Chapter 7
Conclusions Case Study I

7.1. The internal picture – How are reproductive matters dealt with in the various jurisdictions?

7.1.1. Balancing; the same interests but different weights

The present case study has confirmed that the regulation of reproductive matters involves a careful balancing of various individual and general interests. As such, there is not much difference between the kind of interests and considerations that have been addressed in legislative debates and included in decision-making in the various jurisdictions studied. It is the weight that has been accorded to these interests and correspondingly the balancing of the various interests involved that has differed. Some States accord particularly strong protection to a specific interest. The Irish protection of the unborn and the German protection of human dignity, which are included in the Constitutions of these countries, are two examples that stand out in this regard. This is not to say that the other States studied do not protect these interests at all, but they do so less prominently, have interpreted these notions differently and/or have accepted that in certain circumstances counter-values may outbalance these interests.

At the European level, States are left ample room to undertake balancing exercises in reproductive matters, and consequently, to make principled choices in this area. Chapter 3 has shown that EU law basically does not reduce this national freedom, apart from by setting certain safety and quality requirements for the placing in the market of *in vitro* diagnostic medical devices. The ECtHR also generally leaves States a wide margin of appreciation in the area, which extends both to the States' decision to intervene in the area and, once they have intervened, to the detailed rules they set down in order to achieve a balance between the competing public and private interests. As explained in Chapter 2, the margin is wide because morally and ethically sensitive issues are concerned, which involve a complex balancing of various individual interests and upon which generally no European consensus exists. Another reason is that the Strasbourg Court respects the democratic processes at the national level. Especially where a certain national 'choice' emerged from a 'lengthy, complex and sensitive debate' at the domestic level,[1] or where it was the 'culmination of an exceptionally detailed examination of the social, ethical and legal implications of developments in the field […] and the fruit of much reflection, consultation and

[1] ECtHR [GC] 16 December 2010, *A, B and C* v. *Ireland*, no. 25579/05.

debate',[2] has the ECtHR granted the States much leeway to make their own decisions and set their own rules and procedures. The Strasbourg Court has at the same time stressed that the margin of appreciation is not unlimited and that national 'solutions' are not beyond the scrutiny of this Court.[3] The ECtHR supervises whether interferences constitute a proportionate balancing of the competing interests involved.[4] At times such examination has resulted in the finding of a violation. Further, the margin of appreciation has not been wide in all situations covered by this case study.[5]

So what are the various individual and general interests that have been included in balancing exercises at the national level and (approved of at) European level? In all three States, it appears that values like human dignity and non-commercialisation of (parts of) the human body have played a prominent role in (legislative) debates on and standard-setting in reproductive matters.[6] Another such value is personal autonomy, in respect of which it can be noted – in any case in the abortion context that – that it has generally been granted more protection in Germany and the Netherlands, when compared to Ireland. All three States have furthermore protected interests of individuals who cannot easily claim protection of their own rights. These concern the (unborn or future) child and vulnerable parties (indirectly) involved in reproductive matters, such as gamete donors and surrogate mothers.

The unborn is protected to some extent in all three States studied in this research, as well as by the ECtHR, but to differing degrees. The ECtHR has not taken a strong stance on the status of the unborn life, but, leaving a wide margin of appreciation in this particularly sensitive area, it has upheld systems like the Irish that grant the unborn almost absolute protection against abortion. Also in Germany and the Netherlands the principled choice has been made to criminalise abortion in order to give expression to the protection of the unborn life, but both regimes provide for important exceptions to this rule. The Dutch legislature chose to protect the interests of the unborn child through a set of procedural requirements which provide the decision-making procedure with the necessary guarantees (see also section 7.4

2 ECtHR [GC] 10 April 2007, *Evans* v. *the United Kingdom*, no. 6339/05, para. 86.

3 ECtHR 28 August 2012, *Costa and Pavan* v. *Italy*, no. 54270/10 and ECtHR [GC] 3 November 2011, *S.H. a.o.* v. *Austria*, no. 57813/00.

4 ECtHR [GC] 16 December 2010, *A, B and C* v. *Ireland*, no. 25579/05, para. 238 under reference to ECtHR 29 October 1992*, Open Door and Dublin Well Woman* v. *Ireland*, nos. 14234/88 and 14235/88, para. 68. In *S.H. and Others* – a case on gamete donation – the Court held that it fell to it to carefully examine the arguments which had been taken into consideration during the legislative process and which had led to the choices that had been made by the legislature and to determine whether a fair balance had been struck between the competing interests of the State and those directly affected by those legislative choices. While the Court held expressly that a wide margin of appreciation applied in that case, this formulation in fact directs at a stricter scrutiny. ECtHR [GC] 3 November 2011, *S.H. a.o.* v. *Austria*, no. 57813/00, para. 97.

5 One concrete issue in respect of which the margin of appreciation has narrowed over the years, concerns the right to know one's genetic origins. See Ch. 2, section 2.1.4.

6 Non-commercialisation of (parts of the) human body, is in fact one of the few principled standpoints that the EU legislature has taken in this area, as confirmed in Case C-34/10 *Oliver Brüstle* v. *Greenpeace eV* [2011] ECR I-9821, ECLI:EU:C:2011:669. See ch. 3, section 3.1.1.

below).[7] In Germany a similar approach was chosen, albeit that the State's duty to protect unborn life has resulted in stricter time limits and more instructive positive obligations for the authorities in abortion procedures.[8]

Both in the States studied in this research and under the ECHR as well as the EU Charter of Fundamental Rights, it is provided that the best interests of the child must be an important, if not the primordial consideration in any law-making, policy decisions and judicial decisions concerning children. This 'best interests of the child' principle both sees at protection of the child in a more abstract sense, including before it has actually come into being, and at concrete rights that any child bears once it is born and that may extend into adulthood.

It the context of the present case study, protection of the future child, or 'the child' in general, has at times in fact been an argument for not letting a child come into existence in the first place.[9] It has, for example, been put forward – and at times accepted – as (one of the) argument(s) against surrogacy or against certain forms of AHR treatment, such as post-mortem fertilisation or preimplantation genetic diagnosis (PGD). Arguments against surrogacy have been that it was considered unethical to make a child the object of a legal act and that this affected the human dignity of children. Also, divided motherhood has been held not to be in the child's interest.[10] Other concerns have been 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 child could be rejected if the expectations of the intended parents were not met. When it comes to PGD, a fear for eugenics and 'designer babies' has been a concern in all three States. On the other hand, there has been the desire to protect the future child's physical integrity, by protecting it against suffering from a serious genetic disorder.

The rights of the child have, furthermore, been put forward by various AHR clinics as an argument for excluding single women as well as same-sex couples from access to AHR. Reimbursement for AHR treatment has in some States been confined to certain groups on similar grounds has. For example, in Germany the fact that only married couples qualify for such reimbursement under the public health insurance, was held to serve best interests of the child and approved of by the German Constitutional Court.[11] Clear bottom lines that have emerged from the present case study are reproduction for profit and gender selection. It has been

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7 A reflection period, as in place in the Netherlands, is a clear example of such a procedural guarantee. See Ch. 6, section 6.2.2.3.

8 For example, because the goal of counselling in pregnancy conflict situations must be the protection of the unborn child, counsellors must to try to encourage the woman to continue her pregnancy and show her opportunities for a life with the child.

9 In the Netherlands, for example, doctors must refrain from providing assistance to reproduction if they are of the opinion that the future child runs a real risk of serious psychosocial or physical harm. See Ch. 6, section 6.3.2.

10 In the case of Germany this consideration has also been one of the grounds for the German prohibition on egg cell donation. See Ch. 4, section 4.3.4.1.

11 See Ch. 4, section 4.3.8.

considered incommensurable with human dignity to value children, human embryos and gametes in terms of money and thus as objects or trade, or to give reproduction a purely instrumental character.

When it comes to more concrete rights children have once they are born, the right to personal identity and development of the child has proven to be particularly relevant in the present case study. It has been on the basis of this right that a right to know one's genetic origins has been recognised in the States studied for this research, as well as under the ECHR.[12] The level of its protection has varied, however. In the Netherlands, the right of the child to know about its genetic origins has enjoyed protection since 1994 and has been strongly protected through detailed legislation since 2004. In Germany this right has been recognised in case law and in Ireland legislation preserving a child's right to know its identity in the context of gamete donation is in the making. Further, as explained in Chapter 2, under the ECHR a development towards stronger protection of this right has been visible.

Related thereto is the importance that has been attached to genetic lineage in all jurisdictions studied. This is illustrated, for example, by the fact that in the Netherlands only high-technological surrogacy is legalised under certain strict conditions. Another example is the Irish *McD* v. *L & Anor* case (2010), where a sperm donor was granted access to his child, because it was held to be in the interests of the child to establish contact with its genetic father. At the same time, the *mater semper certa est* principle – following which the birth mother is the legal mother of a child whether she is also the genetic mother or not – is adhered to by all three States studied in this research. This principle is closely related to the general principle of legal certainty, which has been another motive for standard-setting in the area.

The present case study has furthermore made clear that States have wished to protect other vulnerable parties involved in abortion, AHR treatment and surrogacy. For example, Germany and the Netherlands have regulated for abortions, *inter alia*, in order to protect women against the health risks involved in illegal abortions.[13] The need has also been felt to protect gamete donors and surrogate mothers against health risks, commodification and commercial exploitation and against psychological or emotional problems in the long run. Further, a prohibition on post-mortem fertilisation without explicit consent, as in place in Germany and the Netherlands, aims to protect the deceased's personal autonomy.

Lastly, quality and safety concerns have been ground for regulating in this area. This certainly also holds for the relevant standard-setting in the area as adopted at EU level, albeit that such requirements also – or primarily – aim to serve the internal market. At national level, quality and safety concerns have been grounds for setting

12 Protection of the child's personal identity was also the primordial consideration of the ECtHR in the cross-border surrogacy cases *Mennesson* and *Labassee* (see ch. 2, section 2.4.2). Because these rulings related to cross-border situations only, they are left out of the equation in the present section that is concerned with the internal picture. See, however, section 7.2 below.

13 Ch. 4, section 4.2.2 and Ch. 6, section 6.2.2.

up licensing systems and for requesting that the medical profession draft guidelines, as has been, for example, the case in the Netherlands.

Thus, there is a wide spectrum of individual and general interests included in the balancing exercises in reproductive matters in the various jurisdictions. As noted above, European regulation and case law leaves the States much room to balance those interests, so long as they ensure that the general legal framework allows the different legitimate interests involved to be adequately taken into account.

7.1.2. Room for bright line rules

Because of the complex balancing exercises involved in reproductive matters, States have at times adopted 'bright line rules', which by nature exclude detailed examinations of individual cases. Examples are complete prohibitions on certain practices, such as the German prohibition on egg cell donation, or principles like the *mater semper certa est* rule – entailing that when a child is born its mother is the woman who gave birth to it – that is upheld in all three States studied.

From the ECtHR's case law it follows that bright line rules in the area of reproductive matters may be acceptable under the Convention. As explained in Chapter 2, this Court has made clear that it is not necessary that legislation governing important aspects of private life provides for the weighing of competing interests in the circumstances of each individual case. Where such important aspects are at stake, so the Court has held, it is not inconsistent with Article 8 ECHR that the legislature adopts rules of an absolute nature which serve to promote legal certainty.[14] It has thereby underlined that concerns based on moral considerations or on social acceptability were not in themselves sufficient reasons for a complete ban on a specific AHR technique.[15] At the same time, the Court has held that the Irish ban on abortion on health and social grounds, could indeed be justified on moral grounds. It accepted that the Irish prohibition of abortion for reasons of health and/or well-being served the legitimate aim of protection of morals, of which the protection in Ireland of the right to life of the unborn was 'one aspect'.[16]

Initially a similar approach was taken by the Strasbourg Court in respect of the question of knowledge about one's genetic origins, as domestic legislation that protected the parent's right to remain anonymous in all situations was upheld by the ECtHR. Over time such bright line rules have become more problematic as increasingly more weight has been attached to the rights of the child in the relevant case law.[17] A similar development has taken place at the national level in the States studied in this research. For example, in the Netherlands initially sperm donors could

14 ECtHR [GC] 10 April 2007, *Evans* v. *the United Kingdom*, no. 6339/05, para. 74 and ECtHR [GC] 3 November 2011, *S.H. a.o.* v. *Austria*, no. 57813/00, para. 110.
15 ECtHR [GC] 3 November 2011, *S.H. a.o.* v. *Austria*, no. 57813/00, para. 100.
16 ECtHR [GC] 16 December 2010, *A, B and C* v. *Ireland*, no. 25579/05, para. 222. See Ch. 2, section 2.2.3.
17 See Ch. 2, section 2.1.4.

remain anonymous indefinitely, but this rule was lifted in 2004 and replaced by a system that provided for rules that differentiate between types of donor information and the age of the child concerned. These developments in respect of the question of knowledge about one's genetic origins fit in with a broader development that once an actual child is concerned, it is important to carry out a concrete examination of each case.[18]

The foregoing confirms that it is thus well possible that the more (regulation in respect of) a certain reproductive matter becomes 'commonplace', the more a desire emerges to provide for differentiation in regulation and for possibilities to pay due regard to the individual circumstances of each case.

7.1.3. Consistency of laws required

Another comparable feature that has come to light as a result of the present case study, is that at times a 'consistency of laws' reasoning has come up in some of the jurisdictions studied in this case study. (Parts of) proposed AHR regulation have been considered inconsistent with existing laws, such as abortion laws. Where existing regulation witnessed that a certain principled choice had been made in the respective jurisdiction, it undermined arguments against the introduction of a new type of treatment which raised similar concerns. For example, in Germany, such a consistency of laws argument has been put forward both in respect to the Embryo Protection Act in general, and in respect to PGD in particular, and it has been one of the grounds for lifting the prohibition on PGD. The ECtHR has employed similar reasoning, and on that basis held Italian legislation prohibiting PGD on grounds for which abortion was allowed for, to be in violation of Article 8 ECHR.[19] Hence, under the ECHR, it can be seen that if States regulate in the area of reproductive matters, they must guarantee that the relevant legislative framework is coherent and consistent. This may be particularly challenging now that the relevant legislative framework is generally fragmented (see below).

7.1.4. Importance of procedures allowing for careful decision-making

What furthermore comes to the fore if one compares how reproductive matters have been dealt with in the various jurisdictions studied, is the importance that has been attached – particularly in the context of abortion – to procedures that allow for careful decision-making. This can of course be explained by the fact that, as discussed above, these matters involve a balancing of various interests and such procedures are aimed to enable balancing exercises with due regard for the individual circumstances of each case.

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18 As also stressed in the cross-border surrogacy cases decided by the ECtHR (see Ch. 2, section 2.4.2, as well as section 7.2 below).

19 See Ch. 2, section 2.3.4.

This attention to procedural guarantees allowing for careful decision-making has been particularly visible in respect of abortion. The Dutch Pregnancy Termination Act, for example, serves first and foremost to guarantee a careful decision-making around abortion. As explained in Chapter 6, the Dutch 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.

As discussed in Chapter 2, an obligation to provide for certain procedural rights in respect of abortion also follows from the ECHR, where the Court has based this obligation on the doctrine that Convention rights must be safeguarded in a practical and effective manner. In other words, once the legislature decides to allow abortion, it must structure its legal framework in a way which allows for real possibilities to obtain it. Hence, while the ECtHR does not rule on the substantive choices of principle made by States with regard to abortion, it does require that when there is a legal option to have an abortion at the domestic level, the pregnant woman at least has a possibility to be heard in person and to have her views considered; that the competent body or person issues written grounds for its decision and that the pregnant woman has effective access to relevant information on her and the foetus' health. The latter requirement includes access to diagnostic services, decisive for the possibility for the pregnant woman of exercising her right to take an informed decision as to whether to seek an abortion or not.[20]

This line of ECtHR case law has had very concrete impact at national level, as is particularly visible in respect of Ireland. The Irish abortion procedures were for long unclear, but following the ECtHR judgment in the case of *A, B and C*, the Protection of Life During Pregnancy Act (2014) was adopted. This Act improved the procedural rights of women and has provided for more clarity for medical practitioners, without bringing about any material change.

7.1.5. Fragmented regulation

Apart from differences in the balancing exercises in the various national jurisdictions, the 'level' at which reproductive matters have been regulated in the States – if there is any regulation at all – also appears to differ. In Ireland Article 40.3.3° of the Constitution plays a dominant role in the abortion legislation, while in Germany and the Netherlands those Constitutional provisions applicable are also important guiding principles for standard-setting in the area – in Germany even more prominently than in the Netherlands – but they are less directive in their wording. In Germany and the Netherlands the legislature has generally set the relevant legal framework, while certain matters are left to the medical profession to regulate. In the Netherlands the medical profession is generally given quite substantial leeway, while in Germany the legislature has generally laid down more detailed rules in statutory legislation.

[20] See Ch. 2, section.

While both these States have an Embryo Act that deals with various issues related to AHR and – in the case of Germany – surrogacy, in Ireland, no such legislative framework is in place for AHR treatment and surrogacy.[21] Also, until as recently as January 2014 there was hardly any legislation on abortion.

The present case study has furthermore made clear that various realms of the law may be involved in the relevant legal framework on reproductive matters. In all three States criminal law applies in the area, in any case in abortion regulation. The maximum penalties for illegal abortions have been most severe in Ireland, with life imprisonment until 2014, and imprisonment for a term of 14 years, maximum, since that time. In the Netherlands and Germany the maximum terms of imprisonment are much lower and many more exemption grounds apply. The latter States have also employed criminal law in their regulation in the area of AHR and surrogacy. In both the Netherlands and Germany surrogacy mediation and gender selection are criminalised, while in Germany by means of the Embryo Protection Act, criminal law applies also in respect of matters like post-mortem fertilisation and PGD. Such criminal law provisions were often deliberately chosen to reflect very principled approaches (such as protection of the unborn life; see 7.1.1 above), and to set the very boundaries of what is (ethically and morally) acceptable. Their actual employment has been much more limited; prosecution practice for abortions has decreased considerably over the decades in all three States, while prosecutions for surrogacy and AHR related matters have been only very incidentally reported.[22]

Other areas of law that are covered by the relevant legal frameworks of the States studied concern social security law for public funding issues and civil law in respect of questions of parenthood. Furthermore, in all three States medical profession sets certain ethical and quality standards, while access to AHR treatment is often regulated by clinics themselves and may thus differ from clinic to clinic.

The various national regimes thus differ not only in respect of substance, but also in respect of form and the level at which reproductive matters are regulated for.

7.1.6. How was change brought about? A typification of (legislative and judicial) processes

Not only do the balancing exercises in reproductive matters and the level at which these matters were regulated differ between the various jurisdictions, but also the way in which change has been brought about. For instance, sometimes the legislature has proven to be the driving force behind change, while in other situations it has been the judiciary. Also, the extent to which European law has been influential in these (legislative and judicial) processes differs between the States studied.

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21 It is reminded that this research was concluded on 31 July 2014.

22 See Ch. 4, section 4.2; Ch. 5, section 5.2.9 and Ch. 6, section 6.2.4 respectively. See also section 7.2.1.1 below.

What the processes in the various jurisdictions have in common is that change has never been brought about quickly. In all three States, there has been generally a certain or even considerable reluctance on the side of the legislature to regulate this area. This can be explained by the sensitivity of the subject-matter and the diversity of interests that need to be balanced in this area, as set out above in section 7.1.1 Also, the area concerned is one in respect of which medical and scientific developments are moving fast. Legislatures and courts – including those at European level – have been uncertain about (the effects of) such developments and have therefore acted with caution. In all three States there have been fairly lengthy debates and considerable lapses in time before regulation has been introduced, if at all. For example, in Germany, adoption of the German Pregnancy and Family Assistance Act of 1992 was preceded by two years of heated and emotive debates that had even jeopardised the signing of the Reunification Treaty. Not uncommonly, practice has outpaced regulation. For instance, the Dutch Pregnancy Termination Act was only adopted after abortion clinics had been in operation for almost a decade, and the introduction of the Embryo Act took until 2002, while IVF treatments had been carried out in the Netherlands since the 1980s. The ECtHR, while at times urging the States to keep the area under review, has not reproached States for such delays in the adoption of legislation on reproductive matters.[23]

As observed in Chapter 6, the Dutch process in respect of AHR legislation can been described as a ritual dance with a 'repeating break', entailing that each new medical technological development has been met with concerns about its ethical acceptability, but has nonetheless been regulated for, by subjecting it to certain limitations.[24] The German legislature has also taken a careful piecemeal approach in the area, but followed a different pattern. From early on it covered many issues in the Embryo Protection Act of 1991 and outlawed a considerable number of practices such as surrogacy, egg cell donation and PGD. Over time some of these rules have been amended and relaxed, for example those in respect of PGD. Also, in Germany the Courts have played a more prominent role in this process. At times, they have given an extra push for change. The lifting of the absolute prohibition on PGD in 2011, for instance, has been the result of a judgment of the Constitutional Court. In other cases, German courts have shown more deference to political and societal sensitivities and have given the legislature discretion to regulate matters, for instance in respect of reimbursement for AHR treatment.

In the case of Ireland, the process has been different. The pattern that can be discerned is that individual cases have frequently caused considerable public outcry, while basically all change – albeit limited in any case – has been triggered or even forced upon the legislature by (European) case law. The legislature has often resisted giving a follow-up to these judgments, or has in any case been hesitant to do so. For

23 Only in the Irish abortion case *A, B and C* did the ECtHR note that Ireland had failed to implement Art. 40.3.3° of the Irish Constitution, and the lack of a regulations on the abortion procedures was a ground for the finding of a violation of Art. 8 ECHR in respect of the third applicant. See Ch. 2, section 2.2.3.

24 Ch. 6, section 6.6.

instance, it was only in 2014, after the ECtHR's *A, B and C* ruling and the public debate sparked by the tragic death of a woman who had been refused an abortion in a hospital in Galway, that a law was adopted that implemented the *X Case* of 1992, and has regulated access to lawful termination of pregnancy in Ireland. AHR and surrogacy have long been, and are mostly still, submerged in legal uncertainty in Ireland. The AHR Commission identified a need for action in 2005, but for years the Irish legislature did not take any action. After the Irish courts unequivocally stated that they did not consider it the task of the judiciary to resolve the existing uncertainty, it has been evidently up to the Irish legislature to fill in the legal vacuum that has continued to exist in Ireland as regards AHR and surrogacy. It was (again) only in 2014 that first steps in this regard were taken, although some initiatives – most prominently the proposed surrogacy legislation – were withdrawn before they were even debated in Parliament.

To remain in the metaphor of dance, other processes can be best described as two steps forward, one step back, resembling the dancing procession of Echternach.[25] Sometimes courts have blown the whistle on excessively proactive legislatures, as was, for example, the case in the German abortion judgment of 1975, in which the Constitutional Court ruled that the Abortion Reform Act as passed by the German legislature insufficiently protected the unborn.[26] On other occasions higher Courts have overruled judgments of lower Courts for being overly progressive. For example, the Irish Supreme Court blew the whistle on the High Court which had, in the of *McD* v. *L & Anor* case, recognised *de facto* family life of a same-sex couple and had accordingly denied a sperm donor access to his biological child.[27] Another such example concerns the ECtHR, where the Grand Chamber of the ECtHR overruled the Chamber in the *S.H. and Others* case, and so upheld the Austrian prohibition on ovum donation, that the Chamber had previously found discriminatory.[28]

7.1.7. Resumé and outlook

In sum, it can be derived from this case study that the balancing of interests related to reproductive matters has resulted different outcomes in the three States studied and the legislative and judicial processes in the States have taken different shapes. European law explicitly allows for such diversity between legal regimes on reproductive matters. States are left room to make their own principled choices in these moral and ethical issues and they are free to prohibit practices, as long as the relevant interests have been balanced in the decision-making and as long as their principled choices are consistent. However, once they decide to regulate in the area, they must also provide for the effective enjoyment of rights and entitlements, which entails that they must ensure that the applicable procedures enable careful decision-making.

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25 The original dancing procession of Eternach consisted of three steps forward, two steps back.
26 See Ch. 4, section 4.2.2.
27 See Ch. 5, section 5.3.4.
28 See Ch. 2, section 2.3.3.

The present case study has furthermore shown that there are not only differences, but also similarities in the ways in which reproductive matters have been dealt with in the various jurisdictions. Generally, over time more reproductive practices have been legalised and regulated for, or at least initiatives to that effect have been taken. Also, a gradual development towards a central role for the best interests of the child is clearly visible, although the views on what these require exactly have in some cases changed over time. Furthermore, blanket rules have been adopted and approved of at the European level, while at the same time a development towards the assessment of reproductive matters with due regard to the individual circumstances of the case has been visible. Both at European and national levels, there has been increased attention focused on the introduction of procedures allowing for careful decision-making in reproductive matters.

Given that AHR is an area with particularly fast-moving medical and scientific developments, it is in this area that there is most potential for new questions being raised by new medical possibilities. It is also possible that the case law of the ECtHR will in the future have a more substantive impact on standard-setting in the area of reproductive matters, particularly if more European consensus would develop on certain issues.

7.2. The cross-border picture – Legal responses to cross-border movement

As set out in the various chapters of this case study, cross-border movement in reproductive matters has taken and is taking place from and to the three States studied in this research and within the European Union as such, and in some cases the scale of this mobility has been considerable. The present case study has shown that the three States studied – functioning as countries of origin or countries of destination or both – have dealt in different manners with such cross-border movement. Firstly, forms of resignation have been identified. For example, as discussed in Chapter 6, Dutch authorities acknowledged that there were no means to stop cross-border reproductive care (CBRC) and concluded that this very fact rendered the question of whether this development was desirable or not, out of order. Secondly, there have been more (pro)active responses to (the effects of) cross-border movement in reproductive matters. This section identifies and categorises various such legal responses on the basis of the present case study. The extent to which European law (both EU law and the ECHR) leaves room for these legal responses at national level, or in fact even encourages or dictates them, is thereby examined.

A first category of legal responses to cross-border movement in reproductive matters that can be distinguished based on the findings of this case study consists of warding off such cross-border movement: States may try to deter people from going to other States or from coming to their State for reproductive matters. As further explained in section 7.2.1, such warding off may take different shapes, ranging from travel bans to non-recognition of legal parenthood established in another State. Secondly,

as a mirror to the 'warding off' approach, States may choose to accommodate (the effects of) cross-border movement in reproductive matters, as is discussed in section 7.2.2. A third type of response is adaptation, which means the adjustment of national standard-setting in the area to that of another State or other States to which cross-border movement takes place (section 7.2.3). Lastly, cross-border movement has in some situations enabled States to outsource the protection of certain interests in these sensitive matters to other States (section 7. 2.4).

Importantly, these responses are generally not mutually exclusive; it has turned out that States often combine various categories of responses in their dealing with cross-border movement in reproductive matters. Nevertheless, for each of these four categories what interests, considerations, perspectives or values have inspired or dictated these legal responses can be examined. Of course, one thereby needs to take care not to ascribe more intentions or underlying motives to the various State measures discussed than can be derived from the type of legal research conducted in this case study. What can be assessed here, however, is what the implications of each respective category of legal responses are, or may be, for the States concerned, as well as for the individuals involved in the cross-border movement. Each subsection therefore finishes with observations about such implications for these actors, whereby reference is also made – where relevant – to sociological research in the area. In the final subsection (section 7.2.5) it is assessed how the various legal responses to cross-border movement relate to one another.

7.2.1. Warding off

Legal responses that ward off (the effects of) cross-border movement in reproductive matters may take different shapes. The most far-reaching response consists in trying to prevent cross-border movement in reproductive matters from taking place in the first place, for instance by imposing a travel ban or by criminally prosecuting people for obtaining treatment abroad (section 7.2.1.1).[29] Other – less drastic – forms of deterring people from crossing borders for reproductive reasons that can be identified on the basis of the present case study are bans on information about such foreign options (section 7.2.1.2), refusals to provide follow-up care (section 7.2.1.3) and refusals to reimburse treatment obtained abroad (section 7.2.1.4). Furthermore, in cross-border surrogacy cases, recognition of legal parenthood established in another State has been refused (section 7.2.1.5). While these measures all concern States that function as countries of origin in cross-border situations, also States that function as countries of destination – States to which cross-border movement takes place – may ward off cross-border movement (section 7.2.1.6).

[29] See also R.F. Storrow, 'Assisted Reproduction on treacherous terrain: the legal hazards of cross-border reproductive travel', 23 *Reproductive BioMedicine Online* (2011) pp. 538–545 and W. van Hoof and G. Pennings, 'Extraterritoriality for cross-border reproductive care; should states act against citizens travelling abroad for illegal infertility treatment?', 23 *Reproductive BioMedicine Online* (2011) pp. 546–554.

7.2.1.1. Travel bans and criminal prosecution upon return

Incidentally, there have been reports of such drastic measures as travel bans being taken by one of the States studied in this research. The Irish *X* and *C* cases of the early 1990s stand out in this regard. As discussed in Chapter 5, these cases where solved at the national level, as the Supreme Court held that there was in the particular circumstance of the cases at hand, where there was a real and substantial risk of loss of the woman's life by way of suicide, a right to an abortion *within* Ireland. This approach could in fact be perceived as a certain form of adaptation (see 7.2.3 below) as it rendered any cross-border movement redundant in such exceptional situations. The *X Case* was, however, also the trigger for the 1992 amendment of Article 40.3.3° of the Irish Constitution, which expressly provides that the freedom to travel between Ireland and other States for the purpose of an abortion will not be limited. The initial warding off that was at stake in the *X Case* and *C Case* thus consequently resulted in an express form of accommodation of cross-border movement for abortions (see also 7.2.2.2 below).[30]

Criminal prosecutions for having obtained reproductive treatment abroad have not been identified in the present case study.[31] They are, however, not illusory. German law, for example, provides expressly for a possibility to criminally prosecute for abortions obtained abroad. At the same time, as noted in Chapter 3, such criminal prosecutions – as for travel bans – seem hard to justify under EU free movement law. Moreover, there may be difficulties in enforcing such prosecutions in cross-border cases.[32]

7.2.1.2. Bans on information about foreign services

Cross-border movement in reproductive matters may also be warded off by means of bans or limitations on information provision about foreign treatment options. As explained in Chapters 2 and 5, Ireland adopted such a policy in respect of information about foreign abortion services in the 1990s, which subsequently proved problematic under the ECHR.[33] The ECtHR's ruling in *Open Door* prompted the adoption of the Abortion Information Act in Ireland, as a result of which, again, the challenge in court of a warding off measure resulted in an accommodation obligation for the

30 This was confirmed by the 2007 ruling of the Irish High Court in the case of Miss *D.*, where the Court ruled that the Health Service Executive could not prevent a 17-year-old pregnant girl from travelling to the UK to obtain an abortion, as there was no stay or constitutional impediment which served to prevent her from travelling to the UK to terminate her pregnancy if she so wished. See Ch. 5, section 5.2.5.

31 As discussed in Ch. 6, in the Netherlands in one case prosecution was initiated for late abortion in Spain, but the charges were later dropped.

32 Van Hoof and Pennings 2011, *supra* n. 29, at p. 551. As also discussed in Ch. 3, section 3.6.4, there are still various open questions as to the application of the European Arrest Warrant in this context.

33 As discussed in Ch. 2, section 2.4.1, in ECtHR 29 October 1992*, Open Door and Dublin Well Woman* v. *Ireland*, nos. 14234/88 and 14235/88, the ECtHR held an injunction restraining Irish counselling agencies from assisting pregnant women in seeking legal abortion services abroad, to violate the freedom to impart and receive information (Art. 10 ECHR).

State.[34] The ECtHR later held the new abortion information legislation acceptable, and considered it one of the elements that justified the restrictive Irish abortion laws (see more elaborately section 7.2.4 below).[35] Given the specific context of the Irish abortion cases, one may need to be careful in applying the ECtHR's findings analogously to situations concerning AHR or surrogacy, but the ECtHR's reasoning concerning effectiveness[36] and the implications of the Irish abortion information ban on the individuals concerned,[37] may very well apply also in such cases.

Moreover, the EU Patient Mobility Directive has introduced considerable rights to information for patients involved in cross-border care (see also section 7.2.2.3 below), rendering bans on information about abortion and AHR treatment options in other EU Member States unacceptable under EU law.

7.2.1.3. Refusals to provide follow-up care

At a more practical level warding off may consist of refusals to providing aftercare. Not many such examples have been found in the present case study.[38] There have been incidental reports from the Netherlands of gynaecologists refusing to treat women who had been to Spain for AHR treatment with the use of commercially and anonymously donated egg cells.[39] Refusals to provide follow-up care have, furthermore, been claimed to have occurred in Ireland in respect of abortion, but in 2010 the ECtHR found the provision of medical care in Ireland for women who had had abortions in other countries to be sufficient.[40]

As discussed in Chapter 3, it remains an open question whether European law leaves room for refusals to provide aftercare.[41] A refusal to provide follow-up care after abortion may furthermore contribute to a violation of the ECHR, as follows from the *A, B and C* case, where the Court considered access to medical care in Ireland after an abortion abroad a precondition for the justification of the very restrictive Irish

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34 The first two applicants in the *A, B and C* case (2010), who sought an abortion for reasons of health and/or well-being, maintained that there was a lack of information on the options available to them and that this added to the burden of the impugned restrictions on abortion in Ireland, but the ECtHR found these submissions to be overly general and unsubstantiated. ECtHR [GC] 16 December 2010, *A, B and C* v. *Ireland*, no. 25579/05, para. 130.

35 *Idem,* para. 241.

36 The Court noted that the an injunction restraining Irish counselling agencies from assisting pregnant women in seeking legal abortion services abroad was ineffective, as it did not prevent large numbers of Irish women from continuing to obtain abortions in the UK.

37 The Court noted that the injunction created a risk to the health of women seeking abortions at a later stage in their pregnancies due to the lack of proper counselling, and it had adverse effects on women who were not sufficiently resourceful or did not have the necessary level of education to have access to alternative sources of information. *Idem*, paras. 73–77.

38 It must be noted that the present research is confined to legal research, while a complete picture of whether such refusals occur and if so at what extent, requires sociological research.

39 Ch. 6, section 6.5.3.

40 See Ch. 2, section 2.4.1.

41 Ch. 3, section 3.6.2.3.

abortion laws (see also 7.2.4 below).[42] Again, while there is no case law on this point yet, it is well possible that such reasoning would also apply in CBRC cases.

7.2.1.4. Refusals to reimburse treatment and prior authorisation requirements

Another way in which countries of origin may ward off cross-border movement in the context of the present case study, is through refusing reimbursement to individuals or couples who availed themselves of foreign treatment options, or by setting prior authorisation requirements.

The present case study has shown several examples where courts in Germany and the Netherlands rejected claims for reimbursement for treatment obtained abroad. As discussed in Chapter 3, the basic rule under EU free movement law is that States do not have to reimburse treatment obtained abroad, if such treatment is prohibited under the domestic law, or if its national scheme does not provide for reimbursement for that kind of treatment.[43] Hence, if a State prohibits certain reproductive treatment, it may also refuse to reimburse the costs if such treatment is obtained abroad. However, as also discussed in Chapter 3, in practice, this rule may prove problematic in the context of reproductive treatment, as it may be debated if medical and ethical standards may be taken into account in this assessment. Also, there are various questions as to whether EU law allows for the setting of prior authorisation requirements for pregnancy terminations and AHR treatment (either or not involving surrogacy).

7.2.1.5. Non-recognition of legal effects

Cross-border movement in reproductive matters may also be warded off by way of refusing to give recognition to the legal effects of such cross-border movement. In the present case study this has been particularly visible in the context of cross-border surrogacy cases. In various such cases States have refused to recognise the legal parenthood of intended parents as established abroad. Intended parents have in some cases met with refusals by authorities in their home country to issue a passport to a child that was born to a surrogate mother in a foreign country. And even if the intended parents were able to enter their State with the child, they often still encountered problems in establishing parental links with the child. Various national courts have, on public policy grounds, refused recognition of foreign birth certificates on which intended parents were stated as legal parents, or refused to enforce a foreign judgment declaring the intended parents the legal parents of the child. There have even been examples where the child was subsequently put up for adoption[44] and the concern has been expressed that children risked being left stateless.[45]

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42 ECtHR [GC] 16 December 2010, *A, B and C* v. *Ireland*, no. 25579/05, para. 241.

43 Ch. 3, section 3.6.2.1.

44 E.g. Paradiso and Campanelli, *Paradiso and Campanelli* v. *Italy*, no. 25358/12, which case was pending before the ECtHR at the time this research was concluded.

45 See Ch. 5, section 5.5.4; and Ch. 6, section 6.5.6.

The public policy grounds relied on in these cross-border surrogacy cases reflect national standard-setting in the area and are consequently often grounded in the same interests, such as human dignity, the interests of the child and protection of the surrogate mother (see 7.1.1 above). For example, as discussed in Chapter 4, in a German case of 2007, a court held a Turkish judgment awarding adoption rights of a child to a German couple who had arranged a surrogacy agreement with a Turkish family, to be against the child's best interests, as the child had only been given birth with the aim of being handed over to the German intended parents.[46]

The ECtHR has shown understanding for States' wishes to deter their nationals from having recourse to methods of assisted reproduction outside the national territory that are prohibited on their own territory. It has accepted that this may, in accordance with their perception of the issue, aim to protect children and surrogate mothers. The Court has furthermore acknowledged that the community has an interest '[…] in ensuring that its members conform to the choice made democratically within that community.'[47] Still, the Strasbourg Court has also found that in cross-border surrogacy cases a fair balance has to be struck between these interests and the interests of the individuals concerned, the children's best interests being paramount.[48] As further explained in section 7.2.2.1 below, the interests of the child have consequently led to exactly opposite conclusions in other – generally more recent – cross-border surrogacy cases.

7.2.1.6. Warding off by countries of destination

The present case study has made clear that States may also wish to ward off cross-border movement to their countries in reproductive matters. The readiest, but also most far-reaching way of doing so is by imposing restrictions on access to services for people from abroad. A unique explicit example of such a measure is the restrictions on access to high-technological surrogacy as they apply in the Netherlands. As explained in Chapter 3, the hospital that is exclusively licensed to carry out high-technological surrogacy has 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. These requirements render it absolutely impossible for intended parents from abroad to engage in surrogacy in the Netherlands. While the rationale of these rules has not been made explicit, the commensurability of these rules with EU free movement law may be seriously questioned.

7.2.1.7. Observations

The warding off of cross-border movement to other States may enable States to uphold and protect – as much as possible – certain national standards in respect of

46 AG Hamm 19 March 2007 (dec.), Az. XVI 23/06. See also LG Dortmund 13 August 2007 (dec.), Az. 15 T 87/07.

47 ECtHR 26 June 2014, *Mennesson* v. *France*, no. 65192/11, para. 84.

48 *Idem*.

their citizens and residents. For example, unborn life may be protected from being terminated on social grounds and the coming into being of a human being by means that are considered to violate human dignity may be prevented. Warding off can thus be seen as a principled and 'protectionist' response of States. Where warding off may aim to protect the interests of legal subjects outside the States' jurisdiction, such as surrogate mothers in other countries, it can also be perceived as an effort to have such national standards apply extra-territorially.[49] Concerns of a less principled nature may further be grounds for States to ward off cross-border movement in reproductive matters. For instance, although not identified as such in the present case study, it is conceivable that States that function as a country of destination wish to ward off cross-border movement to prevent the overburdening of their health systems.

The present case study has shown that it is very difficult, nigh impossible, for States to literally withhold people from actually going to another State for reproductive purposes. In other words, cross-border movement in reproductive matters cannot be ruled out; bans on access to medical services in other Member States, including abortion and AHR treatment, that are not available or even prohibited in their home country, are not easily justified under EU free movement law. Still the warding off measures as described in sections 7.2.1.2 to 7.2.1.5 may deter people from going abroad and States may thus employ these to minimise cross-border movement to the greatest extent possible.

Where warding off measures indeed successfully deter individuals from going to another country for an abortion, AHR treatment or surrogacy, this implies for these individuals that their treatment options are restricted. This can be said to affect their reproductive autonomy. Also, there is a risk that these individuals will instead resort to illegal treatment options within their country, which inevitably carries health risks. This concern has been expressed particularly in respect of illegal abortions.[50]

Where individuals are not deterred from going abroad for reproductive services, they have a broader range of choices when it comes to reproductive treatment. They can access treatment that is not available in the home country.[51] At the same time, these individuals may bear burdens that occur particularly, or may gain particular weight, in cross-border cases and that may consist of physical burdens and health risks, financial burdens, legal uncertainty, legal complications and emotional

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49 According to Storrow '[…] cross-border reproductive care has been shown to have deleterious extraterritorial effects that violate the spirit behind restrictive reproductive laws.' With warding off, such spill-over effects can be reduced or prevented. R. Storrow, 'The pluralism problem in cross-border reproductive care', 25 *Human Reproduction* (2010) p. 2939.

50 E.g. Human Rights Watch, *A State of Isolation, Access to Abortion for Women in Ireland* (New York, Human Rights Watch 2010), online available at www.hrw.org/node/87910, visited June 2010.

51 Sociological research has shown that there are various reasons why people engage in cross-border reproductive care, namely, treatment costs, treatment quality and treatment availability. See G. Pennings and M. Heidi, 'The state and the infertile patient looking for treatment abroad: a difficult relationship', in: A. Tupasela (ed.), *Consumer Medicine* (TemaNord 2010, no. 530) p. 99 at p. 100.

burdens.[52] Treatment is in many instances only available to those with the financial means of travelling[53] and there may be medical risks involved, particularly if there is insufficient information about foreign treatment options. Also, families that were formed in the course of cross-border surrogacy may meet serious difficulties in being legally recognised as families in their home countries.[54] Warding off measures like the ones described in this section may aggravate or even cause such individual burdens. Accommodation measures may, on the other hand, (partly) alleviate them. The discussion of such measures in the following section will make clear, however, that they cannot take away all individual burdens involved in cross-border movement in reproductive matters.

7.2.2. Accommodation

Instead of warding them off, States may also opt for an entirely different approach towards (the effects of) cross-border movement, which is to accommodate them. Because the accommodating responses discussed below form a mirror image to the warding off responses extensively discussed in the previous section, their discussion in the present section is more concise and, in some cases, clustered.

7.2.2.1. Recognition of legal parenthood in cross-border surrogacy cases

A highly visible and concrete way of accommodating the effects of cross-border movement reproductive matters is by recognising the legal effects of foreign treatment options. Such recognition may be inspired or even dictated by overriding interests, such as the rights of the child.

As discussed in Chapter 3, it remains an open question whether EU (free movement) law actually obliges the Member States to adopt such an accommodation approach in cross-border surrogacy situations. In most situations where EU Member States refused recognition in cross-border surrogacy cases, the reproductive treatment

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52 In a 2010 survey into experiences of past services recipients of cross-border reproductive care, the following 'negative experiences' were reported: 'difficulty in finding a clinic in the home country to undertake tests and scans'; 'travel difficulties'; 'higher costs than expected'; 'language problems'; 'lack of regulation in destination country' and 'legal/liability issues'. E. Blyth, 'Fertility patients' experiences of cross-border reproductive care', 94 *Fertility and Sterility* (2010) p. e11 at p. e13.

53 ESHRE*, Comparative Analysis of Medically Assisted Reproduction in the EU: Regulation and Technologies* (SANCO/2008/C6/051), p. 86, online available at www.ec.europa.eu/health/blood_tissues_organs/docs/study_eshre_en.pdf, visited June 2014. Ferraretti et al. have observed that his may promote 'economically based discrimination […] since only services recipients with adequate financial resources can afford treatments abroad.' A.P. Ferraretti et al., 'Cross-border reproductive care: a phenomenon expressing the controversial aspects of reproductive technologies', 20 *Reproductive BioMedicine Online* (2010) pp. 261–266 at p. 264. See also T.K. Hervey and J. V. McHale, *Health Law and the European Union* (Cambridge, Cambridge University Press 2004) p. 142. The authors have furthermore pointed out that even if a service recipient is entitled to reimbursement, the practical reality may still be that only services-recipients with sufficient independent means to pay up-front may have access to cross-border health care services.

54 Individual burdens that may be involved in cross-border movement in reproductive matters are set out more extensively in section 7. 2.4.1 below.

involving the surrogacy agreement had taken place in a third country.[55] Such situations fall outside the scope of EU law and there is thus no obligation under EU law on Member States to recognise court judgments or birth certificates from these countries. This could be different, however, if another EU Member State is involved, but as discussed in Chapter 3, the present state of EU law gives little guidance in this regard.

The ECtHR, for its part, however, has ruled that in cross-border surrogacy cases States must recognise legal parenthood established in another country, regardless of whether the case concerns two EU Member States or at least one non-EU State. Decisive in the relevant *Mennesson* and *Labassee* rulings was the right to personal identity of the child concerned. Nevertheless, it must be noted that the accommodation obligations imposed on States under the ECHR in this context have been thus far restricted to the situation where the intended father is the genetic father of the child. Future case law will have to show whether this obligation also applies in cases where neither of the intended parents is the genetic parent of the child concerned. The ECtHR has furthermore made clear that States may subject accommodation to certain (procedural) conditions. In *D. and Others* (2014) the Court held that States were under no obligation under the Convention to authorise the entry of a child born to a foreign surrogate mother, without first subjecting the case to some form of legal examination.[56]

In various cross-border surrogacy cases national courts have indeed taken such an accommodating approach. Even before the ECtHR issued its important *Mennesson* and *Labassee* rulings, in all three States in recent years a trend has emerged in favour of recognising parental links established in another country or of enabling intended parents to establish parental links with the child under domestic law, because the best interests of the child were held to require this.[57] In the various national jurisdictions, the precondition that at least one of the intended parents is the genetic parent of the child concerned has been set as well.[58]

7.2.2.2. Information, reimbursement and follow-up care

States may also accommodate cross-border movement by providing independent information about foreign treatment options, by reimbursing treatment obtained abroad or by providing follow-up care.

As noted above (in section 7.2.1.2), bans on information about foreign abortion services have proven incommensurable with the ECHR. In fact, from *A, B and C* it can be inferred that States have an obligation under the Convention to provide

55 This, for instance, holds for all relevant surrogacy cases decided by the ECtHR and those currently pending before this Court. See Ch. 2, sections 2.3.5 and 2.4.2.
56 ECtHR 8 July 2014 (dec.), *D. a.o.* v. *Belgium*, no. 29176/13, para. 59.
57 See Ch. 4, section 4.5.3, Ch. 5, section 5.5.4 and Ch. 6, section 6.5.6.
58 *Idem*.

for access to 'appropriate' information about abortion services in other countries.[59] Further, as discussed in Chapter 3, by introducing considerable rights to information for patients involved in cross-border care, the EU Patient Mobility Directive of 2011 has imposed certain accommodation obligations on the Member States. National contact points in each Member State – both States of affiliation and States where the treatment takes place – must deliver information (in their official languages) to patients involved in cross-border care on matters like the applicable standards and guidelines, healthcare providers and patients' rights.

As surrogacy does not qualify as health care under the Patient Mobility Directive, such accommodation obligations by means of information provision do not hold for surrogacy.[60] Some State authorities, like the Irish and the Dutch, have, however, considered it their task to provide clear guidance on the principles they apply in examining applications for a travel document on behalf of children born outside the State as a result of surrogacy arrangements, as well as about the (im)possibilities under their national law to have legal parenthood recognised or established in such surrogacy cases. Here, too, a trend towards accommodation therefore can be discerned.

States may also accommodate cross-border movement in reproductive matters by providing for reimbursement for treatment obtained abroad, even if the treatment is not available domestically. For example, in the Netherlands 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.[61] As explained in Chapter 3, under EU law states are free to offer such reimbursement, although as yet there is no conclusive decision as to the matter of whether they may, in certain circumstances, also be under an obligation to accommodate cross-border movement in reproductive matters in this way.[62] There are in any case presently no indications in the ECtHR case law that hint at any such accommodation obligation.

Another way of accommodating cross-border movement is by means of the provision of follow-up care upon return to the home country. As discussed in Chapter 3 it is insufficiently clear whether under EU law States are under an obligation to provide such aftercare. Under the ECHR access to appropriate follow-up care has in any case been set as a minimum accommodation obligation in cross-border abortion cases.[63] It is very possible that in future case law the Court will define a similar obligation in situations involving CBRC.

59 ECtHR [GC] 16 December 2010, *A, B and C* v. *Ireland*, no. 25579/05, para. 241.
60 See Ch. 3, section 3.6.2.
61 See Ch. 6, section 6.5.2.
62 See Ch. 3, section 3.6.2.1.
63 ECtHR [GC] 16 December 2010, *A, B and C* v. *Ireland*, no. 25579/05, para. 241.

7.2.2.3. Observations

The discussion above has shown that accommodation may be required by interests and perspectives that must be taken into account in all reproductive matters, but which may gain particular importance in cross-border situations. Clear examples are the rights of the child and the possibility of making an informed decision on the basis of appropriate information. In respect of the rights of the child, views have changed over time as to what the best interests of the child require exactly.

States may perceive accommodation, if imposed on them by means of EU legislation or ECtHR judgments, as a thwarting of their national standards, even if accommodation does not require them to amend their internal standard-setting in the area and they remain free to decide what treatment they wish to regulate or to prohibit within their own jurisdictions. Indeed, it cannot be ruled out that certain accommodation measures, like recognition of legal parenthood established abroad, put pressure on States to change their national standards, and may thus force them to adaptation (see below). However, the opposite is also possible. Accommodation may in some cases in effect be seen as another means of protecting national standards, albeit in a more pragmatic way. For example, where States provide information about the legal implications of cross-border surrogacy, they may do so in order to protect the interests of the child. They may want to discourage people from engaging in international surrogacy agreements and minimise or reduce possible harm involved if such movement is taking place after all. Consequently, as further explained below (section 7.2.2.3), accommodation of cross-border movement may sometimes contribute to the maintaining of less permissive national standards.

Accommodation measures as here discussed may alleviate individual burdens, for instance by providing for recognition of legal parenthood established abroad, but they may not take away all burdens. Even if cross-border movement is fully accommodated, there are still – physical, emotional and financial – burdens involved in the travelling itself, as set out more extensively in section 7.2.4 below. The only way to fully take those burdens away as well is by means of adaptation, which, however, may raise other objections.

7.2.3. Adaptation

States may also respond to cross-border movement by removing the need for it, which they can do by adapting their national standards to equalise them to those of the States to which cross-border movement is taking place. In the three jurisdictions studied, the existence of foreign options has never been put forward as the only reason for amending national laws, or for interpreting existing standards differently, but certainly some hints can be found in the present case study that foreign treatment options have played a role in national standard-setting in reproductive matters. For example, as noted above, the judgment of the Irish Supreme Court in the *X Case* could be perceived as such. Further, as observed in Chapter 4, the German

debates about cross-border movement for abortion and PGD have contributed to the relaxation of the relevant national law. The fact that couples from the Netherlands went abroad for PGD, was also for the Dutch legislature one of the reasons to legalise and regulate this method, *inter alia*, because of quality and safety concerns involved in the cross-border movement. Cross-border movement for surrogacy to other States further was one of the reasons for the Dutch government to install a State Commission on Parenthood in 2014, that was, *inter alia*, given the task to reconsider the national surrogacy legislation.

Depending on how one approaches the matter, adaptation either can be regarded as the ultimate form of accommodation, since it can be perceived as 'giving in', or it can be looked at as a variant of warding off, since it makes cross-border movement redundant. Evidently, for individuals who wish to have access to treatment provided abroad, adaptation can be perceived as the most beneficial response of States to cross-border movement. Particularly where it is combined with accommodation of cross-border movement they can be said to have the best of two worlds.

7.2.4. Outsourcing

The last category of legal responses is best described by the term 'outsourcing'. It is not so much expressly voiced at national level, but it is an implication of an approach taken by the ECtHR in certain cross-border cases concerning reproductive matters. The discussion of the ECtHR's case law in Chapter 2 has made clear that in some of those cases the Court accepted the existence of foreign treatment options as an element relevant to the justification of prohibitive domestic laws in reproductive matters. This was especially held in the Irish abortion case of *A, B and C* v. *Ireland* (2010), where the Court concluded that '[…] having regard to the right to lawfully travel abroad for an abortion with access to appropriate information and medical care in Ireland', the prohibition in Ireland of abortion for health and well-being reasons did not exceed the margin of appreciation accorded in that respect to Ireland. The fact that women from Ireland could lawfully travel abroad for an abortion with access to appropriate information and medical care in Ireland, was thus considered sufficient by the ECtHR as minimum level of protection under the Convention.[64]

With this line of reasoning, the Strasbourg Court has thus authorised, if not encouraged, States to outsource their accountability under the ECHR by referring to other States' legal regimes. This approach raises a number of questions that have yet to be addressed by the Court. For example, it is unclear whether distance or the

[64] Another example is *S. H. and Others* (2011) – the Austrian case on gamete donation – where the Court noted that there was '[…] no prohibition under Austrian law on going abroad to seek treatment of infertility that use[d] artificial procreation techniques not allowed in Austria and that in the event of a successful treatment the Civil Code [contained] clear rules on paternity and maternity that respect[ed] the wishes of the parents.' ECtHR [GC] 3 November 2011, *S.H. a.o.* v. *Austria*, no. 57813/00, para. 114.

costs of travelling to the foreign country make a difference in this regard.[65] Also, the question has been raised whether the State is under an obligation to guarantee that the foreign treatment option is actually an option that can be used effectively. For example, it has been questioned whether States must also support the costs of the travelling for such foreign services or allow individuals who are in (aliens') detention to go abroad for an abortion or reproductive treatment if they so desire.[66] In other words, it is as yet unclear to what extent outsourcing must be combined with accommodation. In *A, B and C*, certain accommodation obligations were indeed set as preconditions for outsourcing in the Court's reasoning, as the Court took into account that there was access to abortion information and follow-up care in Ireland. In this case the Court simply took into account what was already provided for under the national law of Ireland. Future case law will therefore have to make clear whether any further such accommodation obligations will be defined as preconditions for outsourcing.

So far, the outsourcing approach has not always been applied by the ECtHR, not even in cases before it where it easily could have done so, such as the *Costa and Pavan* case, concerning PGD. It remains to be seen whether it will also be applied in potential future complaints about restrictive domestic laws on surrogacy. If the Court would indeed hold such a situation to come within the scope of the right to private life under Article 8 ECHR, it cannot be ruled out that in its assessment of the justification for the interference with this right, the Court would take account of the fact that there is a realistic option to engage in a surrogacy agreement in another country. Especially now that the Court, in *Mennesson* and *Labassee*, has formulated certain accommodation obligations for such cross-border surrogacy cases, it is not wholly illusory that such a minimum guarantee contributes to the justification of, or even constitutes the justification of, a restrictive regime at the national level.

Outsourcing allows States to refer people within their jurisdictions to other States for the protection of rights that come within the scope of the ECHR. This way cross-border movement in reproductive matters becomes a 'safety valve',[67] a means to 'hide behind' the more permissive regimes of other States. The existence of foreign options may thus enable States to maintain their own deviating (and generally less permissive) standards. The choice for outsourcing is understandable mainly from a more 'political' perspective. It is a pragmatic approach of the Strasbourg Court,

65 A.C. Hendriks 'Case note to ECtHR [GC] 16 December 2010, *A, B and C* v. *Ireland*, no. 25579/05', 12 *European Human Rights Cases* 2011/40 (in Dutch) and N.R. Koffeman, 'Het Ierse abortusverbod en het EVRM; is uitbesteding de nieuwe norm?' ['The Irish abortion ban and the ECHR: is outsourcing the new standard?'], 36 *NTM/NJCM-Bulletin* (2011) p. 372. As noted by these authors, the bigger the distance, the bigger certain individual burdens may be (see 7.2.4.1 below).

66 Koffeman 2011B, *supra* n. 65, at p. 372.

67 For the use of this term in the context of CBRC, see *inter alia* Hervey and McHale 2004, *supra* n. 53, at p. 157; G. Pennings et al., 'Cross-border reproductive care', 23 *Human Reproduction* (2008) p. 2183 and Ferraretti et al. 2010, *supra* n. 53, at p. 264.

that underlines the subsidiary role of this Court in these morally sensitive cases.[68] Nevertheless, this approach generally can be assessed negatively. First of all, it may take away internal pressure for change and may in fact result in inactivity by the legislature.[69] Gilmartin and White have opined in this regard in 2011, for example, that because women in Ireland have '[…] "won" the right to travel, the Irish state has been excused from any responsibility to provide safe, legal, and affordable abortion services in the years since 1992.'[70]

Moreover, as also noted by the dissenters in *S.H. and Others*, it really is a pragmatic, rather than a principled, approach. Indeed, it is difficult to understand why certain interests that were grounds for restrictive laws on reproductive matters at domestic level – such as the protection of human dignity or the unborn – would no longer hold in cross-border situations.[71] In fact, precisely in cross-border situations may such interests require even more protection. It has been observed in respect of the *A, B and C* case that 'hypocrisy' at national level '[…] should not have been so keenly approved by a Court whose task is to uphold human rights across a region in which it recognised a consensus to prioritise the rights of pregnant women over those of the foetus.'[72]

Outsourcing does not, furthermore, fit in well with the foundations and objectives of the ECHR, following which each State is responsible for securing the Convention rights to everyone within their jurisdiction (the principle of State accountability as laid down in Article 1 ECHR).[73] The Court's reasoning in the relevant cases gives the impression that it is sufficient if the High Contracting Parties at least jointly (rather than separately) provide for a certain minimum level of protection.

The implications for individuals of this outsourcing approach, particularly if not sufficiently combined with accommodation obligations, cannot be overlooked either. In particular, much has been reported in respect of women from Ireland who need to go abroad if they wish to have an abortion on medical and social grounds. It has been claimed that these women bear unduly harsh emotional, medical and financial burdens.[74] The abortion procedures of these women are alleged to be expensive,

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68 The approach is pragmatic particularly in respect of abortion, as that is legalised in almost all Council of Europe Member States. See ECtHR [GC] 16 December 2010, *A, B and C* v. *Ireland*, no. 25579/05, as discussed in ch. 2, sections 2.2.3 and 2.4.1.

69 In fact, resignation (see 7.2 above) can be a hidden form of outsourcing.

70 M. Gilmartin and A. White, 'Comparative Perspectives Symposium: Gender and Medical Tourism. Interrogating Medical Tourism: Ireland, Abortion, and Mobility Rights', 36 *Signs* (2011) p. 275 at p. 277.

71 See the Joint dissenting opinion of Judges Tulkens, Hirvelä, Lazarova Trajkovska and Tsotsoria to ECtHR [GC] 3 November 2011, *S.H. a.o.* v. *Austria*, no. 57813/00. See also R.F. Storrow, 'Judicial review of restrictions on gamete donation in Europe', 25 *Reproductive BioMedicine Online* (2012) p. 655 at p. 657 and I.G. Cohen, 'S.H. and Others v. Austria and circumvention tourism', 25 *Reproductive BioMedicine Online* (2012) p. 660 at p. 662.

72 E. Wicks, '*A, B, C v Ireland*: Abortion Law under the European Convention on Human Rights', 11 *HRLR* (2011) p. 556 at p. 563.

73 See Art. 1 ECHR.

74 See, for instance, ECtHR 27 June 2006 (dec.), *D.* v. *Ireland*, no. 26499/02.

complicated and traumatic.[75] Although perhaps difficult to establish and measure in an objective manner,[76] their emotional burdens may consist of great distress and anguish and the feeling of being stigmatised.[77] Even medical risks may be entailed in cross-border abortions. Such risks may be either directly caused by the travelling itself, or by the inherent delay in the carrying out of an abortion that is to take place abroad.[78] A related difficulty is that not all women can stay in the destination country as long as would be desirable with regard to the necessary post-abortion counselling and care.[79] Language barriers that may occur when women go to other countries, may also have health implications.[80] The costs of travelling abroad for an abortion may furthermore constitute 'a significant financial burden' for the women concerned.[81] The financial burden of having an abortion abroad, may also be the cause of delays in the carrying out of the abortion, which – as yet clarified above – may have

75 See the complaints of the applicants in ECtHR [GC] 16 December 2010, *A, B and C* v. *Ireland*, no. 25579/05, para. 173.

76 Understandably, the ECtHR held in the case of *A, B and C* v. *Ireland* (in para. 126) that the psychological impact of such travelling on the applicants, was '[…] by its nature subjective, personal and not susceptible to clear documentary or objective proof.' The Court nonetheless considered it reasonable to find that '[…] each applicant felt the weight of a considerable stigma prior to, during and after their abortions: they travelled abroad to do something which, on the Government's own submissions, went against the profound moral values of the majority of the Irish people […] and which was, or (in the case of the third applicant) could have been, a serious criminal offence in their own country punishable by penal servitude for life […]. Moreover, obtaining an abortion abroad, rather than in the security of their own country and medical system, undoubtedly constituted a significant source of added anxiety.'

77 Compare the complaints of all three applicants in ECtHR [GC] 16 December 2010, *A, B and C* v. *Ireland*, no. 25579/05, para. 119 ('All felt stigmatised as they were going abroad to do something that was a criminal offence in their own country') and the assessment of their complaints by the Court in para. 127. *Human Rights Watch* (HRW) has observed that '[…] having to travel abroad for a procedure at a time when many women are already in distress because of an unwanted or unhealthy pregnancy' may constitute 'a major source of anxiety'. Human Rights Watch 2010, *supra* n. 50, p. 35, online available at www.hrw.org/node/87910, visited 3 June 2010. Wicks has held: 'Having already recognised the "significant psychological burden" faced by the applicants in being required to leave their home country to seek medical treatment prohibited there, the Court should have been more reluctant to present that psychological burden as the very guarantee of respect for the women's private life.' Wicks 2011, *supra* n. 72, at p. 563.

78 In general it goes that the later an abortion is carried out, the more physically arduous the procedure is, as a late abortion often means a surgical abortion, instead of a medical one. Compare the complaints of the applicants in ECtHR [GC] 16 December 2010, *A, B and C* v. *Ireland*, no. 25579/05, para. 173.

79 The applicant in ECtHR 27 June 2006 (dec.), *D* v. *Ireland*, no. 26499/02, for example, claimed that with two children in Ireland, she could not remain in the UK for counselling after her abortion.

80 Hendriks has also pointed at the risk of such language barriers occurring. Hendriks 2011, *supra* n. 65 .

81 ECtHR [GC] 16 December 2010, *A, B and C* v. *Ireland*, no. 25579/05, para. 128. In its report *A State of Isolation, Access to Abortion for Women in Ireland* of 2010, Human Rights Watch (HRW) concluded that '[…] for someone living under the poverty line, the cost of an abortion could easily represent more than a monthly salary'. HRW referred to Irish service providers estimating the total costs to be between € 800 and € 1,000. By comparison, HRW noted that the average salary in Ireland fluctuated around € 30,000 per year. HRW furthermore claimed that for women who were in the asylum seeking process in Ireland, the travelling abroad to obtain an abortion was 'plainly out of reach' from a financial perspective. The HRW report furthermore outlined that 'service providers interviewed by *Human Rights Watch* confirmed how difficult it is for many women to raise the money to travel and the lengths that some must go to to ensure their access to safe and legal abortions'. Human Rights Watch 2010, *supra* n. 50, at pp. 31–32.

implications for the woman's health.[82] Moreover, in certain cases it is practically impossible for women to travel to another state for an abortion.[83] Particular concerns have been expressed about the vulnerable status of asylum seekers in this regard.[84]

Many of the above described individual burdens may, *mutatus mutandis* also hold in CBRC cases and cross-border surrogacy. Individuals and couples that go abroad for AHR treatment or surrogacy may also carry physical, emotional, financial and medical burdens,[85] or may not be practically in the position to travel abroad. AHR treatment may involve various appointments at different points in time, which may be particularly burdensome if the travel distance to the foreign clinic is considerable.[86] CBRC services recipients returning home without adequate information about their prior treatment, may also run substantial health risks.[87] If services recipients have been self-referred, their prior treatment may go unnoticed. In particular in cases where the foreign treatment is prohibited in their home country, proper monitoring and follow-up may be hindered.[88] This may also be the case if the relevant treatment is not prohibited as such, but still not common practice amongst medical practitioners in the home country. In cross-border surrogacy cases, intended parents may come across legal obstacles with potentially serious implications for their chances of building and enjoying family life with the child concerned. While

82 There are even reports that '[…] many women see through crisis pregnancies "because they can't afford the abortion"'. Human Rights Watch 2010, *supra* n. 50, at p. 36, referring to an interview with Juliet Bressan, *Doctors for Choice*, Dublin, 25 August 2008.

83 Some cannot travel because of their immigration status, because they are in state custody, because they are in mandatory daily treatment for drugs addiction or because of an illness or disability. Human Rights Watch 2010, *supra* n. 50, at pp. 16 and 36–37. See also K.J. Johnson, '"New thinking about an old issue;" the abortion controversy continues in Russia and Ireland – *Could Roe* v. *Wade* have been the better solution?', 15 *Indiana International and Comparative Law Review* (2004) p. 183 at p. 201 and J. Burns, 'Laying down the law' *Sunday Times* 31 October 2004, p. 14. See also C. Staunton, 'As Easy as A, B and C: Will A, B and C v. Ireland Be Ireland's Wake-up Call for Abortion Rights?', 18 *European Journal of Health Law* (2011) p. 205 at p. 218. Gilmartin and White 2011, *supra* n. 70, at p. 278.

84 UN Committee on the Elimination of Discrimination Against Women on the second and third periodic reports of Ireland (CEDAW/C/IRL/2-3) at its 440th and 441st meetings on 21 June 1999 (see CEDAW/C/SR.440 and 441), para 185, online available at www2.ohchr.org/english/bodies/cedaw/docs/IrelandCO21st_en.pdf, visited 15 February 2015. Human Rights Watch 2010, *supra* n. 50, at pp. 5 and 32–33. In August 2003, the Irish newspaper *The Times* reported that 20 asylum seekers in Ireland were granted a temporary permit and visa to leave Ireland to travel to the UK for an abortion and to return to Ireland afterwards. While granting the visa, the authorities had stressed that these concerned highly exceptional measures. Many others had to resort to illegal means. K. Holland, 'Asylum-seekers granted visas for UK abortions' *The Irish Times* 30 August 2003, p. 4.

85 See *supra* n. 52. Ferraretti et. al have furthermore observed that CBRC '[…] is often associated with a high risk of health dangers, frustration and disparities.' Ferraretti et al.2010, *supra* n. 53, at p. 261.

86 The Californian Centre for Surrogate Parenting Inc. for instance indicates that intended parents will need to come to the USA for a minimum of two or three trips. No doubt these overseas trips have financial implications as well. See www.creatingfamilies.com/IP/IP_Info.aspx?Type=18, visited January 2011.

87 B. Dickens, 'Cross-border reproductive services', 111 *International Journal of Gynecology and Obstetrics* (2010) p. 190 at p. 190.

88 The authors of the report *Pre-implantation Genetic Diagnosis in Europe* observe that evidence gathered painted 'a contrasting picture' on this point. While some clinics were clearly not deterred, others did not see it is as their responsibility. A. Coverleyn et al., *Pre-implantation Genetic Diagnosis in Europe'* (Joint Research Centre of the European Commission, January 2007) p. 80, online available at www.ftp.jrc.es/EURdoc/eur22764en.pdf, visited July 2014.

the relevant ECtHR case law has ruled out various such obstacles, the occurrence of such obstacles is still not wholly illusory, for example if the intended parents are not the genetic parents of the child.

7.2.5. Resumé and outlook

In the present case study four types of legal responses to cross-border movement for reproductive matters have been identified: warding off, accommodation, adaptation and outsourcing. For most of these – warding off, adaptation, and at times also accommodation – the initiative was taken at national level, while in respect of some others – accommodation and outsourcing – the European level has also been influential. The States studied in this research have combined various categories of the here described legal responses to cross-border movement and different responses may apply in the same area. Ireland – in any case initially and mainly in the context of cross-border abortions – has resorted more to warding off responses than Germany and the Netherlands. But in all three States such measures have – again in any case initially – been employed in respect of cross-border surrogacy.

Warding off (the effects of) cross-border movement in respect of reproductive services by means of non-recognition of legal effects of foreign options or by means of bans on information on foreign treatment options has, however, generally proven not easily justified under European law. Refusing follow-up care may also be problematic. While a refusal to reimburse the costs of treatment obtained abroad may be acceptable, it is questionable whether prior authorisation requirements can be set.

Various warding off responses have, over time, often been converted into accommodation. In some cases, this was the direct consequence of European law, in others national authorities had decided of their own accord to adopt an accommodating approach. Accommodation – for example providing for information and follow-up care in case of abortion and recognising parental links established abroad in surrogacy cases – may alleviate the individual burdens involved in outsourcing, though the burdens of the actual travelling remain. There is potential for the easing of even more of these burdens, for instance by providing for financial support for those for whom the costs of travelling are insurmountable.[89] The more such accommodating measures are taken, the less there seems to be a need for actual adaptation. This is all the more true since the 'outsourcing' approach of the ECtHR clearly allows for the States' accommodation response and thus does not provide a direct incentive for changing the national standards as such.

[89] There may be limits to the accommodating role of States, however, and perhaps certain burdens involved in travelling abroad will remain the individuals' own responsibility. For example, in the international surrogacy case *D. and Others*, the ECtHR held that the Belgian State could not be held responsible for the fact that the couple had not been granted a visa in the Ukraine for an extended period and thus could not have spent more time with their child in that country.

Whether the legal responses identified on the basis of the present case study are accommodating, adapting or rather warding off, they are all characterised by being mainly unilateral legal responses, even if some responses are imposed or inspired by European law. Nevertheless, there is room and potential for bilateral or coordinated legal responses to develop. This may be done, for example, by means of the harmonisation of Private International Law.[90] In addition, States could bilaterally regulate certain matters. For example, it has been suggested in respect of AHR treatment involving surrogacy arrangements, that countries of origin and countries of destination agree that the latter country will not carry out treatment if the individual or couple concerned do not meet the conditions for access to treatment in the home country.[91] Such changes would basically come down to adaptation in individual cases by the destination country to the standards of the home country. In other words, the standards of the home country are given an extra-territorial effect in individual cases. Such approach could possibly also be taken where people from a State where gamete donors must be known have AHR treatment in a country where use is made of anonymously donated gametes. In this situation even more would be required from the destination country, however, as this State may not even have an infrastructure in place to trace the donor. Such coordinated approaches could be initiated by (a group of) States or imposed on them at European level, either by the EU legislature or judiciary, or by the ECtHR.

90 See, for example, K. Saarloos, *European private international law on legal parentage? Thoughts on a European instrument implementing the principle of mutual recognition in legal parentage* (Maastricht, s.n. 2010).

91 E. Winkel et al., 'Draagmoederschap na ivf in het buitenland. Dilemma's bij de begeleiding' ['Surrogacy after IVF treatment in a foreign country. Dillemas in the counselling'], 154 *Nederlands Tijdschrijft voor Geneeskunde* (2010) p. A1777.