**A BACKGROUND TO ASSISTED REPRODUCTIVE TECHNOLOGY IN NEW ZEALAND – ASSOCIATED PAPER 3**

**BRIEF HISTORY OF ASSISTED REPRODUCTION IN NEW ZEALAND**

1. Donor insemination has been practised for many years in New Zealand. The introduction in the early 1970s of freezing semen enabled sperm to be stored for future use eg, for donation or for fertility preservation purposes. The first *in vitro* fertilisation (IVF) clinic was established at National Women’s Hospital in 1983. The first New Zealand IVF baby was born the following year, six years after the first child was born from IVF, in the United Kingdom.
2. Other New Zealand milestones include:
* 1986 – first embryos frozen
* 1991 - first use of donated eggs in New Zealand
* 1993 – first births from use of donated eggs.
1. New Zealand did not have specific ART legislation until 2004. The former National Ethics Committee on Assisted Human Reproduction (NECAHR), established in 1993, formulated guidelines for the use of some procedures that posed particular ethical challenges (for example, surrogacy and embryo donation), and for human reproductive research. NECAHR also decided case by case applications for those procedures.

**THE HUMAN ASSISTED REPRODUCTIVE TECHNOLOGY ACT 2004**

1. The Human Assisted Reproductive Technology Act 2004 (HART Act) in many ways picked up and codified established practices by New Zealand fertility services providers.
* Providers had incorporated counselling into their services, on the basis that counselling provided an opportunity for donors and intending parents to consider the implications of procedures.
* From the late 1980s providers began a policy of openness by requiring all sperm donors to be identifiable. Providers were also counselling intending parents who were using donated gametes about the importance of children knowing about their origins. This approach reflected changes in adoption legislation and what had been learnt from the era of closed adoption: that it is important for people to have the option of accessing identifying information about their genetic origins. The practice was also consistent with Māori values in respect of whānau/families eg, whakapapa and whanaungatanga.
* New Zealand had an established culture of altruistic donation of human tissue, including sperm donation.
1. The HART Act originated as a Member’s Bill that subsequently became a Government Bill. The original Bill was largely modelled on the United Kingdom legislation, although the HART Act has a distinct framework that is particular to New Zealand.
2. The HART Act incorporates similar values to ART legislation in the United Kingdom and Australian states, including:
* prohibition on commercial trade in gametes and embryos
* prohibition on commercial surrogacy
* access for donor offspring to identifying information about donors.
1. A key difference between the HART Act and legislation in Australia and the United Kingdom is that the HART Act established a framework that does not require the primary legislation to be amended to change the rules about the use of some procedures. The HART Act gave ACART the statutory role of issuing guidelines on particular procedures that are ethically complex and require case by case approval by the Ethics Committee on Assisted Reproductive Technology (ECART).
2. Another associated paper in this Briefing (Associated paper 4) provides details of the ART regulatory framework.

**FERTILITY SERVICES IN NEW ZEALAND**

**Providers**

1. The dominant fertility services provider is a private provider, Fertility Associates, which has clinics in Auckland, Hamilton, Wellington and Christchurch plus outreach to other regions. Fertility Associates has a relationship with a fertility clinic in San Diego for the purposes of supporting patients who choose to access fertility treatment overseas. Fertility Associates has recently established a clinic in Malaysia.
2. Other private providers are Repromed (Auckland) and a new entrant Genea which is an international company. Genea has affiliated with the Oxford Women’s Health Clinic in Christchurch. There are two District Health Board providers: Fertility Plus (Auckland) and Otago Fertility Services (Dunedin).

**Funding**

1. ACART does not have any policy or operational role in respect of funding for fertility treatment. District Health Boards contract with providers for publicly funded fertility services. Providers have both publicly and privately funded patients. Providers use criteria established by the Ministry of Health to determine patients’ priority for publicly funded services.

**Stakeholders**

1. Fertility New Zealand is the national consumer group, comprising people who have had or are undergoing fertility treatment. Fertility New Zealand’s activities include local support groups, a national Fertility Week, and advocacy on behalf of members. Fertility New Zealand regularly makes submissions to ACART about proposals.
2. There are also some web based groups and forums eg, linking potential egg donors and surrogates with intending parents, and sharing information about overseas fertility treatment. Some of these forums are only accessible by members.
3. A range of individuals and organisations regularly respond to ACART public consultations through written submissions and/or meetings. These include ECART, the Human Rights Commission, the Health and Disability Commission, the New Zealand Law Society, the Nathaniel Centre, the Interchurch Bioethics Council, Right to Life, medical professionals, Māori with an interest in family/whānau wellbeing, and academics in various disciplines eg, bioethics, human reproductive research, sociology, and law.
4. The mix of stakeholders varies according to the issue being considered. For instance, members of the gay/lesbian/transgender/intersex community provided feedback to a past consultation on proposed changes to surrogacy guidelines.
5. Donor offspring – that is, those born as a result of assisted reproduction using donated gametes or embryos - are stakeholders who are not currently visible in public input to policy development. It is possible that their views about ART policy will enter public debate when a significant cohort of donor offspring reaches adulthood over the next two decades.

**USE OF ASSISTED REPRODUCTION BY NEW ZEALANDERS**

**Use of fertility treatment in New Zealand**

1. Since 2004 fertility services providers have contributed comprehensive annual data to the Australia New Zealand Assisted Reproduction Database (ANZARD), maintained at the University of New South Wales.[[1]](#footnote-1) The ANZARD data is used to produce an internationally well regarded annual report *Assisted reproductive technology in Australia and New Zealand.*  At the time of writing the most recent report is for 2011.
2. For most data items, the ANZARD reports analyse combined Australian and New Zealand data. In the past three years, ACART has been contracting for and publishing a New Zealand-specific report *Assisted reproductive technology in New Zealand* that includes selected items from the fuller Australasian reports. The most recent report is for 2011, published on ACART’s website. An analysis of New Zealand-specific trends will be possible in future years.
3. ACART’s Annual Reports must include a report of the number and types of decisions made by ECART. ECART also produces an Annual Report which gives details of the type of applications, decisions made and outcomes.
4. Fertility services providers that have contracts with District Health Boards must report on the services provided as part of the contract.
5. Key findings from the report *Assisted Reproductive Technology in New Zealand 2011* are:
* There were 5,189 ART cycles performed in New Zealand in 2011.
* 2.1% of live-born babies in New Zealand were born as a result of ART.
* 5.8% of births resulting from ART were multiple births. The number of multiple births continues to decline due to an increase in the use of single embryo transfer.
* 21.6% of women receiving treatment were 40 years or older.
* 27.8% of women receiving treatment had previously given birth.
* 23.6% of treatment cycles resulted in a live delivery.
* Surrogacy cycles represented 0.9% of all ART cycles.
* 0.9% of cycles used preimplantation genetic diagnosis (a procedure used to test for serious genetic disorders and chromosomal abnormalities).
1. In the period 1 July 2013 – 30 June 2014 ECART considered 28 applications for assisted reproductive procedures.[[2]](#footnote-2) The cases that must be approved by ECART are a small proportion of all assisted reproductive procedures. Most procedures – eg, IVF using a couple’s own gametes – do not require ECART approval.

**Data about human reproductive research in New Zealand**

1. All human reproductive research must be approved by ECART. The Annual Reports of ACART and ECART both include information about applications to undertake human reproductive research and ECART’s decisions. In the period 1 July 2013 – 30 June 2014 ECART received two applications to undertake human reproductive research.
2. Associated paper 6 in this Briefing discusses human reproductive research more fully.

**Use of assisted reproduction in New Zealand outside a fertility services provider**

1. There is no data available about the use and outcomes of donor insemination and surrogacy in informal arrangements outside fertility services providers. Any comment about its scale is therefore speculative. However, it is clear that insemination outside the formal system is practised by, for example, single women and lesbian couples. Informal arrangements are also made for “traditional surrogacy”; that is, surrogacy in which the egg of the surrogate is used.

**Use of assisted reproductive technology overseas by New Zealanders**

1. There is a global market for fertility treatment, with some countries becoming destinations because procedures are more readily available than in patients’ home country, or at lower cost. New Zealanders are taking advantage of opportunities in other countries, with easy access to information about procedures available elsewhere and the associated costs and requirements. Jurisdictions differ significantly in the extent to which ART is regulated, what is allowed and prohibited, and clinical practice.
2. A key driver for New Zealanders to go overseas is the shortage of donated eggs in this country. New Zealand prohibits commercial trade in gametes and embryos, whereas donated gametes are readily available in countries which do not prohibit valuable consideration for gametes, or which allow donors to receive substantial expenses. For instance, California and South Africa are popular destinations to obtain and use donated eggs.
3. The use of donated eggs obtained overseas appears to be a substantial proportion of all cases where New Zealanders use donated eggs. While no data are collected about numbers of New Zealanders going overseas to source donated gametes, anecdotal information suggests that around a third of all donated eggs used by New Zealanders may be obtained overseas. Fertility Associates estimates that it knows of up to 100 couples a year going overseas to access donated eggs. In comparison, in New Zealand in 2011 there were 203 cycles using locally sourced donated eggs.
4. ACART’s statutory role includes giving advice to the Minister of Health on requirements for the import and export of *in vitro* gametes and embryos for human reproductive research and human assisted reproduction. We will provide you with this advice before the end of the year. Our report will include a fuller discussion of the use of overseas fertility treatment by New Zealanders and the impacts.
1. ANZARD supersedes an earlier Australasian database which was established in 1979. [↑](#footnote-ref-1)
2. Numbers of ECART applications are provisional, and will be confirmed in ACART and ECART’s Annual Reports. [↑](#footnote-ref-2)