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Ministry of Justice
Director General Pekka Nurmi
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SURROGACY TREATMENT IN FINLAND

The Ministry of Justice (OM 24/41/2010, 21 December 2010) requested ETENE's statement on surrogacy treatment in Finland. The request refers to an earlier statement issued by ETENE in the context of a statement on the Act on Assisted Fertility Treatments (18 December 2000). The Ministry of Justice now asks ETENE whether the prohibition of surrogacy contained in the Act on Assisted Fertility Treatments in 2007 and the associated actual practices have changed ETENE's earlier assessment of the ethical points of view related to surrogacy and the Advisory Body's recommendation concerning the regulation of surrogacy treatments.

ETENE's statement on assisted fertility treatments (18 December 2000) concluded: "Neither the current legislation nor the draft act assessed by ETENE can adequately safeguard the rights of the child to be born, the surrogate mother, or the woman or the couple wishing for a child in a surrogacy arrangement. Consequently, ETENE finds that while there could be highly valid medical justifications for this practice in individual cases, the act should impose a prohibition on surrogacy."

The National Supervisory Authority for Welfare and Health Valvira (previously the National Authority for Medicolegal Affairs) issued a statement on the Act on Assisted Fertility Treatments (Record no 3068/01/97), which contains the following opinion about surrogacy: "The National Authority for Medicolegal Affairs thus proposes for the Ministry of Justice's consideration that the use of surrogates be discontinued due to the above-described difficulties related to obtaining information and other problems associated with this practice." The Council for Gender Equality, which works under the auspices of the Ministry of Social Affairs and Health, took a position on fertility treatments (1997), in which it expresses its negative attitude to surrogacy treatments and highlights their inherent legal and other problems. The National Council on Disability Vane also took a position on fertility treatments (2010), in which the organisation highlights equality and non-discrimination in fertility treatments.

ETENE discussed the question at its meeting on 10 March 2011. Pirkko Ämmälä, D. Med. Sc., Gynaecologist, Obstetrician and Perinatologist, had been invited to attend the meeting as an expert. ETENE had a referral debate on the questions and appointed a working group to prepare the issue for the Advisory Board. As members of the working group were appointed Viveca Söderström-Anttila, Dr. M. Sc, Adjunct Professor and Associate Chief Physician, Pirkko Ämmälä, Gynaecologist, Obstetrician and Perinatologist, Secretary General Hanna Markkula-Kivisilta and General Secretary Aira Pihlainen. In the course of its work, the working group consulted Lawyer Riitta Burrell. Lawyer Anna Mäki-Petäjä-Leinonen has studied surrogacy practices in other European countries.

In terms of ethics, surrogacy treatments must be examined from the perspective of the rights and position of the various parties: the child, the surrogate mother, and the couple wishing for a child. It is vital that the fundamental and human rights and interests of all parties are implemented, and that the principle of doing no harm is followed.

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Basic values and ethical principles relevant to surrogacy treatments

Fundamental and human rights include human dignity and reproductive freedom, which are linked to personal liberty, personal integrity and the protection of privacy. From this point of departure, surrogacy must be examined from the viewpoint of doing good to the child, the surrogate mother and her family, and the couple wishing to have a child. Surrogacy is questionable in terms of human dignity. From the perspective of the child and the couple wishing for a child, human dignity would seem to be respected, while from the perspective of the woman consenting to act as a surrogate, surrogacy may be seen as problematic from the viewpoint of human dignity, at least in the legal sense, regardless of how the woman feels about it herself. For this reason, particular attention should be paid to the good of the surrogate mother and equality, non-discrimination and avoidance of doing harm in her case.

One point of departure for social and welfare services is promoting human health and wellbeing as well as relieving suffering, to which the requirements of doing good and doing no harm also apply. While there has been little research in the experiences of children born through surrogacy, currently there is no indication that the way he or she was born would be a cause of suffering for the child. For a family hoping for a child, surrogacy is a possibility of having a genetic child of their own, even if the woman was born without a uterus, or has lost her uterus as a result of an illness or an injury. Families where the woman does not have a uterus have described their experiences of human suffering. From their point of view, this is also a question of equality and non-discrimination compared to other families receiving fertility treatment.

The counterargument focuses on doing wrong. These questions are mostly relevant to the position of the woman consenting to be a surrogate. Particular aspects to be considered from her point of view include freedom, self-determination and altruistic reasons for becoming a surrogate. Other elements that must be carefully scrutinised are possibilities of abuse; objectification, subordination, coercion and health risks. To avoid abuses, careful consideration is required, guidance and advice must be provided to the various parties, and support is also needed. The woman consenting to becoming a surrogate, her family and the couple wishing for a child must be provided with adequate information in a comprehensible form in advance to ensure sufficient awareness and consideration of voluntary consent, self-determination and freedom.

Even when surrogacy treatments have been well and carefully prepared in advance, situations may arise where everybody's interests are not served. Such cases have been documented both in countries where surrogacy is unregulated and in countries where legislation on this issue is in place. In this situation, the interests and good of the most vulnerable party, in other words the child, must be safeguarded as a priority. Examples of problems are cases where children born through surrogacy in a foreign country have not be recognized as citizens of the genetic parents' country.

Examination of surrogacy treatments from the perspectives of the parties involved

<u>The child</u>

The best interests of the child should be the primary concern, and the child must be protected as the most vulnerable party. No long-term studies exist on children born through surrogacy. However, openness should be the basis of their upbringing, and it is recommended that children are informed of their origin to the extent allowed by their level of development. Under the Act on Assisted Fertility Treatments, a child to be born has the right to be informed of his or her origin (22.12.2006/1237). Practical experience has also shown that most parents are planning to explain to the child how his or her life started (MacCallum, 2003; Golombok 2006).

There is little information about the state of health of surrogate children in reference literature. In an extensive European study, which analysed the wellbeing of 3-year-olds born through fertility treatments and their

families, no negative effects from using surrogacy were found (Golombok, 2006). In Finland, no negative experiences regarding children born through surrogacy are known.

The surrogate

A pregnancy, and also surrogacy, are associated with health-related and psychological risks. Efforts are made to prevent these risks, for example by selecting a surrogate who already has given birth to healthy children without any complications in her pregnancies. It is crucial that the surrogate's earlier pregnancies and births have been free of problems and that her pregnancies have been full term. The surrogate may not have tendencies for depression or other affective disorders. The surrogate may experience emotional problems or be at risk of depression after giving up the child. This is rare, however (Jadva V. & al 2003). ESHRE (the European Society of Human Reproduction and Embryology) recommends 45 years as the upper age limit of surrogates. During the pregnancy, the surrogate must preserve her right to self-determination and her legal rights, including the possibility of an induced abortion (359/1970) and the right to privacy and data protection during the pregnancy. The surrogate may be known to the parents, for example a close family member, or remain unknown. It has been debated in literature whether, in case of close family members acting as a surrogate, there could be a risk of pressure being put on the prospective surrogate, or whether the situation could confuse the child. There is no evidence of such risks. (See Appendix 1)

The question of whether or not a woman acting as a surrogate is objectified is controversial, and the risk of this happening should be prevented in advance as far as possible. For example, a woman should only be allowed to give birth to a limited number of surrogate children. The surrogate and her spouse (and if necessary, also her children) should have access to legal and medical advice. They should be informed of the treatment process and the risks associated with the pregnancy, even the unexpected ones. The surrogate must also prepare for handing over the child to the biological parents after birth. Psychological advice before the treatment process is vital, and it must continue throughout the pregnancy and also after the birth for as long as necessary.

The couple wishing for a child:

The positions received from couples where the woman does not have a uterus have mainly been positive, as surrogacy would give them a humane and equal possibility of having a genetic child of their own in a society that is tolerant of those who are different. They also hope that during the pregnancy, the couple would be kept adequately informed of the progress of the pregnancy and any problems in it. Their future parenthood should also be supported throughout the pregnancy to ensure that they will not feel excluded. The couples should be assisted on public funding and by legal means. For them, a surrogacy arrangement is associated with a binding commitment to adopt the child to be born. They have a duty to attend advisory services referred to in adoption legislation. They also have to accept that the surrogate is independent and free to decide about her own actions during the pregnancy.

From an ethical viewpoint, the couple wishing for a child must weigh their reproductive freedom, self-determination and a wish to have a genetic child of their own on one hand, and selfish desires and wishes of continuing their biological life in their children on the other.

Review of legislation in other countries (See also Appendix 3 Mäki-Petäjä-Leinonen.)

In Sweden, there are no specific provisions to ban surrogacy, and donating eggs has been permitted since 1 January 2003. However, combining a donated egg with donated sperm is not permitted. Additionally, the woman having given birth to a child is regarded as his or her mother. The Swedish National Council on Medical Ethics took a negative view of surrogacy (1995). Currently, new research and public debate have brought up a number of ethical, social and legal questions. The Swedish National Council on Medical Ethics

is currently examining the issue and drawing up a report on artificial insemination that also touches on the question of surrogacy treatments. The report is due for completion shortly. So far, the Swedish legislator has rejected demands to draft legislation on surrogacy treatments.

In Norway, provisions on fertility treatments and the use of gametes in them are contained in the act on the medical use of biotechnology that entered into force in 2004. Surrogacy treatments are banned in Norway. The Norwegian Biotechnology Advisory Board took a position on surrogacy in March 2011. A majority in the Advisory Board were critical about surrogacy treatments and would prefer to uphold the ban in future legislative projects. A minority finds that there is a need to regulate surrogacy, both nationally and internationally, and feels positively about amending national legislation. The minority further finds that the acts on biotechnology and children should be amended to enable non-commercial surrogacy treatments as an experimental project.

In Denmark, provisions on fertility treatment are contained in an act on assisted fertilisation performed in connection with medical treatment, diagnostics and examinations that entered into force in 1997. While surrogacy is not actually prohibited in Denmark, other provisions of the act prevent surrogacy arrangements. Commercial surrogacy, for example, carries a penalty under the criminal code. Private arrangements are not illegal as such, but legally binding contracts may not be concluded, and only the mother having given birth to a child can have guardianship, unless the authorities consider it in the child's best interest to award the guardianship to somebody else. Additionally, doctors are banned from giving fertility treatments to women who have sought them to act as surrogates. The Danish Council on Ethics gave its position on surrogacy in 2008. The Council opposes to commercial surrogacy activities and did not see it necessary to amend the legislation in force in this respect.

In the Netherlands, surrogacy was permitted in 1994, in which year the act that banned surrogacy in general was amended to only ban commercial surrogacy. The act offers the possibility of surrogacy treatment to couples who are infertile or to same-sex couples.

While no act on surrogacy treatments is as yet valid in Belgium, a legislative project has been pending for some years now. Regardless of the lack of legislation, however, arrangements relevant to surrogacy treatments have been put in place in Belgium.

In the United Kingdom, surrogacy is permitted but restricted by a number of provisions. For example, commercial mediation of surrogacy services is a criminal act. Similarly, surrogacy agreements are not legally valid in British courts, and it is thus not possible to conclude legally binding surrogacy contracts.

The Council of Europe published a report on fertility treatments in 1989, which contains recommendations for legislation on fertility treatments. According to this report, surrogacy should be prohibited. In exceptional cases, however, the member states could allow a woman to give birth on behalf of another woman. The woman carrying the child should not receive financial gain for helping a childless couple, however. The woman should also have the right to decide whether or not she would like to keep the child to whom she gives birth.

Other factors relevant to surrogacy

A clear medical argument for surrogacy is that this treatment makes it possible for a couple to have a genetic child of their own where the reason for childlessness is relevant to the uterus. For some couples it is of primary importance to have a genetic child of their own, and this is medically possible. It is unfair to ban a fertility treatment to a certain group of patients who have a medical reason for their childlessness. In practice, the Act on Assisted Fertility Treatments that is currently valid in Finland allows all other treatment alternatives. All studies indicate that a couple seeking this treatment has a strong wish to have a genetic child, and

they are willing to commit to the demanding treatment process in order to have one. Follow-up studies indicate that interaction between the parents and the child and the attachment shown by the mother towards the child are at least as strong as in families where the mother has given birth to the child. (See Appendix 1 Söderström-Anttila, Ämmälä.)

In 1991–2001, surrogacy arrangements were made in 18 cases in Finland. These mainly were individual cases of pilot treatment. The positive experiences obtained show that the medical expertise and basic technical possibilities for carrying out such treatments are in place. The surrogacy treatments progressed as follows: the couple wishing to have a child donated gametes. After test tube fertilisation, the embryo was transferred into the surrogate uterus. After birth, the surrogate gave the child to the couple for adoption. To be eligible for surrogacy treatment, the couple wishing for a child had to be heterosexual, and the woman either did not have a uterus, had a serious structural abnormality of the uterus, or was affected by a severe physical illness that prevented her from giving birth. The surrogate could be her mother, sister, friend or an unknown woman. To be eligible for surrogacy, the surrogate mother had to be a healthy woman whose family was complete. Her previous pregnancies had been normal, and she was willing to help the couple. The couple wishing for a child found the surrogate themselves. Other operating principles were: careful preparation of the surrogacy, psychological testing of the couple and the surrogate, and establishing that the couple may be accepted as adoptive parents. No written agreement was drawn up between the parties.

In 2011, ETENE has received letters from the citizens (n=10) on the subject of surrogacy. Most of these letters are in favour of permitting surrogacy in Finland. Two persons also contacted ETENE to express their opposition to surrogacy.

In terms of legislation, regulating surrogacy is a difficult task. These difficulties were also reflected in the experiences of passing the Act on Assisted Fertility Treatments (1237/2006). The legal problems are relevant to determination of parentage, adoption and fundamental and human rights. In addition to the Act on Assisted Fertility Treatments, the Act on the Status and Rights of Patients, the Act on induced abortion (laki raskaudenkeskeyttämisestä, 239/1970) the Adoption Act and the Child Maintenance Act have a bearing on surrogacy. (See Annex 2 Burrell)

Commercial surrogacy is fraught with problems. As surrogacy is technically possible, commercial aspects may assume a significant role. In an unregulated black market, the safety and other interests of all parties are also at risk. Additionally, surrogacy as a commercial activity could result in a situation where only wealthy people had access to this treatment, and it would thus be discriminatory. A couple wishing for a child must be assisted on public funds and by public means. The motivation of becoming a surrogate must be altruism. On the other hand, there is no reason why the surrogate could not receive a reasonable compensation for her actual loss of earnings and a reimbursement of costs incurred for maternity clothes, for instance. Altruism also plays a role for organ donors, who receive compensation for sick days (L63/2010). However, No commercial exploitation may be associated with surrogacy.

Permitting surrogacy treatments would reduce problems arising from couples travelling abroad, or surrogates from other countries arriving in Finland. In any case, the issue is relevant to very few (an estimated 5 couples a year), and in terms of public health care expenditure, this is a small group. As the number of couples is low, this treatment form would not push up the costs significantly.

ETENE's position on the use of surrogacy treatments in Finland

ETENE finds that the issue must be examined from the perspectives of the child, the surrogate and the couple wishing for a child. The health care system has used a variety of methods to ensure that parents can fulfil their wish for a genetic child. In this case, only a small number of people are involved, but having a child is

equally important for them as for other parents. An argument in favour of surrogacy has been strongly expressed by citizens who have contacted ETENE.

However, children's rights must be protected in legislation by ensuring that the conditions laid down in statutes are sufficiently binding. The rights of the adults taking part in surrogacy arrangements and of their families, and their right to be heard, should be clarified and set out in the statutes. The basis of surrogacy should be altruism, not financial gain, while compensating the actual costs incurred by the woman who consents to act as a surrogate should also be allowed.

Surrogacy treatments and the associated legislative issues are topical in many European countries. The current legislation prevents fertility treatments through surrogacy in Finland. The issue seems to be problematic in terms of its legal implications, but its pros and cons should not be impossible to balance. Something should not be banned because the issue is difficult and complex, or may result in abuses, without first making a genuine effort to seek for positive alternatives.

ETENE finds that the positive impacts of allowing surrogacy treatments outweigh the negative impacts of problems related to the treatments or of banning the treatments, and after an ethical consideration, it finds that in certain individual cases, treating fertility by means of surrogacy could be ethically acceptable. Detailed further studies, for which the expertise of the Ministry of Justice gives a good point of departure, are called for in order to solve the legal questions associated with surrogacy.

Permitting surrogacy treatments in Finland would not significantly add to the costs incurred by society, or require new structures. We already have experience of these treatments in Finland from times past. A multiprofessional treatment team would be needed to direct the activities, the tasks of which would include providing the various parties with advice, guidance and support for an adequately long period.

ETENE finds it vital that surrogacy treatments are carried out subject to permission.

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APPENDICES
Appendix 1. Söderström-Anttila V., Ämmälä P. 2011 A genetic child through fertility treatment.
Appendix 2. Burrell R. 2011 Surrogacy arrangements - legal aspects.
Appendix 3. Mäki-Petäjä-Leinonen A. 2011 A review of surrogacy legislation in other countries.

A genetic child through fertility treatment

Viveca Söderström-Anttila, Adjunct Professor, and Pirkko Ämmälä, Dr. Sc. Med.

Definition

Surrogacy is a treatment of childlessness that may be indicated when infertility is caused by a lack of a functional uterus, or there is a serious medical contraindication to pregnancy. In a situation of this type, a couple may have a genetic child of their own by means of IVF (in vitro fertilisation) and surrogacy treatment. In literature, IVF surrogacy is also known as ”Full or host surrogacy” or ”Gestational surrogacy”. In this treatment, the woman goes through ovarian stimulation and egg retrieval, after which the eggs are fertilised with her spouse's sperm. In other words, the child originates from the gametes of the woman and the man wishing for a child combined in test-tube fertilisation. The embryo thus produced is transferred into the uterus of a surrogate mother. Once the child has been born, the genetic parents adopt him or her from the surrogate. Globally, the first report of IVF surrogacy dates back to 1985. In Finland, some twenty couples received IVF surrogacy treatment in 1992-2006 (Söderström-Anttila, 2001.

Another form of surrogacy is the so-called traditional or partial surrogacy, where the surrogate's egg is fertilised by artificial insemination. As far as we know, no partial surrogacy treatments have been carried out in Finland.

Treatment indications

Congenital absence of the uterus is rare (Mayer-Rokitansky-Kuster-Hauser's syndrome 1:4,000–5,000 girls at birth). However, the news that she does not have a uterus may be very upsetting for a young woman. A woman in a fertile age may also lose her uterus as a result of a complication of pregnancy or birth, for example a life-threatening haemorrhage. The tragic nature of these incidents is accentuated by the fact that the child is frequently also lost. A hysterectomy may also be necessary because of myomas (uterine fibroids) or malignant cell transformations. The prognosis of these illnesses often is good, and the woman's life expectancy is normal. Serious structural abnormalities of the uterus may result in childlessness or recurring miscarriages, in which case surrogacy treatment may be indicated. Finally, certain medical conditions of a woman, including a serious antiphospholipid antibody syndrome or SLE, may prevent a pregnancy, and in this case surrogacy represents a possibility for the couple to have a genetic child of their own.

Summary of Finnish experiences

Up until 2006, only a handful of surrogacy treatments had been carried out a year, the majority of these at the Family Federation of Finland's infertility clinic. A precondition for treatment was that the couple had themselves organised a surrogate, who in most cases was a close family member, such as the woman's sister or mother, or a close friend. All surrogates had their own biological children. The surrogates took part in the treatment out of pure altruism, and no fee was paid to them. Over one half of the couples who were treated had a child using this method (Söderström-Anttila, 2001).

Surrogacy from the perspective of the surrogate mother

The choice of a surrogate is of vital importance. The surrogate must be in good health, and she must have had at least one child. It is crucial that she has not had complications in her pregnancies and births and that her pregnancies have been full term.

The surrogate must not have tendencies for depression or other affective disorders. In a British follow-up study, 15% of surrogates experienced some emotional difficulty within a few months of giving birth, with the rate reducing to 6% a year after giving birth (Jadva, 2003). In an American study, 5% were found to be effaced by post-partum depression (Parkinson, 1998). In data comprising 10 surrogates from Finland, two experienced mood swings and adjustment difficulties immediately after giving birth (Söderström-Anttila, 2001).

The ESHRE task force recommends 45 years as the upper age limit of surrogates. This is indeed justified; the risk of complications increases as the mother's age goes up, even if the woman is healthy and had no complications in her previous pregnancies. Surrogate pregnancies have progressed equally well as the pregnancies of other fertile women in the same age group (Parkinson, 1998; Gibbons 2010). A multiple pregnancy, which is a major health risk for the mother and the child, can be avoided by only transferring one embryo at the time into the surrogate's uterus.

Legal and medical advice must be provided for the surrogate and her spouse. They must be informed of the treatment processes and also of the unexpected risks associated with the pregnancy. They must prepare for giving the child to the genetic parents as soon as it has been born. Psychological advice is vital before the treatment process, and it should continue throughout the pregnancy and also after birth, at least for two months and longer if necessary. The possibility of the surrogate being unwilling to give up the child once it has been born is considered one of the complications of surrogacy. According to literature, this risk is low. In a set of English data of 34 surrogates, not one hesitated to give up the child (Jadva, 2003). Several studies have found that the surrogates do not become emotionally attached to the child in the usual manner, and a direct detachment takes place early and persists throughout the pregnancy (van den Akker, 2007).

The surrogate may be known or unknown

Various types of surrogate arrangements are possible within families (for example, a mother gives birth on behalf of her daughter). The possibility that these situations could involve a risk of putting pressure on the surrogate or that they could be confusing for the child has been debated in literature. However, there is no evidence to show that arrangements within a family would cause additional problems, if thorough psychological advice is provided.

From the perspective of a couple wishing for a child

A clear argument in favour of surrogacy treatment is that it enables a couple who are childless because of uterus related reasons to have their own genetic child. Why should these couples not use a surrogate arrangement? After all, its aim is to do good, and all parties take part in the arrangement of their own free will. For some couples it may be of primary importance to have a child who is genetically their own, if this is possible by medical methods. It seems unfair to ban fertility treatment to one group of patients with a clear medical reason for their childlessness, while in practice the current Finnish Act on Assisted Fertility Treatments allows all other options. Children's rights can be protected by laying down legislative conditions that are sufficiently binding. All studies also indicate that if the couple's wish for a genetic child of their own is so strong that they are willing to commit to a treatment process as demanding as surrogacy, the child will also be very welcome and much loved.

The surrogate mother and the couple should also already decide on their attitudes towards foetal screening in the treatment planning phase. The surrogate is entitled to her statutory protection of privacy and data protection during the pregnancy. On the other hand, it is hoped that the couple will be kept adequately informed about the progress of the pregnancy and any problems in it. Their future parenthood should be supported throughout the pregnancy to prevent them from feeling excluded as the pregnancy progresses.

The most upsetting situation for a couple wishing for a child would be if the surrogate mother were unwilling to give up the child. This has happened, but only rarely (Brinsden, 2003). In European studies, all genetic parents received the child into their care within 24 hours of the birth (Söderström-Anttila, 2001; MacCallum, 2003; Dermout 2010). Problems may also be expected if the child is not healthy and the genetic parents are unwilling to accept him or her. Experience has shown that this risk is small if everything is prepared carefully enough (Brinsden, 2003; MacCallum, 2003; Dermout 2010).

Wellbeing of children born through surrogacy

Children born through surrogacy are equally healthy as other newborns. In an extensive European study, which analysed the wellbeing of 3-year-olds born through fertility treatments and their families, no negative effects from using surrogacy were found (Golombok, 2006). Follow-up studies have also demonstrated that interaction between the parents and the child, and the affection the mother shows towards the child, are at least equally strong as in families where the child was born spontaneously (Golombok, 2006). Openly discussing the manner in which the child was born is recommended, and experience has also shown that most parents intend to explain to the child his or her origins (MacCallum, 2003; Golombok 2006).

General points

Careful preparation of a surrogacy treatment is a must. It is the duty of the team responsible for the treatment to inform all parties about the medical, social, emotional, moral and legal aspects of surrogacy. Adoption advice is an important part of the preparatory phase. Detailed psychological advice for all parties is of vital importance. It must be possible to expect that the interested parties will be able to follow the plan and fulfil the purpose of the treatment, and that all parties have good prerequisites for coping with the future family situation. An idea must also be formed of the parties' ability to adjust to a situation where everything does not go to plan during pregnancy or after the birth. Courage is needed to openly discuss possible problems and complications.

The surrogate mother's motivation must be altruistic. She goes through the treatment process to enable an infertile couple to have a child. No commercial aspects or abuse between the parties must be associated with surrogacy. However, the surrogate also incurs financial losses for the pregnancy, birth and recovery. Reasonable compensation to the surrogate for losses of income and increased costs is justified.

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Surrogacy arrangements - legal aspects

Riitta Burrell, Adjunct Professor of Medical and Bio Law (University of Helsinki)[1]

I was asked to provide this statement in which I examine surrogacy arrangements in the frame of reference of the currently valid legislation. The first conclusion of this examination is that legal regulation of surrogacy would be difficult, if not impossible. This is due to the nature of surrogacy as an arrangement that produces expectations and meanings related to parenthood that are simultaneous but opposing. Surrogacy thus faces the legal system with an insurmountable task.

The second conclusion is based on a deontological argument. Surrogacy violates against human dignity, and we should make no effort to facilitate it by legal means.

The child born as a result of surrogacy arrangements is at the core of the examination. It is from the very presence of the child that the discussion on surrogacy arrangements derives its strong meanings which debates on such questions as organ donations or prostitution do not fully manage to evoke, even if both have their own links to surrogacy.

The term *biological mother* refers to a woman who is pregnant and gives birth to a child. The persons obtaining a child by means of surrogacy arrangements are referred to as the *intended parents*. The woman having donated the egg is the child's *genetic mother*.

1 Existing legislation in Finland

1.1 Determination of parenthood

Under the Paternity Act, paternity is determined either by a legal presumption of paternity, approval of paternity by the Local Register Office, or a court ruling based on an action for the establishment of paternity.

By virtue of the presumption of paternity, the Local Register Office enters the mother's husband as the child's father in the population register when the child is born during marriage. In other cases, paternity must be established either by acknowledgement of paternity made by the man and approved by the Local Register Office; by an action brought by a child, which is initiated on behalf of the child either by the mother or a child welfare supervisor; or by an action brought by the man having acknowledged paternity when the Local Register Office has not approved the acknowledgement.

Paternity based on the presumption of paternity may be annulled through acknowledgement of paternity if both the mother and the mother's husband accept the acknowledgement of paternity by another man. The legal paternity indicated by the presumption of paternity will also be defended against a man who regards himself as the child's biological father. In surrogacy arrangements, this means the following: If the child's biological mother is married, the intended farther of the child is not entitled to take an action to annul the paternity of the mother's husband, even if the intended farther were the child's biological farther.

If the biological mother is not married, the child's intended, biological farther may acknowledge his paternity similarly to any man. In this case, paternity may be approved if not contested by the child's biological mother. The intended father's legal paternity can only be acknowledged by the consent of the child's mother.

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[1] *The author is employed as a lawyer in the National Supervisory Authority for Welfare and Health Valvira. However, her statement was drawn up in the capacity of an Adjunct Professor of Medical and Bio Law, not as a Valvira civil servant. Valvira will provide its separate statement on the issue if requested to do so.*

According to an unwritten law observed in Finland, the woman who gives birth to a child is the child's legal mother. This legal rule is also applied when the child originates from a donated egg, and permitting surrogacy arrangements would not change this legal rule that has been in force from time immemorial. Maternity based on giving birth cannot be annulled or cancelled except by giving the child up for adoption.

1.2 Act on Assisted Fertility Treatments

Under Section 8 of the Act on Assisted Fertility Treatments, fertility treatment may not be provided if there is reason to presume that the child will be given up for adoption. This provision imposes a ban on surrogacy arrangements.

Surrogacy arrangements were banned in the Act on Assisted Fertility Treatments that entered into force in 2007, as according to the preliminary work on the act, the arrangement is associated with significant problems in principle and at the practical level:

> Permitting surrogacy may put a person who is asked to become a surrogate into a difficult position. If the person making the request is close to the prospective surrogate, refusing may be difficult. A pregnancy and a childbirth are always associated with health risks, and greater than usual risks of post-natal depression may be related to surrogacy arrangements. On the other hand, if a woman other than one who is close to the childless couple were used as a surrogate, permitting the arrangement could lead into a risk of commercial operation and economic exploitation. The parties may also change their minds during the arrangement. The mother giving birth may wish to keep the child and, on the other hand, the couple that originally wished for a child may give up the child, especially if their life situation has changed or the child is not born healthy. In other countries, there have also been cases where the woman, after giving birth, has handed the child over to a different couple, not the one with whom the surrogacy agreement was concluded and whose gametes had been used in the treatment. When the bill was being drafted, giving up fundamental principles related to motherhood was not considered possible. According to them, the woman who gives birth is the mother of the child, and she may only make a valid decision to give up the child at the earliest eight weeks after the birth. Compulsory enforcement to make sure that the adoption takes place as planned was not considered possible, either. A surrogacy arrangement would thus be associated with uncertainty of whether or not it will go ahead and with a risk of serious personal problems.

1.3 Act on the Status and Rights of Patients

The Act on the Status and Rights of Patients defines the patient as a person who uses health care services or is otherwise an object of them. As the patient in surrogacy arrangements is a pregnant woman who will give birth to a child, the provisions of this act on such aspects as self-determination and privacy will solely and fully apply to the biological mother.

Under Section 3 of the Act on the Status and Rights of Patients, the care of the patient has to be arranged so and he/she shall be treated so that his/her human dignity is not violated and that his/her conviction and privacy is respected. The intended parents may only be present at treatments or examinations, for example ultrasound imagings or the birth, by consent of the biological mother. Under Section 6 of the Act, the patient has to be cared for in mutual understanding with him/her. If the patient refuses a certain treatment or measure, he/she has to be cared, as far as possible, in other medically acceptable way in mutual understanding with him/her. Consequently, the wishes of the intended parents concerning the treatment cannot, under this act, influence decisions on the biological mother's treatment. For example, the intended parents cannot intervene in the lifestyle of the biological mother during the pregnancy on the grounds that they put the health or well-being of the child at risk.

Under the Act on the Status and Rights of Patients, a doctor or other health care professional may not give information contained by patient documents to outsiders without a written consent by the patient. In the case of surrogacy arrangements, the intended parents are outsiders referred to in the provisions on the confidentiality of patient documents.

1.4 Act on induced abortion

Under the Act on induced abortion (laki raskaudenkeskeyttämisestä, 239/1970) a pregnancy may, on request of the woman, be terminated in case one of the indications, or grounds for termination, referred to in Section 1 of the Act apply. Section 7 of the Act provides that, before making a decision on terminating a pregnancy, the father of the conceived child should be reserved a possibility to express his opinion on the matter, if this is considered appropriate. In other words, the father of the child may be consulted, but his opinion is not of decisive importance in making a decision on terminating the pregnancy. It should also be noted that according to the presumption of paternity referred to in the Paternity Act, the mother's husband is considered the legal father of a child born in marriage, not the intended father.

If it is found in tests carried out during the pregnancy that the foetus has an illness or a disability, a request to have the pregnancy terminated can only be submitted by the biological mother. If the biological mother, for reasons of her beliefs, refuses to terminate the pregnancy, for example in case that the foetus has been found to present trisomy 21 (Down's syndrome), the intended parents cannot demand that the pregnancy be terminated. On the other hand, the biological mother may have the pregnancy terminated up till the end of the 20th week for social reasons among others. The intended parents cannot prevent this procedure from taking place.

1.5 Adoption Act

Adoption means that the child is taken from his or her previous parents and becomes the child of the adoptive parents. Once the adoption has been confirmed by a court decision, the adoptive parents become the child's legal parents, and the legal parenthood of the previous parents expires. The adoptive parents then have the right as the child's guardians to make decisions about the child's care, upbringing, place of residence and other personal matters. After the adoption has been confirmed, the biological mother does not have a legal right to take part in making decisions on the child's care or upbringing.

A precondition for adoption is that the adoptive parents apply for adoption to a court of law. If, for one reason or another, the intended parents decide not to apply for adoption, the child remains with the biological mother. As mentioned before, maternity based on giving birth may only be annulled or cancelled by giving the child up for adoption. However, the biological mother may of course give the child up to be adopted by other persons than the intended parents.

A precondition for giving a child up for adoption as a rule is the consent of the child's parents, or the biological mother and her husband. The child's mother cannot give a valid consent to the adoption until she has recovered from the birth sufficiently, and never earlier than eight weeks after the birth. In other words, the mother cannot undertake to hand over the child to whom she gives birth for adoption in a legally valid manner in advance.

Under the Adoption Act, an adoption may not be granted if any remuneration for the adoption has been given or promised. This provision excludes the possibility of commercial surrogacy in Finland.

Only married couples can jointly adopt a child. Consequently, a cohabiting couple cannot adopt a child jointly; on the other hand, one partner may adopt the child alone, similarly to any unmarried person. Since the amendment to the Act on Registered Partnership in 2009, a partner in a registered partnership may adopt the child of his or her spouse.

No specific provisions on the right of an adopted person to be informed of his or her biological parents exist. Adopted parents have no obligation to tell the child that he or she has been adopted. However, an adopted child will unavoidably be informed of this fact, since adoption as the grounds for legal parenthood is shown in the population register information of both the child and the adopted parents. In addition, the child as an interested party basically is always entitled to be informed of a decision on adoption made by a court.

The precondition for granting an adoption is that the adoption is in the best interests of the child. This condition has been made more specific with the additional criteria of the child being well taken care of and brought up by the adopted parents in the Adoption Act. This additional condition for adoption is about anticipating the implementation of the child's best interests in the future. On the other hand, as a basic assumption it has been considered a precondition for implementing the child's best interests that the child's legal parents are his or her biological parents and that the child's established family situation is protected.

1.6 Child Maintenance Act

Under the Child Maintenance Act, the child is entitled to be maintained by his or her parents. This obligation is imposed on the child's legal parents. If the child's biological mother refuses to give up for adoption a child to whom she has given birth, the presumption of paternity makes her husband the legal father of the child who, together with the mother, is responsible for the child's maintenance. If the intended farther is, by the mother's consent, approved as the legal farther of the child, he is not released from his obligation to maintain the child even if the mother decided not to give up the child to the intended parents in contrast to the planned surrogacy arrangement.

2 Fundamental and human rights

2.1 Reproductive rights

The Finnish Constitution does not make specific reference to reproductive rights. On the other hand, the Constitution safeguards everyone's right to personal liberty, integrity and private life. According to the preliminary work on the Constitution, personal liberty is a general fundamental right that protects not only the physical liberty but also the free will and right to self-determination of a person. The right to personal integrity protects individuals against medical or similar interventions forcibly carried out. The protection of private life starts from the principle that an individual has the right to live his or her life without arbitrary or unnecessary interference in his or her private life by the authorities or other outsiders. Private life includes an individual's freedom to build and maintain relationships with other people and his or her surroundings, and the right to self-determination and determination over one's own body. The protection of private life also encompasses the protection of family life.

Reproductive rights, or an individual's right to make choices about reproducing, can be read in the aforementioned provisions of the Constitution. In the light of these provisions, reproductive rights mean that each person has the right to, freely and without outside interference, decide whether to have children, when, how many and with whom. The justification of such practices as contraception, abortion and fertility treatments has thus not even been seriously challenged in Finland. With the conditions and restrictions laid down in the Act on induced abortion and the Act on Assisted Fertility Treatments, they are part of reproductive rights, interference in which is an infringement of the right to personal freedom and the integrity and protection of private life enshrined in the Constitution.

So far, there has been no extensive discussion about the nature and content of the reproductive rights in Finnish legal works. The aforementioned fundamental rights – right to personal liberty, integrity and private life – are classical freedoms: they create a circle of freedom protected from outside interference around individuals. Section 19 of the Constitution, on the other hand, contains the so-called fundamental social rights. Under this section, the public authorities shall guarantee for everyone ade-

quate social, health and medical services and promote the health of the population. This provision is the foundation of the obligation to safeguard the provision of health services and the good health of the population imposed on public authorities. As unintentional childlessness is increasingly considered an illness, for the treatment of which society must on certain conditions reserve adequate resources, fertility treatments can also be considered fundamental social rights included in the obligations of the public authorities. From this, we cannot deduce that the government's obligation to safeguard health services would include fighting childlessness with all available means.

2.2 Human dignity

Under its Section 1, the Constitution of Finland guarantees the inviolability of human dignity and the freedom and rights of the individual and promotes justice in society. According to the preliminary work on the Constitution, this provision contains three fundamental values that underpin the entire constitution. Primarily, the provision expresses the value base of the Constitution, but it may also have direct legal relevance. For example, it may influence the interpretation of the actual fundamental rights provisions. The provision may also have an impact on assessing the acceptability of restricting the fundamental rights safeguarded in the constitution.

As a consequence of the evolving medical and bio law in particular, the idea that the concept of human dignity may restrict the personal freedom of individuals (self-determination) by imposing on them duties towards other people, themselves or the community has also become established in Finnish legal literature. This idea stresses the significance of human dignity in restricting the right to self-determination. It must be possible to restrict an individual's personal freedom in order to protect properties that have been considered typical of and valuable for the entire human species or, in a word, humanity. The interested party's own will no longer is considered decisive. The objectification of a human being cannot be tolerated, even if the person in question for some reason consented to it.

In this context, the Council of Europe Convention on Human Rights and Biomedicine is an important document. The principle of self-determination is of central importance in the Convention. According to Article 5 of this Convention, an intervention in the health field may only be carried out after the person concerned has given free and informed consent to it. However, the Convention strongly emphasises the principle according to which an individual may not be subjected to procedures that violate human dignity, even by their own consent. Article 21 of the Convention, for example, prohibits financial gain from the human body or its parts.

The heightened significance of human dignity can also be observed in other branches of law. In a Government proposal submitted to the Parliament in 2005, for example, it was proposed that the buying of sexual services be made into a criminal act. In this proposal, as the justification for criminalising the buying of sexual services was cited an effort to combat "the distorted image of sexuality resulting from prostitution and the buying of sexual services". In its statement on the government proposal, the Constitutional Law Committee of the Parliament noted that "the objectification of human beings as merchandise in the manner typical of human trafficking and procuring is a clear violation of human dignity."

Commercial surrogacy arrangements are referred to as womb rental. Womb rental is permitted in the legislative systems of such countries as India, Russia and certain U.S. states. Womb rental is particularly questionable from the perspective of the child born through commercial surrogacy arrangements. If the matter is examined from the perspective of the prospective surrogate mother, non-commercial, or so-called altruistic surrogacy arrangements are no less fraught with problems than commercial arrangements. Without overlooking the coercive nature of financial motives, we can say that in the context of the Finnish welfare society at least, they are irrelevant to the extent that a decision based on such motives can be made rationally. Friendship, family ties or other ties of affection, on the other hand, can be experienced as so obliging and personal that the woman asked to be a surrogate does not feel she can refuse.

Commercial motives are not a prerequisite for disapproving of the objectification of humans. Using a woman as a treatment method objectifies her and violates her human dignity, regardless of whether she is paid to act as a surrogate or not.

3 Other European countries

Surrogacy arrangements are prohibited in most European countries, including all Nordic countries. The authorities in at least four European countries have refused to recognize the legal effects of a surrogacy arrangement completed abroad, even in a situation where the principle of the child's best interest would have supported such recognition. Courts in France and Spain, for example, have declined to grant citizenship to children of their citizens who were born abroad through surrogacy arrangements. The German embassy in India has refused to grant German passports to children of German citizens who were born through surrogacy arrangements in India. In its ruling of 2006, the Swedish Supreme Court decided not to confirm an adoption in a case where the farther of a child who was born through a surrogacy arrangement in Finland refused to give his approval to the child being adopted by the child's intended (genetic) mother. The Supreme Court ruling was particularly harsh in the light of the child's best interest principle, as the child's biological mother and father were siblings.

Reproductive tourism of this type will result in difficult legal conflicts. If surrogacy arrangements were permitted in Finland, increasing flows or reproductive tourism would be directed to our country. In this connection, we should note the EU Directive that entered into force on 24 April 2011 (2011/24/EU) on the application of patients' rights in cross-border health care. The directive on patients' rights strengthens the patients' rights and improves their possibilities of receiving treatment in another member state. The member states were given a period of 30 months to transpose the directive into their national legislation. After the Directive has been implemented, it will in practice be impossible to restrict the persons entitled to treatment to persons permanently resident in Finland.

4 Conclusion

The first part of this review focuses on the harmful *consequences* of surrogacy. The second part is about surrogacy *as such*. Surrogacy is a violation of human dignity, regardless of whether we are talking about its commercial or non-commercial form. Humanity as a goal in itself is the first and most absolute value of the Western moral code, on which declarations of human rights are based. In 1997, the third working group appointed by the Ministry of Justice to consider fertility treatments proposed that surrogacy arrangements be permitted. The word choices of the working group are worth noting: the event where a woman becomes pregnant and gives birth on behalf of another woman was referred to as a "treatment" and the "use" of a surrogate. Surrogacy, or using a human being as a treatment, means objectifying a person in a manner that negates her humanity.[2]

Above I have examined the provisions of several acts with view to a situation where an amendment to the Act on Assisted Fertility Treatments would allow surrogacy arrangements. Should conflicts arise in a surrogacy arrangement, the aforementioned provisions could easily lead into an unreasonable end result for either the child's biological mother (and her husband) or the child's intended parents. As I mentioned at the beginning of my statement, the difficulty or impossibility of achieving good regulation on surrogacy arises from the nature of surrogacy as an arrangement that produces simultaneous but conflicting expectations and meanings concerning parenthood. By this I mean, above all, the expectation or argument that having a genetic child of their own saves the intended parents from suffer-

[2] *An effort is sometimes made to invalidate the argument concerning the objectifying nature of surrogacy by referring to organ donations: if surrogacy objectifies a woman acting as a surrogate, why is organ donation not seen to objectify the donor? Why would organ donations not represent the use of humans as a treatment in violation of human dignity? The only answer I have for this question is that a child is not an organ. The difference between donating an organ and donating a child is not just a difference of degrees.*

ing and, *at the same time*, having a child should be an almost meaningless event for the mother who gives birth to the child.

In my opinion, surrogacy should not be permitted in Finnish legislation.

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Surrogacy - a review of legislation in other countries

Anna Mäki-Petäjä-Leinonen

This review looks at surrogacy legislation in Sweden, Norway, Denmark, the Netherlands, Belgium and the United Kingdom. In the case of the Nordic countries, it also describes the positions of national ethics councils on surrogacy. To conclude, I look at Council of Europe recommendations on the principles to be complied with in legislation on fertility treatments.

1. Sweden

In Sweden, provisions on assisted fertilisation are contained in an act that entered into force in 2006 (Lag om genetisk integritet, 2006:351). There is no specific provision to ban surrogacy in Sweden, and donating eggs has been permitted since 1 January 2003. However, combining a donated egg with donated sperm is not permitted. Additionally, the woman having given birth to a child is regarded as the child's mother.[3]

On request of the government, the Swedish National Council on Medical Ethics (Statens Medicinsk –Etiska Råd) gave a statement titled ”Assisterad befruktning – synpunkter på vissa frågor i samband med befruktning utanför kroppen” (Assisted fertilisation - viewpoints on certain questions relevant to IVF fertilisation) in 1995. In this statement, the Council expresses a negative opinion on surrogacy. In spring 2010, the Council discussed assisted fertilisation from various viewpoints at the conference ”Assisted reproduction – 15 years on” organised by it. Since the Council issued its statement 15 years ago, a number of new solutions for treating childlessness had been achieved. New research and public debate had brought to the fore many ethical, social and legal questions that were discussed at the conference.[4]

Last year, questions of assisted fertilisation have been the subject of a lively debate in the Swedish media, and a great number of politicians and interest groups have given prominence to the issue. The Swedish Council on Medical Ethics is currently examining the issue and preparing a report on assisted fertilisation that also covers the question of surrogacy. The report is due for completion shortly. So far, the Swedish legislator has rejected demands to draft legislation on surrogacy.[5]

2. Norway

In Norway, provisions on providing fertility treatments and the use of gametes in fertility treatments are contained in the act on the medical use of biotechnology that entered into force in 2004 (lov om humanmedisinsk bruk av bioteknologi, 5.12.2003 nr. 100). The use of surrogates is expressly prohibited in Norway.[6]

The Norwegian Biotechnology Advisory Board issued an opinion on surrogacy in March 2011. A majority in the Advisory Board is critical about surrogacy and would prefer to uphold the prohibition in future legislative projects. According to a minority, surrogacy should be regulated, both nationally and internationally, and they feel positively about amending the national legislation. According to the minority, the act on biotechnology and legislation on children should further be amended to enable non-commercial surrogacy as a pilot project in Norway.[7]

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[3] *HE 3/2006. Government proposal to the Parliament concerning an act on fertility treatments and an act amending the paternity act.*

[4] *For the conference report in Swedish, visit the committee's website at www.smer.se*

[5] *Wesberg, Febe From the Swedish National Council on Medical Ethics (Statens Medicinsk –Etiska Råd).*

[6] *HE 3/2006. Government proposal to the Parliament concerning an act on fertility treatments and an act amending the paternity act.*

[7] *Bioteknologinemnda. Bioteknologinemndas uttalelse on surrogati. 23.3.2011. www.bion.no*

3. Denmark

In Denmark, provisions on fertility treatments are laid down in an act on assisted fertilisation in connection with medical treatment, diagnostics and research that entered into force in 1997 (lov om kunstig befrugtning i forbindelse med lægelig behandling, diagnostik og forskning m.v., 10.6.1997 nr. 460).[8]

While surrogacy has not been actually prohibited in Denmark, other provisions in the act prevent surrogacy arrangements. Commercial surrogacy, for example, carries a penalty under the criminal code. Private arrangements are not illegal as such, but legally binding contracts may not be concluded, and only the mother having given birth to a child can have guardianship, unless the authorities consider it in the child's best interest to award the guardianship to somebody else. In addition, doctors may not give fertility treatment to a woman who seeks such treatment in order to act as a surrogate.[9]

The Danish Council on Ethics gave its position on surrogacy in 2008. The Council opposes to commercial surrogacy activities and did not see it necessary to amend the legislation in force in this respect. [10]

4. The Netherlands

Surrogacy was permitted in the Netherlands in 1994, at which time a legislative amendment replaced a universal ban on surrogacy by a ban on commercial surrogacy.[11] The act offers the possibility of surrogacy to infertile or same-sex couples.

5. Belgium

While no act on surrogacy is valid in Belgium as yet, a legislative project to this effect has been pending for some years.[12] Regardless of a lack of legislation, however, arrangements concerning surrogacy have been implemented in Belgium.[13]

6. The United Kingdom

While surrogacy is not prohibited in the United Kingdom, it is restricted by a number of provisions. Advertising to find a surrogate, or to offer services as a surrogate, meets the characteristics of an offence. Commercial mediation of surrogacy services is also an offence. Additionally, surrogacy agreements are not legally valid in English courts, and consequently, legally binding surrogacy agreements cannot be concluded.[14]

7. Council of Europe

In 1989, the Council of Europe published a report on the provision of fertility treatments, which contains recommendations on principles to be complied with in legislation on assisted fertility treatments (Council of

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[8] *HE 3/2006. Government proposal to the Parliament concerning an act on fertility treatments and an act amending the paternity act.*

[9] *Louis Vingaard Jensen from the Danish Council on Ethics 3 May 2011.*

[10] *Det Etiske Råds udtalelse om rugemødre. http://www.detetiskeraad.dk/Aktuelt/Hoeringssvar-og-udtalelser/2008/21-05-2008-udtalelse-om-rugemoedre.aspx*

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[12] *Monique Bosson from the Belgian Advisory Committee on Bioethics (Comite Consultatif de Bioethique) 27 April 2011.*

[13] *HE 3/2006. Government proposal to the Parliament concerning an act on fertility treatments and an act amending the paternity act.*

[14] *http://www.surrogacyuk.org/whatissurrogacya.html*

Europe, Human Artificial Procreation, Information Document, Strasbourg 1989). According to this report, surrogacy should be prohibited. In exceptional cases, however, the member states could allow a woman to give birth on behalf of another woman. The woman carrying the child should not receive financial gain for helping a childless couple, however. In addition, a woman should have the right to decide whether she wishes to keep the child to whom she gives birth.[15]

[15] *HE 3/2006. Government proposal to the Parliament concerning an act on fertility treatments and an act amending the paternity act.*