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Medically Assisted Reproduction (MAR) on the move*

I. Reproductive Tourism: the phenomenon, its terminology and semantics

Crossing borders from one country (the "country of origin") to another (the "host country"), for the purpose of benefiting from medically assisted reproduction services (hereinafter "MAR") is generally referred to in international scientific literature as "cross-border fertility / procreative / reproductive tourism / travel"[1]. These terms have at times been criticised for being inaccurate as well as for being inappropriate descriptors of the phenomenon[2]. Those scorning the term for being inaccurate maintain that this practice does not really qualify as "tourism" since individuals (or couples) seeking to benefit from the use of MAR methods and techniques do not travel for entertainment purposes or pleasure. An exception to this is sex tourism, which does not qualify as procreative tourism anyway. Moreover, those who criticise the term on the grounds of inappropriateness point out that not enough emphasis is given to the issues of infertility or the difficulties individuals or couples face in gaining access to MAR; they also claim that the public is not aware of the fact that such people are *compelled* to travel / move, precisely as a consequence of such constraints. Under the circumstances, such movement is more like "exile" than "tourism". In the light of

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[1] "Reproductive tourism is the travelling by candidate service recipients from one institution, jurisdiction, or country where treatment is not available to another institution, jurisdiction, or country where they can obtain the kind of medically assisted reproduction they desire", see *G. Pennings*, "Reproductive tourism as moral pluralism in motion", J Med Ethics 2002 (28): 337-341 (p. 337).

[2] On objections to the terminology adopted, cf. inter alia R. *Matorras*, ''Reproductive exile versus reproductive tourism'', Oxford Journals 2005: 3751 (p. 3751).

such considerations, the term "reproductive tourism" is used in this report to correspond with that used in the international literature and in full awareness of the fact that it fails to do justice to the phenomenon and fails to reflect its true nature.

As far as the extent of the phenomenon is concerned, "reproductive tourism" has recently assumed vast proportions, a fact also demonstrated by the interest shown in it by scientific authors worldwide[3]. According to various estimates, in European countries alone – for which there are reliable statistics[4] – some 160 million citizens are refused access to MAR methods and techniques that require the use of third-party donated genetic material, as a consequence of the prohibition of heterologous fertilization under certain national legislations. As a consequence of this, some 80.000 couples are compelled to travel to countries other than those in which they habitually reside, in order to benefit from MAR services. In Europe alone, reproductive "cycles" attributed to such cross-border movements amount to some 24,000 – 30,000 per year.

The figures are equally impressive when viewed on a global scale: it is estimated that some 48.5 million couples around the world –i.e. 15% of the total population of this planet[5]- are facing fertility problems, while 5% of the births worldwide take place with the aid of MAR methods and techniques. In other words, some 5 million children have to this day come into the world through the aid of MAR[6].

II. The causes of "Reproductive Tourism"

There are many and various reasons why individuals and couples decide to travel from their country of origin to another country, in search of MAR services[7]. The cause as well as the motive for such cross-border movement can be found in the legislative (or, in

[3] Inter alia and only indicatively, cf. *S. Bergmann*, ''Fertility Tourism: Circumventive Routes That Enable Access to Reproductive Technologies and Substances'', Chicago Journals 2011 (36): 280-289, *M. Inhorn / P. Patrizio*, ''The global landscape of cross-border reproductive care: twenty key findings for the new millennium'', Curr Opin Obstet Gynecol 2012 (24): 158-163, *A. Donchin*, ''Reproductive Tourism and the Quest for Global Gender Justice", Bioethics 2010 (24): 323-332, *A. Ferraretti et al*., ''Cross-border reproductive care: a phenomenon expressing the controversial aspects of reproductive technologies'', Reprod. BioMed. Online 2010 (20): 261-266, J. Cohen, ''Procreative tourism and reproductive freedom'', Reprod. BioMed. Online 2006 (13): 145-146.

[4] The provision of reliable data is made possible by the existence of a European control mechanism. Cf. a recent report by the European Society of Human Reproduction and Embryology (ESHRE): ''Assisted reproductive technology in Europe, 2009: results generated from European registers by ESHRE'', Hum. Reprod. 2013: 1-14.

[5] Cf. the yearly Surveillance Report by the International Federation of Fertility Societies for 2013.

[6] Since 1978, the year of birth of the first child conceived through in vitro fertilization to this day, according to the relevant data providedby ESHRE. Cf. ESHRE's annual report for 2012.

[7] On this matter, see *Feraretti et al*., ''Cross-border reproductive care: a phenomenon expressing the controversial aspects of reproductive technologies'', *op.cit.,* p. 262 *et seq*. and *G. Pennings et al*., ''ESHRE Task Force on Ethics and Law 15: Cross-border reproductive care'', Hum. Reprod. 2008 (23): 2182-2184.

general, the regulatory) framework of each country, which, in respect of the subject that concerns us here, can differ so widely from country to country, even amongst countries which are geographically or culturally similar. In short, even in the case of European Union Member States, it would be quite difficult to find two legal orders that treat the MAR phenomenon in the same way, given that different social, ethical and religious perceptions are in principle bound to generate different legislations. Moreover, besides legislative restrictions, "reproductive tourism" is often caused by religious perceptions (possibly manifest in the form of prohibitions reflected in formal ecclesiastical texts as is, for instance, the case of the *Donum Vitae* by the Catholic Church[8]); equally, it may be due to psychological and/or social reasons. More specifically, those interested in embarking on "reproductive tourism" are impelled by a variety of motives, which are specified in the following sections.

1. Legislative Constraints

Legislative restrictions –i.e. prohibitions enshrined in law– constitute the commonest reason for persons or couples deciding to resort to "reproductive tourism". Apart from rendering access to MAR practices impossible, such legislative restrictions also provide for penal sanctions against those breaching the law. By means of such restrictions, national legislations regulate MAR by excluding, sometimes *explicitly,* sometimes *tacitly* (i.e. by avoiding regulation altogether), specific *objects* (*methods and techniques)* or *subjects* meeting specific conditions. More specifically:

(a) Concerning MAR *techniques and methods*

In this category fall those countries whose national legislations provide for an explicit and unconditional ban on the use of third-party genetic material within the context of heterologous fertilization, a restriction which, as a rule, also includes surrogacy. While the restriction on the use of third-party donated genetic material seems to have been relaxed in Europe in recent years (a recent example of such relaxation being that of Italy[9]), the prohibition of surrogacy remains to this day the rule, with the exception of only a few countries, one of which is Greece. Similarly, the prohibition of pre-implantation genetic diagnosis, until recently in effect under Italian law, has in practice ceased to be implemented,

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[8] See, inter alia, *M. Rodgers Bundren*, ''The influence of Catholicism, Islam and Judaism on the Assisted Reproductive Technologies (ART). Bioethical and Legal debate: a comparative survey of ART in Italy, Egypt and Israel'', U. Det. Mercy L. Rev. 2013 (715): 1-29 (p. 7 et seq.)

[9] In the wake of Ruling No. 162/2014 by the Italian Constitutional Court.

particularly in the wake of Italy's having been found to violate Article 8 ECHR[10]. As far as MAR techniques and methods are concerned, therefore, a kind of "liberalization" may be observed in the national legislations of EU Member States, thanks to the jurisprudence of the European Court of Human Rights (ECtHR), amongst other things.

Meanwhile, the debate at the European level has for some time now been focusing on the issue of the maintenance of donor anonymity. The principle of anonymity for donors of genetic material has been enshrined in the legislation of most European countries. Arguments in favour of anonymity mostly refer to the need to preserve the peace of the family, in the sense that such peace is safeguarded by excluding (or, at least, limiting) the possibilities of a lawsuit being initiated over the issue of paternity recognition , as well as to the need to dispel the reservations of potential donors of genetic material, who fear that, at some time in the future, they may find themselves faced with an obligation to assume parental duties towards one or several of their biological offspring.

Moreover, those advocating donor anonymity maintain that this regulation is compatible with the principle of socio-emotional kinship governing the entire MAR institution[11]. At the other end of the spectrum, those who are in favour of lifting the donor's anonymity argue that a child has the right to be informed of its origins, in the sense of having access to information relevant to its biological origins. Amongst other things, this argument seeks justification in the fact that children born through use of third-party genetic material will thus be protected from the risk of incest or of hereditary health conditions in the future[12]. In quite a few European countries (including Sweden, Switzerland, the UK and the Netherlands) there is a progressive shift away from the principle of anonymity, with national legislators placing themselves on the side of those arguing that it should be possible to reveal the identity of a donor. Anonymity of course still remains the rule, albeit with certain variations, as is, for instance, the case in Greek law, which allows for the disclosure of medical information to

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[10] Cf. *Costa and Pavan v. Italy* (Recourse No. 54270/0). Ruling handed down on the 28th August 2012, which is analysed in the following section.

[11] For more on the relevant argumentation, see (inter alia) *E. Kounogeri – Manoledaki*, ''Υποβοηθούμενη αναπαραγωγή με ξένο γεννητικό υλικό - Νομικά και βιοηθικά ζητήματα'' (Assisted Reproduction through the use of third-party genetic material), paper presented at the Conference of the Association for the Study of Medical Law and Bioethics, Dec. 11 -13, 2014 – Thessaloniki, also published in the relevant Conference Proceedings (p. 1-16)

[12] For arguments *a contrario*, see (inter alia) *Ph. Panagopoulou*, "Νομικοηθικές προσεγγίσεις της γνώσεως δότη γεννητικού υλικού" (Legal and ethical considerations on the issue of identification of genetic material donors), paper presented at the Conference of the Association for the Study of Medical Law and Bioethics, Dec. 11 -13, 2014 – Thessaloniki, also published in the relevant Conference Proceedings (p. 45-54)

children born through MAR[13]. Another issue, directly related to the question of anonymity, is that of the possibility of prospective parents being able to choose a donor. In other words, once the law of a given country imposes the rule of anonymity, there can be no question of allowing genetic material and/or the donor characteristics to be selected by prospective parents, since MAR clinics and cryopreservation banks are under an obligation to preserve the secrecy of such data on their records.

(b) **Concerning the *subject* of MAR**

Besides prohibitions of specific MAR methods and techniques, national legislations also adopt restrictions on access to Medically Assisted Reproduction for reasons relevant to marital status, gender, sexual orientation and the age of the subject.

i. In respect of *marital status*

In most European countries, not only (heterosexual) married couples have access to MAR, but also (heterosexual) couples living under a "civil union or registered partnership" arrangement, as well as (heterosexual) couples cohabiting in an open relationship. Under the circumstances, countries whose legal system generally bans unmarried people from access to MAR (for instance, France), appear to be the exception to the rule.

ii. In respect of *gender*

When it comes to access to MAR, most European legislations adopt the principle of gender equality. At the other end of the spectrum, there are countries where the legislator - either explicitly or tacitly has adopted provisions that discriminate against both genders, although the discrimination is not justified on the grounds of public interest, such as the need to protect f the child to be born or the need to safeguard the dignity of those participating in the process of Medically Assisted Reproduction. A typical example is the Greek legislation on the subject, which, whilst allowing single women access to surrogacy, remains silent on whether single men have the same opportunity, thereby giving rise to the possibility of contradictory opinions and even judicial decisions.

iii. In respect of *sexual orientation*

Legislation in various European countries tacitly allows all persons to have access to MAR, irrespective of their sexual orientation. In some countries, such as the Scandinavian

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[13] Article 1460 of the Greek Civil Code: "The identity of third parties who have donated their gametes or embryos is not disclosed to persons who wish to have a child. Medical information concerning the donor is kept confidential, without indication as to [the donor's] identity. Access to this information is only allowed to the child and solely for reasons relating to the said child's health. The identity of the child and the child's parents is not disclosed to the donors of gametes or fertilized eggs".

ones, Spain, Belgium and the UK, the law explicitly provides for the right of lesbians[14] to make use of MAR techniques. In any case, the issue appears to be more pronounced in the case of same-sex couples, since the genetic material of one sex is necessarily missing. In this particular case, the exclusion of same-sex couples from access to MAR –whether through an explicit provision in the law or tacitly, in the absence of an *ad hoc* provision– constitutes an unjustified act of discrimination on the grounds of sexual orientation. This is the case with Greek law.

There is an even more blatant contradiction in those countries where the cohabitation (whether under marriage or in the form of a registered partnership) of same-sex couples is legally recognised, but such couples are banned from the possibility of having a child through MAR.

This exclusion from access to MAR is only partially offset by the same-sex couple's ability to travel to another country. So, for example, a gay couple may travel to a country where single men may use surrogacy (e.g. certain US States) and thus be able to procreate but when they return to their home country, they will face the fact that the law will not recognise the biological father's partner as a parent of the child to be born. Similarly, a lesbian couple may travel to a country whose legislation allows single women and/ or same-sex couples access to MAR; and where donor anonymity may not even be obligatory, which means that it would be possible for one of the women to be fertilized with the eggs of her partner. However, upon return to the country of their origin, the couple will also face the prohibition of joint same-sex parenthood.

iv. In respect of *age*

In many national legislations there are minimum and maximum age limits regarding the right of access to MAR. Generally speaking, MAR is primarily intended to serve adults. As an exception to this rule, in some countries (e.g. Greece) the law allows minors' access to MAR methods and practices relating to cryopreservation of their genetic material, as long as they have been diagnosed for an illness likely to undermine their fertility.

On the other hand, maximum age limits may be found in some national legislations (Greece is here again an example, as well as the Netherlands, both of which have established a maximum age limit of 50) just as there are other countries that content themselves with a mere, generic reference to the "physical capacity of reproduction" (e.g. France and Spain). It

[14] On the other hand, the law in those very countries ban homosexual men from access to MAR, on the grounds of the law in such countries (with the exception / particular case of the UK) providing for the institution of surrogate motherhood.

is noteworthy, however, that in most countries, such maximum age limits only apply to women. Only in the case of France is there a maximum age limit applying to men.

2. Quality of MAR services

Just as important a cause of people wishing to procreate taking recourse to “reproductive tourism” is the quality of MAR services available in the “host country” compared to those available in the “country of origin”, combined with such factors as geographical proximity/accessibility (i.e. the distance factor) and the length of waiting time (e.g. waiting lists applying in State clinics) associated with the availability of the relevant services. More often than not, the quality of services provided is also associated with yet another parameter, namely that of previous abortive attempts/failed pregnancies. As a matter of fact, there are countries, both within and outside Europe, that possess an exceptionally well-developed network of MAR services, both in terms of applicable methods and techniques and in terms of their accessibility to those interested in such services, sometimes even over the Internet. Typical examples of European States providing high quality MAR services in combination with easy access – whether through private clinics or/and through the national health care system – are those of Greece and Spain, whereas the US, Russia and India have become the biggest MAR “markets” worldwide. In any case, these two factors (namely, the quality of MAR and the ease of access to them) do not necessarily concur, since ease of access (for instance, the possibility of ordering genetic material and/or of choosing a surrogate mother over the phone or the Internet) might be associated with a lack of State control, a factor eventually affecting the quality of services provided, thus increasing the risk of exploitation of those involved as well as of an eventual commercialisation of the procedure as a whole.

3. Cost of the “cycle”

Relevant to the quality of MAR services, as well as to the access to them, is the cost of the reproduction “cycle” in each country. Comparative data collected by competent organisations in Europe as well as internationally[15] have come to prove that MAR services are provided at a lower cost in countries outside Europe (mostly in India). Even within Europe, however, there are considerable differences in this respect even amongst EU Member States, given that the less wealthy of these States (particularly those which formerly belonged

[15] According to recent reports by ESHRE and IFFS.

to the so-called "East-European Block") have come to be "host countries" for MAR services. On the other hand, we have a paradoxical situation in which MAR services appear to be provided at a lower cost in such countries – always in comparison with the rest of the European countries – although these lower costs remain prohibitive for the nationals of these countries, which means that the latter are practically barred from access to MAR[16] in their own country. Admittedly, however, Greece has as of late come to feature amongst the popular destinations of "reproductive tourism", thanks to its tolerant legislation in this field, as well as to the fact that part of the cost of the "cycles" is absorbed by the national health system, provided the participants are citizens of an EU Member State, according to the relevant provisions in EU legislation, to be discussed below (Section III).

4. **Social and/or Psychological Reasons**

A final set of reasons are those referred to as "social and/or psychological ones", since many individuals set out for another country in an effort to prevent their social milieu or professional environment from finding out that they are about to take recourse to MAR methods and techniques. A couple's concern about their neighbours' and relatives' reactions ("what will people say or think?") should it be revealed that they are facing fertility issues is a matter of great importance, mostly in countries outside Europe (particularly Muslim countries, since in such societies the use of third-party genetic material is equivalent to adultery)[17]. Still, what apparently remains a "taboo" at the European level is the involvement of another woman (the surrogate) in the process, a fact reflected in the prohibition of surrogacy in almost all European States except Greece.

To sum up, it may be seen that in addition to an initial medical inability to reproduce (*medical infertility*), there may also, as a consequence, be an inability of a social kind (*social infertility*), produced by all the factors that constitute the causes of "reproductive tourism".

III. "Reproductive Tourism" within the European Union

As far as the EU Member States are concerned, not only is it impossible to prohibit reproductive tourism but in fact such tourism is reinforced by the structure and aims of the European Union, as these are expressed in both the primary and secondary legislation of the latter. More specifically, as far as European primary law is concerned, Articles 45 et seq. of

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[16] On this issue see, amongst others, *R. Storrow*, "Quests for Conception: Fertility Tourists, Globalization and Feminist Legal Theory". Hastings Law Journal 2005 (57): 295-330 (pp. 327-328).

[17] See *M. Aboulghar*, ''Ethical aspects and regulation of assisted reproduction in the Arabic-speaking world''. Reprod. Biomed. Online 2007 (14): 143-146.

the TFUE on freedom of establishment, as well as Articles 49 et seq. of the TFUE on the freedom to provide services[18], prohibit the preservation or institution of constraints on the freedom of movement, as well as instituting the right of EU citizens to have access to economic activities throughout EU territory. Consequently, as far as the citizens of the European Union are concerned, there may be no question of a prohibition on travel for the purpose of having access to MAR services, precisely because of the existence of a unified EU territory in which citizens may move and establish themselves freely, and may provide or receive services without hindrance. Such services may include health-related ones (including but not limited to MAR services), which belong to the domain of "economic activities".

This general precept of the Treaty has been supplemented by a multitude of more specific EU Regulations and Directives[19]. Directive 2011/24/EC issued in 2011 on the freedom of movement of "patients", a term understood to also include those aspiring to or benefiting from MAR services, for whom there is a provision for a right to compensation, which, however, is limited to the amount provided for in the country of origin. Also of relevance is Directive 2004/23/EC[20] on the "transportation of human cells and tissue", which deals with similar, though not identical issues, to those associated with MAR. Even so, this last Directive has prompted those States not possessing *ad hoc* MAR legislation to harmonize, by instituting the relevant provisions. Thus, there are States where MAR-related legislation has come to be passed in conformity with the terms of the said Directive, whereas in other States, MAR legislation had already been in place before the adoption of the said provisions at the EU level. A recent Directive (2012/25/EC) on transplantations[21] is also relevant .

Together with the adoption of secondary law by the competent institutions at EU level, the Court of Justice of the European Union has lost no opportunity to stress the fact that citizens of the various EU Member States are entitled to move throughout EU territory and benefit from health services, either because a particular treatment is still at the experimental stage and therefore not available in a particular Member State[22] or because a

[18] Cf. Chapter (2) of the Treaty on the Functioning of the European Union (TFUE).

[19] Cf. Regulation 1406/71/EC, as well as Ruling Nos. 120/95 and 158/96 by the Court of Justice in the cases *Kohll and Decker*cases, *ibidem*.

[20] Directive of the European Parliament and of the Council on "establishing quality and safety standards governing the donation, supply, control, processing, preservation, storage and distribution of human tissue and cells", transposed into Hellenic national law by virtue of Presidential Decree 26/2008.

[21] Directive of the European Commission of the 9th October 2012 on procedures for the notification of the exchange, amongst Member States, of human organs destined for transplantation, transposed into Hellenic national law by virtue of Law 4272/2014.

[22] CJEU, 12.7.2001, Case 157/99, *Peerbooms,* Jurisprudence 2001, p. I-5473.

treatment is not yet available in one Member State but may be readily available[23] in the territory of another Member State, or because a particular treatment may be provided in the territory of the host Member State at a lower cost[24] or even under more favourable conditions than in the Member State of origin[25].

From the above arises the question of *to what extent a social right to reproduction through MAR methods and techniques may be claimed to have been instituted at EU level.* The answer to this question is probably negative, at least as far as the current state of EU law is concerned, in the sense that no claim by interested parties to financially safeguarded access to MAR methods and techniques is recognised at EU level[26]. What, however, is recognised on the basis of the jurisprudence of the European Court of Justice is the economic right of EU citizens to travel to Member States other than their state of origin in order to benefit from health services (including services related to MAR) under more favourable terms and conditions and probably at a lower cost than those existing in the State in which they reside , given the fact that no obstacles may be imposed either on the freedom of movement or on the provision of cross-border economic services[27].

The answer to the question of *to what extent a right to reproduction through MAR methods and techniques has been established at the EU level* would nevertheless be different from the perspective of the Council of Europe, on the basis of the European Convention of Human Rights (hereinafter: ECHR). As a matter of fact, a right of this nature could indeed be justified by reference to the terms of Article 8 of ECHR on the protection of private and family life[28]. There are indeed several rulings handed down by the European Court of Human Rights endorsing, albeit quite discreetly, the view of a right to reproduction by MAR methods and techniques. More specifically:

In the case of *Evans v. the United Kingdom*[29], the Court held that the terms of Article 8 of the ECHR are understood to also include the right to decide whether to procreate through

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[23] CJEU 28.4.1998, Case 158/96, *Raymond Kohll v. Union des caisses de maladie*, Jurisprudence 1998, p. I-1931 and CJEU 13.5.2003, Case 385/99, *Müller-Fauré* and *Van Riet*, Jurisprudence 2003, p. I-4509.

[24] CJEU, 12.07.2001, Case 368/98, *Vanbraekel* ea., Jurisprudence 2001, p. I-5363.

[25] CJEU, 13.05.2003, Case 385/99, *Müller – Fauré, op.cit.*

[26] Cf. a recent ruling by the Court of Justice of the European Union whereby the Court rejected a request for extension of maternity leave of a working woman who had had a child through surrogate motherhood: *CJEU* 18.03.2014, Case 167/12, *CD vs. S.T.* , not published in the Court's Jurisprudence.

[27] Moreover, Articles (7) and (9) of the Charter of Fundamental Human Rights read as follows: Article (7) "Everyone has the right to respect for his or her private and family life, home and communications"; Article (9): "The right to marry and the right to found a family shall be guaranteed in accordance with the national laws governing the exercise of these rights".

[28] Article (8) of the ECHR: "Everyone has the right to respect for his private and family life, his home and his correspondence".

[29] Ruling handed down on the 10th April 2007 (Referral no. 6339/05).

the use of MAR or not. The Court chose to maintain the same stance in its ruling in the case of *Dickson v. the United Kingdom*[30], in which the Court held that the right of an individual to have a child by means of MAR methods and through use of one's own genetic material, falls within the scope of the protection of one's private and family life (Article 8 par. 1 of ECHR).

In the well-known case of *S.H. and others v. Austria*[31], two Austrian couples brought a case before the Court in which they protested about what they saw as an undue restriction on their right to private and family life, resulting from a ban on heterologous fertilization under Austrian law. The European Court of Human Rights held that such a ban under Austrian law did not violate the terms of Article 8 of the ECHR since – so the Court reasoned – in the absence of a general consensus amongst contracting States of the Convention as to the use of third-party genetic material, the Austrian legislator rightly had a wide margin of appreciation (*marge d'appréciation*) in evaluating the case and could therefore opt whether to adopt such a ban or not, given that such a ban was in effect at the time that the particular referral was pending before the ECHR, as well as being debated in several other countries, besides Austria. Interestingly, the ruling handed down by the Court in this particular case there was a minority of four members who accepted the appellants' claim that the ban under Austrian law constituted a violation of Article 8 of the ECHR, in that it unduly limited the right of the parties concerned to procreate by means of MAR and more specifically by taking recourse to heterologous fertilization (prohibited under Austrian law). In this particular case, the right in question was a purely individual right as there was no question of the state covering the cost that the parties concerned would have incurred; rather, the right concerned the freedom of access to MAR methods.

In the case of *Costa and Pavan v. Italy*[32], an Italian couple took recourse to the ECHR, claiming that the ban applying under Italian law with respect to PGD (pre-implantation genetic diagnosis) was placing the life of their future child at risk besides placing themselves, the parents, under acute emotional stress (on top of the mother's physical strain), since both parents in that case had been diagnosed as carriers of the cystic fibrosis gene, something they, understandably, had no wish to pass down to the foetus. The European Court of Human Rights upheld the appellants' claim, ruling that the ban under Italian law was inconsistent/incoherent, in the sense that whilst it prohibited pre-implantation genetic diagnosis of the fertilized egg – thereby obliging the mother-to-be to carry a foetus with

[30] Ruling handed down on the 4th December 2007 (Referral no. 44362/04).
[31] Ruling handed down on the 3d November 2011 (Referral no. 57813/00).
[32] Ruling handed down on the 28th August 2012 (Referral no. 54270/10).

health problems – it still allowed the pregnancy to be terminated on medical grounds, namely if during the pregnancy it was determined that the foetus was suffering from a certain condition. Besides, the "margin of appreciation" (*marge d'appréciation*) that the legislator had in instituting such a ban had to be considered in the light of the circumstances prevailing in other countries of the Convention, as far as the level of consensus amongst them was concerned. At the time the European Court of Human Rights was deliberating on the case, apart from Italy, none of the other 32 contracting States, except for Austria and Switzerland, provided for such bans, while in the meantime Switzerland had already taken the necessary steps to change its relevant legislation.

Last but not least, in the recent cases of *Menneson v. France* and *Labasse v. France*[33], two heterosexual French couples travelled to the US and had babies through surrogate mothers who had in both cases been inseminated with the husbands' sperm of the respective couples. In the US, the said French couples were legally recognised as the legitimate parents of the babies born through surrogacy. However, when they attempted to gain similar recognition t in France, the French authorities declined to have their babies registered as such, on the grounds that it violated the ban on surrogacy applying under French law. Both cases eventually ended up before the European Court of Human Rights, which ruled that the ban on surrogacy applying under French law did not constitute a violation of the terms of Article 8 of the ECHR, with regard to the right of parents to acquire children by this particular method; on the other hand, the refusal of the French Authorities to register the children after they had been born, constituted a violation of the said Article (i.e. Article 8 of ECHR) with respect to the children's private lives.

In summing up, whereas it appears that a right to reproduction by MAR methods and techniques cannot in all cases be inferred from the terms of Article 8 of the ECHR, certain bans applying under the national laws of contracting States with respect to those entitled to MAR or the permitted techniques and methods may ultimately conflict with the right private and family life consolidated under the Convention. A key criterion is consensus, or rather the tendency developing among the members of the Council of Europe, which determines a wider or narrower margin of discretion, which the Court gives to the contracting states that diverge from that tendency.

IV. The repercussions of "reproductive tourism" on the economy and society

[33] Ruling handed down on the 26th June 2014 (Referrals Nos. 65192/11 and 65941/11, respectively).

Reproductive tourism is a phenomenon that has repercussions *both on the law itself and on the economy and society as a whole.* Besides the criminal liabilities that the receipt of MAR services in one country is likely to incur in another country when these services are expressly prohibited by the legislation of the latter country, a multitude of civil and international private law issues arise with respect to nationality, kinship and inheritance, especially in the case of the use of third-party genetic material and most particularly in the case of surrogacy. Thus, a child born through the use of MAR runs the risk of ending up *parentless* (i.e. without legally recognised parents) as well as *stateless,* in those cases where the legal ban on particular MAR methods and techniques is accompanied by a negative attitude on the part of the national administrative authorities and/of the national courts towards a regulation, albeit *a posteriori* (i.e. after the child's birth) of the actual situation that has come into existence. .

On the other hand, so long as the reasons motivating people to cross borders in order to procreate persist, there will really be no means of preventing such movements. However explicit, no legal restrictions could really suffice, given that people embarking on "reproductive tourism", will find ways of "getting round", rather than violating the laws of their country of origin. Especially in the case of Member States of the European Union, cross-border travels within EU territory, no restrictions on "reproductive tourism" could ever really be imposed, since such restrictions would be tantamount to placing restrictions on the freedom of establishment or the freedom to provide services.

Considered from an economic perspective, cross-border movements within the EU (where a related obligation to cover costs incurred in the use of MAR services) constitute a burden on those states that essentially function as "host countries", as the national health systems of such states are called upon to pay the MAR-related expenses incurred by citizens of other Member States. The problem becomes even greater in the case of poorer states where national health care services are provided at a lower cost (this being obviously the case in Greece) and which are, as a consequence, more attractive in respect of the provision of health care services in general and of MAR services in particular.

Last but not least, even from a societal perspective, one cannot afford to disregard the fact that "reproductive tourism" functions as a "safety valve", providing conservative national legislators with an alibi. What it also does, however, is to preserve (if not at times exacerbate) existing economic inequalities amongst Member States, with citizens still being unable to gain access to MAR services and techniques whilst citizens from other financially stronger states, in search of such services, help to keep prices in a certain "black market", whether

within Europe (e.g. Bulgaria) or beyond (e.g. India), at a high level. Impossible though it is to handle this issue outside the EU, it is more than obvious that the problem must and should be tackled through harmonising the legal systems of different countries, at least within the territory of the European Union.