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Universiteit Leiden



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Title: Morally sensitive issues and cross-border movement in the EU. The cases of reproductive matters and legal recognition of same-sex relationships

Issue Date: 2015-11-04

6.1. CONSTITUTIONAL FRAMEWORK

At the outset it must be noted that the Dutch Constitution is not a very ‘strong’ Constitution¹ and as a result its prominence in respect of Dutch standard-setting in reproductive matters has been fairly modest. Hereafter first two Articles of the Constitution that are of relevance for reproductive matters are discussed, after which the rights of the (future) child; the status of the unborn under Dutch law and the right to know one’s genetic parents are discussed.

6.1.1. The right to respect for private life (Article 10) and the right to inviolability of the person (Article 11)

Two Articles in the Dutch Constitution are particularly relevant for reproductive matters. Article 10(1) of the Dutch Constitution provides that everyone has a right to respect for his private life (*‘eerbiediging van zijn persoonlijke levenssfeer’*), without prejudice to restrictions laid down by or pursuant to Act of Parliament. The Constitutional legislature explained that this right aimed to guarantee personal freedom, without interference by others.² The subsequent Article 11 (the right to inviolability of the person) is generally perceived as the *lex specialis* of Article 10.³ Article 11 reads:

‘Everyone shall have the right to inviolability of his person, without prejudice to restrictions laid down by or pursuant to Act of Parliament.’⁴

This right has been primarily perceived as a negative right. It grants two sub-rights: everyone has a right to be protected from interferences with his physical integrity and everyone has the right to freely decide upon his own body (the right to

¹ See also ch. 1, section 1.4.

² *Kamerstukken II 1975/76*, no. 13872, nos. 1–5, p. 41.

³ J. Gerards et al., ‘Zelfbeschikking in de Nederlandse Grondwet’ [‘Personal autonomy in the Dutch Constitution’], in: *Achtergrondstudies Zelfbeschikking in de zorg* [Backgroundstudies on Personal autonomy in health care], Reeks evaluatie regelgeving: deel 35 (Den Haag, ZonMw 2013) p. 88, referring (in footnote 260) to B.C. van Beers, *Persoon en lichaam in het recht. Menselijke waardigheid en zelfbeschikking in het tijdperk van biotechnologie* [Person and body under the law. Human dignity and personal autonomy in the era of biotechnology] (Den Haag, Boom 2009) p. 126.

⁴ Translations of the Constitution by the Dutch Ministry of Foreign Affairs, online available at www.rijksoverheid.nl/documenten-en-publicaties/brochures/2008/10/20/the-constitution-of-the-kingdom-of-the-netherlands-2008.html, visited June 2014.

self-determination).⁵ From this a requirement of informed consent follows, which has been very important in Dutch medical/ethical standard-setting.⁶

The Constitutional legislature expressly left it to the legislature and the courts to give (more) concrete interpretation to these rights.⁷ These rights consequently do not play a very prominent role in Dutch debate and law on reproductive matters. This is reinforced by the fact that self-executing International Law standards have direct effect in the Dutch legal order,⁸ while Courts cannot review the constitutionality of acts of parliaments.⁹ In practice, Dutch courts tend to examine the compatibility of statutory law with International Treaty law, with the general effect that the ECHR has come to serve as a kind of shadow constitution.¹⁰ Consequently, when in Dutch case law and academic literature the question is discussed whether a right to procreate exists, reference is generally made to Articles 8 and 12 ECHR and the nuanced jurisprudence of the ECtHR on this issue, as set out in Chapter 2.¹¹

6.1.2. The rights of the (future) child

The Dutch Constitution does not contain a specific provision – comparable to Article 3 of the Convention on the Rights of the Child (CRC) – that establishes the principle of best interests of the child as a primary consideration in all actions and decisions affecting children.¹² However, as goes for many fundamental rights issues, the relevant international standards have played and continue to play a prominent role in the Dutch legal order. In 1997 a Dutch District Court ruled for the first time that Article 3 CRC has direct effect in the Dutch legal order and can thus be invoked in proceedings before the Dutch courts.¹³ This means that Dutch authorities have to put the best interests of the child first in any law-making, policy decisions and judicial decisions. Children's rights have received increasingly more attention in Dutch politics and academia over the past decades, partly thanks to the lobby and

⁵ *Kamerstukken II* 1978/79, 15 463, nos. 1–2, p. 5.

⁶ Gerards et al. 2013, *supra* n. 3, at p. 86, referring to *Kamerstukken II* 1979/80, 16086, no. 3, p. 7.

⁷ *Idem*, at p. 93.

⁸ Art. 93 of the Dutch Constitution.

⁹ Art. 94 of the Dutch Constitution reads: 'Statutory regulations in force within the Kingdom shall not be applicable if such application is in conflict with provisions of treaties or of resolutions by international institutions that are binding on all persons.'

¹⁰ J.H. Gerards & M. Claes, 'National report – The Netherlands', in: J. Laffranque (ed.), *The Protection of Fundamental Rights Post-Lisbon: The Interaction between the Charter of Fundamental Rights of the European Union, the European Convention on Human Rights and National Constitutions*, Reports of the XXV FIDE Congress Tallinn, Vol. 1 (Tartu, Tartu University Press 2012) pp. 613–677.

¹¹ See, for example, M. Eijkholt, 'Het recht op procreatie: voldragen of in statu nascendi?' ['The right to procreate: carried to term or in *statu nascendi*?'], 31 *Tijdschrift voor Gezondheidsrecht* (2007) p. 2 and A.C. Hendriks, 'Het recht op voortplanting en zijn grenzen. Redactioneel' ['The right to procreate and its limitations. Editorial'], 36 *Tijdschrift voor Gezondheidsrecht* (2012) p. 279.

¹² This matter was also not discussed by the State Commission on the Constitution [*Staatscommissie Grondwet*] in its report of November 2010. *Staatscommissie Grondwet, Rapport Staatscommissie Grondwet*, Annex to *Kamerstukken II* 2010/11, 31570 no. 17.

¹³ Rb. Utrecht 26 March 1997 and 10 December 1997, *NJ* 1999 No. 462, ECLI:NL:RBUTR:1997:AC1768.

work of NGOs specialised in the area, such as *Defence for Children* and *Unicef Nederland*.¹⁴

6.1.3. The status of the unborn under Dutch law

Under Dutch law, the unborn does not individually bear rights; only as of birth is a child a bearer of rights. The Dutch Constitution does not contain any provision which explicitly sees at the unborn. In fact, it does not even contain a specific Article on the right to life.¹⁵ This does not mean, however, that the unborn does not enjoy protection under Dutch law. The protection of human life is an important principle in medical-ethical decision-making.¹⁶ It is considered to be always at stake if unborn life is concerned. From the moment of nidation,¹⁷ the foetus enjoys a special status, the so-called '*status nascendi*'.¹⁸ In medical-legal doctrine, the theory of '*groeïende beschermenswaardigheid*' – the idea that the more the unborn develops, the more worthy of protection it is – finds general support.¹⁹ Article 1:2 Civil Code (*Burgerlijk Wetboek*, BW) provides that '[a] child of which a woman is pregnant, is regarded to have been born already as often as its interests require so.' This entails, *inter alia*, that an unborn child can be placed under guardianship ('*voogdij*')²⁰ or temporary supervision ('*voorlopige ondertoezichtstelling*'),²¹ if the responsible authorities fear for the development and health of the unborn.²²

¹⁴ Since 1995 these NGOs are united in the Kinderrechtencollectief [Children's rights Collective]. See www.kinderrechten.nl, visited 15 September 2014.

¹⁵ This right is protected by Arts. 2 ECHR, 2 CFR and 6 ICCPR, which have direct effect in the Dutch legal order. Further, Art. 114 of the Dutch Constitution provides that '[c]apital punishment may not be imposed.' Five out of ten members of the Dutch State Commission for the Review of the Constitution recommended that the right to life were included in the Dutch Constitution. This recommendation was, however, not followed-up by the legislature. State Commission for the Review of the Constitution 2010, *supra* n. 12, at p. 65.

¹⁶ *Kamerstukken II* 2006/07, 30 800 XVI, no. 183 and *Kamerstukken II* 2007/08, 29323, no. 46.

¹⁷ The status of conception before nidation (by Leenen referred to as '*status potentialis*') is not regulated under Dutch law. See H.J.J. Leenen, 'De gezondheidsrechtelijke status van het embryo' ['The status of the embryo in medical law'], in J.K.M. Gevers and H.J.J. Leenen (eds.), *Rechtsvragen rond voortplanting en erfelijkheid* [Legal questions surrounding human reproduction and heredity] (Deventer, Kluwer 1986) p. 14.

¹⁸ *Idem*, at pp. 13–14.

¹⁹ *Inter alia* H.J.J. Leenen, *Handboek Gezondheidsrecht* [Handbook Medical Law], 2nd edn. (Alphen aan de Rijn, Samson 1988) p. 128; D.M. Fernhout, *Rechtsvragen rond in vitro fertilisatie en embryo-transfer* [Questions of law on *in vitro* fertilisation and embryo transfer] (Arnhem, Gouda Quint 1992) p. 5 and Th.A.M. te Braake, 'De juridische status van het embryo: een stevig aangemeerde leer' ['The legal status of the embryo, a firmly anchored doctrine'], 19 *Tijdschrift voor Gezondheidsrecht* (1995) p. 32. Critical was, however, W. van der Burg, 'De juridische 'status' van het embryo: een op drift geraakte fictie' ['The legal 'status' of the embryo: a drifting fiction'], 18 *Tijdschrift voor Gezondheidsrecht* (1994) p. 129. The theory of the '*groeïende beschermenswaardigheid*' of the unborn is clearly reflected in the Dutch abortion legislation, as set out in section 6.2 below.

²⁰ E.g. Rb. Roermond 26 June 2009, ECLI:NL:RBROE:2009:BJ0644 and Rb. Rotterdam 9 May 2006, ECLI:NL:RBROT:2006:AX2185.

²¹ E.g. Rb. Groningen 27 April 2010, ECLI:NL:RBGRO:2010:BM3904; Rb. Dordrecht, 7 February 2012, ECLI:NL:RBDOR:2012:BV6246 and Rb. 's-Gravenhage 7 October 2008, ECLI:NL:RBSGR:2008:BG0849.

²² A still-born child is deemed to have never existed. Art. 1:2 (second sentence) BW.

Like in all medical-ethical issues the legislature's decision-making in respect of abortion and AHR treatment is furthermore guided by the principles of human dignity, personal autonomy of the patient and good health care (*'goede zorg'*).²³ Particularly in AHR cases, the best interests of the future child are, furthermore, an important guiding principle, as will be set out in section 6.3. Again, these principles are not included in the Dutch Constitution,²⁴ but are considered general medical ethical principles and general principles of law, which are furthermore (partly) codified in International Treaties, such as the ECHR and the United Nations Convention on the Rights of the Child.²⁵

6.1.4. The right to know one's genetic parents

In 1994, in the *Valkenhorst* case,²⁶ the Dutch Supreme Court for the first time defined a right to know one's genetic parents (*'het recht om te weten van welke ouders men afstamt'*). The case concerned a woman who wished to know more about her genetic father, while her mother did not want to reveal his identity. The institution that had provided care to the mother right after she gave birth, did have more information about the father though, but refused to give the woman access to it as it relied on its duty of confidentiality towards its client, the mother. The Supreme Court ruled in this case that the plaintiff had a right to be informed by the institution about her genetic father, on the basis of the right to know one's genetic parents.

The Court derived the right to know one's genetic parents from the general personality right that was underlying the right to respect for private life; the right to freedom of thought, conscience and religion and the freedom of speech, which are all included in both the European Convention on Human Rights (ECHR) and the Dutch Constitution.²⁷ The Court thereby referred to both Article 7 of the International Convention for the Rights of the Child²⁸ and to case law of the ECtHR, namely the *Gaskin* case.²⁹

²³ *Kamerstukken II* 2006/07 30 800 XVI, no. 183; *Kamerstukken II* 2007/08, 29323 no. 46 and *Kamerstukken II* 2000/01, 27 423, no. 3, p. 5.

²⁴ The State Commission for the Review of the Constitution [*'Staatscommissie Grondwet'*] recommended in 2010 to include a general clause in the Dutch Constitution, one paragraph of which would read: 'The State respects and guarantees human dignity, fundamental rights and fundamental principles'. Until the day this research was concluded (31 July 2014), this recommendation had however not been followed up by the Dutch constitutional legislature. *Staatscommissie Grondwet*, *supra* n. 12, at p. 40.

²⁵ Following Arts. 93 and 94 of the Constitution provisions of International Treaties which are binding on all persons by virtue of their contents have direct effect and take precedence over conflicting statutory regulations.

²⁶ HR 15 April 1994, *NJ* 1994 No. 608, ECLI:NL:HR:1994:ZC1337 with case-note by W.C.E. Hammerstein-Schoonderwoerd.

²⁷ *Idem*, para. 3.2.

²⁸ Art. 7(1) CRC provides: '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.'

²⁹ ECtHR [GC] 7 July 1989, *Gaskin v. the United Kingdom*, no. 10454/83, as discussed in ch. 2 section 2.1.4.

The Court acknowledged that the right to know one's genetic parents was not absolute and had to be balanced with the rights and freedoms of others. The Court was also quite firm, however, that the right of the child had to prevail over the right of the mother to keep that information disclosed from her child, a right that was covered by the right to respect for private life. The Court stressed the 'vital importance' of this right for the child and held that its precedence was justified by the fact that the mother was partly responsible for the existence of the child. The Court remarked in this context that it was important to note that the case at hand did not concern donor insemination.

Since the year 2004 there is legislation in place that provides for protection of the right to know one's genetic parents in the context of gamete donation. The exact conditions under which this right can be effectuated are extensively discussed in section 6.3.2 below.

6.2. DUTCH ABORTION LEGISLATION

The Dutch abortion legislation takes a primarily procedural approach. Under the Dutch law as currently in force, abortion is in principle lawful until the 24th week of pregnancy. The interests of the unborn child are in practice protected through a set of procedural requirements, which provide the decision-making procedure with the necessary guarantees.³⁰ The Dutch abortion legislation is aimed at ensuring that every decision to terminate a pregnancy is taken carefully and is only carried out if the emergency situation of the woman renders such termination inescapable.³¹ Further, the treatment must be given by a medical practitioner in a hospital or clinic which is licensed to provide such treatment under the Termination of Pregnancy Act (*Wet afbreking zwangerschap*, Waz).³² Abortion in a later stadium of pregnancy is criminalised,³³ but may exceptionally be exempted from punishment (see 6.2.2 below).

³⁰ Commissie evaluatie regelgeving, *Evaluatie Wet afbreking zwangerschap* [Evaluation Termination of Pregnancy Act] (Enschede 2005) pp. 12 en 36, online available at www.ngva.net/downloads/WAZ_evaluatie_Definitieve_webversie_b.pdf, visited June 2014.

³¹ See *inter alia* Art. 5(1) Waz.

³² Act of 1 May 1981, *Stb.* 1981, 257, entry into force per 1 November 1984. Hence, this fifth paragraph functions as a statutory defence (ground for exemption from criminal liability). Paras. 2–4 of this Article provide for aggravating circumstances.

³³ Art. 296(1) Sr provides: 'Any person who provides treatment which he knows, or could reasonably suspect, might terminate a pregnancy is liable to a term of imprisonment not exceeding four years and six months or a fourth category fine.'

6.2.1. Early legislative developments

The Criminal Code of 1881 penalised abortion.³⁴ Both the pregnant woman who carried out an abortion or who gave permission for having an abortion carried out, and the person carrying out an abortion (the abortionist) were liable to punishment. The maximum penalty to be imposed was dependent on whether the woman had given her consent to the termination, whether the abortionist was a medical practitioner and whether the termination resulted in the woman's death.³⁵ In a judgment of 1897 the Supreme Court had ruled that there was only criminal liability if the termination of a pregnancy concerned a foetus which was alive at the moment of termination.³⁶ Because this was practically impossible to prove, there were hardly any criminal convictions on the basis of these provisions.³⁷

Following an amendment of the Criminal Code of 1911, it was no longer necessary to prove that the foetus was still alive at the time of the pregnancy termination.³⁸ This resulted in a certain increase in the number of prosecutions for abortions.³⁹ Nevertheless, a termination of pregnancy was permitted only in case a so-called 'medical indication' ('*medische indicatie*') was present.⁴⁰ According to the Explanatory Memorandum to the 1881 Penal Code, this requirement was met if the life of the woman was endangered by the pregnancy.⁴¹

From the mid-20th century onwards, fundamental societal changes took place, as a result of which abortion became the subject of public debate. During the 1950s and 1960s, opinions on issues like sexuality, marriage, pregnancy, preconception and family building changed.⁴² In the words of the Dutch government:

'Abortion became the subject of public debate in the second half of the 1960s in the context of several far wider issues. The availability of oral contraceptives and sterilisation had

³⁴ Arts. 295 to 298 Sr (*old*), Act of 3 March 1881, entry into force 1 September 1886, *Stb.* 1886, 64. Before 1881 the *Code Pénal* contained provisions concerning abortion. See Commissie evaluatie regelgeving 2005, *supra* n. 30, at p. 23.

³⁵ Commissie evaluatie regelgeving 2005, *supra* n. 30, at pp. 23–24.

³⁶ HR 24 May 1897, W 6978, as referred to in P.F. van der Heijden, 'Juridisch voorspel tot de abortus ontwerpen' ['Legal prelude to the abortion plans'], 13 *Nederlands juristenblad* (1976) p. 425 at p. 426.

³⁷ Heijden, van der 1976, *supra* n. 36, at p. 426 and Commissie evaluatie regelgeving 2005, *supra* n. 30, at p. 24.

³⁸ Art. 251bis Sr (*old*), *Stb.* 1911, 130.

³⁹ Before 1911 there were only a couple of prosecutions per year, whereas after 1911 the number of convictions on the ground of Art. 251 bis Sr (*old*) slowly increased (with some fluctuations), starting with 24 in the year 1912, to 79 in the year 1920. See J. Outshoorn, *De politieke strijd rondom de abortuswetgeving in Nederland 1964–1984* [The political fight surrounding abortion legislation in the Netherlands 1964–1984] ('s-Gravenhage, VUGA 1986), pp. 84 and 330. For more statistics, see section 6.2.4 below.

⁴⁰ See *inter alia* Ch.J. Enschedé, 'Abortus op medische indicatie en strafrecht' ['Abortion on the basis of a medical indication and criminal law'], 41 *Nederlands juristenblad, Njb* (1966) p. 1109 at p. 1114 and Heijden, van der 1976, *supra* n. 36, at p. 427 who refers to the Parliamentary discussions about abortion before the 1911 amendment.

⁴¹ See Commissie evaluatie regelgeving 2005, *supra* n. 30, at p. 27.

⁴² See *Kamerstukken II 1978/79*, 15 475, nos. 1–4, p. 11.

paved the way for family planning, people's attitudes to sex were changing, the influence of the church had declined and abortion had been legalised in Great Britain. At the same time, economic growth in the Netherlands had raised the standard of living, and the population as a whole was more highly educated.⁴³

The possible harmful effects of an unintended pregnancy on the social well-being and personal development of the woman were recognised and the view that – within certain limits – abortion was a right of the woman, received increasing support.⁴⁴ Accordingly, from the beginning of the seventies, voices were raised to amend the existing restrictive abortion legislation.⁴⁵

The call for a change of legislation was also produced by developments in the case law. The Dutch courts brought an increasing number of situations under the notion 'medical indication' and by doing so they gave a wider meaning to this notion than a danger to the woman's life only, as originally foreseen by the legislature. The first step in this direction was taken in 1942 when District Court Amsterdam ruled that a risk of suicide constituted a medical indication justifying an abortion.⁴⁶ Soon after, the physical and mental condition of the woman in a broader sense were accepted as medical indications.⁴⁷ It took until the 1970s, though, before also social factors were accepted as grounds for abortion.⁴⁸

Because of these developments in the case law and the fact that medical profession was divided over the definition of the notion 'medical indication',⁴⁹ the monitoring and enforcement of the Dutch abortion legislation had become practically impossible.⁵⁰ Enforcement of the legislation was furthermore complicated by medical practitioners who refused to provide details on their professional activities to the health inspection

⁴³ Communications Department, Corporate Communications and Public Diplomacy Division of the Dutch Ministry of Foreign Affairs, *Q&A Abortion in The Netherlands* (August 2011), online available at www.minbuza.nl/binaries/content/assets/minbuza/en/import/en/you_and_the_netherlands/about_the_netherlands/ethical_issues/qa-abortus-en-2011.pdf, visited April 2013.

⁴⁴ J. de Buijn, *Geschiedenis van de abortus in Nederland: een analyse van opvattingen en discussies 1600–1979* [History of abortion in the Netherlands; an analysis of views and debates 1600–1979] (Amsterdam, Van Gennep 1979) pp. 185–187, as referred to by Commissie evaluatie regelgeving 2005, *supra* n. 30, at p. 25 (footnote 15).

⁴⁵ Outshoorn 1986, *supra* n. 39, at p. 13.

⁴⁶ Rb. Amsterdam 5 February 1942, *NJ* 1942 No. 244.

⁴⁷ Rb. Amsterdam 20 January 1949, *NJ* 1949 No. 586. See Commissie evaluatie regelgeving 2005, *supra* n. 30, at p. 27. See also the report of the so-called Commission 'Abortion question' ('*Commissie Abortusvraagstuk*') *Kamerstukken II*, 1971, 11321, no. 2, p. 3, which explains that while the notion 'medical indication' was first considered to refer to a somatic indication only, later also psychological factors were accepted as medical indication.

⁴⁸ Rb. Amsterdam 8 July 1976, *NJ* 1977 No. 477, ECLI:NL:RBAMS:1976:AC0431. See the report of the Commission 'Abortion question' 1971, *supra* n. 47, at p. 3. The Court ruled that it was for the medical practitioner to judge 'on good grounds' ('*op goede gronden*') if a medical indication was present. In 1953 the Arrondissementsrechtbank Amsterdam rejected a social indication as justification for an abortion. Rb. Amsterdam 26 March 1953, *NJ* 1953 No. 377. See also Heijden, van der 1976, *supra* n. 36, at p. 427.

⁴⁹ Outshoorn 1986, *supra* n. 39, at p. 292.

⁵⁰ *Kamerstukken II* 1978/79, 15 475, nos. 1–4, p. 9 and Commissie evaluatie regelgeving 2005, *supra* n. 30, p. 27.

by referring to the legal duty of confidentiality.⁵¹ The resulting mismatch between legislation and practice created legal uncertainty. Nevertheless, as a result of the enforcement difficulties, a rather large-scale abortion practice had developed in the Netherlands.⁵² In the year 1970, the national *Stimezo* Foundation (the foundation for medically safe pregnancy terminations, *Stichting medisch verantwoorde zwangerschapsonderbreking*) established its first abortion clinic.⁵³ Many clinics were opened in the following years. The abortions provided by these clinics were, strictly speaking, illegal, but were tolerated by the authorities as long as certain quality standards were met. The Dutch abortion clinics treated a considerable number of women, amongst whom were many from neighbouring countries. For example, it was reported that in the year 1977 approximately 65,000 women were treated in Dutch abortion clinics, of whom about two thirds were women from the German Federal Republic (see also section 6.4.1.1 below).⁵⁴

As a result of all these developments, revision of the abortion legislation was considered inevitable; it was held, even by governing parties, to be the only possible answer to the existing mismatch between legislation and practice and the resulting legal uncertainty and enforcement difficulties.⁵⁵ The first bills to the effect of an amendment of the existing abortion legislation were tabled in the early 1970s.⁵⁶ Serious controversy in Parliament, however, meant that it took another decade before any new abortion legislation was adopted. Abortion was considered ‘extremely controversial’, evoking ‘deep emotions’.⁵⁷ There were confessional parties who held that human life was always to be protected, no matter its stage of development, while other parties felt that abortion was first of all a matter that fell within the woman’s right to self-determination.⁵⁸ Not only was there serious controversy whether the abortion ban had to at all be levied, there was also no consensus on the content of any new abortion regulation. It was, for instance, debated whether legislation had to define the indications for abortion and there was debate about the role of doctors in abortion cases.⁵⁹ Because there were so many different approaches proposed, it was feared that none of the tabled bills would reach the required majority in Parliament,

⁵¹ *Kamerstukken II* 1978/79, 15 475, nos. 1–4, p. 9.

⁵² Outshoorn 1986, *supra* n. 39, at p. 14.

⁵³ See www.mildred-rutgershuis.nl/historie.htm, visited April 2013. On this website it is explained that *Stimezo* was founded by a group of general practitioners who felt that it was not right that women had to go to England for the termination of a pregnancy. The clinic was financed with funds raised during a campaign on national television.

⁵⁴ *Kamerstukken II* 1978/79, 15 475, nos. 1–4, p. 14, referring to ‘E. Ketting and P. Schnabel, De abortus-hulpverlening in 1977’. For more statistics, reference is made to section 6.4.1.1 below.

⁵⁵ *Kamerstukken II* 1978/79, 15 475, nos. 1–4, pp. 9 and 15.

⁵⁶ *Kamerstukken II* 1969/70, 10719, no. 1; *Kamerstukken II* 1971/72, 11890, no. 1; *Kamerstukken II* 1974/75, 11890, no. 6; *Kamerstukken II* 1974/75, 13253, no. 1; *Kamerstukken II* 1974/75, 13302, no. 1 and *Kamerstukken II* 1975/76, 13 909, no. 1, as referred to in *Kamerstukken II* 1978/79, 15 475, nos. 1–4, pp. 11–12. See also the report of the so-called Commission ‘Abortion question’ (*supra* n. 47), which concluded yet in 1971 that the existing legislation had to be amended.

⁵⁷ *Handelingen I* 1976/77, 14 December 1976, p. 136.

⁵⁸ E.g. *Kamerstukken II* 1975/76, 13909, no. 5. For a profound study of the relevant Dutch debate, see Outshoorn 1986, *supra* n. 39. It must be noted, that there was also clear disagreement on the matter within (confessional) political parties. See *Handelingen I* 1976/77, 14 December 1976, p. 135.

⁵⁹ E.g. *Kamerstukken II*, 1975/76, 13909, no. 5, pp. 3 and 11.

as a result of which the existing impasse would not be lifted.⁶⁰ After a ‘compromise bill’ was outvoted by the Senate in the year 1976,⁶¹ a new government tabled a bill in the Parliamentary year 1978–1979. The initiating Ministers of Justice and Health held that abortion practice and abortion legislation had completely drifted apart and that the controversy around abortion formed a ‘continuing burden for the Dutch political and mental climate’.⁶² The Ministers considered that the changed views in society in respect to pregnancy termination rendered an amendment of the law inescapable.⁶³ In 1981 the Pregnancy Termination Act (*Wet afbreking Zwangerschap* (Waz))⁶⁴ was adopted with the smallest possible majority.⁶⁵ Under strong influence of the anti-abortion campaign, there was disagreement about the implementation of the Act, as a result of which it entered into force only more than three years later, in November 1984.⁶⁶ The Act was accompanied by an Implementing Order on Pregnancy Termination (*Besluit Afbreking Zwangerschap*).⁶⁷ The Pregnancy Termination Act was officially evaluated for the first time in the year 2005.⁶⁸ On the basis of that evaluation report, the at the time responsible Ministers saw no reason for amendment of the Act.⁶⁹

6.2.2. The Pregnancy Termination Act (1981)

The 1981 Pregnancy Termination Act amended various existing laws, including the Criminal Code. The legislature attached value to maintaining *abortus provocatus* as separate criminal offence under the Criminal Code, as it gave expression to the protection offered to the unborn human life.⁷⁰ Since the entry into force of the Pregnancy Termination Act, paragraph 1 of Article 296 of the Dutch Criminal Code reads:

‘A person who subjects a woman to treatment, where he knows or should reasonably suspect that by doing so pregnancy may be terminated, is liable to a term of imprisonment of not more than four years and six months or a fine of the fourth category.’⁷¹

⁶⁰ *Kamerstukken II* 1975/76, 13 909, nos. 1–3, pp. 11–12.

⁶¹ *Handelingen I* 1976/77, 14 December 1976, p. 194.

⁶² *Kamerstukken II* 1978/79, 15 475, nos. 1–4, pp. 13 and 15.

⁶³ *Kamerstukken II* 1978/79, 15 475, nos. 1–4, p. 24.

⁶⁴ Act of 1 May 1981, *Stb.* 1981, 257, entry into force per 1 November 1984.

⁶⁵ Parliament (Tweede Kamer) adopted the bill with 76 against 74 votes, the Senate (Eerste Kamer) with 38 to 37 votes. See *Handelingen II* 1980/81, p. 2316 and *Handelingen I* 1980/81, p. 82. See also Commissie evaluatie regelgeving 2005, *supra* n. 30, at p. 28 and Outshoorn 1986, *supra* n. 39, at pp. 13 and 272.

⁶⁶ Outshoorn 1986, *supra* n. 39, at pp. 277–289.

⁶⁷ Order of 17 May 1984, *Stb.* 1984, 356.

⁶⁸ Commissie evaluatie regelgeving 2005, *supra* n. 30.

⁶⁹ *Kamerstukken II* 2005/06, 30 371, no. 2, p. 4.

⁷⁰ *Kamerstukken II* 1978/79, 15 475, nos. 1–4, p. 21.

⁷¹ Translation by L. Rayar and S. Wadsworth, *The Dutch Penal Code* (Colorado, Fred B. Rothman & Co Littleton 1997) p. 201. The Pregnancy Termination Act ended the criminal punishability of the woman, under the until that time existing Art. 295 Criminal Code. Since that time, the woman is only punishable if the child may reasonably be presumed capable of surviving independently of the mother.

Paragraph 5 of this Article provides that the act referred to in the first paragraph is not an offence if the treatment is given by a medical practitioner in a hospital or clinic which is licensed to provide such treatment under the Pregnancy Termination Act.⁷² This statutory defence (*strafuitsluitingsgrond*) does not apply in situations where an aggravating circumstance applies⁷³ or in case the pregnancy has yet lasted more than 24 weeks.⁷⁴ The latter is so, because Article 82a of the Criminal Code clarifies that the killing of a foetus which may reasonably be presumed capable of surviving independently of the mother, amounts to the criminal offence of taking of the life of another person or of a child during or shortly after birth.⁷⁵ Hence, the killing of a viable foetus is qualified as homicide.⁷⁶ Expert opinion considers a foetus to be viable at 24 weeks and consequently 24 weeks is the absolute limit for the termination of a pregnancy.⁷⁷ Termination of pregnancy after 24 weeks of pregnancy (a so-called ‘late abortion’) is exempted from punishment only in cases of *force majeure* (*overmacht*). Such *force majeure* is considered to exist if there are reasons to believe that – despite the duration of the pregnancy – the foetus is not yet viable; in case the emergency situation of the woman has a medical cause; or in case the foetus has been diagnosed with abnormalities which would result in a life with serious and incurable suffering.⁷⁸

This was established by the inclusion of a new Article (Art. 82 Sr) in the Criminal Code (See Art. II (A) and (D) of the Bill *Kamerstukken II 1978/79*, 15 475, nos. 1–4, pp. 22 and 32–34).

⁷² Any doctor who refers a pregnant woman to an illegal abortion clinic is accessory to the act criminalised in Art. 296 Sr. See C. van Oort, *Commentaar op Wetboek van Strafrecht, art. 296* [Commentary to the Criminal Code, Article 296] (OpMaat Sdu 2012).

⁷³ Art. 296(2), (3) and (4) Sr.

⁷⁴ See Van Oort 2012, *supra* n. 72.

⁷⁵ Art. 82a Sr reads: ‘Taking a person’s life or the life of an infant at birth or shortly afterwards’ includes the destruction of a fetus which might be reasonably presumed to have a viable chance of existence independent of the mother’s body.’ Translation by Rayar and Wadsworth 1997, *supra* n. 71, at p. 107.

⁷⁶ HR 29 May 1990, *NJ* 1991 No. 217, ECLI:NL:HR:1990:ZC8539 para. 5.3.2 and Commissie evaluatie regelgeving 2005, *supra* n. 30, p. 31.

⁷⁷ Yet at the time of the drafting of the Pregnancy Termination Act, viability of the foetus was presumed from the 24th week of pregnancy. See *Kamerstukken II 1978/79*, 15 475, nos. 1–4, p. 33. See also HR 29 May 1990, *NJ* 1991 No. 217, ECLI:NL:HR:1990:ZC8539. In 2010 discussion arose in media and parliament on the question whether the time limit had to be brought back to, for example, 22 weeks of pregnancy. This debate arose after the *Nederlandse Vereniging voor Kindergeneeskunde (NVK)* [Dutch Association for Paediatrics] and the *Nederlandse Vereniging voor Obstetrie en Gynaecologie (NVOG)* [Dutch Association for Obstetrics and Gynaecology] published new professional guidelines to the effect that premature born between 24 and 25 weeks of pregnancy were actively kept alive and were treated. *Richtlijn Perinataal Beleid bij Extreme Vroeggeboorte* [Guideline perinatal policy in case of extreme premature birth], online available at www.nvk.nl/Nieuws/Dossiers/DossierRichtlijn24weken.aspx, visited June 2014. The NVK and the NVOG denounced the allegations that these guidelines implicated a lowering of the viability time limit of the foetus. See ‘Reactie NVK op geluiden in de politiek om de abortusgrens te verlagen n.a.v. de richtlijn extreme vroeggeboorte’ [‘Reaction NVK to abortion discussion following the Guideline extreme premature birth’] of 21 February 2011, online available at www.nvk.nl/Nieuws/Dossiers/DossierRichtlijn24weken.aspx, visited May 2011. In 2011 the Minister of Health informed Parliament that following consultations with medical experts she saw no reason to amend the existing legislation and policy. *Kamerstukken II 2010/11*, 30 371, no. 21.

⁷⁸ *Kamerstukken II 1998/99*, 26 717, no. 1 and Commissie evaluatie regelgeving 2005, *supra* n. 30, pp. 21–22. See also J.W. Wladimiroff and G.C.M.L. Christiaens, ‘Het rapport ‘Late zwangerschapsafbreking: zorgvuldigheid en toetsing’ van de overleggroep Late Zwangerschapsafbreking’ [‘The Report ‘Late pregnancy termination: care and examination’ of the consultation group Late pregnancy termination’], 142 *Nederlands Tijdschrift voor Geneeskunde* (1998) p. 2627.

The aim of the Pregnancy Termination Act is ‘[...] to balance two potentially conflicting interests: on the one hand protecting the life of the unborn child, and on the other helping women who are in a difficult position as a result of an unwanted pregnancy.’⁷⁹ Abortion is seen as a measure that can only be justified by an emergency situation for the woman.⁸⁰ Further, the decision to terminate a pregnancy must be taken with due regard for the individual circumstances of each case.⁸¹ The legislature considered it impossible to set a general norm defining when abortion would be lawful or unlawful, as it considered the emergency and distress situations in which an abortion could be considered to be very diverse.⁸² Instead, the legislature chose to set standards ‘[...] in the form of a set of requirements designed to guarantee that the decision to terminate is taken with all due care.’⁸³ The legislature considered it the State’s responsibility to provide for such guarantees, while the woman and the medical practitioner involved in the procedure each have their own responsibility for the actual decision to terminate a pregnancy. According to the legislature the responsibility of the woman and the medical practitioner for such decision could only be done justice if the public authorities ensured that certain conditions were met. Therefore, abortions may only be carried out in licensed clinics and hospitals, a reflection period must be observed⁸⁴ and medical after care must be provided.⁸⁵ The various relevant conditions are explained in further detail in the subsections below. First, however, the scope of the Act is further clarified.

6.2.2.1. *The scope of the Pregnancy Termination Act*

The Termination of Pregnancy Act does not define any statutory time limit for pregnancy termination, but – as explained above – the absolute limit for the termination of a pregnancy is set at the point in time where the foetus may reasonably be presumed capable of surviving independently of the mother.⁸⁶ While expert opinion thus considers a foetus to be viable at 24 weeks,⁸⁷ in practice, ‘[...] most doctors will perform the procedure no later than 22 weeks into the pregnancy, because of the margin of error of ultrasound scans and to be sure they remain within the statutory time limit’.⁸⁸ Late abortions in situations in which the foetus is in principle viable,

⁷⁹ *Kamerstukken II 1978/79*, 15 475, nos. 1–4, p. 17 and www.english.minvws.nl/en/themes/abortion/default.asp, visited April 2012. See also Commissie evaluatie regelgeving 2005, *supra* n. 30, at p. 11. This Commission concluded in 2005 that this aim was generally realised in practice.

⁸⁰ *Kamerstukken II 1978/79*, 15 475, nos. 1–4, p. 15 and Art. 5(1) Waz.

⁸¹ Dutch Ministry of Foreign Affairs 2011, *supra* n. 43 and *Kamerstukken II 1978/79*, 15 475, no. 3, p. 15–16.

⁸² *Kamerstukken II 1978/79*, 15 475, nos. 1–4, pp. 10 and 15–16.

⁸³ Dutch Ministry of Foreign Affairs 2011, *supra* n. 43.

⁸⁴ Art. 3(1) Waz.

⁸⁵ *Kamerstukken II 1978/79*, 15 475, nos. 1–4, p. 17. Art. 3(1) and Art. 5(2)(d) Waz. The after care includes a medical check-up and – if necessary – psychosocial care. If the woman consents, this care may be extended to her relatives. See Commissie evaluatie regelgeving 2005, *supra* n. 30, p. 39.

⁸⁶ Art. 82a Sr.

⁸⁷ *Kamerstukken II 1978/79*, 15 475, nos. 1–4, p. 33.

⁸⁸ Dutch Ministry of Foreign Affairs 2011, *supra* n. 43. See also ‘Verlagen abortusgrens ontneemt vrouwen kans op zorgvuldige afweging’, press release of 12 November 2010 at the website of the KNMG www.knmg.artsennet.nl/Nieuws/Nieuwsarchief/Nieuwsbericht-1/

are excluded from the scope of the Pregnancy Termination Act. Such cases must be reported to a special expert committee, which examines if the medical practitioner in attendance has acted with due care.⁸⁹

Pregnancy is assumed from the moment of nidation of the fertilised egg cell in the uterus. The admission of a drug to prevent nidation (e.g. the ‘morning after pill’) is excluded from the scope of the Termination of Pregnancy Act.⁹⁰ Initially this also held for so-called ‘*overtijdbehandeling*’, i.e., pregnancy termination within 16 days of the expected menstruation failing to occur. At the time of the drafting of the Pregnancy Termination Act it was considered that within that 16-day period it could not be established with sufficient certainty whether the woman was pregnant or not.⁹¹ Hence, the treatment – in practice often curettage – could not automatically be qualified as pregnancy termination.⁹² In 2005 the Evaluation Commission recommended to bring the ‘*overtijdbehandeling*’ within the scope of the Pregnancy Termination Act, as advanced medical techniques enabled to determine a pregnancy in a very early stage. The legislature agreed, but he also held that the existing practice had shown that no legislative amendment was necessary in this regard.⁹³ Hence, ‘*overtijdbehandeling*’ is now considered to be covered by the Act.⁹⁴ As soon as a pregnancy is determined, any termination thereof must be in accordance with the criteria set in the Pregnancy Termination Act.⁹⁵ Administration of the ‘abortion pill’ – a combination of two medications (Mifepristone and Misoprostol (also

Verlagen-abortusgrens-ontneemt-vrouwen-kans-op-zorgvuldige-afweging.htm, visited April 2011 and www.english.minvws.nl/en/themes/abortion/default.asp, visited April 2012.

⁸⁹ The *Centrale deskundigencommissie late zwangerschapsafbreking en levensbeëindiging bij pasgeborenen* [Central expert Commission late pregnancy termination and termination of life of neonates] was established in September 2006 to advise the Public Prosecutor. See www.lza-lp.nl, visited January 2010. See also the Protocol of the NVOG, as online available on www.nvog-documenten.nl/index.php?pagina=/richtlijn/item/pagina.php&richtlijn_id=756, visited 2 May 2010 and the instruction for the Public Prosecutor in cases concerning late pregnancy termination (*Aanwijzing vervolgingsbeslissing levensbeëindiging niet op verzoek en late zwangerschapsafbreking*), online available at www.om.nl/algemene_onderdelen/uitgebreid_zoeken/@151404/aanwijzing_0/, visited June 2010. See furthermore Commissie evaluatie regelgeving 2005, *supra* n. 30, pp. 32–33 G.G. Zeeman et al., ‘Toetsing van late zwangerschapsafbreking, 2004–2007’ [‘Review of late pregnancy terminations, 2004–2007’], 152 *Nederlands Tijdschrift voor Geneeskunde* (2008) p. 2632.

⁹⁰ Art. 1(2) Waz.

⁹¹ *Kamerstukken II* 1978/1979, 15 475, no. 6, pp. 42 and 61 and HR 29 May 1990, *NJ* 1991 No. 217, ECLI:NL:HR:1990:ZC8539, para. 3.10.

⁹² *Kamerstukken II* 2009/10, 32 123 XVI, no. 111, p. 3.

⁹³ See *Kamerstukken II* 2005/06, 30 371, no. 8 and (later) *Kamerstukken II* 2009/10, 32 123 XVI, no. 111, pp. 1 and 3. In 2009 a proposal for an amendment to the Implementing Order was published, which would have the effect that licensed clinics and hospitals would be obliged to determine the duration of the pregnancy in every individual case (See *Staatsblad* 2009, 230). This amendment has, however, not (yet) entered into force. See also *Kamerstukken II* 2010/11, 30 371, no. 20, p. 5 (answer to question 19).

⁹⁴ *Kamerstukken II*, 2005/06, 30 371, no. 3 and *Kamerstukken II*, 2006/07, 30 371, no. 8.

⁹⁵ As Art. 296 Sr applies to the situation of ‘*overtijdbehandeling*’, in any case the treatment must be performed by a medical practitioner in a licensed clinic or hospital. The requirement of a five-day reflection period is in practice often applied in a flexible way. The legislature considered it unnecessary and undesirable to make special provisions for the reflection period in cases of ‘*overtijdbehandeling*’. See *Kamerstukken II* 2009/10, 32 123 XVI, no. 111, p. 3.

know as RU846)) that can cause an abortion until the 9th week of pregnancy – is unquestionably covered by the Pregnancy Termination Act.⁹⁶

6.2.2.2. *Emergency situation*

The termination of a pregnancy may only be justified if the pregnant woman finds herself in an emergency situation.⁹⁷ The notion ‘emergency situation’ has not been defined by the legislature. Such definition was considered impossible as situations too diverse in nature could be covered by the notion (see also above).⁹⁸ The 2005 Commission evaluating the Act, did not see any reason to change this. The legislature also rejected a situation in which the medical practitioner in attendance would impose his or her judgment regarding the existence of an emergency situation on the woman.⁹⁹ As a result, it is actually the woman who decides if an emergency situation is present.¹⁰⁰ The medical practitioner has, however, the duty to inform the woman during the decision making process about alternative options and solutions.¹⁰¹ At the same time, no-one can be obliged to carry out an abortion, or to participate in it.¹⁰²

6.2.2.3. *Five-day reflection period*

To give a woman time for reflection, a five-day consideration period must be observed.¹⁰³ Article 3 of the Pregnancy Termination Act provides that an abortion cannot be carried out any sooner than on the 6th day after the woman has first consulted a doctor with whom she discussed her intention to have an abortion.¹⁰⁴ This reflection period – reportedly one of the most debated elements of the Pregnancy Termination Act¹⁰⁵ – is considered a means to protect the interests of the unborn and must

⁹⁶ See *Aanhangsel Handelingen II* 1997/98, 1593 and *Aanhangsel Handelingen II* 1998/99, 1851.

⁹⁷ See, *inter alia*, *Kamerstukken II* 1978/79, 15 475, nos. 1–4, p. 15.

⁹⁸ *Kamerstukken II* 1978/79, 15 475, nos. 1–4.

⁹⁹ Commissie evaluatie regelgeving 2005, *supra* n. 30, p. 37, under reference to *Kamerstukken II* 1979/80, 15 475, no. 6, pp. 9–10.

¹⁰⁰ *Idem*, pp. 114 en 122.

¹⁰¹ Art. 5(2)(a) Waz.

¹⁰² Art. 20 Waz. If the doctor has (conscientious) objections against the abortion, he must inform the woman about it. If so requested and with the consent of the woman, the doctor has to give information to other doctors about the medical condition of the woman. The scope of this provision extends to non-medical staff members of clinics and hospitals, but the tax payer in general is not covered by it. *Kamerstukken II* 1978/79, 15 475, nos. 1–4, p. 22; HR 29 May 1990, *NJ* 1991 No. 217, ECLI:NL:HR:1990:ZC8539, para. 3.9 and Commissie evaluatie regelgeving 2005, *supra* n. 30, p. 39.

¹⁰³ Art. 3(1) Waz. See also www.english.minvws.nl/en/themes/abortion/default.asp, visited April 2012 and Commissie evaluatie regelgeving 2005, *supra* n. 30, p. 41.

¹⁰⁴ Under the Dutch health system it is usually the general practitioner with whom the woman first discusses her intention to have an abortion. The carrying out of an abortion before this reflection period has lapsed, is liable to punishment on the basis of Art. 16(1) Waz. The Act provides for a few exceptions to this rule, such as the situation where the health or the life of the woman is endangered by the pregnancy (Art. 16(2) Waz). See also *Kamerstukken II* 1979/80, 15 475, no. 6, pp. 40–41.

¹⁰⁵ Commissie evaluatie regelgeving 2005, *supra* n. 30, p. 40. As the Evaluation Commission explains, it was initially debated whether the reflection period would commence at the moment the woman contacted a licensed abortion clinic or hospital or yet when she discussed her intention to have an abortion with her general practitioner. The latter was in the end decided.

therefore be strictly applied.¹⁰⁶ The medical practitioner in attendance must ascertain that the woman has maintained her intention for an abortion in full awareness of her responsibility for the unborn life and the consequences of the abortion for herself and others involved.¹⁰⁷ The legislature did not wish to formalise this issue any further.¹⁰⁸

The 2005 Evaluation Committee recommended dropping the fixed term for the reflection period and instead to provide by law that in each individual case where a woman considered having an abortion, a reflection period was to be observed that would enable those involved to come to a well-considered decision.¹⁰⁹ This recommendation was not however followed-up by the legislature, as it held that observation of the minimum reflection period had not proven problematic in practice.¹¹⁰

6.2.2.4. *Licensing and registration*

The licensing system as introduced by the Pregnancy Termination Act aims to guarantee high quality of medical care.¹¹¹ In 2012 there were 16 licensed abortion clinics and 92 hospitals in the Netherlands who were licensed to carry out abortions.¹¹² The Health Inspectorate is responsible for monitoring their compliance with the Pregnancy Termination Act.¹¹³ Licensed clinics and hospitals must submit quarterly reports to the Healthcare Inspectorate. These, *inter alia*, include information about the number of patients treated, their country of residence and age and the duration of the pregnancy at the time it was terminated.¹¹⁴

6.2.3. Reception of the Pregnancy Termination Act

The entry into force of the Pregnancy Termination Act did not take away all abortion controversy. From the moment of its adoption, the anti-abortion campaign continued its activities.¹¹⁵ The legality of the Act has been (indirectly) challenged by lawyers' association *Pro Vita* who claimed that by financing the termination of pregnancies, the State and the National Medical Insurance Board (*Ziekenfondsraad*), *inter alia*, violated the rights of the unborn. In 1995 the Supreme Court dismissed their claims, ruling, amongst other things, that Article 2 ECHR did not preclude national legislation under which abortion was legalised under certain circumstances.¹¹⁶ Since

¹⁰⁶ *Kamerstukken II* 1978/79, 15 475, nos. 1–4, p. 18.

¹⁰⁷ Art. 5(2) Waz.

¹⁰⁸ Commissie evaluatie regelgeving 2005, *supra* n. 30, at p. 38.

¹⁰⁹ *Idem*, at p. 13.

¹¹⁰ *Kamerstukken II* 2005/06, 30 371, no. 2, pp. 3–4.

¹¹¹ *Kamerstukken II* 1978/79, 15 475, no. 6, p. 31 and Commissie evaluatie regelgeving 2005, *supra* n. 30, at pp. 28–29.

¹¹² See www.rijksoverheid.nl/onderwerpen/abortus, visited 17 October 2012.

¹¹³ Art. 14a Waz.

¹¹⁴ Art. 11 Waz. See also the statistics as discussed in section 6.4.1 below.

¹¹⁵ See *Outshoorn* 1986, *supra* n. 39, at p. 282.

¹¹⁶ HR 16 June 1995, *NJ* 1997 No. 131, ECLI:NL:HR:1995:ZC1757.

that time, the anti-abortion campaign has become less prominent in Dutch society and politics.

6.2.4. Criminal prosecutions for abortions in the Netherlands

Before the 1911 amendment of the Criminal Code, there were hardly any criminal convictions on the basis of Article 295 et seq. Criminal Code (see 6.2.1 above).¹¹⁷ After 1911, the number of convictions on the basis of the new Article 251*bis*, apart from some fluctuations from year to year, generally increased until the late 1940s.¹¹⁸ From that time the number of convictions slowly decreased. In the 1960s the number of criminal convictions dropped considerably¹¹⁹ and in the 1970s, there were even years without any convictions (see also section 6.2.1 above).¹²⁰ The present author is not aware of any specific prosecution statistics since the 1970s.¹²¹

6.2.5. Abortion and public funding

Since the entry into force of the Pregnancy Termination Act, women resident in the Netherlands who have their pregnancy terminated, do not have to pay for the abortion. The costs of a termination performed by a licensed clinic are covered by the Exceptional Medical Expenses Act (*Algemene Wet Bijzondere Ziektekosten* (AWBZ)), while abortions carried out in a licensed hospital are covered by the health

¹¹⁷ In 1911 a Member of Parliament maintained that there were no more than one to two criminal prosecutions or convictions per year. *Handelingen II* 1910/11, 2 March 1911, p. 1584. Enschedé 1966, *supra* n. 40, at p. 1111. See also Heijden, van der 1976, *supra* n. 36, at p. 426 Outshoorn 1986, *supra* n. 39, at p. 84.

¹¹⁸ The number of convictions on the basis of Art. 251 bis Sr (*old*) (following which treating a woman or subjecting a woman to treatment while indicating or arousing the expectation that the treatment could interrupt her pregnancy, was criminalised ('[...] *opzettelijk een vrouw in behandeling nemen of een behandeling doen ondergaan, te kennen geven of de verwachting opwekkende dat daardoor de zwangerschap kan worden verstoord.*')) during the years 1911–1978 were as follows: 1911: 3; 1912: 24; 1913: 34; 1914: 23; 1915:27; 1916: 44; 1917: 43; 1918:47; 1919: 32; 1920: 79; 1921: 69; 1922: 50; 1923: 55; 1924: 50; 1925: 72; 1926: 70; 1927: 98; 1928: 97; 1929: 53; 1930: 44; 1931: 75; 1932: 48; 1933: 97; 1934: 95; 1935:98; 1936: 112; 1937: 92; 1938: 119; 1939: 125; 1940: 74; 1941: 100; 1942: 96; 1943: 138; 1944: *no statistics available*; 1945: *no statistics available*; 1946: 235; 1947: 233; 1948: 237; 1949: 177; 1950: 201; 1951:183; 1952: 180; 1953: 136; 1954: 120; 1955: 120; 1956: 113; 1957: 95; 1958: 105; 1959: 81; 1960: 83; 1961: 82; 1962: 71; 1963: 48; 1964: 38; 1965: 38; 1966: 29; 1967: 33; 1968: 32; 1969: 23; 1970: 14; 1971: 6; 1972: 1; 1973: 3; 1974: 0; 1975: 0; 1976: 0; 1977: 0; 1978: 0. Bruijn, de 1979, *supra* n. 44, at p. 239. See Heijden, van der 1976, *supra* n. 36, at pp. 429–430 and Outshoorn 1986, *supra* n. 39, at p. 330.

¹¹⁹ The 2005 Evaluation Commission pointed out that in the 1960s, there was no systematic practice of prosecution of medical practitioners. Commissie evaluatie regelgeving 2005, *supra* n. 30, at pp. 25–26. When the Amsterdam District Court ruled in 1976 that social factors could justify an abortion, it took into account that in the preceding two decades the Public Prosecutor had only exceptionally initiated prosecution in abortion cases, whereas it was common knowledge that in hospitals and – since 1971 – abortion clinics ten thousands of women, had had an abortion. Rb. Amsterdam 8 July 1976, *NJ* 1977 No. 477, ECLI:NL:RBAMS:1976:AC0431.

¹²⁰ See also *Kamerstukken II* 1974/75, 13 161, no. 1.

¹²¹ Only incidental and controversial cross-border cases have been reported in the media (see section 6.4 below).

insurer.¹²² Women from abroad who have a pregnancy terminated in the Netherlands have to bear the expenses themselves.¹²³

6.3. DUTCH LEGISLATION ON ASSISTED HUMAN REPRODUCTION AND SURROGACY

While the first child was born through IVF treatment in the Netherlands in 1983,¹²⁴ the general legislative framework for assisted human reproduction (AHR) was set and is set by the Embryo Act of 2002.¹²⁵ This Act sets limits to the handling and use of human gametes and embryos¹²⁶ in fertility treatment and scientific research, ‘by prohibiting what is deemed impermissible and attaching conditions to other procedures’.¹²⁷ The following section sketches the parliamentary history and the main features of the Embryo Act. The subsequent subsections discuss various elements of the Act and related acts thematically. It will become clear that the introduction and regulation of each new AHR technique was accompanied by elaborate public and political debate.

6.3.1. The Embryo Act (2002)

When the first *in vitro* fertilisation (IVF) treatments took place in the Netherlands in the 1980s, the debate on reproductive medicine and the use of embryos was triggered.¹²⁸ It was clear that very diverse views existed in society in respect of these sensitive issues¹²⁹ and that these views changed as medical science advanced continuously.¹³⁰ From the outset, the Dutch government developed a (provisional) policy in the field,¹³¹ as it felt that certain interests at stake in matters of assisted

¹²² Dutch Ministry of Foreign Affairs 2011, *supra* n. 43.

¹²³ *Idem*.

¹²⁴ *Kamerstukken II* 2012/13, 33 400 XVI, no. 155.

¹²⁵ *Wet van 20 juni 2002, houdende regels inzake handelingen met geslachtscellen en embryo's (Embryowet)* [Act of 20 June 2002, containing rules relating to the use of human gametes and embryos], *Stb.* 2002, 338.

¹²⁶ Under this Act the term ‘gametes’ is defined as: ‘human spermatozoa and oocytes’ and ‘embryo’ is defined as: ‘a cell or a complex of cells with the capacity to develop into a human being’. Art. 1(a) and (b) Embryowet.

¹²⁷ E.T.M. Olsthoorn-Heim et al., *Evaluatie Embryowet* [Evaluation Embryo Act], Reeks evaluatie regelgeving deel 20, Den Haag: ZonMw 2006, Annex to *Kamerstukken II* 2005/06, 30486 no. 1, pp. 9 and 17. Those provisions that govern the use of embryos in research are not discussed in this chapter.

¹²⁸ Artificial insemination has been applied in the Netherlands since the 1950's. *Kamerstukken II* 1987/88, 20 706, no. 2, p. 8 and 13.

¹²⁹ *Kamerstukken II* 2000/01, 27 423, no. 3, p. 2.

¹³⁰ *Idem*, p. 5.

¹³¹ The first step towards this policy was the government's request to the Health Council in July 1982 for an advice on the medical, ethical, financial and legal implications of *in vitro* fertilisation. This was followed by a *Besluit tijdelijke regeling ivf ex artikel 18 lid 3 van de WZV* [Decree temporary regulation of IVF under Article 18(3) WVZ]] of 18 July 1985. Further, IVF treatment was (provisionally) excluded from the national health insurance by means of the *Besluit niet-klinische buitenlichamelijke bevruchting ziekenfondsverzekering* (*Stcrt.* 1985, 113). See *Kamerstukken II* 1987/88, 20 706, no. 2, pp. 13–14.

human reproduction needed protection by the State. It held this to be the case in particular for the interests of the unborn and the child. Additionally, the quality and financing of health care were considered grounds for government intervention.¹³² Since 1988 a licensing system has been in force, on the basis of which IVF treatment can only be carried out in a limited number of licensed hospitals.¹³³

The drafting of a special legislative act on the matter took considerably longer;¹³⁴ it was only in 2002 that the *Act containing rules relating to the use of gametes and embryos* (Embryo Act) (*‘Wet houdende regels inzake handelingen met geslachtscellen en embryo’s’* (*‘Embryowet’*)) was adopted. This was partly due to the fact that the legislature felt that most groups in society had to agree with the decisions that were made in this field and that the choices were to retain some degree of validity in the face of advances in medicine.¹³⁵

It has been held that the drafting of the Embryo Act must also be seen against the background of the Biomedicine Convention of the Council of Europe of 1997.¹³⁶ Until today, however, this Convention has been signed, but not ratified by the Netherlands.¹³⁷ Should the Netherlands proceed to ratification, a few reservations must be made in respect of points on which the Embryo Act conflicts with the Convention.¹³⁸

Taking human dignity and respect for human life in general as basic point of departure,¹³⁹ the Embryo Act imposes conditions and limitations on the use of gametes

¹³² *Kamerstukken II* 1987/88, 20 706, no. 2, pp. 6 and 10.

¹³³ Koninklijk besluit [Royal Decree] of 11 August 1988, *Stb.* 379. This was later replaced by the *Planningsbesluit in-vitrofertilisatie* [Planning decree on *in vitro* fertilisation], *Stcrt.* 1998, 95 in conjunction with Art. 1 (i) Besluit aanwijzing bijzondere medische verrichtingen [Exceptional Medical Expenses Order], *Stb.* 2007, 238 and Art. 2 Wet op de Bijzondere Medische Verrichtingen (WMBV) [Exceptional Medical Expenses Act], *Stb.* 1997, 515. See als *Kamerstukken II* 1987/88, 20 706, no. 2, pp. 14 and 16; *Kamerstukken II*, 2000/01, 27 423, no. 3, p. 3 and L.E. Kalkman-Bogerd, ‘Het nieuwe Planningsbesluit in-vitrofertilisatie. Enkele kanttekeningen’ [‘The new planning decree *in vitro* fertilisation. Some comments’], 23 *Tijdschrift voor Gezondheidsrecht* (1999) p. 56.

¹³⁴ See also T.A.M. te Braake, ‘The Dutch 2002 Embryos Act and the Convention on Human Rights and Biomedicine: Some Issues’, 11 *European Journal of Health Law* (2004) p. 139 at p. 148. The 2006 Evaluation Commission spoke of a ‘carefull manoeuvring’ legislature in the various periods of government, on a ethically and emotionally charged terrain, about which the views in society widely differed, and in respect of which medical science developed at a high pace. Olsthoorn-Heim et al. 2006, *supra* n. 127, at p. 35.

¹³⁵ *Kamerstukken II* 2000/01, 27 423, no. 3, p. 6. For the English translation, see Olsthoorn-Heim et al. 2006, *supra* n. 127, at p. 17.

¹³⁶ B. Winter et al., *Evaluatie Embryowet en Wet donorgegevens kunstmatige bevruchting* [Evaluation of the Embryo Act and the Donor Information Act on Artificial Insemination] (Den Haag, ZonMw 2012), Annex to *Kamerstukken II* 2012–2013, 30486 no. 4, at p. 256.

¹³⁷ State of affairs on 31 July 2014.

¹³⁸ According to the authors of 2012 Evaluation of the Embryo Act this would in any case concern Art. 13 (concerning interventions on the human genome) and Art. 18 (concerning research on embryos *in vitro*) of the Convention. Were the legal exceptions on the prohibition on gender selection to be broadened, possibly a reservation had to be made in respect of Art. 14 of the Convention. Winter et al. 2012, *supra* n. 136, at p. 256.

¹³⁹ *Kamerstukken II* 2000/01, 27 423, no. 3, p. 5. For the English translation, see Olsthoorn-Heim et al. 2006, *supra* n. 127, at p. 17.

and embryos and limits the purposes for which these may be used.¹⁴⁰ The legislature has strived to find a balance between the principles of respect for human dignity and human life, and various other interests and values such as the advancement of the quality and safety of reproductive medicine, the best interests of the future child, the cure of illnesses and the interests of infertile couples.¹⁴¹

The Embryo Act is based on a system of standard-setting, formulating rights and defining responsibilities, whilst also drafting protocols and providing for reporting obligations.¹⁴² Certain practices – namely the creation of chimeras (human-animal hybrids); cloning and gender selection (see section 6.3.4 below) – are explicitly prohibited under the Act.

The Embryo Act entered into force on 1 September 2002. It has since been evaluated twice, in 2006 and 2012.¹⁴³ The Act is supplemented by the Model Regulations Embryo Act (*Modelreglement Embryowet*).¹⁴⁴

6.3.2. Access to AHR treatment

In the Netherlands, the standard applied in decision-making around reproduction is the reasonable well-being of the child (*het redelijk welzijn van het kind*): doctors must refrain from providing assistance in reproduction if they are of the opinion that the future child runs a real risk of serious psychosocial or physical harm.¹⁴⁵ Any decision must be made on the basis of an individual assessment of the case at hand; the categorical exclusion of certain groups in society is not allowed.¹⁴⁶

¹⁴⁰ *Idem*, at p. 6. The Preamble to the Act reads: ‘We have considered that it is desirable out of respect for human life to prohibit certain uses of human gametes and embryos, to regulate the conditions under which other uses of human gametes and embryos with a view to improving medical care may be permitted, and to lay down rules regarding control over gametes and embryos [...]’.

¹⁴¹ *Idem*, at pp. 3 and 5.

¹⁴² *Idem*, at p. 7.

¹⁴³ Olsthoorn-Heim et al. 2006, *supra* n. 127 and Winter et al. 2012, *supra* n. 136. By Act of 10 July 2013 the Embryo Act was amended as a follow-up to the 2006 evaluation. Wet van 10 juli 2013 tot wijziging van de Embryowet in verband met de evaluatie van deze wet [Act of 10 July 2013 amending the Embryos Act with a view to the evaluation of this Act], *Stb.* 2013, 306. The amendment that is most relevant for the present research concerns counselling for egg cell donors.

¹⁴⁴ Following Art. 2 Embryowet the establishments where embryos are created outside the human body, or other procedures involving embryos are carried out, must draw up a protocol regarding the use of gametes and embryos. The establishments draw up their protocol on the basis of the *Modelreglement Embryowet* [Model Regulations Embryo Act], which is online available at the website of the *Centrale Commissie Mensgebonden Onderzoek (CCMO)* [The Central Committee on Research Involving Human Subjects], [www.ccmo-online.nl/hipe/uploads/downloads/Modelreglement-Embryowet\(1\).pdf](http://www.ccmo-online.nl/hipe/uploads/downloads/Modelreglement-Embryowet(1).pdf), visited April 2013.

¹⁴⁵ NVOG, *Modelprotocol Mogelijke morele contra-indicaties bij vruchtbaarheidsbehandelingen* [Model Protocol concerning possible moral counter-indications for fertility treatment] pp. 2–3, online available at www.nvog.nl/Sites/Files/0000000935_NVOG%20Modelprotocol%20Mogelijke%20Morele%20Contraindicaties%20Vruchtbaarheidsbehandelingen%202010.pdf, visited June 2014.

¹⁴⁶ *Idem*, p. 3.

IVF treatment is only provided if there is a medical indication for the treatment.¹⁴⁷ Further, IVF clinics have a certain discretion when it comes to access to treatment.¹⁴⁸ For example, Dutch legislation does not oblige IVF clinics to offer treatment to single women.¹⁴⁹ The Dutch Equal Treatment Commission (now the Human Rights Institute) held in 2000 that a refusal to offer IVF treatment to singles could be justified on grounds of the best interests of the child.¹⁵⁰ IVF clinics are also in principle free to decide if they wish to cooperate with a sperm bank. This has as a result that the access to IVF treatment may be more limited for same-sex couples when compared to different-sex couples, but the Dutch government has held this to be acceptable.¹⁵¹

Different age limits apply for different kinds of AHR treatment. Generally the limits range between 40 and 45 years.¹⁵² For example, in respect of egg cell donation, it has been specified in the Model Regulation Embryo Act that the donor must be between 18 and 40 years old, while the maximum age of the acceptor is 45 years.¹⁵³ Age is also a relevant factor for reimbursement of the costs of AHR treatment under the Health Insurance Act (see 6.3.7 below).

6.3.3. Donation of gametes and embryos

Insemination with donated sperm (semen) has been practice in the Netherlands for a long time and artificial insemination has been made possible through the establishment of sperm banks, in the late 1980s. Egg cell (oocyte or ovum) donation

¹⁴⁷ The relevant principles are laid down in the *Richtlijn Indicaties voor ivf* [Guideline indications for IVF] as drafted by the the Dutch Association for Obstetrics and Gynaecology (*Nederlandse Vereniging voor Obstetrie en Gynaecologie (NVOG)*) in the year 1998, online available at www.nvog-documenten.nl/uploaded/docs/09_indicaties_ivf.pdf, visited February 2010. Medical practitioners can find further guidance in the NVOG's Model Protocol concerning possible moral counter-indications for fertility treatment, *supra* n. 145 and the Landelijke Netwerkrichtlijn Subfertiliteit [National guideline subfertility], online available at www.nhg.artsennet.nl/kenniscentrum/k_richtlijnen/k_nhgstandaarden.htm, visited April 2012.

¹⁴⁸ See also Rb. 's-Gravenhage (pres.) 17 July 1990, ECLI:NL:RBSGR:1990:AD1197.

¹⁴⁹ See on this question also T. Veerman and A. Hendriks, 'Recht op toegang tot IVF. IVF bij alleenstaande, lesbische en oudere vrouwen' ['A right to access to IVF treatment. IVF treatment for single, lesbian and women of age'], 12 *Nemesis* (1996) p. 136 and College voor zorgverzekeringen 27 April 2000, BZ-00-1103.

¹⁵⁰ Dutch Equal Treatment Commission, Decision 2000-4, online available at www.mensenrechten.nl/publicaties/oordelen, visited June 2014.

¹⁵¹ *Kamerstukken II* 32 500 XVI, no. 112, p. 3. See also Dutch Equal Treatment Commission, Decision 2009-31 online available at www.mensenrechten.nl/publicaties/oordelen, visited June 2014.

¹⁵² J.T.M. Derksen and P.C. Staal, *Rapport Een leeftijdsgrens voor vruchtbaarheidsbehandelingen* [Report an age limit for fertility treatment] (Diemen, CVZ 2012) p. 8, Annex to *Kamerstukken II* 33000-XVI, no. 188. For an example see www.umcutrecht.nl/zorg/patienten/poliklinieken/V/vruchtbaarheid/Veel-gestelde-vragen.htm, visited January 2013.

¹⁵³ Modelreglement Embryowet, paras. 3.2.2, 3.3.1 and 3.3.2, online available at [www.ccmo-online.nl/hipe/uploads/downloads/Modelreglement-Embryowet\(1\).pdf](http://www.ccmo-online.nl/hipe/uploads/downloads/Modelreglement-Embryowet(1).pdf), visited April 2013. The Model Regulation recommends caution with donors under the age of 30 years (para. 3.3.2). In 2007 the government saw no reason to codify the age limit of 45 for acceptors of donor gametes in legislation, as they held that the age limit was widely supported in medical profession. *Kamerstukken II* 2007/08, *Aanhangsel* No. 113, p. 242.

became technically possible only much later. For many years egg cell donation was hardly practiced in the Netherlands, as the technique for vitrification of egg cells had not yet been developed.¹⁵⁴ This only changed in the last decade and in 2012 the first egg cell donation bank opened its doors in the Netherlands.¹⁵⁵ Perhaps for reasons of its limited practical relevance, egg cell donation has never been criminalised under Dutch law. This is different, however, for egg cell donation in combination with surrogacy (see section 6.3.8 below).¹⁵⁶

The Embryo Act sets conditions for the donation of gametes and embryos.¹⁵⁷ It is based on two central principles namely: (1) consent for donation must be given freely; and (2) payment for gametes (as goes for organs and human tissue) is considered incommensurable with human dignity.¹⁵⁸

Adults who are capable of making a reasonable assessment of their interests in this regard may make their gametes available in order to induce pregnancy in another person or for research purposes.¹⁵⁹ Donating ‘surplus’ embryos which have been created in the course of an IVF treatment, for the purpose of inducing a pregnancy in another person, is also permitted.¹⁶⁰

Gametes and embryos may be made available only by means of a written donation and without consideration, and only after the donor has been informed by the person storing the gametes or embryos regarding the nature and the purpose thereof.¹⁶¹ The donor may revoke his or her decision at any time before the gametes or embryos are used, without giving reasons.¹⁶² If an invasive procedure is required in order to obtain gametes from the donor, the consent must be given in writing and the donor must be informed by the person who performs the procedure of the attendant risks and

¹⁵⁴ *Kamerstukken II* 1993/94, 23 207, no. 6, p. 1.

¹⁵⁵ ‘Eicelbank op zoek naar vrouwen die doneren’, *Algemeen Dagblad* 2 April 2012, p. 4.

¹⁵⁶ Annex to Planningsbesluit *in vitro* fertilisatie 1989, *Stcrt.* 31 July 1989 and *Handelingen II* 1998/99, 818.

¹⁵⁷ Arts. 5, 6 and 8 Embryowet.

¹⁵⁸ *Kamerstukken II* 2012/13, 33 400 XVI, no. 155, p. 2.

¹⁵⁹ Art. 5(1) Embryowet. With the sperm of one donor a maximum of 25 children may be conceived. J.K. de Bruyn, *Advies medisch-technische aspecten van kunstmatige donorinseminatie* (Utrecht: Centraal Begeleiding Orgaan voor de intercollegiale toetsing 1992). The Guideline was drafted in consultation with the Dutch-Belgian Association for Artificial Insemination (Nederlands-Belgische Vereniging voor Kunstmatige Inseminatie), the Dutch Association for Obstetrics and Gynaecology (Nederlandse Vereniging voor Obstetrie en Gynaecologie (NVOG)) and the Dutch Association on Clinical genetics (de Vereniging voor Klinische Genetica Nederland).

¹⁶⁰ Art. 8(1)(a) Embryowet provides that adults who are capable of making a reasonable assessment of their interests in this regard may make available embryos which have been created outside the body for their own pregnancy, but which will no longer be used for this purpose, to induce pregnancy in another person. Embryos may also be donated to culture embryonic cells for medical purposes, medical and biological research and medical and biological education or to carry out research that is permissible under the Embryo Act using those embryos. Art. 8(1)(b) and (c) Embryowet.

¹⁶¹ Arts. 5(2) and 8(2) Embryowet. By Act of 21 December 2006 (*Stb.* 2007, 58), two new paragraphs were included in Art. 5 Embryowet, in order to implement the rules of Directive 2004/23/EC in respect of the information that must be provided to the donor.

¹⁶² Arts. 5(2) and 8(2) Embryowet.

draw-backs.¹⁶³ The donor must be given sufficient time for reflection to allow him or her to make a carefully considered decision on the basis of the information provided about making his or her gametes available.¹⁶⁴ If gametes are made available in order to induce pregnancy in another person, the donor must be given the opportunity to stipulate that his or her consent is required for the use of embryos created using his or her gametes for any other purposes.¹⁶⁵

By providing that the provision of gametes and embryos should not be remunerated, the legislature ‘[...] wanted to ensure that the pursuit of profit [did] not play a role in donation’.¹⁶⁶ The legislature felt that to value gametes and embryos in terms of money was in violation with human dignity and endangered the special protection the embryo enjoys.¹⁶⁷ Reimbursement of expenses directly incurred as a result of treatment in which the said gametes and embryos are used is, however, lawful.¹⁶⁸ Further, mediation in the demand and supply of egg cell and sperm donors is not prohibited under Dutch law, as long as no profit is pursued.¹⁶⁹

Until the year 2004, when the Donor Information Act on Artificial Insemination (*Wet donorgegevens kunstmatige bevruchting*, hereafter ‘Donor Information Act’) entered into force, a gamete donor could remain anonymous permanently.¹⁷⁰ The first initiatives to change this date back to the late 1980s.¹⁷¹ In 1992 a bill on donor

¹⁶³ Arts. 5(3) and 6(1) Embryowet. See also *Kamerstukken II*, 2000/01, 27 423, no. 3, p. 17. In 2013 the Act was amended so as to rescind the mandatory assessment by the Medical-ethical examination Committee (*medisch-ethische toetsingscommissie* (METC)) in cases of egg-cell donation. Wet van 10 juli 2013 tot wijziging van de Embryowet in verband met de evaluatie van deze wet [Act of 10 July 2013 amending the Embryo Act with a view to its evaluation], *Stb.* 2013, 206.

¹⁶⁴ Art. 6(2) Embryowet.

¹⁶⁵ Art. 6(4) Embryowet.

¹⁶⁶ Olsthoorn-Heim et al. 2006, *supra* n. 127, at p. 19.

¹⁶⁷ *Kamerstukken II* 2000/01, 27 423, no. 3, p. 16.

¹⁶⁸ Art. 27 Embryowet provides: ‘It is prohibited to charge a fee for providing gametes and embryos made available pursuant to Sections 5, 8 and 9 of this Act to third parties if the said fee exceeds the costs directly incurred as a result of procedures carried out using the said gametes and embryos.’ In the 2006 Evaluation Report it was noted that ‘[i]n practice reimbursement of expenses is evidently accepted.’ Olsthoorn-Heim et al. 2006, *supra* n. 127, at pp. 11 and 19. In 2012 the Minister of Health informed Parliament that medical profession, even though it had not yet issued a formal opinion on the matter, considered an amount between 500 and 1,000 euros reasonable. *Aanhangsel Handelingen II* 2011/12, 1162, pp. 1–2. The authors of the 2012 Evaluation went even a bit further; it was held that it was acceptable if the reimbursement of expenses to some extent encouraged women to donate, as long as it did not lead to a financially motivated donation. The report invited the government to reconsider how the reimbursement for costs related to the prohibition to charge a fee. Winter et al. 2012, *supra* n. 136, at pp. 252–253.

¹⁶⁹ *Aanhangsel Handelingen II* 2011/12, 792, pp. 1–2. Trade in gametes has always been prohibited under Dutch law. Annex to Planningsbesluit *in vitro* fertilisatie 1989, *Stcrt.* 31 July 1989 and *Handelingen II* 1998/99, 818.

¹⁷⁰ Wet donorgegevens kunstmatige bevruchting [Donor Information Act on Artificial Insemination] Act of 25 April 2002, *Stb.* 2002, 240, entry into force per 1 January 2004. The Act is accompanied by an Implementing order (*Besluit donorgegevens kunstmatige bevruchting*, *Stb.* 2003, 320). The first Evaluation of this act was published in 2012. Winter et al. 2012, *supra* n. 136.

¹⁷¹ The 2012 Evaluation report noted that in 1988 there had yet been a bill tabled for the amendment of the parentage laws (*‘herziening van het afstammingsrecht’*). Winter et al. 2012, *supra* n. 136, at p. 50. The bill was revoked five years later. The coalition agreement of 1989 provided that a survey would be

information in cases of artificial insemination was drafted and sent to various interest groups for feedback.¹⁷² Its drafters considered knowledge about one's genetic origins a fundamental foundation for a deeper understanding of one's self.¹⁷³ Extensive political debate delayed the adoption of the Donor Information Act with another eight years. There was disagreement about the question of whether the long-term psychosocial effects for children conceived through anonymous donation had to be researched, before the law was amended. Furthermore, concerns were expressed that lifting of the anonymity would lead to a serious reduction of the number of donors and to a 'black market' in gametes and that people would have their recourse to other countries, where anonymous donation was legal.¹⁷⁴ The government, however, felt and maintained that these concerns were outweighed by the right of the child to know about its genetic origins.¹⁷⁵ In this reasoning the government was supported by a ruling of the Supreme Court of 1994, where it was held that the right to know one's genetic origins prevailed over the right to privacy of the (living) genetic parent.¹⁷⁶

The Donor Information Act (2004) regulates the storing, administration and provision of the data of donors involved in artificial insemination.¹⁷⁷ Following its Article 2(1), all establishments that offer AHR treatment with the use of donated gametes have to provide data about these treatments and the donors involved to the Donor Information Registration Foundation (*Stichting Donorgegevens Kunstmatige Bevruchting*).¹⁷⁸ Apart from the personal data of the woman involved in the artificial insemination with the use of donor gametes, information about the donor must be registered.¹⁷⁹ In this regard a distinction is made between the donor's medical information; physical information (such as weight and colour of the hair and eyes); information about the donor's education; social information (such as the social situation and civil status) and personal (identifying) information (such as family name, name, date of birth and address) of the donor. While all these data are recorded by the Donor Information Registration Foundation and saved for at least 80 years,¹⁸⁰ the passing on of such information to third parties is subject to certain limitations.

conducted into the possible effects on children of not having access to information about their genetic links. *Kamerstukken II* 1989/90, 21 132 no. 8, p. 33.

¹⁷² *Kamerstukken II* 1992/93, 23 207, no. 3, p. 3. It was feared that an immediate lifting of the existing permanent donor anonymity would result in a strong decline in the number of donors and in an increase in what was called '*KID-toerisme*' (i.e. resorting to artificial insemination with the use of donated sperm in foreign countries).

¹⁷³ *Kamerstukken II* 1992/93, 23 207, no. 3, p. 1.

¹⁷⁴ See *Kamerstukken II* 2012/13, 30 486, no. 5, p. 17.

¹⁷⁵ *Kamerstukken II* 1997/98, 23 207, no. 10, p. 8. For an adequate description of the legislative history of the Donor Information Act, see Winter et al. 2012, *supra* n. 136, at pp. 50–59. See also G.T. Oudhof, 'Het wetsvoorstel 'Wet donorgegevens kunstmatige inseminatie' en de (tegengestelde) belangen van het kind' [The Bill 'Act Donor Information Artificial Insemination' and the (conflicting) interests of the child'] *Tijdschrift voor Familie en Jeugdrecht* (2000) p. 229.

¹⁷⁶ HR 15 April 1994, *NJ* 1994 No. 608, ECLI:NL:HR:1994:ZC1337.

¹⁷⁷ Preamble to the Donor Information Act (*Wet donorgegevens kunstmatige bevruchting*), Act of 25 April 2002, *Stb.* 2002, 240 and *Stb.* 2003, 510.

¹⁷⁸ Art. 2(1) *Wet donorgegevens kunstmatige bevruchting*.

¹⁷⁹ Art. 3(2) *Wet donorgegevens kunstmatige bevruchting*. These personal data concern the woman's surname, given names, date of birth and address.

¹⁸⁰ Art. 8 *Wet donorgegevens kunstmatige bevruchting*.

Medical information may be important for the health of the child conceived with gametes of a donor, and must therefore always be passed on to the child's general practitioner.¹⁸¹ As of the age of 12, any child who reasonably suspects to have been conceived by artificial insemination with donated gametes can request information about his or her donor from the Donor Information Registration Foundation. The donor's medical, physical and social information, as well as information about the donor's education must be provided, if so requested by the child.¹⁸² If the child has not yet reached the age of 12, any request of the child's parents for such information must be complied with.¹⁸³ Donors cannot object to and are not informed about the passing on of this information to the child or their parents by the Foundation.¹⁸⁴

If the child has reached the age of 16, he or she may, furthermore, submit a request to obtain the donor's personal (identifying) information. This information is provided if the donor has given written permission for the passing on of this information to the child.¹⁸⁵ If the donor does not consent to the revelation of his personal data, only very weighty reasons may justify a refusal of the child's request for personal information.¹⁸⁶ In its assessment of the donor's refusal, the Donor Information Registration Foundation takes the interests of the child as a point of departure. Information about the donor may thus only be provided if the child (or exceptionally his or her parents or medical practitioner) so requests. The child must furthermore reasonably suspect to have been conceived by artificial insemination with donated gametes.¹⁸⁷ If no initiative is taken by the child, a gametes donor can remain anonymous.¹⁸⁸ Donors cannot themselves trace children conceived with their gametes.¹⁸⁹

¹⁸¹ Art. 3(1)(a) Wet donorgegevens kunstmatige bevruchting. See also Art. 2 Besluit donorgegevens kunstmatige bevruchting [Donor Information Order] for a definition of the term 'medical information' in this context.

¹⁸² Art. 3(1)(b) Wet donorgegevens kunstmatige bevruchting. See also Art. 3 Besluit donorgegevens kunstmatige bevruchting for a specification of physical and social information of the donor.

¹⁸³ Art. 3(1)(c) Wet donorgegevens kunstmatige bevruchting.

¹⁸⁴ See www.donorgegevens.nl/informatievoordonoren, visited January 2013.

¹⁸⁵ Art. 3(2) Wet donorgegevens kunstmatige bevruchting. If a child is conceived – whether before or after the entry into force of the Act – with the gametes of a donor who has declared in writing before June 2004 that he or she wishes to remain anonymous, no personal (identifying) information will be given to the child. If the donor has not made any such written statement, his or her consent will be sought by the Donor Information Registration Foundation. Only if the donor gives his or her permission, such personal data may be passed on to the child. See www.donorgegevens.nl/informatievoordonoren, visited January 2013.

¹⁸⁶ Art. 3(2) Wet donorgegevens kunstmatige bevruchting. Boele-Woelki et al. give as an example of such a very weighty reason the situation in which the donor has founded his own family. K. Boele-Woelki et al., *Draagmoederschap en illegale opnemings van kinderen* [Surrogacy and unlawful placement of children] (Utrecht, Utrecht Centre for European research into Family Law 2011) p. 54, Annex to *Kamerstukken II* 2010/11, 32500-VI, no. 83 and online available at www.wodc.nl/onderzoeksdatabse/draagmoederschap.aspx?cp=44&cs=6837, visited June 2014.

¹⁸⁷ Some have held it to be a bottleneck that a child does not by definition know that its legal parents are not its genetic parents. Boele-Woelki et al. 2011, *supra* n. 186, at p. 54.

¹⁸⁸ P.M.W. Janssens et al., 'Wet Donorgegevens Kunstmatige Bevruchting: inhoud en gevolgen' ['Act Donor Information Artificial Reproduction: content and consequences'], 149 *Nederlands Tijdschrift voor Geneeskunde* (2005) p. 1412 at p. 1416.

¹⁸⁹ *Idem*, at p. 1412.

Donors of gametes or embryos do not, furthermore, establish any *de lege* family ties with a child born after donation.¹⁹⁰ The *mater semper certa est* principle implies that the woman who gave birth to a child after gamete or embryo donation is the legal mother of the child.¹⁹¹ If she is married and her husband has consented to an act capable of resulting in conception – e.g. IVF treatment with the use of donated gametes – he is by law the legal father.¹⁹² If the woman who gives birth is not married, her partner may acknowledge the child.¹⁹³ Hence, no adoption procedure is required for the acceptor parents to establish parental links.¹⁹⁴

6.3.3.1. *Post-mortem reproduction*

Post-mortem reproduction was initially expressly rejected by the Dutch legislature.¹⁹⁵ As of the 1980s, however, the views in legal doctrine on this matter gradually changed, which development was reflected in the Embryo Act.¹⁹⁶ Its Article 7 provides that stored gametes are destroyed if the establishment responsible for their storage is informed that the donor has deceased, unless the donor has explicitly consented to the use of his gametes after his death.¹⁹⁷ In situations where such consent has been given and a request for use of the deceased's gametes has been made, the medical professionals involved in the AHR treatment must assess whether the interests of the future parent and child are sufficiently protected.¹⁹⁸ AHR establishments are under no obligation to assist in post-mortem reproduction¹⁹⁹ and some indeed refuse to do so.²⁰⁰

At the time when the Embryo Act was adopted, vitrification of egg cells was not yet common practice. When this method became lawful in the Netherlands in 2011, the legality of post-mortem reproduction through egg cell donation was debated by

¹⁹⁰ Such family ties are established neither before nor after the birth of the child. *Aanhangsel Handelingen II* 2007/08, 1061, p. 2262.

¹⁹¹ Art. 1:198 BW.

¹⁹² Art. 1:200(3) BW. Paternity cannot be denied in this situation. See also *Kamerstukken II* 1995/96, 24 649, n. 3, p. 7.

¹⁹³ Art. 1:199(c) BW.

¹⁹⁴ *Aanhangsel Handelingen II* 2007/08, 1061, p. 2262.

¹⁹⁵ Regeringsnota (Notitie) "Kunstmatige bevruchting en draagmoederschap" [Memorandum of the Dutch government on artificial insemination and surrogacy], *Kamerstukken II* 1987/88, 20706, no. 2, pp. 27 and 30.

¹⁹⁶ For an overview of the relevant literature, see para. 3.4 of Hof Arnhem 16 April 2002, ECLI:NL:GHARN:2002:AE1479. See also Rb. 's-Gravenhage (pres.) 9 March 1989, ECLI:NL:RBSGR:1989:AH2615.

¹⁹⁷ See also Hof Arnhem 16 April 2002, ECLI:NL:GHARN:2002:AE1479.

¹⁹⁸ *Kamerstukken II* 2001/01, 27 423, no. 3, p. 19. See also T. Oudhof, 'Het belang van het kind bij kunstmatige voortplanting na overlijden: What's in the name', *Tijdschrift voor Familie- en Jeugdrecht* (2002) p. 288.

¹⁹⁹ Modelreglement Embryowet [Model Regulations Embryo Act], pp. 25 and 39–44, online available at [www.ccmo-online.nl/hipe/uploads/downloads/Modelreglement-Embryowet\(1\).pdf](http://www.ccmo-online.nl/hipe/uploads/downloads/Modelreglement-Embryowet(1).pdf), visited April 2013.

²⁰⁰ W.J. Dondorp and G.M.W.R. de Wert, 'Postmortale eiceldonatie: wat is er tegen?' ['Postmortal egg-cell donation; what to object against it?'], 156 *Nederlands Tijdschrift voor Geneeskunde* (2012) p. 564 at p. 565.

some, but the relevant laws do not make a distinction between different types of gametes.²⁰¹

6.3.4. Gender selection

In the mid-1990s, an initiative to open a so-called ‘gender clinic’ in the city of Utrecht where gender selection would be practised, attracted wide attention in media and politics.²⁰² Even though the Minister of Health denounced the clinic’s practice immediately, it took until 1 October 1998 before a Ministerial Order prohibiting gender selection entered into force.²⁰³ The clinic was ordered to close its doors as of the same date.²⁰⁴

The legislature considered gender selection to reduce children to the mere object of the wishes and desires of their parents and to give reproduction a purely instrumental character.²⁰⁵ For that reason, a prohibition on gender selection was included in the Embryo Act. Its Article 26(1) prohibits gender selection in the course of the handling and use of gametes and embryos,²⁰⁶ subject to a maximum penalty of one year imprisonment or a fine of the fourth category.²⁰⁷ So-called ‘additional’ gender selection in the course of preimplantation genetic diagnosis (see 6.3.5 hereafter), is also prohibited.²⁰⁸ The gender of the unborn in itself can never constitute a lawful

²⁰¹ *Idem*. The authors of the 2012 Evaluation of the Embryo Act held, however, that from an ethical point of view, there was no fundamental difference between post-mortem reproduction with donated sperm and post-mortem reproduction with donated egg cells. They therefore held that the latter also had to be considered lawful and ethically acceptable. Winter et al 2012, *supra* n. 136, at p. 231. The Minister of Health, Welfare and Sports seemed to endorse this approach, as she did not make any distinction between the two types of gametes in her official reaction to the Evaluation. *Kamerstukken II* 2012/13, 30 486, no. 5.

²⁰² *Kamerstukken II* 1994/95, 24 238, nos. 1 and 2. See also ‘Er is ook veel te zeggen voor sekse-selectie’, *de Volkskrant* 17 June 1995.

²⁰³ Besluit verbod geslachtskeuze om niet-medische redenen [Ministerial Order gender selection on non-medical grounds] of 16 June 1998, *Stb.* 1998, 336 and *Stb.* 1998, 567.

²⁰⁴ *Kamerstukken II* 1997/98, 26 083, nos. 362 and 1. Criminal charges were brought, but later dropped against the founder of the clinic. See *Aanhangsel Handelingen II* 2004/05, 825 and 1797. The founder unsuccessfully tried to re-open his clinic in 2002. *Kamerstukken II* 2002/03, 28 600 XVI, no. 4. In 2010 new controversy arose when it was – inaccurately – reported that the genderclinic had re-opened its doors. *Inter alia*, *Aanhangsel Handelingen II* 2009/10, 2408 and 2409.

²⁰⁵ *Kamerstukken II* 2000/01, 27 423, no. 3, p. 48.

²⁰⁶ With the entry into force of the Embryo Act in September 2002, the existing Ministerial Order of 1998 (*supra* n. 203) was repealed.

²⁰⁷ Art. 28 Embryowet.

²⁰⁸ ‘Additional selection’ may occur ‘[...] when the sex is known as a result of the PGD or PGS procedure (which was carried out for a medical reason) and a choice is possible without further interventions being required.’ The Health Council of the Netherlands held for the first time in 1995 that there was little objection in that situation to respecting the parents’ wishes, provided that indeed no further interventions were carried out. It reiterated its opinion of 2006. See Gezondheidsraad, *Advies Preïmplantiatie genetische diagnostiek en screening* [Advice preimplantation genetic diagnosis and screening], Advice no. 2006/1, pp. 19 and 22, online available at www.gezondheidsraad.nl/sites/default/files/06@01N3.pdf, visited June 2014. The legislature, however, disagreed and considered that also in this situation reproduction would have a purely instrumental character. Additional sex selection is therefore prohibited in Annex 2 to *Regeling preïmplantiatie genetische diagnostiek* [Regulation

ground for abortion.²⁰⁹ However, the second paragraph of Article 26 provides for an exception to this prohibition if there is a risk that the child suffers from a serious gender-linked hereditary disorder, such as Duchenne muscular dystrophy.²¹⁰ Recommendations by the relevant Evaluation Committees in 2006 and 2012 to reconsider this strict prohibition on gender selection, were only partly followed up by the legislature.²¹¹

6.3.5. Preimplantation genetic diagnosis (PGD)

Prenatal screening – blood tests, echoes and/or (non-)invasive diagnoses – forms part of the medical screening of the population and is therefore covered from public funds.²¹² Such screening is not obligatory, but available to pregnant women in the Netherlands if they so desire.²¹³

Preimplantation genetic diagnosis (PGD) has been subject to much debate since it was first practiced in the Netherlands in 1995.²¹⁴ The Dutch government's decision-making in medical-ethical matters, including PGD, is based on the principles of personal autonomy, protection of human life and good care.²¹⁵ While

preimplantation genetic diagnosis] *Stcrt.* 2009, 42. See also *Kamerstukken II* 2005/06, 30 300 XVI, no. 136, pp. 8–9.

²⁰⁹ *Aanhangsel Handelingen II* 2003/04, 1914, p. 4049 and *Aanhangsel Handelingen II* 2006/07, 2267, p. 4804.

²¹⁰ See also www.pgdnederland.nl/wat-is-pgd/wat-wordt-onderzocht/geslachtsgebonden-aan-doeningen, visited March 2013.

²¹¹ The 2006 Evaluation Commission suggested that the prohibition of Art. 26 Embryowet was (possibly) too strictly formulated, as selection could also be desired in cases where the child risked to be the carrier of a serious gender-linked hereditary disease. The legislature disagreed and saw no ground for amendment of the law on this point. *Kamerstukken II*, 2006/07, 30 486, no. 3, p. 12. See earlier yet *Kamerstukken II* 2005/06, 30 300 XVI, no. 136, p. 10. The 2012 Evaluation Report recommended to reconsider the prohibition on gender-selection on non-medical grounds (Recommendation 4); to clarify whether the prohibition in Art. 26(1) Embryowet also saw at additional gender-selection in the course of genetic tests on medical grounds (Recommendation 5); to allow for gender-selection on grounds of a risk for 'non-Mendelian' hereditary disorders with unequal gender incidence (Recommendation 6) and to allow for gender selection in cases where the child risked to be the carrier of a serious gender-linked hereditary disease (Recommendation 7). Winter et al. 2012, *supra* n. 136, at p. 238. In respect of Recommendation 6, the Minister of Health considered that this matter required further scientific research and therefore considered it not (yet) correct to amend the law. The seventh recommendation was followed up though. *Kamerstukken II* 2012/13, 30 486, no. 5, pp. 5–6.

²¹² The costs of non-invasive prenatal testing are reimbursed from Public Health Insurance to women up to 36 years old. See *Kamerstukken II* 2013/14, 29 323, no. 90.

²¹³ See the website of the *Rijksinstituut voor Volksgezondheid en Milieu* (RIVM) [National Institute for Public Health and the Environment] www.rivm.nl/Onderwerpen/B/Bevolkingsonderzoeken_en_screeningen/Juridische_informatie_Screeningen_bij_zwangeren_en_pasgeborenen, visited 9 September 2014.

²¹⁴ *Kamerstukken II* 2011/12, 25424 no. 135, p. 1. In the year 1997 the first child was born after PGD in the Netherlands. PGD Nederland, *Jaarverslag PGD Nederland 2008 en cumulatief overzicht 1995–2008* [Annual Report PGD the Netherlands and cumulative overview 1995–2008] p. 3, Annex to *Kamerstukken II* 2009/10, 29323, no. 76.

²¹⁵ *Kamerstukken II* 2007/08, 29323 no. 46, pp. 5–6. These principles were first set out in the Government Position on Medical-Ethical Policy-making, as laid down in *Kamerstukken II* 2007/08, 30 800 XVI, no. 183.

often these principles complement and strengthen one another, in the case of PGD, the legislature considered that personal autonomy of the patient had to be balanced against the protection of the (unborn and future) life.²¹⁶

Under the present state of the law couples only qualify for PGD if they run a high individual risk of conceiving a child with a serious, hereditary illness or disorder that presents in most cases and which can be detected with PGD.²¹⁷ Further criteria to assess if an individual case qualifies for PGD are: the gravity and nature of the illness concerned; the treatment options; complementing medical criteria; and physical and moral factors.²¹⁸ PGD on non-medical grounds is prohibited.²¹⁹ Preimplantation genetic screening (PGS) – automatic screening in the course of every IVF treatment – is not regular practice in the Netherlands, but it has been on trial.²²⁰ Selection on the basis of a child's human leukocyte antigen system (HLA system) with a view to future donorship for the child's sibling²²¹ is permitted only in case the future child itself runs a serious and individual risk of contracting the hereditary disease.²²²

The first initiative of State regulation in respect of PGD was taken in 2003, when a planning decree on clinical genetic research and heredity counselling (*Planningsbesluit klinisch genetisch onderzoek en erfelijkheidsadviesing*) was issued. Since then it has been provided that PGD may only be carried out in a licensed establishment.²²³ To date, the government has considered one establishment sufficient to meet the demand for PGD in the Netherlands and consequently the

²¹⁶ *Kamerstukken II 2007/08*, 29323 no. 46, p. 6. On relevant ethical principles in respect to PGD see also Th.A.M. te Braake, 'Preimplantatie genetische diagnostiek: een stand van zaken' ['Preimplantation genetic diagnosis: a state of affairs'], 32 *Tijdschrift voor Gezondheidsrecht* (2008) p. 174.

²¹⁷ Annex 2 to *Regeling preimplantatie genetische diagnostiek* [Regulation preimplantation genetic diagnosis], *Stcrt.* 2009, 42.

²¹⁸ *Idem.*

²¹⁹ *Idem.*

²²⁰ As the Health Council of the Netherlands explained in its 2006 report on PGD: 'Pre-implantation genetic screening (PGS) involves *in vitro* investigation of embryos to detect numerical chromosomal abnormalities (aneuploidies).' The Council, furthermore, explained that the CCMO [Central Committee on Research involving Human Subjects] had 'issued permits for PGS trial protocols to four centres.' *Gezondheidsraad 2006*, *supra* n. 208. See also *Kamerstukken II 2005/06*, 30 300 XVI, no. 136 10.

²²¹ As the Health Council of the Netherlands explained in its 2006 report on PGD: 'The question of selecting a future child on the basis of its HLA system can arise if a child already born to the couple has a life-threatening condition that needs stem cell therapy, but no suitable donor is available. Stem cells are rejected if the HLA systems of the donor and recipient are too different from one another. The required stem cells can be obtained from the navel cord blood of a brother or sister with a matching HLA system. The conditions for which this treatment is carried out include certain forms of leukemia and hereditary anemia that are associated with a severely diminished life expectancy if a transplant is not performed.' *Gezondheidsraad 2006*, *supra* n. 208, at, p. 20.

²²² *Kamerstukken II 2005/06*, 30 300 XVI, no. 136, p. 10.

²²³ Art. 1 *Planningsbesluit klinisch genetisch onderzoek en erfelijkheidsadviesing* [Planning decree clinical genetic research and heredity counselling], *Stcrt.* 2003, 16 and Art. 1 (h)(fifth dash) *Besluit aanwijzing bijzondere medische verrichtingen* [Order instructions medical performances], *Stb.* 2007, 238.

University Hospital, Maastricht²²⁴ presently has the monopoly on PGD.²²⁵ The Centre has concluded partnership agreements with other Academic Medical Centres in respect of so-called ‘transport PGD’.²²⁶

After the entry into force of the aforementioned 2003 planning decree, the Minister of Health requested the Health Council of the Netherlands (*Gezondheidsraad*) to deliver its opinion on PGD.²²⁷ Following this opinion, the Secretary of State for Health announced in 2008 that PGD would also be made possible in respect of hereditary cancers, such as breast cancer and some forms of intestinal cancer.²²⁸ These types of cancer are diseases that do not present themselves in all cases, which means that ‘[...] not all individuals with the mutation contract the disease’.²²⁹ The letter by the Secretary of State caused political controversy about – what was called – ‘embryo selection’.²³⁰ Despite the strong opposition of certain confessional political parties, the government maintained its position on this point. This position was codified in a new Regulation on PGD (*Regeling preïmplantatie genetische diagnostiek*) which entered into force in 1999.²³¹ In the same year a national Committee on PGD indications (*Landelijke Indicatiecommissie PGD*) was established, which had the task of drafting guidelines and assessing new indications for PGD.²³²

The new Regulation did not end the debate. Particularly as medical science advanced, the debate about possible new indications and grounds for PGD continued.²³³ In the 2010, political controversy emerged with regard to PGD for Huntington’s disease (HD).²³⁴ HD is a ‘dominant genetic neurodegenerative disease, which causes physical

²²⁴ www.english.azm.nl, visited June 2014.

²²⁵ Art. 1 and Annex 1 to *Regeling preïmplantatie genetische diagnostiek* [Regulation preimplantation genetic diagnosis], *Stcrt.* 2009, 42 (earlier Art. 2.3 of Annex to Planningsbesluit klinisch genetisch onderzoek en erfelijkheidsadviesing [Planning decree clinical genetic research and heredity counselling], *Stcrt.* 2003, 16). The option is left open that in the future the capacity will be extended to two establishments (see Annex 1).

²²⁶ The term ‘transport PGD’ sees at the situation where in the course of IVF treatment carried out in a partner Medical Centre, certain cells from the embryo created in the course of that IVF treatment are transported to the licensed Academic Hospital Maastricht for the actual PGD. Annex 1 to *Regeling preïmplantatie genetische diagnostiek*, *Stcrt.* 2009, 42.

²²⁷ *Gezondheidsraad* 2006, *supra* n. 208. For the government’s reaction to the Advice, see *Kamerstukken II* 2005/2006, 30 300 XVI, no. 136.

²²⁸ *Kamerstukken II* 2007/08, 31 200 XVI, no. 147. For earlier opinions on the matter see *Kamerstukken II* 2005/06 30 300 XVI, no. 136 and *Kamerstukken II* 2007/08, 31 200 XVI, no. 10.

²²⁹ *Gezondheidsraad* 2006, *supra* n. 208, at, p. 18.

²³⁰ See, *inter alia*, *Kamerstukken II* 2007/08, 29 323, nos. 41, 43, 46 and 47 and *Aanhangsel Handelingen II* 2007/08, 6593 no. 93. See also PGD Nederland, *Annual Report PGD the Netherlands and cumulative overview 1995–2008* (Jaarverslag PGD Nederland 2008 en cumulatief overzicht 1995–2008), p. 4, Annex to *Kamerstukken II* 2009/10, 29323, no. 76.

²³¹ *Stcrt.* 2009, 42.

²³² See www.pgdnederland.nl/pgd-en-de-samenleving/landelijke-indicatiecommissie, visited January 2012. The Committee was established at the request of the Secretary of State of Health and consists of prominent medical experts, ethicists and a representative of patient interest groups.

²³³ See, for example, G. de Wert and I. De Beaufort, ‘Sta nú ook andere varianten van PGD toe’, *NRC* 1 July 2008, online available at www.nrc.nl/article1933210, visited August 2010.

²³⁴ *Kamerstukken II*, 2010/11, 25 424, no. 117.

and cognitive deterioration.²³⁵ All carriers of the HD gene contract the disease at some point in life, usually between the ages of 35 and 45. Each child of a parent with HD carries a 50 per cent risk of inheriting the HD gene. Persons with a family history of HD may prefer not to know their carrier status. They may, however, still wish to prevent the birth of a carrier child. With the combination of IVF treatment and PGD it is possible to select embryos without the HD gene. This can be done without informing the person at risk and his or her partner whether any embryos were found to have the HD gene. This so-called ‘non-disclosing PGD’, where the person at risk is thus not informed if he or she carries the HD gene was explicitly ruled out in the Netherlands, as the 2009 PGD Regulation provided that in order to qualify for preimplantation genetic diagnosis (PGD), prospective parents had to be willing to find out their own genetic status.²³⁶

An alternative method is ‘exclusion PGD’. Because in this method DNA linkage testing is utilised, the screening does not reveal if the person at risk in fact carries the HD gene.²³⁷ For a long time this method was prohibited under Dutch law and as a consequence various couples in which one partner was at 50 per cent risk, went to Belgium for exclusion PGD.²³⁸ In January 2011 the Committee on PGD indications recommended lifting the prohibition on exclusion PGD.²³⁹ The Secretary of State for Health agreed with the Committee that the parent’s right not to know had not been taken into consideration sufficiently in the debate on exclusion PGD.²⁴⁰ He therefore announced that an amendment of the PGD-regulation would legalise exclusion PGD for HD and similar diseases.²⁴¹

The PGD regulation was evaluated in 2012.²⁴² The authors of the report, *inter alia*, identified a couple of moral matters involved in PGD which needed further research,

²³⁵ E. Asscher and B.-J. Koops, ‘The right not to know and preimplantation genetic diagnosis for Huntington’s disease’, 36 *J Med Ethics* (2010) p. 30.

²³⁶ See *Kamerstukken II* 2005/06, 30 300 XVI, no. 136, p. 10.

²³⁷ As explained in an article by Van Rij et al.: ‘The exclusion test is based on identifying the grandparental origin of the two HTT alleles. If one of the two alleles from the affected grandparent is found in the fetus after exclusion PND, a termination of pregnancy [...] is offered, although the fetus only has a 50 per cent risk of being a carrier of the CAG expansion. In exclusion PGD, only embryos with one of the two HTT alleles from the non-affected grandparent are transferred. Both the availability and cooperation of family members in providing a sample for PGD workup is necessary for exclusion testing.’ M.C. Van Rij et al., ‘Preimplantation genetic diagnosis (PGD) for Huntington’s disease: the experience of three European centres’, 20 *European Journal of Human Genetics* (2012) p. 368. For another explanation of the method, see www.pgd.org.uk/resources/tests/huntingdon_exclusion.pdf, visited November 2012.

²³⁸ *Kamerstukken II* 2011/12, 25 424, no. 135, p. 3.

²³⁹ www.pgdnederland.nl/pgd-en-de-samenleving/standpunt-werkgroep-PGD-HD, visited July 2011.

²⁴⁰ *Kamerstukken II* 2011/12, 25 424, no. 135, p. 4. On ‘the right not to know’, see also Asscher and Koops 2010, *supra* n. 235.

²⁴¹ *Idem*.

²⁴² N. Steinkamp et al., *Evaluatie Regeling Preïmplantatie Genetische Diagnostiek (PGD). Besliskader – behoeferaming – ethisch debat* [Evaluation of the Regulation preimplantation genetic diagnosis (PGD). Framework for decision-making – assessment of needs – ethical debate] (Nijmegen, IQ healthcare 2012), online available at www.zonmw.nl/nl/projecten/project-detail/evaluatie-van-het-beslissingskader-pgd-ervaringen-van-professionals-en-paren-met-kinderwens/rapport, visited June 2014.

such as a further broadening of the indications for PGD (e.g. hereditary cancers) and the concept of ‘desire health care’ (*wensgeneeskunde*) which could lead to ‘designer babies’.

6.3.6. Vitrification of egg cells

Vitrification of egg cells (oocyte vitrification or freezing) and subsequent cryopreservation have been lawful in the Netherlands since 2011. When the Medical Centre of the Free University of Amsterdam announced in 2009 that it intended to start offering this treatment, including on non-medical grounds, this attracted media attention²⁴³ and various parliamentary questions were asked.²⁴⁴ These prompted the Minister of Health, Welfare and Sports to ask the Amsterdam Medical Centre to postpone the actual carrying out of the treatment until political agreement upon the matter was reached.²⁴⁵ The most controversial was cryopreservation of egg cells on non-medical grounds.²⁴⁶ Some (confessional) political parties claimed, *inter alia*, that vitrification of egg cells was a form of ‘desire health care’, that it encouraged the postponement of family planning and that the method unacceptably stretched the moratorium on embryo research, as in force at the time.²⁴⁷ Various other parties did not object to the method as such, but felt that vitrification was not to be covered by the Health Insurance Act, as they considered it ‘a luxurious type of care’.²⁴⁸ In 2011 a majority in Parliament agreed that vitrification of egg cells, both on medical and non-medical grounds, was lawful under the existing Dutch legislation, provided some conditions were met.²⁴⁹ The reimbursement question was postponed. In 2012 the Health Care Insurance Board (*College voor zorgverzekeringen* (CVZ)

²⁴³ *Inter alia*, J. Koelewijn, ‘AMC vriest eicellen in voor de 35-plus wensmoeder’, *NRC Handelsblad* 3 October 2009 and p. 1; ‘AMC biedt eicelbewaarservice’, *De Telegraaf* 5 October 2009, p. 5.

²⁴⁴ *Aanhangsel Handelingen II* 2009/10, 255–257. See also W. Dondorp and G. de Wert, *Reageerbuisdebat. Over de maakbaarheid van de voortplanting* [Test tube debate. On the manipulability of human reproduction] (Den Haag, ZonMw 2012) pp. 15–16, online available at www.zonmw.nl/uploads/tx_vipublicaties/ZonMw_E_G_Reageerbuisdebat170x240.pdf, visited June 2014.

²⁴⁵ ‘Kamer staat vitrificatie toe’, *Trouw* 15 April 2011, p. 10 and P. Herderscheë, ‘AMC zet gezinspolitiek op de agenda; Eicellen invriezen om zwangerschap tot het 50^{ste} jaar mogelijk te maken is volgens CU en CDA een brug te ver’, *de Volkskrant* 16 July 2009, p. 3.

²⁴⁶ Winter et al. 2012, *supra* n. 136, at pp. 177–178. See also J. Nekkebroeck et al., ‘A preliminary profile of women opting for oocyte cryopreservation for non-medical reasons’, 25 *Human Reproduction* (2010) p. i15. See furthermore W. Dondorp et al., ‘Oocyte cryopreservation for age-related fertility loss’, 27 *Human Reproduction* (2012) p. 1231 and H. Mertes et al., ‘Implications of oocyte cryostorage for the practice of oocyte donation’, 27 *Human Reproduction* (2012) pp. 2886–2893.

²⁴⁷ P. Herderscheë, ‘AMC zet gezinspolitiek op de agenda; Eicellen invriezen om zwangerschap tot het 50^{ste} jaar mogelijk te maken is volgens CU en CDA een brug te ver’, *de Volkskrant* 16 July 2009, p. 3.

²⁴⁸ A. Reerink, ‘Alleen rijke vrouwen zullen zwangerschap kunnen uitstellen; Politieke partijen voelen in periode van bezuinigen weinig voor vergoeden van invriezen eicellen via verzekering’, *NRC Handelsblad* 31 August 2010, p. 3; A. Reerink, ‘Alleen voor rijke vrouwen; Politiek: invriezen eicellen voor later gebruik is luxezorg’, *NRC Next* 1 September 2010 and ‘Eicellen invriezen mag, maar wel op eigen kosten’, *Nederlands Dagblad* 7 April 2011.

²⁴⁹ *Kamerstukken II* 2010/11, 32 500 XVI, no. 141 and ‘Kamer staat vitrificatie toe’, *Trouw* 15 April 2011, p. 10. The conditions are, *inter alia*, that women are well informed about the chances of reproduction after vitrification and that they are informed that little is as yet known regarding the long-term effects for children born through this technique. Another condition is that the women who make use of

now *Zorginstituut Nederland* (the National Health Care Institute)) recommended reimbursing vitrification only in cases where certain medical indications were present,²⁵⁰ advice which the Minister for Health, Welfare and Sports followed on.²⁵¹

6.3.7. AHR treatment and public funding

Reimbursement for AHR treatment under the Health Insurance Scheme, which is based on the principle of solidarity, has always been a much debated issue in the Netherlands. Debates have focused on the ethical acceptability and the medical necessity of (certain types of) AHR treatment, as well as on questions of cost efficiency.

In 1985 the Central Appeals Court for Public Service and Social Security Matters (*Centrale Raad van Beroep*) ruled that IVF treatment had belonged to standard medical practice in the Netherlands since the year 1983.²⁵² This ruling was, however, no ground for the legislature to include IVF treatment in the cover under the Health Insurance Act (*Ziekenfondswet*).²⁵³ Instead, the Health Care Insurance Board (at that time named the *Ziekenfondsraad*)²⁵⁴ decided to include IVF treatment in its subsidy scheme (*subsidieregeling*) on the basis of which experimental care was financed.²⁵⁵ At maximum three cycles were reimbursed.²⁵⁶ This situation lasted for many years.²⁵⁷

cryopreserved egg cells, may not be older than 45 years old. See Winter et al. 2012, *supra* n. 136, at p. 178.

²⁵⁰ CVZ, ‘Vitrificatie van eigen eicellen’, report of 3 April 2012, Annex to *Kamerstukken II* 2011/12, 33 000 XVI, no. 190, online available at www.cvz.nl, visited June 2014. See also Dondorp and De Wert 2012B, *supra* n. 200, at p. 62.

²⁵¹ *Kamerstukken II* 2011/12, 33 000 XVI, no. 190.

²⁵² CRvB 19 November 1985, ECLI:NL:CRVB:1985:AK2681.

²⁵³ See also G. van Malestein, ‘In vitro fertilisatie in het ziekenfondspakket! Afwijzend besluit Van der Reijden juridisch niet meer houdbaar’ [‘In vitro fertilisation in the National Health Scheme! Refusal Van der Reijden no longer legally tenable’], 41 *Medisch Contact* (1986) p. 722. Van Malestein notes, however, that many private insurers nevertheless provided for reimbursement for IVF treatment.

²⁵⁴ Until 1999 the relevant body was called *Ziekenfondsraad*. From 1999 to 2014 it was named *College voor zorgverzekeringen* (CVZ) and since 1 April 2014 it carries the name *Zorginstituut Nederland* [National Health Care Institute]. See www.zorginstituutnederland.nl/organisatie/historie, visited June 2014.

²⁵⁵ This decision had retrospective effect until the year 1983. Van Malestein 1986, *supra* n. 253, at p. 41.

²⁵⁶ Yet in 1993 critique was issued by medical profession on this limitation to three cycles. It was held that because of this limitation doctors felt under pressure to make the IVF treatment successful and therefore often implanted too many embryos in one cycle, thereby increasing the chances of multiply births (and accompanying costs). ‘IVF vaker vergoeden’ *Grens dwingt artsen tot verhoging*, *Trouw* 9 August 1993.

²⁵⁷ See ‘Simons wil subsidie IVF voorlopig handhaven’, *Trouw* 5 November 1993, p. 5. As of 1998 de *Ziekenfondsraad* even reimbursed IVF treatment carried out in a private (initially non-licensed) clinic. ‘Ziekenfonds gaat IVF vergoeden in prive-kliniek’, *de Volkskrant* 25 March 1998, p. 7 and ‘Ook vergoeding IVF-behandeling in kliniek Leiden’, *NRC Handelsblad* 25 March 1998, p. 3. The *Regeling subsidiëring ziekenfondsraad IVF* [Regulation public financing IVF] of 23 November 1989, *Stcrt.* 1990, 20 expired per 1 January 2001.

In 2002 the Health Care Insurance Board held that IVF treatment could no longer be considered ‘experimental’ and proposed including it amongst the benefits under the Health Insurance Act.²⁵⁸ This recommendation was not fully followed up by the legislature; as of 2004 only the second and third IVF cycles were reimbursed under the Health Insurance Act.²⁵⁹ The first IVF cycle (including all medicine involved) was at the patient’s own cost.²⁶⁰ From the beginning this measure was criticised in politics²⁶¹ and in medical professional circles²⁶² as well by patient interest groups.²⁶³ *Inter alia*, the argument was made that infertility was an illness and that this plan involved serious medical risks, for instance because patients would seek less expensive, but risky alternatives. The Netherlands Organisation for Health Research and Development furthermore endorsed the widely supported finding that it was possible to organise fertility treatment in a more efficient manner (*‘doelmatiger zorg’*), for instance by setting a limit on the number of embryos that could be implanted in one IVF cycle.²⁶⁴ At the same time there were (confessional) political parties who felt that imposed solidarity by means of the Health Insurance Act was undesirable for ‘ideologically highly controversial’ types of treatment like IVF treatment, abortion and euthanasia.²⁶⁵ After lengthy discussions,²⁶⁶ the government decided to reverse the measure from 2007; the first three IVF/ICSI cycles – including necessary medicine and including situations where gametes were donated – were reimbursed under the Health Insurance Act. The treatment had to be carried out in a licensed establishment; a female insured was entitled to reimbursement up the age of 40 only and patients had to pay a fixed amount of 500 euros per IVF cycle.²⁶⁷

This legislation soon again came under pressure as part of the government’s general austerity policy. The coalition agreement of 2010 provided that as of January 2013

²⁵⁸ CVZ, *IVF/ICSI: aanbevelingen voor wijziging van de regeling op basis van de resultaten van effect- en evaluatieonderzoek* [IVF/ICSI: recommendations for amendment of the regulation on the basis of the results of effects and evaluation research] (Diemen, CVZ 2002).

²⁵⁹ See *Kamerstukken II* 2005/06, 30 300 XVI, no. 9.

²⁶⁰ This austerity measure was expected to bring in 25 million euros, but in fact brought in 20 million. Stichting Farmaceutische Kengetallen, ‘IVF-maatregel bespaarde € 20 miljoen’, *Pharmaceutisch Weekblad* (2007) p. 13.

²⁶¹ *Kamerstukken II* 2003/04, 29 200 XVI, no. 143.

²⁶² F. Santing, ‘Meer meerlingen als patient betaalt; Deskundigen vrezen onbedoeld effect van schrappen IVF-vergoeding’, *NRC Handelsblad* 28 August 2003, p. 2. The *Nederlandse Vereniging voor Obstetrie en Gynaecologie (NVOG)* [Dutch Association for Obstetrics and Gynaecology] even called the austerity measures ‘inhuman’. ‘Bezuinigingen op ivf zijn onmenselijk’, *de Volkskrant* 13 November 2003, p. 3.

²⁶³ E. Bor, ‘Harde streep door kinderwens’, *Algemeen Dagblad* 2 December 2003, p. 9.

²⁶⁴ ZonMw [The Netherlands Organisation for Health Research and Development], *Vruchtbaarheidsstoornissen. Kansen voor doelmatiger zorg* [Fertility problems. Opportunities for more efficient care], report of June 2005, p. 12, Annex to *Kamerstukken II* 2004/05, 29800 XVI, no. 191. See also ‘IVF kan twaalf miljoen euro goedkoper; Onderzoek voor ministerie’, *NRC Handelsblad* 28 June 2005, p. 3.

²⁶⁵ *Kamerstukken II* 2004/05, 29 763, nos. 23 and 57.

²⁶⁶ *Inter alia* ‘Kamer wil IVF in basisverzekering’, *Algemeen Dagblad* 6 October 2005, p. 5; ‘Politiek kibbelt nog over vergoeding ivf’, *Het Financieele Dagblad* 19 October 2005, p. 5; ‘Hoogervorst en Kamer botsen over vergoeding ivf’, *Trouw* 14 October 2005, p. 218.

²⁶⁷ *Kamerstukken II* 2005/06, 30 300 XVI, no. 142, p. 3 and Art. 2.5(1)(3) in conjunction with Art. 1(e) Besluit Zorgverzekering [Health Insurance Order], *Stb.* 2005, 389.

only the first IVF cycle would be reimbursed.²⁶⁸ This plan met with criticism from Members of Parliament²⁶⁹ and medical professionals²⁷⁰ and discussions arose which were similar to those held in 2004. Once again, more efficient and more patient-friendly alternatives were sought.²⁷¹ Following a report of the Health Care Insurance Board on the matter of 2012,²⁷² a more diversified approach was taken, whereby the entitlement to reimbursement was, *inter alia*, made dependent on the woman's age.²⁷³

Since 2013, reimbursement under the Health Insurance Act is provided for the first two IVF cycles for female insured patients until the age of 38, provided only one embryo is implanted in the woman's body.²⁷⁴ If the woman is between 38 and 43 years old, the first three cycles are reimbursed, provided no more than two embryos are implanted during the treatment. If the woman has reached the age of 43, IVF treatment and other fertility treatment is reimbursed under the Health Insurance Act in exceptional circumstances only.²⁷⁵ Preimplantation genetic diagnosis (PGD) – if carried out in conformity with the relevant regulations (see 6.3.5 above) – is also covered by the Health Insurance Act.²⁷⁶ Treatment to obtain gametes from a

²⁶⁸ 'Vrijheid en verantwoordelijkheid' ['Freedom and Responsibility'], Regeerakkoord [Coalition Agreement] VVD-CDA, 30 September 2010, p. 18, online available at www.rijksoverheid.nl/documenten-en-publicaties/rapporten/2010/09/30/regeerakkoord-vvd-cda.html, visited February 2011. See also *Kamerstukken II* 2011/12, 33 000 XVI, no. 24. This austerity measure brought in 30 million euros. *Kamerstukken II* 2005/06, 30 300 XVI, no. 142, p. 1.

²⁶⁹ *Kamerstukken II* 2010/11, 32 500 XVI, no. 46. See also F. Weeda, 'Ivf bij 41-plus, dat zijn meestal hoger opgeleiden; Vier vragen over bezuinigingen op ivf-behandelingen', *NRC Handelsblad* 15 May 2012.

²⁷⁰ See C. Vos, 'Bezuinigen op ivf jaagt de kosten op', *de Volkskrant* 6 November 2010.

²⁷¹ *Kamerstukken II* 2011/12, 33 000 XVI, no. 24.

²⁷² CVZ, *Rapport Uitvoeringstoets alternatieven IVF-pakketmaatregel* [Report examining alternatives to the regulation in relation to reimbursement for IVF treatment under the Health Insurance Act], June 2012, Annex to *Kamerstukken II* 33000 XVI, no. 188, online available at www.cvz.nl/binaries/live/cvzinternet/hst_content/nl/documenten/rapporten/2012/rptl206-uitvoeringstoets-alt-ivf-maatregel.pdf, visited October 2012.

²⁷³ See *Kamerstukken II* 2011/12, 33 000 XVI, no. 188 and CVZ, *Een leeftijdsgrens voor vruchtbaarheidsbehandelingen* [An age limit for fertility treatment], Annex to *Kamerstukken II* 2011/12, 33000-XVI no. 188.

²⁷⁴ Exceptionally the implantation of two embryos is reimbursed under the Health Insurance Act.

²⁷⁵ *Kamerstukken II* 2011/12, 33 000 XVI, no. 188, p. 2. See also www.rijksoverheid.nl/onderwerpen/zorgverzekering/basisverzekering, visited January 2013.

²⁷⁶ See CVZ, *Preimplantatie genetische diagnostiek (PGD) bij erfelijke borst/ovariumkanker is een te verzekeren prestatie* [Preimplantation genetic diagnosis (PGD) in case of hereditary breast or ovary cancer is a performance that qualifies for insurance under the Health Insurance Act], standpunt Zvw [Opinion Health Insurance Act] of 30 June 2008, online available at www.cvz.nl/binaries/live/cvzinternet/hst_content/nl/documenten/standpunten/2008/sp0806+pgd+bij+borst-ovariumkanker.pdf, visited June 2011 and CVZ, *Preimplantatie genetische diagnostiek (PGD) in combinatie met HLA-typering van IVF-embryo's ten behoeve van eventuele stamceltransplantatie is verzekerde prestatie* [Preimplantation genetic diagnosis (PGD) in combination with HLA typification of IVF embryos with a view to a possible stem cell transplantation is a performance that qualifies for insurance under the Health Insurance Act], adviesaanvraag Zvw [request for advice under the Health Insurance Act] of 24 September 2007, online available at www.cvz.nl/binaries/live/cvzinternet/hst_content/nl/documenten/standpunten/2007/sp0709+typering+ivf-embryo-s.pdf, visited June 2011. It is noteworthy that the CVZ had held yet in 2010 (thus before the treatment was legally available in the Netherlands) that exclusion-PGD for HD was covered by the Health Insurance Act. CVZ, *Preimplantatie genetische diagnostiek (PGD) met exclusietest bij de ziekte van Huntington* [Preimplantation genetic diagnosis

donor,²⁷⁷ high-technological surrogacy²⁷⁸ and egg cell vitrification on other grounds than medical grounds (see above) are not covered.

Certain costs made in the course of AHR treatment may furthermore qualify for tax deductions, so long as these costs are directly related to illness, invalidity or child delivery.²⁷⁹

6.3.8. Surrogacy

Dutch legislation and policy takes the discouragement of commercial surrogacy as a starting point. With a view to protecting both the interests of the child and the interests of the surrogate mother, the relevant legislation has since the late 1980s aimed to prevent commercial surrogacy from developing as a phenomenon in society.²⁸⁰ The legislature at the time pointed at the risk of emotional problems for the surrogate mother in the long run; increased identity problems for any child born through surrogacy; the possibility that the natural process of bonding between mother and child after birth would be distorted; and the risk that the expectations of the intended parents (also referred to as commissioning parents) would not be met, even risking their rejection of the child.²⁸¹ Further grounds for this approach of discouragement that have been put forward also more recently are the complex ethical and legal questions involved in surrogacy; the view that this practice degrades a surrogate mother to a mere ‘means of reproduction’; risks of exploitation of generally less wealthy and less educated surrogate mothers; and risks of trade in babies.²⁸²

With the inclusion of Articles 151b and 151c in the Criminal Code in the 1993,²⁸³ all conduct that may advance the supply and demand of surrogacy – such as mediation by means of a professional practice or company and advertisements for surrogacy – is

(PGD) with exclusion test for Huntington’s disease], Standpunt Zvw [Opinion Health Insurance Act] of 30 August 2010, online available at www.cvz.nl/binaries/live/cvzinternet/hst_content/nl/documenten/standpunten/2010/sp1008+pgd+bij+ziekte+van+huntington.pdf, visited July 2011. See also *Kamerstukken II* 2011/12, 25 424, no. 135, p. 5.

²⁷⁷ College voor zorgverzekeringen [Health Care Insurance Board] Opinion of 24 October 2006, no. 26084415.

²⁷⁸ College voor zorgverzekeringen [Health Care Insurance Board] Opinion of 20 November 2006, no. 26080732.

²⁷⁹ Art. 6.17 Wet Inkomstenbelasting 2001 [Income Tax Act 2001]. Rb. ’s-Gravenhage 8 January 2013, ECLI:NL:RBDHA:2013:18948, referring (in para. 11) to HR 22 April 2005, ECLI:NL:HR:2005:AT4486.

²⁸⁰ *Kamerstukken II* 1987/88, 20 706, no. 2, p. 30 et seq; *Kamerstukken II* 1990/91, 21 968, no. 3, p. 3 and *Kamerstukken II* 2011/12, 33 000 VI, no. 69, p. 2.

²⁸¹ *Kamerstukken II* 1990/91, 21 968, no. 3, pp. 1–2.

²⁸² *Kamerstukken II* 2009/10, 32 123 XVI, no. 30, p. 2.

²⁸³ Act of 16 September 1993, *Stb.* 1993, 486. The Act entered into force on 1 November 1993. Its Art. 151b Sr reads:

‘1. A person, who, in the practice of a profession or in carrying on a business, intentionally brings about or encourages either direct or indirect negotiations between a surrogate mother or a woman who wishes to be a surrogate mother and another person or arranges an appointment in order to carry out the intention specified in section 3, is liable to a term of imprisonment of not more than one year or a fine of the fourth category.

punishable.²⁸⁴ In practice hardly any prosecutions have been brought on the basis of these provisions.²⁸⁵ This has been held to be due to a lack of clarity of the rules and difficulties in meeting the burden of proof.²⁸⁶

Altruistic surrogate motherhood or the conclusion of a surrogacy contract as such are not punishable, but any such contract cannot be legally enforced in practice.²⁸⁷ It is not lawful for Dutch clinics to assist in low-technological surrogacy, but people can establish this without medical assistance. As further explained hereafter, the

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2. The punishment in section 1 is also applicable to a person who:
 - a. publicly offers services consisting of bringing about or promoting negotiations or an appointment as specified in section 1;
 - b. discloses that a woman wishes to be surrogate mother or is available as such, or that a woman is being sought who wishes to be a surrogate mother or is available as such.
 3. The term 'surrogate mother' is to be taken to mean a woman who has become pregnant with the intention of bearing a child for another who wishes to acquire parental authority over the child or otherwise wishes on a permanent basis to care for the child and bring it up.

Art. 151c Sr reads:

1. A person, who, in the practice of a profession or in carrying on a business, intentionally brings about or encourages either direct or indirect negotiations between a woman and another person or arranges an appointment with respect to her wish on a permanent basis to leave the care for and the upbringing of her child to another person, is liable to a term of imprisonment of not more than six months or a fine of the third category.
2. Without prejudice to the provisions in Art. 151b, section 1, section 1 of this Article is not applicable:
 - a. where the bringing about or promotion specified in that section is by the Child Care and Protection Board or by a juristic person so designated by this Board;
 - b. where the bringing about or promoting specified in that section consists in a referral to an organization as specified under *a*.'

Translations by Rayar and Wadsworth 1997, *supra* n. 71, at pp. 142–143. Other relevant provisions of the Criminal Code are Art. 225 Sr (forgery); Art. 236 Sr (embezzlement of civil status); Art. 442a Sr (placement of a child younger than six months old, without permission of the Dutch Children Protection Board). Another relevant provision concerns the penalisation of placement of a foreign child for adoption without permission of the Central Authority for International Adoption under Art. 28 Wet openeming buitenlandse kinderen ter adoptie (Wobka) [Act on the fostering of children from foreign countries with the purpose of adoption]. See also *Kamerstukken II* 2011/12, 33 000 VI, no. 69, p. 3.

²⁸⁴ *Kamerstukken II* 2011/12, 33 000 VI, no. 69, p. 2. For an overview of the legal situation in respect of surrogacy until the 1993 legislation, see *inter alia* A.M.L. Broekhuijsen-Molenaar, *Civielrechtelijke aspecten van kunstmatige inseminatie en draagmoederschap* [Civil law aspects of artificial insemination and surrogacy] (Deventer, Kluwer 1991) pp. 151–177.

²⁸⁵ Boele Woelki et al. point out: 'An analysis of the legal databases in the field does [...] indicate that there are very few actual prosecutions. However, it is extremely difficult to obtain a clear impression of why few of the cases reported ultimately lead to charges being brought or penalties levied. Nevertheless, no real conclusion can be attached to this factual situation, as the causes for the low number of prosecutions are diverse and have not been able to be identified.' Boele-Woelki et al. 2011, *supra* n. 186, at p. 305. For cases brought on the basis of related provisions of the Criminal Code, see also pp. 44–48 of the report. In 1997 report was made of two criminal convictions for mediation in commercial surrogacy by the District Court Zutphen. See 'Vrouw veroordeeld voor advertentie draagmoeder', *de Volkskrant* 3 April 1997. For a published case in which the Dutch State put forward that an international commercial surrogacy agreement was against Art. 151b (2)(b) Sr, see Rb. 's-Gravenhage (vrzr.) 9 November 2010, ECLI:NL:RBSGR:2010:BP3764.

²⁸⁶ *Kamerstukken II* 2011/12, 33 000 VI, no. 69, p. 3.

²⁸⁷ *Idem*, p. 2 and Boele-Woelki et al. 2011, *supra* n. 186, at pp. 36 and 59. The authors conclude (on p. 61 of the report) that on the one hand a surrogacy agreement has limited effects, but on the other hand, it is not entirely without importance. For instance, a contractual agreement is a prerequisite for access to supervised high-technological surrogacy in the VU Medical Centre (see below).

establishment of parental links between the intended parents and the child may, however, be difficult. The Dutch medical profession may only lawfully assist in so-called high-technological surrogacy and this is subject to strict conditions.²⁸⁸ In 1998 the Dutch Association for Obstetrics and Gynaecology (*Nederlandse Vereniging voor Obstetrie en Gynaecologie* (NVOG)) drafted a guideline on high-technological surrogacy (*Richtlijn Hoogtechnologisch draagmoederschap*)²⁸⁹ which, *inter alia*, set medical indications for access to this treatment and conditions for the intended parents and the surrogate mother. Also, it provided that counselling must always be provided in surrogacy situations. In the Dutch context only the gametes of the intended parents may be used in high-technological surrogacy,²⁹⁰ which implies that same-sex couples are excluded from this treatment. Since 2006 the Medical Centre of the Free University of Amsterdam has been exclusively licensed to carry out this kind of treatment²⁹¹ and access to it is subject to strict conditions.²⁹² For instance, there must be a medical reason for the surrogacy and the surrogate mother must have at least one child of her own. Further, the surrogacy must be altruistic in character, although the reimbursement of certain expenses is accepted.²⁹³ The Medical Centre of the Free University of Amsterdam itself has furthermore set the conditions that both the intended parents and the surrogate mother must have Dutch nationality, must speak the Dutch language and must be resident in the Netherlands.²⁹⁴ The Minister of Health, Welfare and Sports announced in 2012 that she intended to critically review the conditions set by the medical profession,²⁹⁵ but, as far as the present

²⁸⁸ High-technological surrogacy was introduced in the Netherlands in 1997. See also M.F.M. van den Berg and C. Buijssen, 'Hoogtechnologisch draagmoederschap' ['High-technological surrogacy'], 79 *Nederlands Juristenblad* (2004) p. 724 and S.M. Dermout, *De eerste logeerpartij, hoogtechnologisch draagmoederschap in Nederland* [The first time staying over, hightechnological surrogacy in the Netherlands] (Groningen, s.n. 2001).

²⁸⁹ Nederlandse Vereniging voor Obstetrie en Gynaecologie (NVOG) [Dutch Association for Obstetrics and Gynaecology], *Richtlijn Hoogtechnologisch draagmoederschap* [Guideline on high-technological surrogacy] (Utrecht 1999), online available at www.nvog-documenten.nl/uploaded/docs/richtlijnen_pdf/18_hoog_draagmoeder.pdf, visited June 2010.

²⁹⁰ Other forms of high-technological surrogacy – e.g. with the use of donated gametes – are not lawful in the Netherlands. See, however, Rb. 's-Hertogenbosch 18 August 2011, ECLI:NL:RBSHE:2011:BR5334. In this surrogacy case the Court entrusted the guardianship to the commissioning parents, while the child had been conceived during an IVF treatment, whereby use had been made of an egg cell donated by a third party (neither the commissioning mother, nor the surrogate mother).

²⁹¹ *Kamerstukken II* 2011/12, 33 000 VI, no. 69, p. 2. From 1997 to 2004 high-technological surrogacy was provided in the Dutch Centre for non-commercial IVF Surrogacy in Zaandam. Due to financial problems, this centre closed its doors in 2004. In 2006, the Medical Centre of the Free University of Amsterdam initiated the second Dutch centre. See S. Dermout et al., 'Non-commercial surrogacy: an account of patient management in the first Dutch Centre for IVF Surrogacy, from 1997 to 2004', 25 *Human Reproduction* (2010) p. 449. The Amsterdam centre '[...] receives on average 20 requests annually from those wishing to conceive a child using a surrogate', of which 'approximately 10 cases annually actually lead to a course of treatment.' Boele-Woelki et al. 2011, *supra* n. 186, at p. 305.

²⁹² Art. 2(4) of Annex to Planningsbesluit in-vitrofertilisatie, *Stcrt.* 1998, 95 and the (outdated) guideline on high-technological surrogacy by the Dutch Association for Obstetrics and Gynaecology of 1999, *supra* n. 289.

²⁹³ E.g. Rb. 's-Gravenhage 11 December 2007, ECLI:NL:RBSGR:2007:BB9844.

²⁹⁴ See www.vumc.nl/afdelingen/patientenfolders-brochures/zoeken-alfabet/D/hoog_technologisch_draagmoel.pdf, visited October 2012.

²⁹⁵ As indicated by the Secretary of State of Justice in his letter to Parliament on surrogate motherhood of 16 December 2011, *Kamerstukken II* 2011/12, 33 000 VI, no. 69.

author is aware, this has as yet not resulted in any changes. Also, the aforementioned guidelines on high-technological surrogacy from 1998 have been outdated since 2003,²⁹⁶ but have not yet been renewed.²⁹⁷

Dutch civil law does not contain any specific provision on surrogacy.²⁹⁸ Hence, ‘the regular rules in the field of parentage, parental responsibility and child protection’ apply in surrogacy situations.²⁹⁹ A 2011 research report on surrogacy and unlawful placement of children in the Netherlands, concluded that ‘[...] the position of a child born by means of surrogacy [was] legally unclear, and uncertainty exist[ed] with respect to the legal position of the commissioning parents and the surrogate parents.’³⁰⁰ The fact that it is so difficult to establish parental links in surrogacy cases, fits in with the policy of discouragement of this phenomenon.³⁰¹

Following the *mater semper certa est* rule, the surrogate mother is automatically regarded as the legal mother of the child, even if the intended mother is in fact genetically related to the child.³⁰² In the case that the surrogate mother is married or has a registered partner, her spouse or registered partner is, by operation of the law, the second legal parent.³⁰³ The establishment of parental links between the intended parents and the child requires a (court) procedure.³⁰⁴ While surrogacy agreements are non-enforceable under Dutch law, parties are nonetheless advised to draft an agreement, because the Child Welfare Council and the courts may take this into account in their assessments related to the establishment of parental links.³⁰⁵

²⁹⁶ *Supra* n. 286. At p. 6 of the Guideline it is indicated that it ceases to be valid five years after their publication.

²⁹⁷ See also *Kamerstukken II* 2012/13, 33 400 XVI, no. 155, p. 7.

²⁹⁸ See Boele-Woelki et al. 2011, *supra* n. 186, at p. 310.

²⁹⁹ *Idem*, at pp. 306–307.

³⁰⁰ *Idem*, at p. 310. At pp. 306–307 of the report, the authors explain in more detail: ‘Dutch law does not specifically regulate the consequences of surrogacy in the field of parentage. Accordingly, the regular rules in the field of parentage, parental responsibility and child protection apply in these cases. The legal position of a child born as a result of surrogacy is uncertain and dependent upon a significant number of factors that in and of themselves have little relevance to the surrogacy arrangement. The surrogate is always regarded as the legal mother of the child, regardless of whether she has also provided the genetic material for the birth. If the surrogate is married, then her husband is also automatically the child’s legal father. The transfer of parental rights to the commissioning parents is difficult and the result dependent upon a variety of different circumstances. Adoption by at least one of the commissioning parents will also be necessary prior to the final transfer of parental rights to both commissioning parents. [...] The law with respect to the legal transfer of parental rights from the surrogate family to the commissioning family is also not catered specifically, meaning that the normal rules of parentage law will apply in these cases too.’

³⁰¹ *Idem*, at p. 52.

³⁰² Art. 1:198 BW. See also *Kamerstukken II* 2011/12, 33 000 VI, no. 69, p. 2.

³⁰³ Arts. 1:199(a) and 1:198(2) BW. When the surrogate mother is not married, the intended father may legally recognise the child before it is born (Art. 1:230 BW).

³⁰⁴ Boele-Woelki et al. noted in 2011 that in case of supervised high-technological surrogacy, the procedure may be accelerated. In that case the intended parents may be awarded parental rights within one year after the child’s birth. Boele-Woelki et al. 2011, *supra* n. 186, at p. 52.

³⁰⁵ See www.rijksoverheid.nl/onderwerpen/erkenning-kind/vraag-en-antwoord/wat-is-een-draagmoeder.html, visited September 2012.

To establish parental links, first the parental rights of the surrogate mother (and her spouse or registered partner) must be removed. This is a child protection measure, which requires the involvement of the Child Welfare Council.³⁰⁶ While the intended father can recognise the child before birth, joint parental authority with the surrogate mother thus must be removed, and the father must be exclusively entrusted with parental authority over the child.³⁰⁷

The intended mother – even if she is the genetic mother of the child – or the same-sex partner of the intended father, must subsequently start an adoption procedure.³⁰⁸ The couple can ask the Child Welfare Council in advance for permission to foster the child (be guardian of the child, ‘*voogdij*’) until the other intended parent adopts it.³⁰⁹ Initially it was provided that the other intended parent could request from the Court the authorisation of such adoption only if (s)he and the intended father had lived together uninterruptedly for a period of at least three years and had jointly cared for the child for a period of at least one uninterrupted year immediately preceding the adoption request.³¹⁰ The latter requirement was, however, successfully challenged in 2013. On 11 September 2013, the District Court of Northern Netherlands ruled that the requirement of Article 1:228(1)(f) that intended parents could adopt a child in surrogacy cases only after foster care of one year, constituted an unjustified difference in treatment under Article 8 and 14 ECHR.³¹¹ Since the year 2009, Article 1:228(3) provides for an exception to this rule where a child was born ‘within the relationship’ of the birth mother and her same-sex life partner (the so-called social mother; see Chapter 12, section 12.3.6.4). The Court ruled that in the case at hand, the child was not born within the relationship of the intended parents, since a third person (the surrogate mother) was involved. Still, the Court compared the situation of the intended mother with that of a social mother and concluded that the possibilities to establish legally recognised parental links with the child were more limited for the intended mother when compared to a social mother. The Court found this difference in legal position incompatible with Article 8 (the right to respect for family life) in conjunction with Article 14 (prohibition on discrimination) ECHR. It held the relevant Article 1:228(1) Civil Code not applicable in this case³¹² and granted the adoption order.³¹³

³⁰⁶ *Kamerstukken II* 2011/12, 33 000 VI, no. 69, p. 2.

³⁰⁷ Art. 1:253c (1) and (3) BW.

³⁰⁸ See, *inter alia*, Hof ’s-Gravenhage 21 August 1998, ECLI:NL:GHSGR:1998:AD2927; Rb. Arnhem 20 February 2008, ECLI:NL:RBARN:2008:BC8012; Hof ’s-Gravenhage 10 February 2010, ECLI:NL:GHSGR:2010:BL8563 and Hof ’s-Gravenhage 1 December 2010, ECLI:NL:GHSGR:2010:BO7387. See also Rb. Noord-Holland 20 November 2013, ECLI:NL:RBNHO:2013:11109, where in a case concerning low-technological surrogacy, an adoption order was granted to the unmarried, cohabiting intended mother of the intended (and genetic) father.

³⁰⁹ Art. 1:241(3) BW.

³¹⁰ Art. 1:227(3) and Art. 1:228(1)(f) BW.

³¹¹ Rb. Noord-Nederland 11 September 2013, ECLI:NL:RBNNE:2013:5503.

³¹² Following Art. 94 of the Dutch Constitution, statutory regulations in force within the Kingdom are not applicable if such application is in conflict with provisions of treaties or of resolutions by international institutions that are binding on all persons.

³¹³ The Court found it established in this case that the surrogate mother had, after the birth of the child, confirmed her decision to give up the child and that she had not developed any emotional parental

The scale on which surrogacy takes place in the Netherlands seems to be fairly limited, although exhaustive statistics are lacking. In 2012 the Secretary of State for Security and Justice informed Parliament that ‘over the past years’ 10 children had been born following high-technological surrogacy in the Amsterdam VU Medical Centre.³¹⁴ He also mentioned that the Child Welfare Council had come across about ten cases of unlawful placement of children (following surrogacy).³¹⁵ The need for a better insight in the scale of the phenomenon has been recognised at government level.³¹⁶

The Dutch government has put an effort in providing clear and accessible information about the legal situation concerning surrogacy in the Netherlands, for instance, through the websites of the Dutch Ministries of Justice and Security and of Foreign Affairs.³¹⁷ In 2014 it was decided to establish a State Commission on Parenthood (*‘Staatscommissie Herijking Ouderschap’*), which, *inter alia*, was given the task to examine whether there is a need for providing for particular regulation of surrogacy in the Dutch Civil Code.³¹⁸ The Commission will have to issue a report before May 2016.

6.4. STATISTICS ON CROSS-BORDER MOVEMENT

6.4.1. Statistics on cross-border abortions

6.4.1.1. Cross-border movement towards the Netherlands

The Netherlands has been a ‘destination’ country in respect of abortion since the first moment abortion practice was liberalised in the 1970s. Cross-border movement took place on a great scale, even though at the time abortions were, strictly speaking, illegal (see 6.2.1 above). Because the Pregnancy Termination Act does not set any domicile requirement, women from abroad can legally have an abortion in the Netherlands.³¹⁹ Non-resident women remain anonymous. They have to bear their own costs (see 6.2.5 above) and are responsible for obtaining medical aftercare upon return to the country of origin.³²⁰

relationship with the child. This constituted a sufficient ground for removing her parental authority. Also, the best interests of the child did not stand in the way of such removing of her parental authority, now that it had been established that the intended parents were the genetic parents of the child.

³¹⁴ *Aanhangsel Handelingen II* 2012/13, 646.

³¹⁵ *Idem*, under reference to *Kamerstukken II* 2010/11, 32 500 VI, no. 83.

³¹⁶ *Kamerstukken II* 2011/12, 33 000 VI, no. 69, pp. 4–5.

³¹⁷ E.g. www.rijksoverheid.nl/onderwerpen/erkenning-kind/vraag-en-antwoord/wat-is-een-draagmoeder.html, visited July 2013. See also *Kamerstukken II* 2011/12, 33 000 VI, no. 69, pp. 4–5.

³¹⁸ Regeling van 28 april 2014, no. 512296, houdende instelling van een Staatscommissie Herijking Ouderschap [*Regulation of 28 April 2014, no. 512296, concerning the installation of a State Commission on Parenthood*], *Stcrt.* 2014, 12556.

³¹⁹ *Kamerstukken II* 2010/11, 30 371, no. 20, p. 8.

³²⁰ *Idem*, at p. 3.

The Healthcare Inspectorate has been reporting on recorded abortion data since 1985. Earlier statistics are based on estimates. For a long time registration on the basis of the Pregnancy Termination Act provided a specification for four countries only: Germany, Belgium, Luxembourg and Spain. In 1984, when the relevant registration forms were drafted, most foreign women who had an abortion in the Netherlands came from these four countries.³²¹ Other countries of origin were not explicitly specified in the registration. Since 1 January 2011 a new registration form has been in use, in which Belgium, Germany, France, Ireland and Poland are included. The duration of the pregnancy of women who are not resident in the Netherlands is not separately registered.³²²

It was estimated that in 1975 approximately 80,000 non-resident women were treated in Dutch abortion clinics,³²³ compared to 15,000 women resident in the Netherlands. Most of the foreign women were resident in the Federal Republic of Germany, Belgium and Luxembourg.³²⁴ For the 1977 it was reported that approximately 65,000 women were treated in Dutch abortion clinics, of whom about two thirds were women from the Federal Republic of Germany.³²⁵ Only since 1986 has the number of women residing in the Netherlands, outweighed the number of non-resident women.³²⁶ Since that time the number of non-resident women who had their pregnancies terminated in the Netherlands has gradually declined.³²⁷ In 2010 approximately one out of eight abortions involved a woman who was resident outside the Netherlands.³²⁸

³²¹ *Jaarrapportage 2010 van de Wet afbreking zwangerschap* [Annual Report under the Pregnancy Termination Act 2010] Utrecht, December 2011, Annex 2, table A, online available at www.rijksoverheid.nl/onderwerpen/abortus/documenten-en-publicaties/rapporten/2011/12/14/igz-jaarrapportage-2010-wet-afbreking-zwangerschap.html, visited March 2012.

³²² *Kamerstukken II* 2010/11, 30 371, no. 20, pp. 7–8. See also Appendix B to Besluit vaststelling model formulieren Besluit afbreking zwangerschap [Decree on model forms for Decree termination pregnancy], *Stcr.* 2010, no. 20555.

³²³ *Kamerstukken II* 1978/79, 15 475, nos. 1–4, p. 14.

³²⁴ J. Rademakers, *Abortus in Nederland 1993–2000. Jaarverslag van de landelijke abortusregistratie* [Abortion in the Netherlands 1993–2000. Annual report of the national abortion registration] (Heemstede, StiSAN 2002) p. 37.

³²⁵ *Kamerstukken II* 1978/79, 15 475, nos. 1–4, p. 14, referring to ‘E. Ketting and P. Schnabel, De abortus-hulpverlening in 1977’. See also Rademakers 2002, *supra* n. 324, at p. 37.

³²⁶ Rademakers 2002, *supra* n. 324, at p. 37.

³²⁷ The exact numbers of pregnancy termination with non-resident women, when compared to the total number of pregnancy terminations in the Netherlands are as follows: 1980: 36,700 out of 56,400 (65.07 per cent); 1985: 20,721 of 37,900 (54.57 per cent); 1995: 7,753 of 28,685 (27.02 per cent); 2000: 6,130 of 33,335 (18.39 per cent); 2005: 4,244 of 28,738 (14.77 per cent); 2006: 5,251 of 32,992 (15.92 per cent); 2007: 4,818 of 33,148 (14.53 per cent); 2008: 4,513 of 32,983 (13.38 per cent); 2009: 4,108 of 32,427 (12.67 per cent); 2010: 4,260 of 30,984 (13.75 per cent). The figures in respect of the year 2010 were estimated. *Jaarrapportage 2010 van de Wet afbreking zwangerschap*, December 2011, p. 14, online available at www.rijksoverheid.nl/onderwerpen/abortus/documenten-en-publicaties/rapporten/2011/12/14/igz-jaarrapportage-2010-wet-afbreking-zwangerschap.html, visited March 2012.

³²⁸ *Jaarrapportage 2010 van de Wet afbreking zwangerschap*, December 2011, p. 7, online available at www.rijksoverheid.nl/onderwerpen/abortus/documenten-en-publicaties/rapporten/2011/12/14/igz-jaarrapportage-2010-wet-afbreking-zwangerschap.html, visited 30 March 2012.

6.4.1.2. *Cross-border movement from the Netherlands*

Halfway through the first decade of the new millennium, some media reports were made of women having abortions in countries where the statutory limit for a lawful abortion was set later than the 24-week limit of the Netherlands. Consequently parliamentary questions were asked.³²⁹ The Dutch Secretary of State for Health, Welfare and Sports responded that this occurred only incidentally and that a Dutch doctor who referred a woman to a foreign clinic was not liable to punishment.³³⁰ Soon, a new controversy arose in respect of a particular abortion clinic in Barcelona (Spain), where – so it was reported – women who were seven months pregnant could have their pregnancies terminated.³³¹ In one case charges were brought against a Dutch woman who had an abortion in the Spanish clinic after 28 weeks of pregnancy, but later these were dropped, on grounds of the special circumstances of the case.

6.4.1.3. *Women on Waves*

The Dutch NGO *Women on Waves* (WoW) has played its own particular role in respect of cross-border abortions. WoW ‘aims to prevent unsafe abortions and empower women to exercise their human rights to physical and mental autonomy.’³³² With its ship that sails under the Dutch flag, WoW regularly sets sail to countries with restrictive abortion regimes. Just outside the territorial waters – where the local laws do not apply – the organisation provides ‘contraceptives, information, training, workshops, and safe and legal abortion services’.³³³ Since 2008, the organisation has been licensed to carry out first trimester abortions in a mobile clinic aboard the ship.³³⁴ Various court proceedings preceded the award of this license, as the Minister of Health, Welfare and Sports first refused to award any license and later subjected the license to the condition that pregnancy termination could only be carried out within a radius of 25 kilometres from the Slotervaart hospital in Amsterdam, with which WoW had concluded a cooperation-agreement.³³⁵ This requirement was, however, nullified by the highest administrative court, after which the Minister awarded the license without the radius condition.³³⁶ Before the license was awarded, *Women on Waves* was active in respect of the so-called ‘overtijdbehandeling’, as this treatment was, at the time, held to fall outside the scope of the Pregnancy Termination Act (see

³²⁹ *Handelingen II* 2004/05, 71, pp. 4362–4364.

³³⁰ *Kamerstukken II* 2004/05, 29 800 XVI, no. 211, pp. 1–2.

³³¹ See ‘Spaanse kliniek aborteert foetussen van zeven maanden’, *de Volkskrant* 31 October 2006, online available at www.volkskrant.nl/vk/nl/2668/Buitenland/article/detail/788533/2006/10/31/Spaanse-kliniek-aborteert-foetussen-van-zeven-maanden.dhtml, visited June 2010. See also www.eenvandaag.nl/buitenland/31272/abortus_na_zwangerschap_van_7_maanden, visited June 2010; www.netwerk.tv/node/1696, visited June 2010 and www.nos.nl/artikel/58692-abortuskliniek-k-spanje-opnieuw-in-opspraak.html, visited June 2010. See also *Aanhangsel Handelingen II* 2006/07, 987.

³³² www.womenonwaves.org/en/page/650/who-are-we, visited June 2014.

³³³ *Idem*.

³³⁴ The license has been awarded on the basis of Art. 2 Waz.

³³⁵ Rb. Amsterdam 1 June 2004, ECLI:NL:RBAMS:2004:AP1251 and Rb. Amsterdam 28 February 2005, AWB 04/3469, unpublished. See also *Aanhangsel Handelingen II* 2003/04, 1895.

³³⁶ ABRvS 3 May 2006, ECLI:NL:RVS:2006:AW7365.

6.2.2.1 above).³³⁷ Within Europe WoW has visited Ireland (2001),³³⁸ Poland (2003), Portugal (2004) and Spain (2008)³³⁹ and by doing so it has facilitated cross-border movement for abortions in its own and unique way.

6.4.2. Statistics on cross-border reproductive care

Cross-border reproductive care (CBRC) is a hot topic in Dutch media, academia and politics.³⁴⁰ The incidence of CBRC is generally acknowledged by the Dutch government, and has in some cases formed part of the grounds on which policy choices were based. As is the case for many more countries, the Dutch authorities do not keep statistics on CBRC on a structural basis. For example, unlike abortion clinics, AHR clinics are not under a legal obligation to register the country of residence of their patients, the services recipients. This is different, however, when it comes to donation of gametes, as the Donor Information Act requires clinics to register all personal information of the donor, as well as of the woman receiving the donor material (see 6.3.3 above).

In general it is estimated that annually 9,000 IVF treatments are carried out in the Netherlands. In addition, on an annual basis approximately 1,000 women from the Netherlands have IVF treatment in a foreign country.³⁴¹ The Dutch authorities are not aware how many of them are reimbursed for the costs under the Health Insurance Act.³⁴² The estimates for the wider Europe are between 10,000 and 15,000 patients involved in CBRC every year.³⁴³

The following subsections discuss statistics (to the extent that these are available) as well as estimates of the scale on which cross-border movement takes place in respect of particular kinds of treatment. Discussed are, *inter alia*, cross-border donation of gametes and the import of gametes, PGD and surrogacy.

³³⁷ www.womenonwaves.org/en/page/611/legal-position-of-women-on-waves, visited June 2014. See also 'Abortusboot mag de overtijd pil geven', *Het Parool* 1 July 2002, p. 6.

³³⁸ According to CNN about 80 Irish women had contacted *Women on Waves*. 'Crossing the sea for an abortion', *cnn.com* 4 March 2002. *The Lancet* even spoke of more than 300 women. K. Birchard, 'Abortion boat faces legal complications', *The Lancet* 23 June 2001. See also 'Irish should not have to travel for abortion – poll', *The Irish Times* 1 June 2001, p. 5 and 'Abortusboot vaart volgende week uit; Women on Waves verwacht geen juridische problemen in Ierland', *de Volkskrant* 7 June 2001, p. 38.

³³⁹ See www.womenonwaves.org/en/page/2582/ship-campaigns, visited June 2014. On its visit to Portugal, see also ch. 2, section 2.4.1.

³⁴⁰ E.g. '600 paren jaarlijks naar België voor ivf', *Algemeen Dagblad* 30 June 2009, p. 11; 'Vergoeding Ivf-behandeling leent zich niet voor 'u vraagt, wij draaien' Nadya wilde groot gezin', *Nederlands Dagblad* 11 February 2009, p. 12.; J. Kremer et al., 'Zorg over de grens. Geen grip op kwaliteit van buitenlandse fertiliteitsbehandelingen' ['Care across the border. No grip on the quality of foreign fertility treatment'], 62 *Medisch Contact* (2007) p. 1343 and *Aanhangsel Handelingen II* 2010/11, 238.

³⁴¹ Derksen and Staal 2012, *supra* n. 152, at p. 19 and 'Uw lichaam is geld waard', *Trouw* 4 March 2011.

³⁴² Derksen and Staal 2012, *supra* n. 152, at p. 19.

³⁴³ *Idem*, at p. 6.

6.4.2.1. Cross-border donation of gametes and import of gametes

Dutch media regularly report on Dutch women and couples going abroad – many to Belgium or Spain – for IVF treatment with the use of (anonymously and/or commercially) donated gametes.³⁴⁴ The strict Dutch legislation in respect of the donation of gametes and embryos is often held to be a cause for the shortage of gametes in the Netherlands and therefore a ground for going abroad. Some Dutch couples find donor identifiability simply not desirable.³⁴⁵ The Dutch age limits for access to IVF treatment are another often reported reason.³⁴⁶ It has been reported that in addition to the 100 to 150 women who have IVF treatment with the use of donated gametes in the Netherlands, every year another 1,000 women go to Spain and Belgium for such treatment.³⁴⁷ According to Pennings, the entry into force of the Donor Information Act in 2004 led to a ‘steep increase in patients going to Belgium where anonymity [was] maintained’. He reported that ‘[...] between 2004 and 2005, the number of Dutch patients going to Belgium for donor insemination almost doubled from 57 to 99 patients’.³⁴⁸

In 2010 a team of researchers from various Dutch universities carried out a survey on egg cell donation amongst gynaecologists registered with the Dutch Society of Obstetrics and Gynaecology (NVOG). The following results were reported:

‘Of 94 out 101 Dutch fertility units at least one gynaecologist answered the questionnaire (response 93.1%). Gynaecologists in 47 hospitals supported patients who participated in commercial egg donation programmes in a foreign country. The same number provided no support for these patients. Compared to the interval 2000–2004 in the interval 2005–2008 requests for participation increased from 62 to 179 (increase 288%). We also found a three fold increase of patients who actually went abroad to participate in a commercial egg donation program (45 versus 149, increase 331%) and a similar increase in care for pregnancies originating from commercial egg donation (32 versus 98, increase 306%).

³⁴⁴ E.g. E. van Zalinge, ‘In Nederland bijna geen eiceldonor beschikbaar Buitenland kan oudere vrouw uitkomst bieden’, *Het Parool* 25 August 1994, p. 5; ‘Uw lichaam is geld waard’, *Trouw* 4 March 2011; C. Houtekamer, ‘Het lichaam is geld waard, maar niet bij ons; Daarom wijken sommige kopers voor een nier, bot of een eikel uit naar het buitenland’, *NRC Handelsblad* 4 March 2011, p. 5. The CVZ reported that many Dutch women go to Spain and Russia, where young women donate egg-cells in return for high sums of money. CVZ, *In-vitrofertilisatiebehandelingen. Een verkenning* [IVF treatment. An exploration] Report of 10 April 2010, pp. 11–12, online available at www.cvz.nl/binaries/live/cvzinternet/hst_content/nl/documenten/rapporten/2010/rpt1004+pakketaadvies+2010-+-ivf.pdf, visited October 2010. See also *Aanhangsel Handelingen II* 2010/11, 238 and I. Geesink and C. Steegers, *Nier te koop, baarmoeder te huur: wereldwijde handel in lichaamsmateriaal* [Kidney for sale, uterus to let: worldwide trade in human body material] (Amsterdam, Bakker 2011).

³⁴⁵ G. Pennings, ‘The rough guide to insemination: cross-border travelling for donor semen due to different regulations’, *Facts, Views and Vision in ObGyn, Monograph* (2010) pp. 56–57, online available at www.fvvo.eu/assets/103/21-Pennings.pdf, visited May 2014. See also *Kamerstukken II* 2012/13, 30 486, no. 5, p. 18.

³⁴⁶ ‘Uw lichaam is geld waard’, *Trouw* 4 March 2011.

³⁴⁷ C. Houtekamer, ‘Het lichaam is geld waard, maar niet bij ons; Daarom wijken sommige kopers voor een nier, bot of een eikel uit naar het buitenland’, *NRC Handelsblad* 4 March 2011, p. 5.

³⁴⁸ Pennings 2010, *supra* n. 345, at pp. 56–57, referring to G. Pennings et al., ‘Cross-border reproductive care in Belgium’, *24 Human Reproduction* (2009) p. 3108.

The large majority of patients took their own initiative to find an institution to help them with their aim to achieve a pregnancy. [...] Only in about 10% gynaecologists referred patients to an acquainted clinic abroad or recommended such a clinic. Most Dutch couples visit Spain (n=109) for commercial-egg donation, followed by Belgium (n=32), Eastern Europe (15) and the United States of America (11). Most women who travel abroad for a commercial egg donation program are 41 years or older. [...] The estimated price per treatment cycle lies between 3,000 and 10,000 euro's. Especially in the United States couples paid up till more than 30,000 euro's per treatment.³⁴⁹

The Dutch Minister of Health, when referring to this research, underlined that these only concerned cases in which Dutch gynaecologists were involved. The Minister therefore assumed that the actual numbers were higher. Still, the Minister considered this to be a small portion of the 9,000 IVF treatments carried out in the Netherlands annually. She maintained that a (possible) shortage in donated egg cells was not an automatic consequence of the Dutch prohibitions on anonymous and commercial egg cell donation.³⁵⁰

The aforementioned researchers furthermore concluded that 34 per cent of the Dutch gynaecologists who participated in their research, considered commercial egg donation unethical, while 56 per cent were willing to provide support for those who seek help for commercial egg donation abroad. It was reported that 36 per cent of the responding Dutch gynaecologists were of the opinion that commercial egg donation should be legalised in the Netherlands.³⁵¹

Cross-border movement may also take more implicit forms, for instance when gametes originating of foreign donors are used in the course of IVF treatment in Dutch clinics. Statistics of the Dutch Donor Information Registration Foundation (*Stichting Donorgegevens Kunstmatige Bevruchting*)³⁵² paint the following picture.³⁵³ In the period May 2006 – the date when the central digital registration system of the Foundation came into operation – up until 2012, 320 egg cell donors

³⁴⁹ M.H. Van Hooff et al., 'O-199 Cross-border reproductive care for egg-donation in Dutch women', 25 *Human Reproduction* (2010) p. i79, online available at www.humrep.oxfordjournals.org/content/25/suppl_1/i77.abstract3, visited May 2014. The authors explicitly stated that '[t]he incidence of cross border reproductive care for commercial egg-donation between 2000–2008 was estimated.' See also *Aanhangsel Handelingen II* 2010/11, 2303, p. 2, where reference to this research is made. The same research was also discussed in I. van der Meer-Noort et al., 'Cross border reproductive care; gebruik van eiceldonatie in het buitenland door Nederlandse vrouwen' ['Cross-border reproductive care; use of egg cell donation by Dutch women in foreign countries'], 128 *Nederlands Tijdschrift voor Obstetrie & Gynaecologie* (2011) p. 98.

³⁵⁰ *Aanhangsel Handelingen II* 2010/11, 2303, p. 2. See also Derksen and Staal 2012, *supra* n. 152, at p. 6, where – so it seems- reference is made to the same survey.

³⁵¹ Van Hooff et al. 2010, *supra* n. 349, at p. i79.

³⁵² Following Art. 2(1) Wet donorgegevens kunstmatige bevruchting, all establishments who offer AHR treatment with the use of donated gametes have to provide data about these treatments and donors involved to the *Stichting Donorgegevens Kunstmatige Bevruchting* [Donor Information Registration Foundation].

³⁵³ Stichting Donorgegevens Kunstmatige Bevruchting, *Jaarverslag 2012* [Annual report 2012], Annex to *Kamerstukken II* 2012/13, 33750-XVI-76.

where registered, of which 4 donors were resident abroad.³⁵⁴ This resulted in 289 successful treatments including donated egg cells, 4 of which involved acceptors resident abroad.³⁵⁵ The Foundation registered 1,224 sperm donors, of whom 157 were resident abroad.³⁵⁶ A total number of 4,381 successful treatments with donated sperm were registered, of which 146 concerned situations where the acceptors (the women) were resident abroad.³⁵⁷ Particularly since the 2010 a clear increase in cross-border cases is visible.³⁵⁸

6.4.2.2. *Cross-border movement for PGD*

When it comes to PGD, little is known in respect of cross-border movement to and from the Netherlands. There are no official statistics kept in this respect. The Maastricht Medical Centre only registers the number of official references to their Brussels based partner clinic.³⁵⁹ For example, in the period 1995–2010 – before exclusion PGD for HD was lawful in the Netherlands (see 6.3.5 above) – the Maastricht Medical Centre referred 22 couples to the Brussels clinic.³⁶⁰

6.4.2.3. *Miscellaneous*

In addition to cross-border movement related to IVF, gamete donation and PGD, other types of CBRC involves movement from (and possibly to) the Netherlands. In the past, there have been various reports of cross-border movement in respect of treatment which at the time was still considered ‘experimental’ and thus not offered in the Netherlands, such as ICSI,³⁶¹ TESA and MESA.³⁶² Further, there have been

³⁵⁴ One egg cell donor was resident in Belgium, one in France and two others in Germany.

³⁵⁵ One acceptor was resident in France, the other three in Germany.

³⁵⁶ The breakdown of these numbers is as follows: 1 in Australia; 4 in Belgium; 101 in Germany; 2 in Canada; 1 in Costa Rica; 32 in Denmark; 1 in France; 1 in Greece; 1 in Indonesia; 1 in Latvia; 1 in New Zealand; 1 in Portugal; 1 in Surinam and 2 in Switzerland; and 7 in the United States of America.

³⁵⁷ The breakdown of these numbers is as follows: 1 in Australia; three in Belgium; 92 in Germany; 38 in France; 7 in Italy; 1 in Luxembourg; 1 in Austria; 1 in Spain; and 1 in Switzerland.

³⁵⁸ In the period May 2006 up until 2010, 152 egg cell donors were registered, of which three were resident abroad. This resulted in 152 successful treatments including donated egg cells, two of which involved acceptors resident abroad. The Foundation registered 696 sperm donors, of whom 54 were resident abroad. A total number of 2,798 successful treatments with donated sperm were registered, of which 79 concerned situations where the acceptors (the women) were resident abroad. Stichting Donorgegevens Kunstmatige Bevruchting, *Jaarverslag 2010* [Annual report 2010], Annex to *Kamerstukken II 32500-XVI*, no. 154, pp. 8–9.

³⁵⁹ See www.brusselsivf.be/default.aspx?lang=EN, visited July 2013 and *Kamerstukken II 2011/12*, 32279, no. 24, p. 7.

³⁶⁰ *Kamerstukken II 2011/12*, 25 424, no. 135, p. 4, specifying (in footnote 9) the following numbers for the following years: 2010: 3 referrals; 2009: 7 referrals; 1995–2008: 12 referrals.

³⁶¹ *Inter alia*, V. Cotterell, ‘Supermethode in buurlanden’, *Het Parool* 24 March 1997, p. 1 and Ziekenfondsraad (Commissie beroepszaken) [Health Care Insurance Board (Appeals Commission)] 24 November 1994, case 260-4451.

³⁶² See ‘Zorgverzekeraars: reageerbuisbaby hoort thuis in ziekenfondspakket’, *de Volkskrant* 27 March 2002, p. 1, where it was reported that annually ‘hundreds of Dutch people’ went to Belgian and German hospitals for PESA, MESA and TESE techniques. See also Health Care Insurance Board (CVZ) 19 December 2006, case GS/26100379.

reports of couples or women going abroad for so-called ‘assisted hatching’³⁶³ and for egg cell vitrification on social grounds at a time when it was not yet practiced in the Netherlands.³⁶⁴ Also, in early 2011, it was reported that a Dutch IVF clinic referred clients to a clinic in Belgium, where – allegedly – gender selection was carried out.³⁶⁵ Indirect forms of cross-border movement concern situations in which certain aspects of AHR treatment are outsourced to foreign clinics.³⁶⁶

6.4.3. Cross-border surrogacy

There are no official or exhaustive statistics in respect of the number of Dutch couples and individuals who conclude surrogacy agreements in foreign countries. There is only incidental evidence from case law or cases that are reported to authorities in any other way. As Boele-Woelki et al. explain:

‘[...], it is [...] difficult to determine the scope of occurrence of surrogacy and any connected unlawful placements of children in The Netherlands. The Child Protection Board and the Central Authority for Adoption probably only receive a section of the surrogacy cases that occur in The Netherlands or abroad.’³⁶⁷

That some cross-border movement takes place, is not, however, in question.³⁶⁸ Particularly in the past decade, various cross-border surrogacy cases have come before the Dutch courts, some of which attracted wide media coverage and political attention.³⁶⁹ Greece is the most often mentioned destination country within the EU,

³⁶³ The American Society for Reproductive Medicine defines assisted hatching as ‘a procedure in which the zona pellucida (outer covering) of the embryo is partially opened, usually by application of an acid or laser, to facilitate embryo implantation and pregnancy.’ See www.asrm.org/topics/detail.aspx?id=374, visited June 2014.

³⁶⁴ Van der Meer-Noort et al. 2011, *supra* n. 349, at p. 100.

³⁶⁵ The report was made in the TV programme *Uitgesproken EO* (broadcast of 27 January 2011), online available at www.eo.nl/tv/devijfdedag/aflevering-detail/uitgesproken-94, visited April 2011. As is the case under Dutch law, gender selection is prohibited under Belgian law. The Minister of Health, Welfare and Sports informed Parliament that the Belgian Health Inspectorate had referred the case to the police and that the Dutch Public Prosecutor saw no reason to prosecute the case. Possible grounds for criminal liability were Art. 26(2) Embryowet; Wet op de beroepen in de individuele gezondheidszorg (Wet BIG) [Act on professions in individual health care] and Art. 326 Sr (the relevant provision of the Criminal Code on fraud). *Aanhangsel Handelingen II* 2010/11, 2019–2020.

³⁶⁶ For example the Dutch Geertgen clinic, a non-licensed IVF clinic which operates the only egg cell donation programme in the Netherlands, outsources the actual *in vitro* fertilisation of embryos to an IVF-clinic in Düsseldorf (Germany). The Dutch Minister of Health, Welfare and Sports held this to be not against the relevant Dutch legislation, such as the WMBV and the IVF planningsbesluit. *Aanhangsel Handelingen II* 2011/12, 761, p. 3 and *Aanhangsel Handelingen II* 2011/12, 819, p. 2.

³⁶⁷ Boele-Woelki et al. 2011, *supra* n. 186, at p. 310.

³⁶⁸ *Idem*, at p. 303.

³⁶⁹ A case which attracted an extraordinary amount of media and political attention concerned the case of ‘baby Donna’, concerning a Belgian woman who had concluded a surrogacy agreement with a Belgian couple. She became pregnant after insemination with the sperm of the intended father. Halfway the pregnancy she falsely informed the intended parents that she had had a miscarriage. After the child was born, a Dutch couple adopted the child, paying the surrogate mother an amount of – so it was reported – 12,000 euro. When the Belgian couple found out about the deceit, they initiated

but there have also been reports from couples who went to Belgium,³⁷⁰ the United Kingdom³⁷¹ and France³⁷² for surrogacy purposes. Most other reported cases concern countries outside the EU, such as Ukraine, India and the United States of America.³⁷³

Given the strict Dutch legislation in respect of surrogacy, it is not very likely that the Netherlands functions as a destination country in respect of surrogacy. In fact, the (debatable) rules set by the Medical Centre of the Free University of Amsterdam (see 6.3.8 above) – the only licensed centre in the Netherlands for high-technology surrogacy – explicitly exclude foreigners, whether intended parents, or surrogate mothers.

6.5. DUTCH ABORTION AND AHR LEGISLATION AND CROSS-BORDER MOVEMENT

6.5.1. Criminal liability for abortions and AHR treatment carried out abroad

The Dutch Criminal Code applies to anyone who commits a crime on Dutch territory.³⁷⁴ The Dutch Criminal Code may also apply to certain crimes committed outside Dutch territory, but its provisions on abortion and surrogacy are not amongst the provisions of the Criminal Code in respect of which this is made possible.³⁷⁵ The same holds for the penal provisions of the Embryo Act.

court proceedings against the surrogate mother and the Dutch adoptive parents. The Dutch Court of Appeal ruled in 2008 that it was in the child's best interests if she stayed with the Dutch couple who had adopted her. In 2012, the Belgian judge imposed (modest) fines on all persons involved in the illegal adoption of the child. See, *inter alia*, J. van Poppel, 'Draagmoederdrama verscheurt Vlaams gezin; Baby Donna', *Algemeen Dagblad* 24 May 2005, p. 3; D. de Gruijl, 'Kinderdroom gezin uit Leusden loopt uit op nachtmerrie, draagmoeder van Donna opgepakt; Jansen: 'het is mijn kind. we zijn een gelukkig gezin'', *Het Parool* 25 May 2005, p. 99; 'Baby Donna blijft na kort geding voorlopig in Nederland', *Trouw* 6 July 2005, p. 6 and 'Rechter geeft boetes voor babyverkoop', *AD/Algemeen Dagblad* 13 October 2012, p. 10. For the Dutch court judgments in this case, see Rb. Utrecht 24 October 2007, ECLI:NL:RBUTR:2007:BB6360 and Hof Amsterdam 25 November 2008, ECLI:NL:GHAMS:2008:BG5157. For other examples see *Kamerstukken II* 2007/08, 31 200 XVI, no. 154 and *Kamerstukken II* 2008/09, Aanhangsel, nos. 1225, 1226 and 1227.

³⁷⁰ Although from the Dutch perspective it was strictly speaking an interstate adoption case, the *Baby Donna* case (see above), was an example of cross-border movement from the Netherlands to Belgium in which surrogacy was involved. Rb. Utrecht 24 October 2007, ECLI:NL:RBUTR:2007:BB6360 and Hof Amsterdam 25 November 2008, ECLI:NL:GHAMS:2008:BG5157. Another Belgian surrogacy case was reported in E. Winkel et al., 'Draagmoederschap na ivf in het buitenland. Dilemma's bij de begeleiding', 154 *Nederlands Tijdschrift voor Geneeskunde* (2010) p. A1777.

³⁷¹ Rb. 's-Gravenhage 11 December 2007, ECLI:NL:RBSGR:2007:BB9844.

³⁷² Rb. 's-Gravenhage 14 September 2009, ECLI:NL:RBSGR:2009:BK1197.

³⁷³ E.g. Rb. 's-Gravenhage (vrzr.) 9 November 2010, ECLI:NL:RBSGR:2010:BP3764; Rb.'s-Gravenhage 24 October 2011, ECLI:NL:RBSGR:2011:BU3627 and Rb. 's-Gravenhage 18 January 2012, ECLI:NL:RBSGR:2012:BV2597.

³⁷⁴ Art. 2 Sr.

³⁷⁵ Art. 4 Sr.

Article 5(1) of the Criminal Code provides that the Criminal Code may also be applicable in situations where a Dutchman has committed a crime in another country, but a requirement of double criminality applies in these cases.³⁷⁶ This condition renders criminal prosecution for abortions, AHR treatment or surrogacy on the basis of this Article uncommon. A rare example where criminal investigations were initiated (but later dropped) against a Dutch woman who had had an abortion in Spain, has been referred to above (section 6.2.4).

6.5.2. Public funding for treatment obtained abroad

Dutch legislation does not make special provision for the reimbursement for abortions obtained abroad under the statutory health scheme, but there is no reason to assume that this would not be remunerated if the general conditions for reimbursement for medical treatment obtained abroad have been met.³⁷⁷

Reimbursement for AHR treatment obtained abroad, however, has been and is much debated and has resulted in various legal disputes.³⁷⁸ The CJEU's case law in respect of cross-border health care (see chapter 3) has had a clear impact on the relevant rulings of the Dutch Courts.

Until 2004, AHR treatment, including IVF treatment, was not covered by the Dutch Health Insurance Act (*Ziekenfondswet*), but only financed on the basis of the subsidy scheme (*Subsidieregeling*; see 6.3.7 above). This had as a consequence that in cross-border situations, Dutch courts initially ruled that the reciprocity rule did not apply and hence that a refusal to reimburse AHR treatment obtained in another EU Member State constituted no violation of free movement rules.³⁷⁹ Later, various courts accepted that a refusal to reimburse IVF treatment obtained in another EU Member State under the subsidy scheme constituted a restriction of free movement, but held that this restriction could be justified, for instance, as some Dutch courts held, for reasons of complexity of the treatment and quality of the care as well as on ethical grounds.³⁸⁰

³⁷⁶ See Boele-Woelki et al. 2011, *supra* n. 186, at pp. 40–41, under reference (in footnote 49) to: 'Noyon Langemeyer Rammelink, *Het wetboek van strafrecht, Artikel 5*, J.W. Fokkens, aantek. 9.'

³⁷⁷ See Ch. 3, section 3.5 for the relevant standards in the EU context. As noted above in section 6.2.5 women from abroad who have a pregnancy terminated in the Netherlands have to bear the expenses themselves.

³⁷⁸ Derksen and Staal 2012, *supra* n. 152, at p. 6. See also *inter alia* Rb. Utrecht 24 May 2002, ECLI:NL:RBUTR:2002:AE3518; and CRvB 31 January 2007, ECLI:NL:CRVB:2007:AZ8510.

³⁷⁹ In the year 2000 – when IVF treatment was not yet covered by the Health Insurance Act – the Central Appeals Court for Public Service and Social Security Matters ruled that an insured was not entitled to reimbursement for IVF treatment obtained in a Belgian clinic. CRvB 11 July 2000, ECLI:NL:CRVB:2000:ZB8921.

³⁸⁰ For example, in 2002 the District Court of Utrecht ruled that a refusal by a health insurer to reimburse the costs of treatment carried out in a Belgian IVF clinic constituted a restriction of the freedom to receive services, which could be justified on grounds of the CJEU judgments in the cases *Decker and Kohll* and *Smits and Peerbooms* (see Ch. 3). Rb. Utrecht 24 May 2002, ECLI:NL:RBUTR:2002:AE3518. See also Rb. Almelo 13 November 2003, ECLI:NL:RBALM:2003:BM5834. The Court ruled first of all

As the case law of the CJEU on cross-border health care evolved,³⁸¹ Dutch courts increasingly often ruled that a refusal to reimburse IVF treatment obtained in a clinic in another EU Member State on the ground that this clinic was not licensed under Dutch law, constituted an unjustified restriction of free movement.³⁸² Of particular importance was a ruling of the Central Appeals Court for Public Service and Social Security Matters of 2007.³⁸³ This Court accepted that the Dutch rule that treatment was only reimbursed if obtained in a licensed establishment, constituted a restriction of the freedom to receive services. In its assessment of the possible justifications for this restriction, the Court held that purely financial reasons were insufficient. It was not convinced that without the licensing requirement, it would be impossible to control expenditure without adversely affecting the overall level of public health protection. The Court furthermore rejected the argument put forward by the health insurer that an efficient organisation of the supervision of the quality of care could only be guaranteed if AHR treatment was only reimbursed when obtained in a clinic licensed under Dutch law. The Central Appeals Court did not exclude that ethical reasons could constitute an imperative requirement under *rule of reason* exception, but held that these ethical objectives could be attained by a less restrictive measure, namely by the relevant Planning Order for *in vitro* fertilisation (*Planningsbesluit in vitro fertilisatie*).³⁸⁴ With this ruling, many of the previously accepted justifications were no longer valid.

In line with the case law of the CJEU, it is now well-established case law that all medical care – including AHR treatment – that is covered by the Dutch Health Insurance Act, is also reimbursed if obtained in another EU Member State.³⁸⁵ Further, also in line with CJEU case law, various Dutch Health Insurers require a referral from the general practitioner and set a prior authorisation requirement for IVF treatment in a foreign country.³⁸⁶ More controversial are those situations where the treatment

ruled that IVF treatment was not amongst the benefits provided for under the Health Insurance Act, and that therefore Art. 22 of Regulation 1408/71 did not apply to a case where IVF treatment was obtained in a German clinic. It furthermore ruled that the *Subsidieregeling* did not apply to the case at hand as the German clinic was no licensed establishment within the meaning of the *Subsidieregeling*. See also Rb. Maastricht 28 June 2004, ECLI:NL:RBMAA:2004:AP8808.

³⁸¹ Most importantly Case C-385/99 *Müller-Fauré and van Riet* [2003] ECR I-4509, ECLI:EU:C:2003:270. See ch. 3 section 3.5.2.1.

³⁸² E.g. Rb. Amsterdam 7 October 2003, ECLI:NL:RBAMS:2003:AN9606 and Rb. Utrecht 13 July 2004, case no. SBR03/1073, unpublished. For a ruling to a contrary effect, see Rb. Maastricht 28 June 2004, ECLI:NL:RBMAA:2004:AP8808.

³⁸³ CRvB 31 January 2007, ECLI:NL:CRVB:2007:AZ8510.

³⁸⁴ *Idem*.

³⁸⁵ See Ch. 3, section 3.5.2.4. In some cases, the Dutch Courts found no violation of the free movement rules, because a particular type of AHR treatment that was available abroad, was (still) considered experimental in the Netherlands, and therefore excluded from cover under the Health Insurance Act. For example, in 2007 the Central Appeals Court ruled that the at the time of treatment still experimental ICSI MESA treatment, was not covered under the Dutch Health Insurance Act, and that there was accordingly no entitlement to reimbursement for such treatment obtained abroad. CRvB 14 February 2007, ECLI:NL:CRVB:2007:AZ9694. This ruling confirmed the judgment of Rb. 's-Gravenhage 12 February 2004, ECLI:NL:RBSGR:2004:AO3791. See also College voor zorgverzekeringen 27 April 2000, case no. BZ-00-1156 and CRvB 13 July 2005, ECLI:NL:CRVB:2005:AT9545.

³⁸⁶ See *inter alia* www.zilverenkruis.nl/consumenten/vergoedingen/Pages/ivf.aspx, visited June 2013; www.menzis.nl/web/Consumenten/VergoedingZorgverzekering/VergoedingenAZ/Invitrofertili

is carried out in a manner that is not in compliance with Dutch medical and ethical standards, for instance if gametes have been used which were donated anonymously and/or on a commercial basis, or if more than two embryos have been implanted in the course of one IVF cycle.³⁸⁷ The Health Care Insurance Board ('CVZ', now the National Health Care Institute³⁸⁸) and the Dutch government have taken the position that it is irrelevant for the entitlement to reimbursement of the costs whether AHR treatment is obtained within the Netherlands or abroad, as long as the conditions of the Health Insurance Act and the Health Insurance Order are met.³⁸⁹ Accordingly, age limits apply also in respect of foreign treatment.³⁹⁰ Medical and ethical standards in Dutch legislation concerning the carrying out of AHR treatment, such as those laid down in the Embryo Act, are directed to health care providers within the Dutch jurisdiction, not to the persons insured under the Health Insurance Act.³⁹¹ These conditions therefore do not have automatic effect in respect of the Health Insurance Act and thus, do not affect the insurance coverage.³⁹² This also holds for the licensing obligation under the Dutch Exceptional Medical Expenses Act (*Wet bijzondere medische verrichtingen* (WBMV))³⁹³ and the Dutch rules concerning donation of gametes and embryos, as provided for in the Donor Information Act.³⁹⁴ This means that, for example, where anonymously donated gametes are used in the course of IVF treatment, this treatment nevertheless belongs to the entitlements under the

satieIVFInHetBuitenland.htm, visited June 2013; www.cz.nl/ivf-icsi-fertiliteitsbehandeling-buitenland.pdf, visited June 2013 and www.anderzorg.nl/web/Vergoedingen/Vergoeding/IVFBehandelingInHetBuitenland.htm, visited June 2013.

³⁸⁷ *Aanhangsel Handelingen II* 2010/11, 238.

³⁸⁸ See *supra* n. 354.

³⁸⁹ *Aanhangsel Handelingen II* 2010/11, 238, pp. 1–2. See also CVZ, *IVF behandelingen uit 2005 tellen mee voor de zorgverzekeringswet* [IVF treatment obtained in 2005 counts for the Health Insurance Act], adviesaanvraag Zvw [Request for advice under the Health Insurance Act] of 23 May 2006, online available at www.cvz.nl/binaries/live/cvzinternet/hst_content/nl/documenten/standpunten/2006/sp0606+ivf-behandelingen+2005.pdf, visited June 2013.

³⁹⁰ CVZ Report *Een leeftijdsgrens voor vruchtbaarheidsbehandelingen* [An age limit for fertility treatment], Annex to *Kamerstukken II* 2011/12, 33000-XVI no. 188, p. 17. This is in line with a judgment by the District Court Amsterdam of 2003. Under reference to Case C-157/99 *Geraets-Smits and Peerbooms* [2001] ECR I-5473, ECLI:EU:C:2001:404 and Case C-385/99 *Müller-Fauré and van Riet* [2003] ECR I-4509, ECLI:EU:C:2003:270, this Court ruled that a refusal to reimburse IVF treatment obtained by a woman over 45 years of age in a Belgian clinic, constituted no violation of the free movement rules, as this treatment was not amongst the benefits provided for under Dutch law, given that under Dutch law a age limit of 40 was set (while one licensed hospital by way of experiment treated women until the age of 45). Rb. Amsterdam 7 October 2003, ECLI:NL:RBAMS:2003:AN9605. See also College voor zorgverzekeringen, Opinion of 25 May 2010, *LJN* BN1229.

³⁹¹ *Aanhangsel Handelingen II* 2010/11, 238, pp. 1–2.

³⁹² Derksen and Staal 2012, *supra* n. 152, at p. 5.

³⁹³ *Inter alia*, Geschillencommissie Zorgverzekeringen [Conciliation Board Health Insurance], Opinion of 8 August 2007, case no. ANO07.155 and the following Opinions of the College voor zorgverzekeringen [Health Care Insurance Board]: no. 26026338 of 23 May 2005; no. 26035826 of 19 June 2006 and no. 27028502 of 24 September 2007.

³⁹⁴ CVZ, *IVF met gebruik van anonieme eiceldonatie (in het buitenland) in beginsel een te verzekeren prestatie* [IVF with the use of anonymous egg-cell donation (in a foreign country) is in principle a performance within the meaning of the Health Insurance Act], adviesaanvraag Zvw Zvw [Request for advice under the Health Insurance Act] of 24 October 2006, online available at: www.cvz.nl/binaries/live/cvzinternet/hst_content/nl/documenten/standpunten/2006/sp0606+ivf+met+eiceldonatie.pdf, visited June 2013.

Health Insurance Act.³⁹⁵ Under the Health Insurance Act only high-quality health care is reimbursed, however, as the Dutch government is aware – on the basis of CJEU case law (*inter alia*, *Decker and Kohl* and *Smits-Peerbooms*) – the relevant standard is whether the care has been sufficiently tried and tested by *international* medical science. In other words, States must trust each other’s health care standards. In the words of the Minister of Health, Welfare and Sports: no matter how important the Dutch society may find it that a child can learn about his or her genetic origins, the fact that use is made of an anonymous donor, does not affect the quality of the care provided.³⁹⁶

The Central Appeals Court for Public Service and Social Security Matters has taken a different approach. This Court ruled in 2007 that IVF treatment with the use of anonymously donated egg cells was not amongst the benefits provided for under the Dutch Health Insurance Act and that therefore the refusal to reimburse for such treatment obtained abroad, constituted no obstacle of the freedom to receive services.³⁹⁷

Although not uncontroversial, it is generally accepted that the Dutch Health Insurance bears the costs that occur when insured persons return to the Netherlands after having obtained treatment abroad, even if that treatment itself would not be reimbursed under the Health Insurance Act. For example, the implantation of two or more embryos in the course of one IVF cycle frequently results in multiple births, which often involve premature births and an increased risk of complications during the pregnancy and thus extra costs.³⁹⁸

Tax deductions have generally been held to apply also in cross-border cases, so long as the relevant criteria are met that would apply if the costs had been made in the Netherlands.³⁹⁹

6.5.3. Information about treatment abroad and follow-up treatment

Dutch legislation or policy does not provide anything particular in respect of access to information about foreign abortion services or AHR treatment. The Dutch government has, however, considered it its task to inform the Dutch public about the legal complexities that may be involved when entering into surrogacy agreements

³⁹⁵ Derksen and Staal 2012, *supra* n. 152, at p. 6, *Aanhangsel Handelingen II* 2010/11, 238, pp. 1–2 and College voor zorgverzekeringen [Health Care Insurance Board] Opinion no. 26084415 of 24 October 2006.

³⁹⁶ *Aanhangsel Handelingen II* 2010/11, 238, pp. 1–2.

³⁹⁷ CRvB 31 January 2007, ECLI:NL:CRVB:2007:AZ8510. See also CRvB 14 February 2007, ECLI:NL:CRVB:2007:AZ9700.

³⁹⁸ CVZ 2010, *supra* n. 344, at pp. 11–12.

³⁹⁹ See Rb. ‘s-Gravenhage 8 January 2013, ECLI:NL:RBDHA:2013:18948, where various non-medical costs in the course of an international surrogacy agreement (such as hotel costs, the reimbursement of the surrogate mother and the egg-cell donor and the costs of counselling) were not held to qualify for tax deduction.

abroad.⁴⁰⁰ In particular, the government has provided information about the legal situation upon return to the Netherlands on relevant Ministerial websites (see 6.3.8 above).

As goes for any other medical treatment legally obtained abroad, people who had an abortion or AHR treatment abroad, are entitled to medical follow-up treatment upon return to the Netherlands. In practice, they may, however, encounter objections of medical practitioners. For example, in 2010 it was reported that 50 per cent of the Dutch gynaecologists refused to provide treatment to women who had AHR treatment with the use of commercially and anonymously donated egg cells in Spain.⁴⁰¹ Apart from such incidental reports, is the present author not aware of any established practice of refusing follow-up treatment, save of any official policy in this respect.

6.5.4. Access to abortion for foreign women

In the Explanatory Memorandum to the Pregnancy Termination Act (1981) it was acknowledged that the requirement of a five-day reflection period (see 6.2.2.3 above) could imply for non-resident women that they had to extend their stay in the Netherlands before they could have an abortion. This could be held to constitute an obstacle to the free movement of these women. The legislature submitted, however, that this was the inescapable consequence of the fact that the abortion legislation of the (then) EEC Member States varied considerably. It held that the requirement aimed to guarantee that any decision to terminate a pregnancy was taken carefully and well-considered, so it was justified and proportionate and therefore raised no issue under EEC free movement law.⁴⁰²

6.5.5. (Non-)applicability of the Dutch Donor Information Act in cross-border situations

It has been reported that '[d]uring the period preceding and immediately following the enactment of the Donor Information Act law, the number of semen (sperm) donors

⁴⁰⁰ In 2012 the Dutch National Rapporteur on Trafficking in Human Beings also advised the government to inform the public that surrogacy in foreign countries may involve human trafficking. National Rapporteur on Trafficking in Human Beings, *Human trafficking for the purpose of the removal of organs and forced commercial surrogacy* (The Hague, BNRM 2012), online available at www.bnrm.nl/publicaties/orgaanverwijdering-draagmoederschap/index.aspx, visited June 2014.

⁴⁰¹ As stated by the spokesman of the Dutch Association for Gynaecologists during an interview for the Dutch tv programme *Nieuwsuur*, broadcasted on Dutch television on 9 September 2010, www.nieuwsuur.nl/onderwerp/183384-spanje-is-hoop-voor-onvruchtbare-vrouwen.html, visited March 2014. The spokesman held that 50 per cent of the gynaecologists in the Netherlands refused to provide treatment to women who had AHR treatment with the use of commercially and anonymously donated egg cells in Spain. Their reasons to refuse treatment were twofold: (1) because commercial and anonymous egg cell donation was illegal under Dutch law and (2) because they were concerned about quality and safety of the treatment in Spain.

⁴⁰² *Kamerstukken II 1978/79*, 15 475, no. 3, pp. 25–26.

and semen banks dropped drastically and there was a change in the type of donor.⁴⁰³ Waiting lists were the result.⁴⁰⁴ In addition, there was a clear deficit in donated egg cells in the Netherlands.⁴⁰⁵ Presumably as a consequence, there have been reports of women and couples resident in the Netherlands who resorted to foreign donation options (see also 6.4.2.1 above).⁴⁰⁶ Although the reasons for going abroad were often not made explicit, these women and couples regularly travelled to countries which provided for permanent anonymity of gamete donors.⁴⁰⁷

When a child is born or raised in the Netherlands that was conceived in another country with the use of (anonymously) donated gametes, the Dutch Donor Information Act does not apply. It only imposes an obligation on AHR clinics established under Dutch law to register the details of gamete donors. In cross-border situations, children depend on their parents if they wish to be informed about their genetic origins.⁴⁰⁸ The Dutch government has called this an ‘undesirable’ situation but felt that it could, nonetheless, not be prevented from occurring.⁴⁰⁹ Nevertheless, concerns have been expressed that this involved medical risks for children conceived through IVF treatment with the use of anonymously donated gametes in a foreign country, as the hereditary family history may be unknown.⁴¹⁰

Gametes which have been donated in a foreign country may only be used in IVF treatment in a Dutch establishment if all requirements of the Donor Information Act – including those regarding the information about the donor – have been met.⁴¹¹

⁴⁰³ Janssens et al. 2005, *supra* n. 188, at p. 1416. See also Pennings 2010, *supra* n. 345, at pp. 56–57; ‘Dutch sperm laws threaten donations’, *BBC* 12 August 2004, www.news.bbc.co.uk/2/hi/europe/3555202.stm, visited 30 March 2014 and Winter et al. 2012, *supra* n. 136, at p. 248.

⁴⁰⁴ Winter et al. 2012, *supra* n. 136, at p. 114.

⁴⁰⁵ As the 2012 Evaluation Report explains, this has to do with the burdens involved in the procedure of egg cell donation and with the fact that donation has to be altruistic under Dutch Law. Apart from women who donate in the course of the (much debated) ‘cooperative reciprocity’ (‘coöperatieve wederkerigheid’) programme of one Dutch AHR-clinic (the Geertgen clinic, see www.geertgen.nl/onze-werkwijze/coöperatieve-wederkerigheid, visited July 2013), there are hardly any egg cell donors in the Netherlands. This cooperative reciprocity programme (also referred to as ‘mirror-donation’ (‘*spiegeldonatie*’)) implies that people who receive donated gametes, also (indirectly) provide gametes for donation. Winter et al. 2012, *supra* n. 136, at pp. 223 and 252. See also *Aanhangsel Handelingen II* 2011/12, 761 and Nederlandse Vereniging voor Obstetrie en Gynaecologie (NVOG) [Dutch Association for Obstetrics and Gynaecology], *Standpunt Gameetdonatie in een systeem van faire wederkerigheid* [Opinion on gamete donation in a system of fair reciprocity], online available at www.nvog-documenten.nl/richtlijn/item/pagina.php?richtlijn_id=900, visited July 2013.

⁴⁰⁶ *Aanhangsel Handelingen II* 2010/11, 238, p. 1.

⁴⁰⁷ *Idem*.

⁴⁰⁸ *Kamerstukken II* 2012/13, 30 486, no. 5, p. 18.

⁴⁰⁹ *Aanhangsel Handelingen II* 2007/08, 113, p. 242 and *Aanhangsel Handelingen II* 2013/14, 702.

⁴¹⁰ CVZ 2010, *supra* n. 344, at pp. 11–12.

⁴¹¹ *Aanhangsel Handelingen II* 2007/08, 113, p. 242.

6.5.6. Cross-border surrogacy under Dutch law

The strict conditions for surrogacy in the Netherlands, and the legal uncertainty surrounding it, have been reason for some Dutch couples to engage in surrogacy agreements abroad.⁴¹² Couples or individuals from the Netherlands who entered into surrogacy agreements abroad may encounter problems in establishing parental links with the child upon return to the Netherlands. Different situations are conceivable, and accordingly, different rules of Dutch Private International Law may apply.

As Boele-Woelki et al. have made clear, the intended parents may rely on different grounds for their claim that parentage has been created; they may refer to a decision of a foreign judge; or they may rely on legal fact or act.⁴¹³ Consequently, different regimes may apply.

Article 9 of the Parentage (Conflicts of Laws) Act (*Wet conflictenrecht afstamming (Wca)*)⁴¹⁴ provides for the recognition of foreign judgments in which family ties (*familierechtelijke betrekkingen*) are established. Although this provision foresees in a public policy exception, reportedly '[...] few problems have arisen thus far concerning surrogacy arrangements [...] in cases where recognition of a foreign judgment was sought.'⁴¹⁵

The intended parent(s) may also rely on a foreign birth certificate on which he/she/they is or are stated as legal parent(s).⁴¹⁶ Under Dutch law this is, however, considered to be contrary to public policy.⁴¹⁷ Apart from the fact that surrogacy is considered to be in violation of the *mater semper certa est* rule,⁴¹⁸ generally the view is taken that the rationale lays in the right of the child to know his or her genetic origins (Article 7 of the United Nations Convention on the Rights of the Child).⁴¹⁹ Where intended parents rely on a foreign birth certificate, it may therefore first of all be difficult to enter the Netherlands with the child, as Dutch authorities may refuse a Dutch passport

⁴¹² S.C.A. van Vlijmen and J.H. van der Tol, 'Draagmoederschap in opkomst: specifieke wet- en regelgeving noodzakelijk?' ['Surrogacy booming: specific regulation necessary?'], *Tijdschrift voor Familie- en Jeugdrecht* (2012) p. 160. In 2012 the Dutch National Rapporteur on Human trafficking concluded that a liberalisation of the strict conditions for supervised high-technological surrogacy could reduce the demand for foreign surrogate mothers, who may be vulnerable to exploitation. See National Rapporteur on Trafficking in Human Beings 2012, *supra* n. 400.

⁴¹³ Boele-Woelki et al. 2011, *supra* n. 186, at p. 308.

⁴¹⁴ Act of 14 March 2002, *Stb.* 2002, 153. The Act entered into force per 11 April 2003.

⁴¹⁵ Boele-Woelki et al. 2011, *supra* n. 186, at p. 308.

⁴¹⁶ This is for example the case in Ukraine.

⁴¹⁷ E.g. Rb. 's-Gravenhage 24 October 2011, ECLI:NL:RBSGR:2011:BU3627.

⁴¹⁸ *Kamerstukken II* 2001/02, 26 675, no. 6, p. 19.

⁴¹⁹ Van Vlijmen and Van der Tol 2012, *supra* n. 412. This approach was also taken by Rb. 's-Gravenhage 14 September 2009, ECLI:NL:RBSGR:2009:BK1197. The case concerned a Dutch married same-sex couple, who entered into a surrogacy agreement with a Dutch woman. The woman gave birth to the child – to whom she and one of the spouses were genetically related – in France, so that she could give the child up for adoption anonymously. The genetic father recognised the child and was stated as being the father on the French birth certificate. The certificate did not mention the mother. The Court refused to recognise the French birth certificate, because it held it to be contrary to Dutch public policy that the child would not be able to know who his genetic mother was.

to the child on public order grounds. This implies that the child – who has no other passport – cannot leave the country where it was born. In two such cases the Dutch judge ordered the Ministry of Foreign Affairs to issue emergency travel documents, as the judge considered this in the best interests of the child.⁴²⁰ The issuance of such travel documents neither automatically implies the establishment of parental rights for the intended parents, however, nor the awarding of Dutch nationality or residence rights to the child.⁴²¹

If the intended parents subsequently try to establish their parental links by means of a court procedure, the foreign birth certificate on which they are stated as legal parents, may not – again on public policy grounds – be recognised under Dutch law. In that situation, the Dutch court has to establish the necessary data for the drawing up of a birth certificate.⁴²² It can only do so if the child has Dutch nationality; which may require, first of all, that the paternity of the intended and genetic father is determined by the court.⁴²³

In all cases the Dutch Courts put the interest of the child first, which may – as time elapses – lead to the awarding of parental rights to (at least one of) the intended parents.⁴²⁴ As Boele-Woelki et al. explain:

‘Although up until now it is clear that a birth certificate upon which no mother is recorded will be regarded as contrary to Dutch public policy, other cases are far from clear. This uncertainty exists with respect to original birth certificates in which the genetic mother is recorded instead of the birthmother, or where the non-genetic commissioning parents are recorded on the birth certificate. Nevertheless, children do arrive in The Netherlands with such birth certificates. Once these children have remained in The Netherlands for some time, it is very difficult for the State to remove the child from the commissioning parents, due to the weight given to the best interests of the child and the protection of the family life created between the child and the commissioning parents.’⁴²⁵

The Dutch Secretary of State for Security and Justice concluded in 2011 that as a result of the approach of the Dutch courts, standing policy was overtaken by practice and its enforcement was rendered more difficult.⁴²⁶ He therefore proposed that foreign surrogacy agreements would be given legal effect in the Netherlands if at least one of the intended parents was genetically related to the child and the other genetic parent

⁴²⁰ Rb. 's-Gravenhage (vrzr.) 9 November 2010, ECLI:NL:RBSGR:2010:BP3764 and Rb. Haarlem (vrzr.) 10 January 2011, ECLI:NL:RBHAA:2011:BP0426.

⁴²¹ *Kamerstukken II* 2011/12, 33 000 VI, no. 69, p. 3.

⁴²² Art. 1:25c BW. See also Rb. 's-Gravenhage 24 October 2011, ECLI:NL:RBSGR:2011:BU3627 and Van Vlijmen and Van der Tol 2012, *supra* n. 412.

⁴²³ E.g. Rb. 's-Gravenhage 24 October 2011, ECLI:NL:RBSGR:2011:BU3627.

⁴²⁴ E.g. Rb. 's-Gravenhage 11 December 2007, ECLI:NL:RBSGR:2007:BB9844 and Rb. 's-Gravenhage 18 January 2012, ECLI:NL:RBSGR:2012:BV2597. For a critical note, see the case note (in Dutch) of P. Vlaardingebroek to the 2007 judgment in *JPF* 2008/72.

⁴²⁵ Boele-Woelki et al. 2011, *supra* n. 186, at p. 308.

⁴²⁶ *Kamerstukken II* 2011/12, 33 000 VI, no. 69, p. 4.

was known.⁴²⁷ In line therewith he proposed that the reimbursement of expenses for foreign surrogate mothers would not be taken into account in the examination of the public policy exceptions in international surrogacy cases, as – so he alleged – ‘profit’ could not be defined unequivocally in the international context. The Secretary of State furthermore submitted that on the basis of Article 7 of the United Nations Convention on the Rights of the Child, any child born through surrogacy – be it with the use of donor gametes or not – had the right to know who his or her genetic parents were.⁴²⁸ Still, this has proven difficult to enforce in cross-border situations (see 6.6.4 above). The proposed policy for cross-border surrogacy cases has been endorsed by the authorities,⁴²⁹ but the present author is not aware of any published policy documents in which the policy has been laid down.

The Dutch government at the same time saw no need to amend Dutch law fundamentally so as to ensure that people would no longer feel a need to go abroad for surrogacy. They acknowledged that the Netherlands could not take an isolated position on this matter, but they also held it to be impossible to rule out any cross-border movement for this purpose.⁴³⁰ The Dutch government has furthermore seemed somewhat sceptical about the feasibility of the adoption of international instruments in respect of surrogacy. For example, they felt that the development of an International Treaty on surrogacy by the Hague Conference for Private International Law could not be awaited, as the occurring questions were too pressing.⁴³¹

The courts have, since then, continued to decide international surrogacy cases on the basis of the best interests of the child. In most – if not all – cases, the genetic parenthood of the intended father played an important role.⁴³² A case of 2013

⁴²⁷ This has been characterised as a ‘defeatist and pragmatic’ stance. B. van Beers, Case-note to ECtHR [GC] 3 November 2011, *S.H. a.o v. Austria*, no. 57813/00, 13 *European Human Rights Cases* 2012/38 (in Dutch).

⁴²⁸ *Kamerstukken II* 2011/12, 33 000 VI, no. 69, p. 4.

⁴²⁹ *Kamerstukken II* 2011/12, 31 265, no. 42.

⁴³⁰ *Kamerstukken II* 2012/13, 33 400 XVI, no. 155, pp. 7–8.

⁴³¹ *Kamerstukken II* 2011/12, 33 000 VI, no. 69, p. 4. See also Hague Conference of Private international law, Council on General Affairs and Policy of the Conference (17–20 April 2012), *Conclusions and Recommendations adopted by the Council*, 2012, www.hcch.net/upload/wop/gap2012concl_en.pdf, visited June 2014.

⁴³² For example, in a case of 2012, the District Court of Haarlem entrusted an intended father exclusive parental authority over his genetic child that was born to an Indian surrogate mother who was married. The intended father, who had recognised the child before the Dutch Registry and was subsequently appointed as the child’s guardian, requested the Court to entrust him with parental authority under Art. 1:253 c (1) BW. The man had concluded a surrogacy agreement in India with a surrogate mother who was married. From the judgment it does not become clear whether she was also the genetic mother of the child, but the court found it established that the intended father was the genetic father of the child. The judgment also gives no information about the birth certificate. However, the surrogate mother had waived all her rights and obligations towards the child, by means of an affidavit. The Court ruled that the it was in the interests of the child concerned, that the intended father, who had cared for the child from the moment of its birth, could make parental decisions, without needing to acquire the consent of the Indian surrogate mother, who was difficult to reach as she lived in India and who had never intended to care for the child. The Court accordingly entrusted the intended father (exclusively) with authority over the child. It is stated in the case that the intended father had a partner, but the case did not deal with the question of the legal recognition of her or his relationship to the child. *Rb. Haarlem* 6 November

concerned a same-sex couple.⁴³³ The child in this case had been born to an Indian surrogate mother who was married, with the use of an anonymously donated egg cell and sperm of the Dutch intended father who was in a same-sex relationship.⁴³⁴ The District Court of Haarlem held that by way of recognition before the Dutch Registry, the legal paternity of the intended father of his genetic child had been established. The Court subsequently granted an adoption order for the same-sex partner of the intended father, because such adoption was in the best interest of the child, and because the child could not – as could be reasonably foreseen – expect anything from the surrogate mother in her capacity as mother.⁴³⁵

6.6. CONCLUSIONS

Both abortion and AHR treatment have been the subject of heated discussions in Dutch society and politics. In respect of both these sensitive issues it took the legislature considerable time to draft and adopt legislation and in most cases this regulation followed an already existing practice. For instance, the Pregnancy Termination Act was only adopted after abortion clinics had been in operation for almost a decade, and until the entry into of the Embryo Act in 2002, assisted human reproduction (AHR) was only marginally regulated. Further, in both areas of law, criminal law sets the very boundaries of what is (ethically) acceptable. In practice, criminal law is, however, enforced to a very limited extent only. The relevant legislation primarily aims to provide for the necessary safeguards in respect of quality and safety of the treatment. Particularly in respect of abortion a rather procedural approach has been taken by the legislature; the Pregnancy Termination Act serves to guarantee a careful decision-making around abortion.

In a way the abortion debate paved the way for the introduction of AHR, as some form of human interference with the natural process of procreation was thereby accepted. Nevertheless, each new technological development in the field of AHR has stirred

2012, ECLI:NL:RBHAA:2012:5285. In another case, concerning the Philippines, the judgment did not state explicitly who the genetic parents of the child were, but the impression is conveyed that these were the surrogate mother and the intended father, because they were stated as the parents of the child on the Philippine birth certificate. The Court determined that the intended father had established his legal paternity under Philippine law, by means of signing an affidavit of acknowledgment – admission of paternity. Because a close personal relationship existed between the intended father and child, this recognition of paternity was recognised under Dutch law on the basis of Art. 10:101 BW. The Court accordingly ordered the entry of the birth certificate in the Dutch Register. Rb. ‘s-Gravenhage 13 August 2013, ECLI:NL:RBDHA:2013:12313.

⁴³³ Rb. Noord-Holland 18 December 2013, ECLI:NL:RBNHO:2013:12578.

⁴³⁴ The Indian birth certificate – which had stated that the surrogate mother was the mother and the intended father was the father of the child – could not be entered in the Dutch registry on public order grounds, because this was a surrogacy case. As the husband of the Indian surrogate mother (whom under Dutch law would be presumed the father of the child, due to the fact that the child was born within his marriage to the surrogate mother) had expressly denied paternity of the child, the Court established that the child would have no legal father under Dutch law, had the intended (and genetic) father not recognised the child. The Court declared for law that with this recognition the legal parenthood of the father had been established.

⁴³⁵ Art. 1:227(2) and (3) and Art. 1:227(3) BW.

a new and often heated debate about the acceptability of the new technique from an ethical viewpoint. Dondorp and De Wert have characterised the structure of the Dutch debate on AHR as a ‘repeating break’ (*de repeterende breuk*).⁴³⁶ According to the authors the debate repeatedly follows the same pattern: each time there is a new medical technological development, the argument is put forward that this new development crosses the line of ethical acceptability. However, these objections of principle soon prove to enjoy too little support to stop the development. No matter how heated the debate has been, the outcome is the same each and every time: subject to certain conditions, the new medical technology can be employed.⁴³⁷ This chapter has shown that in this regard the argument that people will otherwise resort to foreign treatment options, is frequently heard.

Through licensing systems and by requesting the medical profession to draft guidelines, the legislature has aimed to regulate these sensitive areas of laws. Prominent guiding principles for the legislature’s decision-making in respect of abortion and AHR are the protection of human life, the personal autonomy of the patient, the principle of good medical care and the best interests of the (future) child (see section 6.1.2). These principles are not embedded in the Dutch Constitution but follow from general principles of medical ethics and from International Treaty instruments. In all situations the legislature has aimed to strike a balance between these (competing) interests. In some cases greater weight has been attached to one of these interests. While the personal autonomy of the woman was in the end the most dominant principle on which the abortion legislation was based, the right of the child to know ones genetic origin was a decisive consideration for the legislature to set limits to the donation of gametes.

Cross-border movement has been taking place in respect of both abortion and AHR treatment. In respect of abortion, movement to the Netherlands was particularly large in scale in the 1970s and 1980s. Nonetheless, the number of abortions carried out in Dutch clinics involving non-resident women still makes up a non-negligible percentage of the total number of abortions carried out in the Netherlands. There have been only incidental reports of Dutch women going to other EU Member States for abortions. In respect of AHR treatment, most reports of cross-border movement concern couples and individuals from the Netherlands who go abroad for AHR treatment, for instance for IVF treatment with the use of anonymously donated egg cells. Cross-border movement to the Netherlands for reproductive care has also been reported, but no official statistics are available.

The existence of CBRC is expressly acknowledged by the Dutch authorities. Although (medical) risks may be involved, it is felt that such cross-border movement cannot be prevented from occurring. In fact, a certain form of resignation on the side of the government can be noticed. For example, in response to parliamentary questions, the

⁴³⁶ Dondorp and De Wert 2012B, *supra* n. 200, at pp. 7–12.

⁴³⁷ *Idem*, at pp. 5–6. The present chapter has shown that the only exception to this ‘ritual dance’ is the case of gender selection, which has been prohibited soon after it was introduced and still is prohibited under Dutch law.

Minister of Health held in 2011 that she had no means to stop women from turning to foreign clinics for anonymous egg cell donation. According to the Minister this very fact rendered the question of whether this development was desirable or not, out of order.⁴³⁸ It is furthermore generally accepted that the Dutch Health Insurance system has to carry the costs of foreign treatments, even if they are not in conformity with the Dutch professional standards or laws.⁴³⁹ Some difference of opinion on this issue between the government and the Health Care Insurance Board on the one side, and the Central Appeals Court for Public Service and Social Security Matters on the other, has been, however, visible (see section 6.5.2 above).

Cross-border movement and related quality and safety concerns have in some cases been an express ground for the Dutch legislature to regulate certain issues. The fact that couples from the Netherlands went abroad for PGD, for instance, was one of the reasons for the Dutch legislature to legalise and regulate this diagnosis and surrogacy agreements concluded in other countries, made the Dutch government feel that the Private International Law rules on the establishment of parental links had to be amended (see sections 6.4.3 and 6.5.6 above).

⁴³⁸ *Aanhangsel Handelingen II* 2010/11, 2303, p. 2.

⁴³⁹ CVZ 2010, *supra* n. 344, at pp. 11–12.

