue containing gametes) or embryos into New Zealand from another country.
15. Export means to carry or send *in vitro* gametes or embryos out of New Zealand to another country.
16. In practice, import or export means transporting human sperm, eggs and embryos in liquid nitrogen in special containers. People may carry gametes and embryos across borders in the containers, or the gametes and embryos may be freighted in the containers.
17. Our advice to the Minister will involve the import and export of human gametes and embryos, including:
 - an individual's own sperm or eggs
 - donated sperm and donated eggs
 - embryos created from the sperm and eggs of a couple
 - embryos created from an individual's own eggs or sperm, in conjunction with donated eggs or sperm
 - embryos created from donated eggs in conjunction with donated sperm
 - donated embryos
 - ovarian and testicular tissue.
18. Our advice will be concerned with import and export for both treatment and research purposes.
19. The HART Act says that ACART's advice on import and export for treatment purposes must address *donated* gametes and *donated* embryos. However, some policy and ethical issues related to import and export arise regardless of who provided the gametes and embryos.

⁵ 4.2.11 of the Fertility Services Standard.

20. For this reason, we are also considering import and export of individuals' *own* sperm and eggs, and also of embryos made from a couple's *own* sperm and eggs, in cases where individuals and couples intend to use the material for their own treatment.

1.4.2 *Out of scope*

21. Our advice will *not* address requirements associated with movements of people between countries, for example where:
 - people travel overseas for treatment
 - people travel overseas to be involved in human reproductive research projects
 - pregnant women return to New Zealand after treatment overseas
 - people come to New Zealand for fertility treatment
 - children created from assisted reproduction enter or leave New Zealand (for instance, as a result of surrogacy arrangements).
22. Such movements may, of course, be associated with import or export of gametes and embryos.
23. Our advice will *not* address import or export of embryonic stem cell lines. The HART Act definition of an embryo excludes stem cells derived from an embryo.



2 Issues for discussion

24. Our advice to the Minister will include weighing up the ethical and policy issues associated with various options. We would like to hear your views on six key issues where there is potential for a significant clash between New Zealand requirements and those elsewhere:
- altruistic donation v. commercial supply
 - right to access identifying information about donors v. no right to access identifying information about donors
 - family size requirements
 - use of sex selection
 - scope of informed consent
 - use of gametes and embryos overseas in procedures or research prohibited or precluded in New Zealand.
25. For each issue, we have identified ethical and policy arguments that can be made in support of and opposition to different positions. We have taken into account the Principles of the HART Act, other ethical principles, and public policy issues.
26. Please note that the arguments presented should not be read as ACART's position on the matters discussed.
27. We include some examples of the potential impact of current requirements. We are keen to hear views about where New Zealand should hold the line on current requirements, and if there are situations where flexibility is justified. We are also interested in hearing about other areas where there may be a significant mismatch between New Zealand requirements and those in other jurisdictions.

2.1 Altruistic donation v. commercial supply

2.1.1 *Current requirements*

28. The HART Act prohibits the commercial supply of gametes and embryos. The Ministry of Health's advice to clinics says that any treatment in New Zealand using imported gametes or embryos must meet the same requirements for the use of gametes and embryos sourced/formed in New Zealand.

Example – import for treatment

Tom and Mary had IVF in the United States and a child was born from the treatment. They have five embryos stored in that country. They have migrated to New Zealand and want to have more children. They want to bring the remaining embryos from the United States to New Zealand for treatment through a New Zealand clinic, to try for a sibling who is genetically related to their first child.

The embryos were made from donated sperm. The sperm donor was paid to donate. The New Zealand clinic refuses to use the embryos.

2.1.2 Arguments for using imported gametes and embryos (including embryos created from donated gametes) from non-commercial sources only

Health and wellbeing of children

- Financial rewards to donors may have a psychological impact on future children, who may believe they were “bought” by their parents.
- Commercial sourcing has the effect of making children “products” who may be at risk of rejection if they do not meet specifications.

Health and wellbeing of women, future children, and donors

- Financial rewards may encourage donors to lie about their health. This in turn may compromise the health of women, donor offspring, and donors themselves.

Capacity to make an informed choice and give informed consent

- Substantial financial incentives may hamper the ability of donors to make clear, informed decisions, eg, take into account risks associated with egg donation.

Altruism

- The ability to use commercially sourced gametes and embryos would crowd out altruism.
- Birthparents cannot be paid for relinquishing a child to adoption. Payment for gametes and embryos would commodify children. Some relationships and exchanges properly lie outside the market model.
- Altruistic donation means that donors are currently seen as giving a gift, and valued for that exchange.

We could retain and strengthen altruistic donation by raising the amount paid to donors in recompense for expenses incurred (as has happened recently in the United Kingdom – see <http://www.hfea.gov.uk/500.html>).⁶ Expenses paid to egg donors in particular need to be at a level that recognises that egg donation is comparatively invasive and carries more risks than does sperm donation.

⁶ ACART’s understanding is that New Zealand clinics pay donors’ expenses at a similar level to that indicated on Fertility Associates’ website (\$30 per visit).

Justice and equality

- Allowing some New Zealanders to use commercially sourced gametes or embryos would be unfair because those people would not be subject to the constraints that apply to people being treated in New Zealand using donated gametes and embryos. Not everyone can afford to 'buy' their way out of local requirements.

Supporting unethical practices

- New Zealand should not support, or be seen to support, policies and practices in other countries that would be regarded as unethical in this country.
- Some clinics in other countries may behave in ways that are inconsistent with requirements or best practice in that country. Two recent papers found discrepancies between the recommendations of the American Society for Reproductive Medicine (ASRM) and the practices of some United States clinics and agencies.^{7,8,9} A report of the ASRM Practice Committee says that embryo donors should not receive any compensation for the embryos.¹⁰

Public policy

- Allowing the use of commercially sourced gametes and embryos would be an exception to general public policy in New Zealand. Altruistic gamete and embryo donation (and surrogacy) is consistent with blood and organ donation. A sense of mutuality and community is fostered by exchanges that do not involve money.

⁷ ASRM guidelines are recommendations only, without statutory force.

⁸ Keehn J, Holwell E, Abdul-Karim R, et al. 2012. Recruiting egg donors online: an analysis of in vitro fertilization clinic and agency websites' adherence to American Society for Reproductive Medicine guidelines. *Fertility and Sterility* 98(4): 995–1000. 34% of 102 websites did not comply with ASRM guidelines that compensation to egg donors should not be based on a donor's traits, 41% were non-compliant with the ASRM's recommended donor minimum age (21 years), and 56% were non-compliant with the ASRM's recommendation that information about risks be presented alongside compensation information.

⁹ Alberta HB, Berry RM, Levine AD. 2012. Compliance with donor age recommendations in oocyte donor recruitment advertisements in the USA. *Reproductive BioMedicine Online* 3 December. [http://www.rbmojournal.com/article/S1472-6483\(12\)00696-7/abstract](http://www.rbmojournal.com/article/S1472-6483(12)00696-7/abstract). The other paper also looked at compliance with minimum age recommendations for egg donors, using 539 advertisements through Craigslist and college newspapers. Sixty percent of the Craigslist advertisements and 40% of the college newspaper advertisements listed a lower minimum age than the recommended 21 years.

¹⁰ Practice Committee of ASRM. 2012. Recommendations for gamete and embryo donation: a committee opinion. [http://www.asrm.org/uploadedFiles/ASRM_Content/News_and_Publications/Practice_Guidelines/Guidelines_and_Minimum_Standards/2008_Guidelines_for_gamete\(1\).pdf](http://www.asrm.org/uploadedFiles/ASRM_Content/News_and_Publications/Practice_Guidelines/Guidelines_and_Minimum_Standards/2008_Guidelines_for_gamete(1).pdf)

2.1.3 Arguments for allowing the use in New Zealand of gametes and embryos (including embryos created from donated gametes) that have been commercially sourced overseas

Health and wellbeing of women and children

- The current restrictions incentivise women, when overseas, to have multiple embryos replaced in their wombs, and to thus incur risks associated with multiple pregnancies. Recent research using the Australian and New Zealand Assisted Reproduction Database has established that double and higher order embryo transfer is associated with a higher risk of perinatal mortality when compared to single embryo transfer. Single embryo transfer, say the authors, is the single most effective public health intervention for preventing excess perinatal mortality amongst assisted reproduction pregnancies.¹¹
- If people are not able to travel to use their surplus embryos stored in another country, the embryos will not be used and may be discarded. This would be a waste, given the cost and physical risks involved in creating embryos that would otherwise be used in different circumstances. Further costs and risk of harm arise if new embryos must be created in New Zealand or elsewhere, assuming a donor can be found.
- Assumptions are made, with little evidence, that children are harmed or not harmed if born from the use of commercially sourced gametes and embryos. We should not assume that harm will be done. Children are born in a wide variety of circumstances that have little or no effect on how they are subsequently loved and valued.¹²
- If embryos cannot be brought back and used in New Zealand, and parents cannot return overseas for further treatment, children will miss out on having full genetic siblings.

Needs, values and beliefs of Māori

- Embryos created overseas with whakapapa to New Zealand should be brought back to New Zealand for protection.

Justice and equality

- People who stored embryos or gametes overseas may have done so before they considered migrating to New Zealand. If they followed the law in the country where they were treated, they should not be subsequently penalised.

¹¹ Sullivan E, Wang YA, Hayward I, et al. 2012. Single embryo transfer reduces the risk of perinatal mortality, a population study. *Human Reproduction* 27(12): 3609–15.

¹² “In order to properly inform this debate, good quality empirical research is needed as to what, if any, effects financially incentivised gamete donation has on children conceived as a result of such donation.” In Nuffield Bioethics Council. 2012. Human bodies: donation for medicine and research. Summary and Recommendations p.13.

- Children born overseas from commercial gamete or embryo donation, and from commercial surrogacy arrangements, are able to enter New Zealand. Women treated overseas and who are pregnant are able to return to New Zealand and give birth here, regardless of whether or not donors were paid. It is unfair to treat the import of gametes and embryos differently, simply because they have not yet become either a pregnancy or a child.
- The ideal of a society based on sharing and mutuality is not working in practice for many people who need to use donated gametes in order to have a child. Altruism can be selective, benefiting groups and individuals seen as 'deserving'.
- There is a shortage of donated gametes in New Zealand, particularly from donors with particular ethnic or cultural characteristics. While in many cases donations come from friends or family members, not everyone has a suitable and willing donor in their networks. The use of commercially sourced gametes from other countries would reduce the demand in New Zealand for a scarce resource.
- The boundary between expenses and commercial supply does not always appear clear. Expenses in one country may be seen as commercial supply here. There is wide variation internationally as to what is seen as acceptable payment to cover expenses, even in jurisdictions that do not allow commercial supply.

Public policy

- Transborder reproduction appears to be well established as an accessible option for people wanting to have children. Any measures put in place to increase the supply of New Zealand-sourced donated gametes or to discourage people from going overseas would not be effective in all cases. For instance, Australian evidence about the use of overseas surrogacy arrangements indicates that people are not deterred where such arrangements are criminalised.
- The shortage of donated eggs in New Zealand means that people will continue to travel to access commercially sourced donated eggs. Where people cannot use in New Zealand embryos created from commercially sourced eggs in another country, there is an incentive for them to have multiple embryos replaced overseas.

Question 1: Should it be possible to use commercially sourced gametes and embryos from other countries in New Zealand?

- In all circumstances?
- In no circumstances?
- In some circumstances? If so, what circumstances might be acceptable, and what circumstances would not be acceptable?
- Would a higher level of donor expenses in New Zealand increase the supply of locally sourced gametes?

Please give reasons for your views.

2.2 Right to access identifying information about donors v. no right to access identifying information about donors

2.2.1 Current requirements

29. The HART Act has established a comprehensive regime for obtaining and keeping identifying information about donors and donor offspring. Donor offspring born from donations made after the commencement of the HART Act are able to access identifying information about donors at the age of 18 years, or younger in some circumstances. Donor offspring born from donations made before the commencement of the HART Act have more limited rights. Donor offspring siblings also have rights to information about each other, subject to certain conditions.
30. The long term security of information about donors and donor offspring is centrally managed and does not depend on providers: the Registrar-General must keep indefinitely all information provided by providers about donors and donor offspring.
31. The Ministry of Health's advice about import and export includes an expectation that clinics act ethically in relation to requirements about keeping information about donors and donor offspring.

Example – import for treatment

Peter and Sue travelled to another country to undergo IVF with Peter's sperm and donated eggs because they couldn't find an egg donor in New Zealand. They returned to New Zealand after treatment leaving embryos stored overseas. Further travel overseas to use the stored embryos would cause substantial disruption to their work and family responsibilities. They want to bring the embryos to New Zealand to continue treatment through a New Zealand clinic.

The egg donor made an anonymous donation. In the country where the eggs were donated, there is no right to access identifying information about donors. New Zealand law requires donors to be identifiable. The New Zealand clinic refuses to use the embryos.

2.2.2 Arguments in support of not using imported gametes and embryos unless donor offspring have the right to access identifying information about donors

Health and wellbeing of children

- Children have a strong interest in the opportunity to access identifying information about a donor. A sense of personal identity draws on knowledge about genetic, family and cultural factors that have contributed to an individual's creation and development.

- There is a public interest in ensuring, as far as possible, that identifying information about donors is preserved and available, even if parents do not initially recognise its significance. Evidence shows that over time, parents become more aware of the importance of children knowing how they were created and who contributed to their creation.
- The capacity to trace donors and families created from the use of donated gametes and embryos means that crucial health information can be shared, including information not known at the time of the donation.

Promote health and wellbeing of current and future generations

- Access to identifying information recognises that gamete donation results in relationships that extend into the future and go beyond the donor and offspring.

Needs, values and beliefs of Māori

- Knowledge of whakapapa is important for children, whānau and iwi.
- Iwi membership, regardless of where people live, is critical to accessing the benefits of resources obtained through Treaty settlements.

Justice and equality

- Access to identifying information is consistent with values and requirements elsewhere in New Zealand public policy and culture. Adopted people have the right to access identifying information about birthparents.
- The United Nations Convention on the Rights of the Child recognises the “right to know one’s parents” as a fundamental human right. While gametes and embryos are not yet children, the rights of children who will potentially be born from their use need to be considered.

2.2.3 Arguments for allowing the use of imported gametes and embryos from non-identifiable donors

Autonomy

- People using assisted reproductive procedures should have the same rights to privacy in their reproductive choices as do parents who have children without fertility treatment.
- Ethnicity may be more important than identifiability for some intending parents when sourcing gametes, particularly where there are shortages of gametes from some ethnic groups. Parents should be able to weigh up for themselves the importance they give to the impacts of the choices available to them.

Health and wellbeing of children

- The United Nations Convention on the Rights of the Child was not written with gamete donation in mind. Donor offspring are in a very different position to adopted children within the family: they have not been abandoned or relinquished by their genetic parents and they are often biologically related to an intending parent.

Question 2: Should it be possible to use gametes and embryos in New Zealand where donor offspring do not have access as of right to identifying information about donors?

- In all circumstances?
- In no circumstances?
- In some circumstances? If so, what circumstances might be acceptable, and what circumstances would not be acceptable?

Please give reasons for your views.

2.3 Family size requirements

2.3.1 Current requirements

32. New Zealand requirements can be different to those in other countries in regard to how widely donated gametes and embryos can be used in treatment. New Zealand requirements are:
- gametes (Fertility Services Standard Audit Workbook): maximum of 10 families from one donor, or lower depending on donor's consent
 - embryos (ACART guidelines on embryo donation): one other family besides that of donor couple
 - use of embryos created from donated eggs with donated sperm (ACART guidelines): full siblings in only one other family.

Example – import for treatment

Jane lives in New Zealand and wants to use donated sperm to have a child. An overseas sperm bank is willing to ship sperm to New Zealand for her use.

An unknown number of families have received donated sperm from Jane's preferred donor. The Fertility Services Standard provides that a donor should not be used to donate for more than ten families.

Even if the number of families assisted at the time of the donation is below the New Zealand maximum, the number of families assisted in the long term by the same donor may substantially exceed the New Zealand maximum. New Zealand has no jurisdiction over the subsequent use of sperm from the same donor.

Example – export for treatment

Sarah is a New Zealander living overseas. She wishes to have a child. Her friend Bill in New Zealand is willing to donate sperm. Bill donated via a New Zealand clinic. The New Zealand clinic has been asked to send Bill's donated sperm to an overseas clinic for Sarah's treatment.

Bill wants to limit the number of children born from his donation, and wants to be able to find out about any births. New Zealand has no jurisdiction over the use of gametes and embryos that leave New Zealand. The clinic is not able to assure Bill that the conditions set on his donation will be upheld.

2.3.2 Arguments in support of requiring import/export to adhere to New Zealand family size requirements

Health and wellbeing of children

- Setting limits on the number of families networked through donations avoids the complexity of resulting relationships where there may be many genetic siblings across a number of different countries. Access to information about genetic siblings is very important to many donor offspring.
- Incest between donor siblings is a genuine concern for donor offspring. A United States writer noted that “almost every clinic reports having a most-requested donor, whose gametes are so popular with prospective parents that the clinic (and the donor) has trouble keeping up with the demand”. For example, a search on the voluntary Donor Sibling Registry in the United States showed that one particular donor is the biological father of at least 36 children, all born between 2002 and 2007.¹³
- If a donor is later found to have a heritable condition, adherence to New Zealand family limits will limit the spread of the condition.

2.3.3 Arguments for allowing import and export that may result in many families assisted by one donor

Health and wellbeing of children

- The impact at a New Zealand level will be small.

Justice and equality

- Many children born without assisted reproductive technology live in and manage complex family networks.

¹³ Dennison M. 2007. Revealing your sources: the case for nonanonymous gamete donation. *Journal of Law and Health* 21(1). <http://claradoc.gpa.free.fr/doc/200.pdf>

Public policy

- Given that New Zealand cannot control the number of families assisted in other countries by donors whose gametes and embryos have been sourced here or overseas, there is little point in trying to manage family limits. The key issue is ensuring people understand the implications in their particular case.
- Flexibility is justified in light of the shortage of donors in New Zealand.

Question 3: Should it be possible to use donated gametes or embryos in import/export where the use may exceed New Zealand limits on the number of families assisted?

- In all circumstances?
- In no circumstances?
- In some circumstances? If so, what circumstances might be acceptable, and what circumstances would not be acceptable?

Please give reasons for your views.

2.4 Use of sex selection

33. The HART Act prohibits selecting an embryo for implantation on the basis that the embryo is a particular sex. The only exception is where the sex selection was undertaken to prevent or treat a serious genetic disorder or disease, eg, to avoid using an embryo affected by a serious genetic disorder where there is a family history or increased risk of a disorder.
34. In some jurisdictions sex selection is possible for other reasons, eg, 'family balancing'.

Example – import for treatment

Steve and Eve have three boys and would dearly like a girl. A doctor in the United States is reported to be attracting international patients who want to undertake sex selection for family balancing reasons. Steve and Eve travel to the United States where they have embryos created and screened to identify those likely to result in the birth of a girl. They want to bring the stored embryos back to New Zealand for treatment here.

The embryos have been subject to sex selection without the justification of preventing a serious sex linked genetic condition. The New Zealand clinic refuses to treat Eve with the embryos.

2.4.1 *Arguments for allowing the use of imported embryos subject to sex selection only to prevent a sex linked genetic condition*

Health and wellbeing of children

- It is in the best interests of children for them to feel valued for themselves, not because they are a particular sex. Children have a right to be treated as an end in themselves, not as the means to someone else's ends.
- There is no strong evidence that 'family balancing' provides a significant benefit for individual children or society as a whole.
- Culturally based arguments (eg, preference for a boy) are not relevant in a country such as New Zealand which does not allow discrimination on the basis of sex.
- The current New Zealand requirements are based on giving parents a choice where a family is faced with the potential suffering associated with some disorders.

Public policy

- New Zealand requirements are consistent with those in other jurisdictions with a similar ethical approach, eg, Australia, United Kingdom.

2.4.2 *Arguments for allowing import of embryos subject to sex selection*

Autonomy

- People should be able to make reproductive choices in line with personal and cultural preferences.
- The ethical distinction between medical uses of preimplantation genetic diagnosis (PGD) for sex selection and non-medical uses is not as clear as might appear. Where a family has a history of a sex-linked serious condition, the choice to use PGD is based on personal preferences and values.

Question 4: Should it be possible to use imported embryos subject to sex selection for reasons prohibited in New Zealand?

- In all circumstances?
- In no circumstances?
- In some circumstances? If so, what circumstances might be acceptable, and what circumstances would not be acceptable?

Please give reasons for your views.

2.5 Scope of informed consent

35. The HART Act requires (s.4(d)) that no assisted reproductive procedure should be performed on an individual and no human reproductive research should be conducted on an individual unless the individual has made an informed choice and given informed consent. The Code of Health and Disability Services Consumers' Rights also places importance on informed consent in the context of treatment and research. Informed consent includes the right not to agree, and to withdraw or vary consent.
36. ACART has a separate project concerned with advice to the Minister of Health on informed consent requirements. For this current discussion, we are particularly interested in whether there should be consent to export to or from New Zealand. In other words, should export occur only where a gamete provider has given explicit consent to export?
37. The issue particularly arises where gametes or embryos have been donated or embryos have been created with donated eggs and/or sperm, with a view to treatment. However, the issue is also relevant where gametes or embryos have been donated for research purposes, and where a couple has jointly created embryos.
38. While other jurisdictions also have informed consent requirements for human assisted reproduction and human reproductive research, there is variation in standards and processes for informed consent. This variety has implications for import and export.
 - Gamete providers may not be able to withdraw or vary consent after export if gametes and embryos are exported to a country with different rules or practices concerning when a donor can withdraw consent.
 - Parties involved in import and export may have different or mistaken assumptions about when they or others may withdraw or vary their consent.
 - Conditions attached to consent given in New Zealand may not be upheld after export.
 - Individuals who decide to withdraw consent to the use of their gametes or of embryos formed from their gametes may face difficulties in notifying the appropriate party or body that they have withdrawn consent.

Example – import for research

Tom undertakes research in New Zealand on an aspect of male infertility. He submitted his research to a leading international research journal, but the journal has asked that his investigation include more patient samples. Tom's colleagues in other countries undertaking similar research have many more patient samples. Tom wants to import some of these overseas samples for use in his project in New Zealand.

The consents signed by the sperm donors do not refer to consent to their sperm being used in a research project in another country.

Example – import for treatment

Brenda has identified a sperm bank in the United States which is willing to send sperm to her New Zealand clinic.

The consent signed by the sperm donor does not refer to consent to his sperm being used by a patient in another country.

Example – export for research

Rafal is a researcher in Poland. He is undertaking a large international project on Polycystic Ovarian Syndrome (PCOS). He has approached a New Zealand clinic to gain access to surplus frozen eggs from women with PCOS, because his project includes looking at the effect of different ovarian stimulation protocols. Rafal has asked the New Zealand clinic to export the eggs to Poland so they can be used in his research.

The clinic does not have consent to send the eggs outside New Zealand.

Example – export for treatment

Sarah is a New Zealander living overseas and wishes to have a child. Sarah had a child some years before after treatment in New Zealand using Bruce's donated sperm. The New Zealand clinic has been asked to send Bruce's remaining sperm to an overseas clinic for use by Sarah.

Bruce cannot be contacted. His original consent did not take into account the possibility of his donated sperm being used in another country.

2.5.1 Arguments in support of requiring explicit consent to gametes and embryos being exported to or from New Zealand

Informed consent

- The Fertility Services Standard requires consumers to give informed consent before shipment of gametes or embryos. This implies that such consent should be obtained regardless of whether the shipment is within or out of New Zealand. The Standard definition of 'consumers' includes gamete donors.¹⁴
- In most cases, donors will not have considered the possibility that their donated gametes, or embryos created from their donated gametes, might be sent to another country for use in treatment or research.

¹⁴ Fertility Services Standard p.17.

- Informed consent involves gamete providers making an informed choice that takes into account the implications of gametes being used in another country, including the legal and social implications for themselves and any resulting children.

Public policy

- Parliament appears to have taken the view that specific consent is important, by providing for the making of import/export regulations that include, without limitation, requirements for the giving of informed consent by persons from whom gametes are obtained overseas (s.76(1)(iii)).

Needs, interests and values of Māori

- Individuals must have the opportunity to consider the impact on whakapapa and consult with whānau before gametes and embryos are exported and used overseas.

2.5.2 Arguments for not requiring explicit consent to export to or from New Zealand

Health and wellbeing of women

- Once a donor has made a donation, he or she no longer has a role in decision making about gametes or embryos created from his/her gametes. The interests of women using donated gametes and embryos should outweigh the interests of donors.

Public policy

- There is a risk that requirements and documentation for taking and recording consents become overly complex, trying to cover every possible situation. Most gametes and embryos will not be sent to and used in other countries.

Question 5: Should explicit consent to export gametes and embryos to and from New Zealand:

- Be required in all circumstances?
- Not be required?
- Be required in some circumstances? What are those circumstances?

Please give reasons for your views.

2.6 Use of gametes and embryos overseas in procedures or research prohibited or precluded in New Zealand

39. A procedure or research involving gametes or embryos may not be possible in New Zealand, either generally or in particular cases. Reasons include:
- a procedure is specifically prohibited in the HART Act, eg, commercial surrogacy; use of a cloned embryo; use of a genetically modified human gamete or human embryo; storage for more than 10 years without ethical approval
 - a procedure or type of research is precluded because it would require ethical approval, but no guidelines have been issued, eg, use of cryopreserved ovarian tissue; human reproductive research using viable surplus embryos.¹⁵
40. Where guidelines have been issued, individuals may nevertheless be unable to use a procedure.
- A clinic may advise a consumer that ECART approval in a particular case appears unlikely because the circumstances are outside the guidelines, eg, a couple wishes to donate an embryo created from donated sperm, but the embryo donation guidelines require that donated embryos are created from a couple's own gametes.
 - ECART may decide not to approve an application.

Example – export for research

Janet and Jack have a daughter with cystic fibrosis. For their next pregnancy, they had IVF in New Zealand which generated 10 embryos. PGD was used to screen the embryos to ensure that only an unaffected embryo was used. Janet and Jack have now been approached by an American researcher who would like to make embryonic stem cells from their surplus affected embryos, in a hope that the cells might be used to test some experimental treatments for cystic fibrosis.

The surplus embryos, while affected, appear to be viable. They could not be used for human reproductive research in New Zealand because the human reproductive research guidelines do not cover research using surplus viable embryos.

¹⁵ Ovarian tissue can be stored in New Zealand without requiring ethical approval. ECART is able to consider and decide applications to carry out human reproductive research on gametes or non-viable embryos.

Example – export for treatment

Mary had treatment for cancer three years ago and wanted to preserve the future option of having a child. Before her treatment began there was time only to obtain some of her ovarian tissue and store it. She is now ready to try to have a child.

Mary cannot use the cryopreserved ovarian tissue in New Zealand, because no guidelines have been issued by ACART. The use of cryopreserved ovarian tissue is still generally seen as experimental, and there is a lack of evidence about the safety of the procedure. Mary would like to export the cryopreserved tissue to an Australian clinic to use it there.

Example – export for treatment

Alice and Mark have embryos, created from their own gametes, stored in New Zealand. They need to use a surrogate. They have found a willing surrogate who lives overseas.

The surrogate was found through a United States broker. Alice and Mark will need to pay the surrogate. Commercial surrogacy is prohibited in New Zealand.

Example – export for treatment

David and Margaret have stored surplus embryos created from Margaret's eggs and sperm donated by a friend. They want to donate the embryos to another couple. The donor says he is happy for the surplus embryos to be donated. David and Margaret have friends in another country who would like to use the embryos.

ACART's embryo donation guidelines require the donated embryos to be created from the donors' own gametes.

2.6.1 Arguments for not allowing export for uses prohibited or precluded in New Zealand

Justice and equality

- The ethical concerns underlying domestic public policy must apply to gametes and embryos sourced in New Zealand, regardless of whether the gametes and embryos are used here or in another country.
- People should not be able to use export to circumvent requirements in New Zealand.

Health and wellbeing of children

- Children may be born from the use of exported gametes and embryos, and the history of the children includes New Zealand. New Zealand has a duty of care to children born from gametes and embryos exported from this country, and therefore should ensure as far as possible that the gametes and embryos are used only in ways that are acceptable here.
- New Zealand has no control over how gametes and embryos are used once they leave New Zealand. The risks of gametes and embryos being used in ways that are not acceptable here can be managed to some extent by allowing export only where the intended use would be allowed in New Zealand.

Needs, interests and values of Māori

- The use of gametes and embryos in New Zealand is subject to taking into account, at a policy and individual level, the needs, interests and values of Māori. If gametes and embryos are used overseas, whether for treatment or research, the process will not include considering Māori needs and values.

2.6.2 Arguments for allowing export for uses prohibited or precluded in New Zealand

Health and wellbeing of women and children

- New Zealanders benefit from the findings of overseas research that is precluded here, eg, research on viable surplus embryos. Individuals should not be prevented from exporting surplus embryos for research that may eventually help New Zealanders.

Autonomy

- People should be able to choose what they do with their own gametes or an embryo created from a couple's own gametes. This would be consistent with the reproductive liberty of people who have not stored gametes or embryos.

Justice and equality

- It is unfair to further restrict the choices of people who have limited options for trying to have a child.

Public policy

- Policy in this area should be consistent with other policy. New Zealanders are able to choose to travel to other countries for medical treatment that may be unaffordable or not available here. This includes fertility procedures that do not involve export.
- People are able to come to New Zealand to use procedures that may not be available in their own countries for a variety of reasons.

- Prohibitions are more significant than procedures which are precluded, because prohibitions are decided by Parliament and included in the HART Act. In comparison, ACART is responsible for issuing guidelines and the provisions in guidelines are decided by ACART in accord with requirements in the HART Act. The differences should be recognised in any policy about export.

Professional autonomy

- Clinicians should be able to refer patients to treatment opportunities that may be available in other countries, eg, export cryopreserved tissue to be replaced in another jurisdiction.

Question 6: Should people be able to export gametes and embryos for uses prohibited or precluded in New Zealand?

- In all circumstances?
- In no circumstances?
- In some circumstances? If so, what circumstances might be acceptable, and what circumstances would not be acceptable?

Please give reasons for your views.

2.7 Other areas where there may be a mismatch

41. While we have focused above on some key issues where there may be a mismatch between New Zealand requirements and those in other jurisdictions, there are other areas where a significant mismatch may occur, for example:

- protection of patient confidentiality
- whether records will be safeguarded (including if a clinic or sperm bank is no longer in business and there is no centralised statutory register of identifying information)
- whether a donor or surrogate will receive counselling and / or legal advice
- complaints processes
- parentage laws
- process for ethical review of research proposals.

Question 7: Are there other areas of potential mismatch that should be considered?

2.8 Ranking the issues discussed above

42. Up to this point, we have discussed each issue separately and asked for feedback about the extent to which imported and exported gametes and embryos should be compliant with various New Zealand requirements.
43. However, we recognise there are relationships between the issues. We are interested in your views about how important each issue is compared to the other issues discussed. For instance, you might consider that the issue of compliance with New Zealand family size requirements is less important than ensuring that there is explicit informed consent for gametes and embryos to be sent to another country.
44. How would you rank each issue in regard to requiring that import and export of gametes and embryos be undertaken only where requirements in the other country are consistent with New Zealand requirements?

Question 8: For import and export, please put in order the importance you give to each of the following issues being consistent with New Zealand requirements, with 1 being the most important.

Altruistic donation

New Zealand's level of donor expenses

Donor offsprings' right to access identifying information about donors

New Zealand's family size limitations

Require explicit informed consent to export to another country

Use of gametes and embryos overseas in procedures or research prohibited or precluded in New Zealand

Another issue or issues (please describe)



3 Import and export requirements in some comparable jurisdictions

3.1 United Kingdom

45. The United Kingdom provides for clinics to decide if the import and export of gametes and embryos is consistent with directions issued by Human Fertilisation and Embryology Authority (HFEA). The directions include:
- clinics must be licensed to import and export
 - transfer must be clinic to clinic
 - gamete providers, including where an embryo has been formed, must give informed consent
 - informed consent must include a written notice that the law in the other jurisdiction about the use of the material and the parentage of a resulting child may be different to that of the sending country
 - clinics must report import and export within a set period to the HFEA, using standard documents
 - gametes and embryos cannot be exported if they could not be lawfully used in the United Kingdom in the same way as proposed in the receiving country.
46. While the directions apply to import and export for research as well as treatment, import and export for research purposes requires an application to the HFEA for Special Permission.
47. The formal General directions covering import and export are available at: http://www.hfea.gov.uk/docs/2009-09-09_General_directions_0006_-_Import_and_export_of_gametes_and_embryos_-_version_2.pdf¹⁶

¹⁶ Import and export of gametes and embryos: General Directions Ref. 0006, Version 3, 6 April 2010.

3.2 Australia

3.2.1 Victoria

48. The Assisted Reproductive Treatment Act 2008 requires that the Victorian Assisted Reproductive Treatment Authority (VARTA) decide applications for import and export, for treatment purposes, of donated gametes and embryos created from donated gametes. VARTA's guidelines are available at: <http://www.varta.org.au/import-export-of-gametes-embryos/w1/i1003328/>¹⁷
49. The requirements apply whether the import and export is between Victoria and another Australian state or between Victoria and overseas, and include:
 - generally, approval will be given to export only where the intended use is consistent with a purpose which is lawful in Victoria. The recipients of the donated material must be counselled by a fertility counsellor
 - conditions for import are that the same conditions apply as for donated gametes and embryos created in Victoria. Donors must be counselled by a fertility counsellor and information about the donor must be lodged with the clinic which will store the imported material
 - donors must consent to import and export.

3.2.2 New South Wales

50. The Assisted Reproductive Technology Act 2007 (s.22) says that a fertility services provider must not export, or cause to be exported, a gamete or embryos from New South Wales except with the consent of the gamete provider and in a manner that is consistent with the consent of the gamete provider.

3.2.3 Western Australia

51. The Reproductive Technology Council issued advice in 2009 on the import of donated reproductive material. Compliance with requirements is left to clinics. The advice particularly notes that consents associated with imported material must comply with requirements in the Human Reproductive Technology Act 1991 and Directions issued under the Act. The advice also says that there should be no more than five known donor families, including within and outside Western Australia, from the use of imported donated human reproductive material, and notes that this limit may be less than in some jurisdictions from which donated material is imported.
52. Further information is available at: http://www rtc.org.au/faqs/docs/Import_Donor_Notice.pdf

¹⁷ Guidelines on the Import and Export of Donor Gametes and Embryos Produced from Donor Gametes. December 2009.

3.2.4 *South Australia*

53. The Assisted Reproductive Treatment Act 1988 and the Assisted Reproductive Treatment Regulations 2010 do not include any references to import or export.

3.2.5 *Canada*

54. The Assisted Human Reproduction Act 2004 does not include any specific requirements for import and export. The Processing and Distribution of Semen for Assisted Reproduction Regulations 1996 (regulations under the Food and Drugs Act) include requirements for the import of semen. The requirements focus on health and safety issues. Establishments (eg, clinics) that import, or intend to import, semen for distribution are required to notify Health Canada in writing at least 10 days before the date on which they begin importing semen. Information can be found at: http://www.hc-sc.gc.ca/dhp-mps/compli-conform/info-prod/don/gui_41-eng.php



Glossary

Clinic in this document means a fertility services provider (regulated under rules in own country and in New Zealand, audited under the Fertility Services Standard). For import, clinic could include sperm banks in other countries.

Cryopreserved tissue means frozen ovarian or testicular tissue.

Donor means a person from whose cells a donated embryo is formed or from whose body a donated cell is derived.

Fertility Services Standard is a document issued by Standards New Zealand which sets out the requirements for the safety and quality of fertility services in New Zealand. Clinics are audited and certified against the Standard.

Gamete is defined in the HART Act 2004 as:

- (a) an egg or a sperm, whether mature or not; or
- (b) any other cell (whether naturally occurring or artificially formed or modified) that –
 - (i) contains only 1 copy of all or most chromosomes; and
 - (ii) is capable of being used for reproductive purposes.

ACART considers that “human gametes” includes ovarian tissue and testicular tissue, as the purpose of obtaining, storing and using the tissue is to use the eggs or sperm the tissue contains.

Gamete provider means a person from whose body a gamete is derived. The gamete may be for the person’s own use, or may be donated for the use of another person.

Intending parent means a person who hopes to become a parent following fertility treatment.

In vitro means outside a living organism.

Researcher means a person who conducts human reproductive research that is subject to the requirements of the Human Assisted Reproductive Technology Act 2004.



Appendix 1: Members of ACART

The members of ACART are:

Dr John Angus (Chair)

Associate Professor Andrew Shelling (Deputy Chair)

Alison Douglass

Dr Karen Buckingham

Cilla Henry

Nikki Horne

Associate Professor Mike Legge

Judy Turner

Further information about the members and ACART can be found on ACART's website www.acart.health.govt.nz



Feedback form

Please provide your contact details below.

Name:	
If this feedback is on behalf of an organisation, please name the organisation:	
Please provide a brief description of the organisation if applicable:	
Address/email:	
Interest in this topic (eg, user of fertility services, health professional, researcher, member of the public):	

We will place all feedback on ACART’s website, except where we are asked that feedback be withheld in full or part for reasons of confidentiality. We will remove contact information from all feedback.

I **request** that my feedback be withheld in full or part from publication on ACART’s website (if you wish a part to be withheld, please clearly indicate which part).

Please note that all feedback may be requested by any member of the public under the Official Information Act 1982 (the Act). If there is any part of your feedback that you consider should be properly withheld under the Act, please make this clear in your feedback, noting the reasons.

If information from your feedback is requested under the Act, the Ministry of Health (the Ministry) will release your feedback to the person who requested it. The Ministry will remove your name and/or contact details from the feedback if you check one or both of the following boxes. Where feedback is on behalf of an organisation, the Ministry will not remove the name of the organisation.

I **do not** give permission for my name to be released to persons under the Official Information Act 1982.

I **do not** give permission for my contact details to be released to persons under the Official Information Act 1982.

We will acknowledge all feedback.

Questions about the issues discussed in the paper

Question 1: Altruistic donation v. commercial supply

Should it be possible to use commercially sourced gametes and embryos from other countries in New Zealand?

- In all circumstances? Yes No
- In no circumstances? Yes No
- In some circumstances? Yes No

If so, what circumstances might be acceptable, and what circumstances would not be acceptable?

Would a higher level of donor expenses increase the supply of locally sourced gametes?

Yes No

Please give reasons for your views.

Question 2: Right of access to identifying information about donors v. no right of access to identifying information about donors

Should it be possible to use gametes and embryos in New Zealand where donor offspring do not have access as of right to identifying information about donors?

- In all circumstances? Yes No
- In no circumstances? Yes No
- In some circumstances? Yes No

If so, what circumstances might be acceptable, and what circumstances would not be acceptable?

Please give reasons for your views.

Question 3: Family size limitations

Should it be possible to use donated gametes or embryos in import/export where the use may exceed New Zealand limits on the number of families assisted?

- In all circumstances? Yes No
- In no circumstances? Yes No
- In some circumstances? Yes No

If so, what circumstances might be acceptable, and what circumstances would not be acceptable?

Please give reasons for your views.

Question 4: Prohibitions on the use of sex selection

Should it be possible to use imported embryos subject to sex selection for reasons prohibited in New Zealand?

- In all circumstances? Yes No
- In no circumstances? Yes No
- In some circumstances? Yes No

If so, what circumstances might be acceptable, and what circumstances would not be acceptable?

Please give reasons for your views.

Question 5: Scope of informed consent

Should explicit consent to export gametes and embryos to and from New Zealand:

- Be required in all circumstances? Yes No
- Not be required? Yes No
- Be required in some circumstances? Yes No

What are those circumstances?

Please give reasons for your views.

Question 6: Use of gametes and embryos overseas in procedures or research prohibited or precluded in New Zealand

Should people be able to export gametes and embryos for uses prohibited or precluded in New Zealand?

- In all circumstances? Yes No
- In no circumstances? Yes No
- In some circumstances? Yes No

If so, what circumstances might be acceptable, and what circumstances would not be acceptable?

Please give reasons for your views.

Question 7: Other areas where there may be a mismatch between New Zealand and overseas requirements

Are there other areas of potential mismatch that should be considered? Please describe.

Question 8: Ranking issues in importance

Please put in order the importance you give to each of the following issues in regard to import and export of gametes and embryos with 1 being the most important.

- Altruistic donation
- Right of donor offspring to access identifying information about donors
- New Zealand requirements for family size limitations
- Explicit informed consent to export to another country
- New Zealand prohibitions on the use of sex selection [box]
- Use of gametes and embryos overseas in procedures or research prohibited or precluded in New Zealand
- Another issue or issues (please describe)

Question 9

Do you have any other comments or suggestions about the issues discussed in this background paper?