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Cross Border Reproductive Services

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Simon (42) and Susan (40) have had several failed treatment cycles with donor sperm. They had always assumed that Simon's diagnosis of a low sperm count was the only factor limiting their fertility. As a result of treatment taking several years, Susan has also been diagnosed with infertility due to poor ovarian response. She was advised that it has become very unlikely that she will conceive using her own oocytes. The couple is now considering oocyte donation in combination with ICSI. As oocyte donation is prohibited in their home country, they have to travel abroad. In addition, they only find very limited information and are uncertain which country and which clinic to travel to. They feel confused by the infinite amount of information they find online and have the impression that much of this information is unreliable. At the same time, they feel time is pressing, and they want to continue treatment as soon as possible and hopefully finally conceive.

Traveling to another country for medical and for fertility treatment is not a new phenomenon. For centuries, couples have traveled to places considered conducive to infertility such as spas, fertility shrines and specific landmarks in the hope that these will have a positive impact on their fertility. The development of in vitro fertilization (IVF) has brought hope to many experiencing infertility and, together with quick and affordable international travel, has provided the momentum for cross border reproductive services (CBRS). Those experiencing fertility problems who faced limited access to, or availability of, appropriate services in their own countries started to consider travel abroad to access services that they hoped would realize their family-building aspirations. Although IVF and related procedures have become available quickly in many developed and developing countries, various factors have contributed to individuals and couples travelling for treatment. Key amongst these are:

- law evasion in jurisdictions with restrictive legislation (e.g. prohibition of oocyte donation in Italy and Germany; prohibition of sperm donation in jurisdictions subject to Sharia law; prohibition of either commercial or altruistic surrogacy in many jurisdictions);
- lengthy waiting lists for, or unavailability of, specific services (e.g. oocyte donation in the United Kingdom, sperm donation for couples in a same-sex relationship or single women in several jurisdictions);
- the wish to undergo fertility treatment without the knowledge of family or friends;
- the wish to undergo treatment in the individual's or couple's country of origin; and
- beliefs that treatment in another country may be more successful and/or less costly.

As a consequence, although accurate and robust data are not available, the number of individuals and couples engaging in CBRS is believed to have risen significantly over the last 20 years. [1-3] According to a pilot study carried out by ESHRE (European Society of Human Reproduction and Embryology), 24,000 to 30,000 treatment cycles alone were provided annually to foreign patients in the following six destination countries: Belgium, the Czech Republic, Denmark, Slovenia, Spain and Switzerland. [4] Patients had travelled from forty-nine different "home" countries, with approximately two thirds of patients

coming from Italy (31.8%), Germany (14.4%), the Netherlands (12.1%) and France (8.7%). It is not surprising that country-specific associations were observed. The majority of Italians traveled to Switzerland and Spain, most Germans to the Czech Republic, most Dutch and French patients travelled to Belgium and – to a lesser extent – Spain. The nature of these flows can be explained largely by the relatively easy access provided by shared national borders. French, Norwegian and Swedish patients were the most likely to travel for sperm donation, while Denmark, Belgium and Switzerland were the most popular destinations for sperm donation. Patients from Germany and the UK were the most likely to travel for oocyte donation, and Spain and the Czech Republic were the most popular destination countries for both oocyte and embryo donation. Extrapolating the data relevant for Germany, we can assume that approximately 2000 German couples travel annually mainly for egg donation. [See Table 1 for a listing of patient’s home countries and the destination country for treatment.] Survey data from the United States indicate that 4% of all fertility treatments (around 6,000 cycles p.a.) is provided for non-US domiciliaries [12,13]. The largest groups of incoming patients are from Latin America (39%) - as with the European findings, geographical proximity contributing to a significant extent - and Europe (25%). By contrast, the incidence of patients from the US traveling abroad for care is estimated to be far lower than the rate of incoming patients [6,12].

On an international level, Blyth et al. [14] have shown that:

- patients travel from more or less anywhere to everywhere, although not all destination countries have a reputation for high-quality service provision;
- a number of countries are both home and destination countries; and
- although, in general, patients report a relatively high level of satisfaction with the services they have received, clinical experience also suggests that some clinics leave questions unanswered. For example, there can be little transparency regarding recruitment strategies and financial compensation for donors and surrogates, and counseling is seldom available. In addition, treatment contracts may be minimal and only cover issues relevant for the clinic.

While not all CBRS arrangements give major cause for concern, those that are potentially most problematic remain under-researched. There is emerging evidence of potentially serious risks to patients, donors, surrogates and children such as high numbers of multiples, unknown quality of medical services for donors and surrogates, and offsprings’ lack of access to their gamete or embryo donor or surrogate. [see, for example, 3, 15]. Furthermore, there has been criticism regarding the dearth of available information. Despite the growth of the CBRS industry, there is only minimal international monitoring and little is known of the services provided by, and remuneration of, intermediary agencies. These organizations symbolize the interface of medicine and business in this field and the internet has become a “virtual site” of CBRS activities. Utilizing CBRS to evade domestic restrictions and/or to restrict other people’s knowledge of recourse to assistance with family-building, in turn, promotes secrecy. This ensures that many of the practices relating to CBRS remain “hidden”, with significant potential psychosocial, ethical and legal consequences [16]. However, the secrecy has also impacted on the uptake of counseling. CBRS is only beginning to emerge as a theme for infertility counseling and little has been published by experts in this field, with the German Society for Fertility Counselling being the only organization that has developed CBRS guidelines for counselors. [17]

Lack of a framework for CBRS

Due to different and sometimes contradictory cultural and ethical values, the harmonization of legislation between different jurisdictions is unlikely to occur. It has also been argued that harmonization may not be desirable as it denies ethical, cultural and religious pluralism. Thus, “harmonization” may actually result in “uniformization” and CBRS could be considered a “safety valve” that helps to avoid conflicts. [18] On the other hand, the current situation lends itself to the exploitation of vulnerable parties, above all, the donors, surrogates and children born from these services. Their voices so far have not been heard to any significant degree. Furthermore, with the exception of a small British study relating to the impact of overseas multiple-embryo transfer during single IVF cycles [15] no research has been conducted on or with children born as a result of CBRS, especially on the psychosocial impact of their mixed cultural/ethnic background. Last but not least, worries have been expressed that CBRS could create demands and burdens on both the home and the destination countries. [15]

These concerns have led to the development of practice guidelines by two professional bodies, ESHRE and ASRM respectively. ESHRE’s “Good practice guide for cross border reproductive care for centers and practitioners” [19] and the ASRM Ethics Committee’s “opinion” [20] are both welcomed for making a start in acknowledging the challenges as well as the opportunities presented by CBRS. However, the scope of both documents as regards infertility counseling practice is modest. The ESHRE guidelines identify the need of foreign patients to receive the same level of medical care; information, counseling and psychosocial support as are provided for domestic patients; the need to minimize health risks for donors and surrogates; and the possibility of professional collaboration in those countries where this does not pose a legal problem. It fails to acknowledge the problematic areas: the interests of donors or surrogates, or the possibility of children born as a result of treatment to access information about them.

The committee opinion of the Ethics Committee of the American Society for Reproductive Medicine (20) summarises what is currently known about the incidence of, and the key reasons for utilizing CBRS. It describes the potential benefits of travel to access fertility services and acknowledges the potential harms of CBRS, It focuses only on the responsibilities of physicians; there is no mention of the roles of counselors. Physicians in departure countries are not considered to have any duty to be informed about or disclose risks and benefits of treatment elsewhere and physicians in destination countries are seen to have a duty to deliver the same quality of care required for all domestic patients. The ASRM does not consider that the physician is obliged “to discuss the patient’s circumvention tourism”.

In order to expand on these existing practice guides, minimum standards of care have been proposed [21] that could be implemented on a voluntary basis by clinics, professionals and research institutions, and thus provide a degree of transparency to other professionals as well as to potential patients, donors and surrogates. Most importantly, they could contribute to national and pan-national discussion of the challenges in CBRS. These minimum standards cover the following issues:

1. Voluntary commitment to the standards to be followed as well as voluntary oversight by a national or supra-national body. This is especially pertinent for those countries that have not yet established legislation.
2. A commitment to altruistic donation and surrogacy and a ban on commercial procedures. It is difficult to say the least to determine a just price for services

- such as donation or surrogacy. There should be national and pan-national discussions regarding financial compensation in order to agree on a “just” price.
3. Gamete donors and surrogates should receive the same level of care as recipients. They should be provided with full healthcare coverage to enable them to access free medical treatment required after potential complications and they should be insured for any (long-term) health impairment resulting from the donation or surrogate service.
 4. Since donors and surrogates undergo health risks for the benefit of others, a high level of informed consent should be ensured. They should receive comprehensive and accurate information regarding the medical procedure and the psychosocial implications in an unbiased manner. This should also include legal information such as the status of the donor/surrogate, her husband (in the case of a married surrogate or female donor) and the recipients/intended parents. An independent ombudsman or a donor/surrogate advocate can be established to represent the interests of these parties.
 5. All parties involved should have access to psychosocial counseling prior to, during and post treatment. Psychological assessment may be necessary in some cases, but this should neither be confused with, nor substituted for, counseling.
 6. In complex cases, prior to new and/or innovative treatment, multi-disciplinary ethics committees installed in the clinic providing treatment should be involved.
 7. In order to avoid conflicts of interest, the recruitment of donors and surrogates should be carried out independently from those institutions that are responsible for the informed consent procedure, the psychosocial counseling and the legal advice.
 8. There has been a lot of controversy regarding the anonymity and ability to identify donors and surrogates. From a moral perspective, offspring should be granted as much autonomy as possible, including the possibility of accessing full information about their biological and genetic origins, if they so wish to do so. Therefore, clinics should document records for a minimum of 80 years and offspring should be entitled to access this information. As a complementary requirement, donors should be able to learn about the outcome of their donation and the number of offspring conceived with their gametes, if they wish. Registers should also enable contact between half-siblings, if mutually agreed upon.
 9. All countries should strive towards self-sufficiency as regards ART services so as to reduce the need for patients to travel. Donors and surrogates do not need to provide their service to recipients from abroad (usually with a higher living standard) in order to generate income. In accordance with national cultural and ethical principles, ARTs should be regulated so that this aim is achieved.
 10. There are a number of international regulations and conventions on human rights such as the Convention of Human Rights and Biomedicine of the Council of Europe [22], the Convention for the Protection of Human Rights and Fundamental Freedoms [23], the Ethical Issues in Obstetrics and Gynecology [24] or the International Alliance of Patients’ Organisations (IAPO) – Declaration on Patient-Centered Healthcare [25] that can serve as a framework for CBRS.

While adherence to such minimum standards can contribute towards more ethical and respectful treatment, considerable challenges lie in the way of their acceptance. However, they can form the basis of discussion and collaboration between different professional groups, and between professionals in different countries, to ensure that

patients, donors, surrogates and the children born as a result of CBRS are not exposed to unnecessary risks.

Counseling in Cross Border Reproductive Services

The provision of appropriate counseling as an integral part of fertility services has been well documented [for an overview see 26-28] and qualification guidelines have been issued by several organizations. [29] There is agreement that professionals offering fertility counseling should:

1. hold a graduate level qualification in a psychosocial profession;
2. hold a relevant professional license to practice;
3. demonstrate relevant training in the medical and psychosocial aspects of infertility;
4. demonstrate a minimum level of relevant clinical experience; and,
5. demonstrate engagement in continuing professional education.

When counseling in CBRS, additional requirements arise for professionals. These include: knowledge and information regarding the legislation of typical destination countries; awareness of societal attitudes and their impact on patients; attentiveness for ethical issues, such as commodification, and the potential of exploitation of donors and surrogates, and its effect on patients; as well as being able to raise these issues with patients.

Given that counseling is non-directive, supports the decision-making process of patients, and explores the implications of family building options rather than recommends specific treatments, counseling does not direct patients towards treatments that may not be allowed in their home country. Whether counseling in this area may entail punitive consequences, however, is dependent upon national legislation and/or case law. Fertility counselors, therefore, need to be informed about the implications of relevant legislation and proceed with care, even though supra-national bodies such as ESHRE [30] endorse evasion of domestic law by medical professional as in the interest of patient autonomy by providing information on treatment options abroad.

Fertility counselors also need to explore their personal and professional attitude regarding CBRS, especially regarding treatment options that are controversial in their country and that raise moral dilemmas. There is a risk of exploiting donors and surrogates, especially when CBRS takes place between countries with very different living standards and customs (e.g. North America and Europe on the one hand, and Eastern Europe and South East Asia on the other). Counselors need to explore their professional attitude towards such challenging issues, beware of transference issues and make use of professional supervision to clarify these. Patients deserve understanding and respect for their family building plans. This does not imply that counselors should refrain from raising controversial issues. In fact, it is often a relief for patients to be able to explore these in a supportive and empathetic environment, and counseling often affords the only possibility to provide time and space for this. The counseling process, however, should not be influenced by the attitude of the fertility counselor.

The case presented at the beginning illustrates many common matters presented in CBRS counseling: patients pursuing treatment that is not available in their home country, dealing with limited information, resources and a sense of time pressure. The following section will further examine these clinical issues and provide case vignettes

when working with (a) patients, (b) donors and surrogates and (c) the resulting children. [17] Given that CBRS is a relatively new phenomenon, there is little research on which these issues can be based. Therefore, counseling interventions are based on existing knowledge in the area of fertility counseling, especially third party reproduction, although the focus will be on issues that are relevant where treatment takes place outside the patients' country of residence. For specific counseling in third party reproduction, reference should be made to the relevant chapters in this book.

Preparing for CBRS

Fertility counselors should respect the reproductive autonomy of all parties involved, including the interest of offspring created, resulting in a well-considered and measured use of reproductive medicine. Counseling should be accessible prior to, during and after fertility treatment in a language that patients can use to explore emotional issues; counseling in the country of residence is most likely to fulfill these conditions. Providing counseling *prior* to treatment may mitigate the risk of accepting treatment that could entail physical or psychological risks for patients or the future child. However, clinical experience indicates that many patients take up counseling after failed treatment cycles, and in the area of CBRS, after having decided on a clinic and thus the country of treatment.

Susan and Richard sought counseling after they had signed a contract with a clinic and had already made payments towards their first treatment cycle. During the counseling sessions, they raised their frustration regarding the lack of communication by the clinic. Their emails remained unanswered, the responsible staff could not be reached by telephone and they were unable to clarify several issues in the treatment protocol they did not understand. This could not be rectified by counseling. We focused one session on this frustrating situation and this helped the couple develop a greater understanding of the gullibility their emotional situation had resulted in when signing the contract. They developed more confidence and were able to proceed with much more assertiveness during medical treatment.

From a counseling perspective, this is frustrating from several perspectives. This situation is indicative of the importance of pre-treatment counseling. Although fertility counselors are not in a position to recommend specific clinics, even though there may be no adverse legal consequences for doing so where the treatment planned is possible in the "home" country, we firmly believe that patients who have considered their needs prior to medical treatment and have developed their personal "check-list" for the clinics they consult, are more likely to choose a clinic that fulfills their needs. In the case of CBRS, this "check-list" includes issues such as reliable communication via email or telephone and the possibility of contacting staff in emergency situations. This is one of the tasks of counseling before treatment: preparing patients for what lies ahead of them and supporting them to make informed choices.

Exploring infertility always includes a critical appraisal of limits in life, limits of medical treatment, and limits of emotional suffering. It, therefore, may also result in patients deciding against pursuing treatment abroad, in which case counseling focuses on developing strategies for a life without children.

As many patients who intend to undertake treatment abroad have already experienced treatment failure in their home country, fertility counselors should explore whether

they have sufficient psychological, emotional and financial resources to continue treatment, and whether this is feasible given their physical, psychological and emotional health. Furthermore, treatment abroad can be associated with moral qualms, especially if the treatment intended is prohibited in the patients' home country. Careful exploration is necessary in order to assess whether the patients are sufficiently confident to proceed. Moral doubts can also result in keeping the treatment a secret from family members and friends and thus, vital emotional and practical support may be absent during treatment. In some cases, time off treatment may be indicated to work through and resolve some of these issues; in others, patients may decide not to proceed with treatment altogether. For those who proceed, fertility counseling should include the exploration of general issues, issues related to the use of their own gametes and issues related to third party reproduction.

Treatment Issues

Patients need to ensure that they fully understand the information regarding the treatment planned and counselors should advise patients of the importance of being as fully informed as possible before they embark on overseas treatment. Patients who are not sufficiently proficient in the language of destination countries, or where competence in a common language with service providers is limited, may often struggle to understand details. If a translation and/or interpretation service is required, patients should ensure – as well as they can – that the translation is correct. They should resist any pressure to sign consent forms they do not fully understand. Patients can request clinics to provide treatment plans, consent forms and contract drafts prior to their first visit. This gives them the opportunity to read them through and make arrangements for independent translation, if necessary. They should also ensure that there are no medical counter-indications against the treatment planned and that there are adequate success rates.

In order to facilitate the flow of necessary information, clinics in both home and destination countries should be provided with relevant medical records which patients may have to facilitate on their own. In some countries, there are restrictions, such as oocyte donation can only be carried out for medical reasons, and clinics need to have documentation confirming this. Medical documents may also be important in case of complications or malpractice. Patients, however, should be aware that it may be difficult to take effective legal action in the case of medical malpractice in a destination country, especially where no protective regulation or legislation is in place.

Under certain conditions, patient health insurance may reimburse costs for treatment abroad. This is dependent upon the legal status of the treatment and upon the state or the individual insurance policy. Patients should be encouraged to clarify any available reimbursement prior to treatment. Clinics should provide a transparent and legally binding treatment plan, which also details the cost (including the compensation or payment for donors and surrogates, if applicable). Couples should be aware that several treatment cycles may be necessary to achieve pregnancy and that carrying out treatment abroad also entails traveling, accommodation and incidental costs (such as visas, for example). For costs during pregnancy and for birth, the country of conception is irrelevant; reimbursement is dependent upon the parent's/parents' health insurance scheme.

Patients may be more willing to risk multiples after having experienced recurrent treatment failure in their home country. Although the high number of multiples following CBRS has been criticized [15, 31], and recent European data indicate that the general rate of multiple pregnancy is decreasing within Europe, there are significant national differences, with four and more embryos regularly transferred in several countries (e.g. Bulgaria, Lithuania, Moldova, Romania and Serbia) [32]. Similar practices may be prevalent in other countries, especially in the absence of formal policies or guidelines restricting the number of embryos that may be transferred in a single IVF cycle. [31]. For example, one American study found that at least half of the clinicians surveyed would deviate from ASRM embryo transfer number guidelines in certain situations (33)

Couples should be made aware of this risk whenever more than one embryo is transferred or hormonal induction is used to stimulate the growth of oocytes, and be informed that current guidelines seek to minimize the risk of multiples by only transferring one or two embryos. [31,34, 35]

After five failed IVF cycles, Steven and Joyce, both in their mid-thirties, were very frustrated as the clinic would only transfer two embryos per treatment cycle in order to minimize the risk of multiples. They had contacted a clinic abroad that offered to transfer a higher number of embryos with the promise of a higher pregnancy rate. As their financial resources were such that they could afford only one more cycle, they contemplated having four embryos transferred, hoping to increase their chances of conceiving.

It is easy for the fertility counselor to develop empathy for couples who have had to experience so many “mini losses” as couples often described failed treatment. The couples’ desire to “put all their eggs into one basket” (pun intended) is also understandable. At the same time, the counselor’s emotional distance allows a greater degree of reflection and enables him/her to understand the risks of transferring three or more embryos to such a relatively young woman. The issues here are two-fold: to use professional knowledge in a way that helps clients to make informed decisions and to appreciate that the information of transferring a certain number of embryos was given by medical doctors who tend to be afforded a higher professional status than mental health professionals.

One way of avoiding a professional power struggle (for oneself as well as for patients who would find them in between two professional views) is to focus on the psychosocial issues. Fertility counselors can and should inform couples like Steven and Joyce of the medical and physical consequences of multiple pregnancies. Focus should be on questions regarding the scope of social support typically required after multiples are born, the realistic options of both partners to share child care, and equally important, the financial burden multiples can result in.

Counseling prior to treatment using the patients’ own gametes

Many patients travel in the hope that less restrictive legislation will enable medical practitioners to offer different or innovative treatment that may result in higher pregnancy rates. Such treatment can include PGD or blastocyst transfer with selected embryo transfer. Others travel in the hope that treatment is less costly outside their country of residence. Patients considering traveling abroad should be informed that it is

vital that treatment adheres to international standards and they should satisfy themselves regarding the standards of care available; caution is advised if independent confirmation of standards is not readily available. Should innovative treatment be offered, patients should be adequately informed about the implications, including the financial cost, as well as any risks this treatment may entail for themselves or the resulting child. This requires fertility counselors to continuously stay up-to-date with medical and scientific developments.

Counseling prior to third party reproduction

Patients need to be knowledgeable of the legal regulations, guidelines or common practice regarding anonymity or identifiability of the donor. In many countries, legislation mandates anonymity [31] and patients are given little or no non-identifiable information about their donor(s). Clinical experience indicates that at the time of treatment, for several reasons, many patients pay little attention to legal regulations. They are unaware of legislation, they naively follow recommendations of their previous clinic, or their desire is focused on the short-term need to conceive and have a child rather than on long-term issues relevant for the child.

Once the child is born and parents consider disclosure, however, having undergone treatment in a country where donors or surrogates remain anonymous may result in a dilemma: parents can disclose the use of a donor or surrogate, but the child will not be able to access any information about his/her biological background. Furthermore, in many countries, it may be legally possible for clinics to provide non-identifiable information, although they are reluctant to do so. It is important for fertility counselors to explore with patients their intentions regarding disclosure and draw attention to the need for selecting a country and a clinic that provides the future child with the possibility to access information about the donor or surrogate, should he/she wish so.

Counseling should also explore the values and attitudes of patients regarding the circumstances of the donor(s) and/or surrogate(s). Whether the donation was altruistic and/or an autonomous decision or the result of a financial need, the fact that gamete donors and surrogates are typically young and healthy men and women, who take medical risks for the benefit of others, usually are considerations that impact on the patients' moral assessment. Although these issues cannot be resolved, in many cases, counseling is the only opportunity that provides time and space to raise them:

After cancer of the uterus and a hysterectomy, Julie and Ben were confident that surrogacy was a positive choice for them to have children. They had explored clinics in several countries and were unable to decide which clinic and country to choose. They struggled most with what they called "belly-buying", the concept that, as a couple from a developed country in a comfortable financial situation, they were able to "buy" the "belly" of a woman who would use this payment for life necessities. The agencies they had contacted described their payment as "a wonderful gift to the surrogate and her family" and failed to acknowledge couple's different perspective. Although the issue of payment could not be resolved in counseling, it was a relief for Julie and Ben to have time and space to explore their feelings and their moral concerns.

Surrogacy arrangements may be most challenging for counselors' ethical values. In these situations, typically young women make available their body and risk the potential side effects of ART treatment, pregnancy and birth. Whereas historically, these were women

often known to the patients who had altruistic motives, nowadays, commercial agencies around the globe are involved, collaborating with clinics and legal advisors. In many, if not most cases, we can assume that the costs paid to the professionals involved are higher than the compensation or payment the surrogate receives. In some countries, there is contact between the surrogate and the intended parents, which allows intended parents to show their gratitude and appreciation beyond the financial transaction that takes place. In others, such contact is banned. Our experience shows that intended parents can struggle with the concept of payment to donors and surrogates. They find it difficult, if not impossible, to “fix a price” for oocytes, semen or pregnancy. If this exchange is anonymous, they also struggle with the concept that they cannot show any appreciation for this “gift of life”. Some have written a letter to donors and surrogates in which they describe their experiences and gratitude and hoped that the clinics passed them on.

In some cases, these issues only become relevant to patients once pregnancy has been established and having a child becomes a reality. In other cases, they become acute after the child is born or starts to ask questions about her/his conception. It is therefore important for counseling to be available at every stage of treatment and after the child is born, to be available in the parents’ home country, and for parents to be informed about further resources, such as support organizations.

Although fertility counselors are not in a position to provide binding legal advice, they should raise the legal implications of gamete and embryo donation, and surrogacy. The legal implications of international surrogacy are very complex, and intended parents should ensure that they have all the relevant information relating to the country of treatment. In most jurisdictions, the woman giving birth is the legal mother and her husband or partner, the legal father. Consequently, the intended parents, even if their gametes were used, are not the legal parents. Intended parents, who are single or in a same sex relationship, should be informed about the legal status of the donor in relation to the child. In cases where there is no male partner to automatically assume legal paternity, in some jurisdictions the donor may both run the risk of assuming parental obligations and be able to claim visitations rights. Fertility counselors should encourage legal consultation in these situations.

Regardless of their genetic relationship to the child, intending parents may need to apply to adopt him/her or take other available legal measures to ensure a transfer of parentage from the surrogate to themselves [36]. In some jurisdictions, transfer of legal parentage is stipulated in legally enforceable contracts prior to treatment (See chapter 9), although in most jurisdictions such contracts are not legally enforceable.

In some international surrogacy arrangements there have been disputes about the nationality of the child [14], especially in those cases where surrogacy is prohibited in the intended parents’ country of residence, and embassies have been reluctant to issue birth certificates, passports, or other legal documents which are required for the intending parents’ to return home with the child [37]. It is therefore vital for intended parents to be knowledgeable about the documents they need in the country of treatment, the documents they need in order to travel home with the baby and those required for the legal proceedings in their home country to transfer parentage.

It is also advisable for intended parents not to rely on the legal information provided by the clinic or the agency, but to seek independent advice from a legal expert experienced in this area. The legal information should also entail details about the documents regarding donors and surrogates, such as what information is recorded, how long and where these records are kept. Countries belonging to the European Union, for example, must keep documents for a minimum of 30 years. [38] However, there is currently no evidence that this document retention period is adhered to in all EU member countries. The right of offspring to access these documents is subject to national legislation. Intended parents should also be informed that these records may be relevant beyond the 30-year period and that it may be necessary in the case of medical complications to have access to the identity of the donor or the surrogate.

Counseling donors and surrogates

In many destination countries, there is no evidence that counseling is available for donors and surrogates. Therefore, in addition to the general counseling interventions for donors and surrogates described in Chapters 8 and 9, fertility counselors need to raise issues specific to CBRS. These include issues, such as the question whether donors are aware of, and have consented to, the use of their oocytes or their semen for recipients from other countries; in this case, their future children will have half-siblings living in other countries. There is little international agreement regarding the number of offspring per semen donor, [39] and there is no international agreement regarding the number of offspring per oocyte donor, let alone the maximum number of treatment cycles to which she should be subjected. In those jurisdictions where there are no legal limits, donors should be informed about national guidelines applicable to them and be encouraged to determine the number of offspring they wish to contribute to. Similarly, surrogates should be informed about relevant national guidelines regarding the maximum number of embryos to be transferred (in order to minimize the risk of multiples for surrogates and any consequent multifetal reduction) and of pregnancies or, if there are no guidelines, be encouraged to determine themselves the number of pregnancies they are willing to carry out for others.

The meaning of financial compensation or payment should be carefully explored in order to assess financial coercion. Although this is especially pertinent in developing and emerging countries such as India and Thailand, it is also relevant in countries such as Spain, the Czech Republic or the USA where donors and surrogates typically are young women with (considerably) less financial resources than patients. [40] Last but not least, more research is required on the short and long-term implications for donors and surrogates. There is a dearth of information on how these groups fare with their decision in later life and what their needs are regarding information about and contact to offspring they have helped to conceive.

Counseling offspring

The psychosocial needs of offspring conceived via donated gametes, embryos, and via surrogacy in a foreign country is another issue the fertility counselor should address with intended parents, ideally prior to treatment [41]; these are covered in detail in chapter 18. For offspring conceived abroad, there may be additional issues such as exploring the meanings of have a dual cultural/ethnic background. In inter-country adoption, racial, ethnic and cultural awareness have been found to be essential ingredients for successful identity formation [42]. Currently, there is little evidence either from formal research or from clinical practice that this issue is considered at all

by those providing services for individuals and couples traveling for treatment. It is highly likely, however, that similar issues will apply to offspring following CBRS whose parents may be of different races or cultures. More research is also required for this group, especially if conceived via CBRS, in order to understand both the short and long term needs of these children.

Counseling Resources

Information on legislation and international guidelines

As the policy situation in many countries is dynamic and many countries do not have legislation pertaining to ART or to specific aspects of ART such as the establishment of legal parenthood following[43] surrogacy, the number of offspring a donor can help to conceive or the right of offspring to access biological information, it will be difficult for counselors to stay abreast of these developments. An overview has been put together by ESHRE (<http://www.eshre.eu/Guidelines-and-Legal/Legal-documentation.aspx> and <http://www.eshre.eu/Guidelines-and-Legal/Legislation-for-MAR-treatments.aspx>), the website "Biopolicywiki" (www.biopolicywiki.org) and the German Max-Planck Institute for International Penal Law (http://www.mpicc.de/meddb/show_all.php, only available in German).

Patient organizations

It can be helpful to refer to patient organizations in the country of treatment where they exist. These are generally knowledgeable not only in the legal area but can also provide information regarding the medical practice in their country. In addition, they can help to establish contact to other patients in their country to provide support. The international umbrella organization iCSi (International Consumer Support for Infertility; www.icsicomunity.org) and the European organization "Fertility Europe" (www.fertilityeurope.eu) have compiled a list of national patient organizations.

Fertility counseling organizations

In several countries, specialist fertility counseling organizations have been founded. These can provide information for counselors regarding national legislation, guidelines and practices and also provide a list of counselors that can be contacted by patients. The international umbrella organization IICO (International Infertility Counseling Organization - <http://www.iico-infertilitycounseling.org/about-us/iico-members>) provides links to national organizations.

Guidelines for counseling in the area of CBRS

The German Fertility Counselling Organisation has published guidelines for counseling in the area of CBRS. These guidelines have also been published in English (17). In addition, **Table 2** provides questions for fertility counselors to consider regarding counseling issues occurring in the context of CBRS.

Reflections of the Authors

PT: I think all infertility counselors worldwide have seen tremendous changes in our field in recent years. Working in Germany, it is fascinating to see how many couples travel in order to obtain treatment, mainly oocyte donation, which is prohibited in Germany. Whereas 6 or 7 years ago, I hardly did any counseling in this area, I now usually have several clients every week. These counseling sessions can pose challenges,

for both the clients and myself. Many German couples are considering treatment in Spain, which is considered to be the hub for oocyte donation in Europe. This is also the country suggested by many medical professionals. From a psychosocial perspective, however, treatment in Spain cannot be recommended. Legislation is such that all donors remain anonymous and children born as a result from third party treatment in Spain will not be able to access their biological origins. In a sense, this is a déjà-vu situation: Many years ago, there were controversial discussions regarding sperm donor anonymity in Germany. This is now – to a large degree – resolved and offspring are able to access the identity of the donor. Now, we are having very similar discussions with patients considering treatment in Spain (and any other country that grants anonymity to donors and/or surrogates). Often, couples know very little about the legal implications and are not aware of the rights and possibilities of their future children. Often, too, the needs of their children are so far in the future that they are not taken into consideration before or during treatment. The couples' focus is on getting pregnant and it can be a challenge to raise long-term implications that do not affect them, but their future child. Given the legal situation in Germany, counselors are also concerned about potential legal issues if they counsel in an area that is prohibited; they fear criminal penalties. At the same time, there is little discussion about counseling issues in this area and thus little awareness. This is the reason why, as chair of the German Society for Fertility Counselling, I have been involved in issuing guidelines for counseling in third party reproduction as well as for counseling individuals and couples traveling for treatment. Both guidelines provide psychosocial professionals with background of the international scientific discussion in this area and describe issues relevant for counseling in these areas.

As fertility counselors, we work in a dynamic area, both technically and ethically. We have seen and will continue to see many changes, both in the way infertility is treated and regarding the groups that access medical treatment. I am certain that the future will hold new challenges for us – and I hope that we will continue professional development and exchange so that our role in the provision of treatment will continue to grow.

EDB: It is now almost a decade since I first commented on what was then generally referred to as “reproductive tourism“ (44). This paper has now become a routinely-cited work in this field (89 citations according to Google Scholar as of March 31 2014). Over that time I have also undertaken further research, commentary and professional practice (3, 12, 14, 45-48). What has become apparent over this period is both increased professional and academic interest in the field and increased media interest in the more exotic/problematic examples of cross border reproductive travel. The effect of this appears to be increasing awareness of both the opportunities and the hazards associated with cross border reproductive travel and realization of the need to ensure the effective protection of the interests of patients, donors, surrogates, the children to be born as a result of the procedures undertaken, as well as and any existing children that the patients, donors or surrogates may already have. It is gratifying to have been able to contribute to policy developments in this area (20), a report that incidentally credits me with drawing attention to unscrupulous “bait and switch“ practices. I did, indeed, refer to the plight of some parents and their children once the children started to grow up and it was evident from the children's physical characteristics that a different donor had been used to the one stated by the clinics. I wish I had also been sufficiently inventive to come up with the “bait and catch“ phrase. Unfortunately I didn't!

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Table 1: CBRS: Home and Destination Countries (compiled by the authors based on data from recent studies [3-11])

Home country	Destination country	Service
Australia	Thailand	Sex selection
Canada	USA	Donor oocytes
Denmark	Baltic States, Czech Republic, Greece, Russia, Spain,	Donor oocytes
Egypt	Spain, other European countries	Donor oocytes
France	Belgium	Donor Sperm
Germany	Spain, Czech Republic	Donor oocytes
Hungary	USA	Surrogacy
India	Europe, USA, United Arab Emirates	Standard IVF
India	Thailand, USA	Sex selection
Israel	Romania	Donor oocytes
Italy	Austria, Belgium, Czech Republic, Greece, Slovenia, Spain, Switzerland, UK	Donor oocytes, donor sperm, embryo cryopreservation, PGD
Japan	USA	All services
Macedonia	Belgium	ICSI-TESE
Macedonia	Czech Republic	Donor oocytes
Middle East	Jordan	Sex selection
Netherlands	Belgium	Donor sperm
Norway	Denmark	Donor sperm
Portugal	Russia, Spain	Donor oocytes
Sweden	Denmark	Donor sperm
Sweden	Baltic States, Finland, Russia	Donor oocytes
Switzerland	Austria	Standard IVF
Switzerland	Eastern Europe, Spain	Donor oocytes
UK	Czech Republic, Spain	Donor oocytes
USA	India	Surrogacy

Table 2. Questions for fertility counselors to consider on counseling issues arising in the context of CBRS

- What do I know about the implications of legislation relevant to me when providing counseling to patients who travel for treatment, especially those who intend treatment prohibited in my country of practice?
- What type of legal and medical information can I provide as a psychosocial professional? Are there any restriction/limitations by professional bodies or by legislation? (Typically, counselors can provide basic medical and legal information but are not in a situation to provide binding information.)
- What is my attitude towards treatment prohibited or not offered in my country? Do I think patients have a right to exert their reproductive autonomy even if they engage in an activity that is illegal if carried out at home? Does my attitude vary according to the type of treatment; if yes, can I describe why?
- How do I feel about women who undergo invasive procedures for the sake of others (oocyte donors, surrogates)?
- How do I feel about these groups receiving financial compensation/payment for these procedures? Should there be a lower and/or upper limit for such payment? What or who should determine the amount of this payment?
- How do I feel about the need or right of offspring conceived by third party reproduction to access information about the donor and/or surrogate? How do I feel if this is possible in my country, but not the treatment country of patients (or vice versa)?