# Reactie op Wijziging van de Wet donorgegevens kunstmatige bevruchting in verband met tweede evaluatie, actieplan donorkinderen en omvorming Sdkb

Zelf ben ik donorkind en heb ik mijn donor opgespoord via genetic genealogy. De man bleek 10 jaar lang 3x in de week gedoneerd te hebben – dit betekent ongeveer 1000 halfbroers en/of -zussen (‘halfjes’ in het vervolg) die rondlopen! Veel te veel. De kans op blinde incest is heel erg groot! Niet alleen tussen halfjes onderling, maar ook tussen onze kinderen en halfjes, en onze kinderen onderling. En wat als halfjes ook nog eens donor worden in de toekomst!?

> ‘Consanguineous Relationships
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> Australia precludes consanguineous relationships on moral and biological grounds and prohibits them by the Australian Marriage Act (Commonwealth of Australia 1961, s 23). The current ability of donor offspring to know who their siblings and half-siblings are is severely hampered. Not only must they have been informed of their conception status, they must also have access to the identity of their donor’s biological children — born both “naturally” and via other donations. While current practice restricts the number of recipient families for one donor, for those conceived before restrictions were imposed there is concern about the possibility of a consanguine event, as records show that the number of donations for some donors exceeded several hundred (Donor Conception Support Group of Australia 2011). Thus, there is the very real potential for a donor offspring to have numerous siblings. A compounding factor for these children is that they are often born within a relatively short timeframe when compared to normal sibship construction, and birth generally occurs within geographical boundaries. Coupled with a sizable proportion of a person’s behaviour and other attributes being inherited, there is a possibility that these offspring could meet through vocational interests. There has since been very little achieved, apart from a reduction in the number of families assisted, to prevent consanguinity from occurring, even though this was recognised as a concern more than 30 years ago (Curie-Cohen, Luttrell, and Shapiro 1979). Exacerbating the problem is the possibility of **genetic sexual attraction** (Gonyo 1987; Greenberg1993), whereby kin who have been separated since birth or conception become attracted to each other due to shared similarities, which normally is quashed due to the Westermarck effect (Westermarck 1921) of cohabitation in early childhood. Removing cohabitation, as can occur in donor offspring, potentially also removes the kin recognition model of the persons involved and their aversion to consanguinity; this aversion is nonconscious and predicated by individuals’ cohabitation and not their beliefs (Lieberman, Tooby, and Cosmides 2003). The onus is then forced on the offspring themselves to ask all potential partners of their conception status and to possibly test them genetically to ensure that they are not related, provided that they know of their mode of conception themselves. The emotional and financial burdens of ensuring non-consanguinity is already being carried by donor offspring but is not being addressed by states or clinics that hold records that could prevent such an event from occurring. Recently, the concern has been highlighted by federal and Victorian inquiries (SLCAC 2011; VLRC 2012). **Knowledge of kinship reduces the total number of possible relationships a person is able to have when consanguinity is entered into the equation, even though the reduction in number is insignificant.** (..)’ (Adams, 2013, pp.376-377).

In de nieuwe wetswijziging komt er een wettelijk maximum van 12 moeders. Maar wat als deze allemaal 3 kinderen krijgen? Dan heb je alsnog 36 (!) halfjes in plaats van 25 (zoals het eerst was). Wat sowieso al teveel is. Elk halfje wat je niet kent en waar je niet mee opgroeit is al een teveel.

Daarbij kun je het niet controleren! Wie zegt dat een donor niet 'illegaal' zijn eigen sperma rondstrooit? Zoals in het boek Alle kinderen van Louis - Kamil BałUk (2018) ook is beschreven zijn er veel donoren die dit uit narcistisch oogpunt doen. Ze hebben een grootheidswaanzin en willen zoveel mogelijk nazaten. Er valt niet te controleren hoe vaak een donor zijn sperma buiten de Nederlandse klinieken aanbiedt. Of dit nou op de zwarte markt is of via een buitenlandse (vaak Deense) spermabank is… Het enige is, zoals Adams (2013) hierboven al schrijft, is door het testen van DNA. Er staat dan ook dat het aantal kinderen van 1 donor kan worden gecontroleerd door SDKB in de wetswijziging. Maar gaan ze dit controleren met DNA? Dat is namelijk het enige bewijs wat er ECHT toe doet – maar dan nog kun je andere verspreiding niet tegenhouden.

In de wetswijziging wordt gesteld dat halfjes op aanvraag met elkaar in contact gebracht kunnen worden (nu mag dat niet via SDKB). Ik wil hieraan toevoegen dat het absoluut van groot (soms van levensbelang) is dat ze in contact met elkaar MOETEN worden gebracht.

> 'Kinship Separation
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> All DC (donor conceived) offspring, irrespective of their knowledge of their conception, are separated from their next of kin on their donor's side. For some who are aware of their conception, **this loss has the potential to be traumatic**. The National Health and Medical Research Council (NHMRC), which provides the framework for clinic accreditation, states that a donor-conceived person is entitled to know his or her genetic parent(s) and stipulates that all clinics must not use donors unless they have consented to the release of identifying information (NHMRC 2004). This stance was reaffirmed by the Australian Senate Legal and Constitutional Affairs Committee (SLCAC) inquiry into DC practices. The SLCAC recommended that there be nationally consistent legislation ensuring the right of a donor-conceived person to access not only identifying information on donors but also donor half-siblings (SLCAC 2011). Clearly, the importance of and reverence to biological kinship is being valued at the level of governance. Additionally, the majority of offspring believe that they should know the identity of their donors (86 percent, Scheib, Riordan, and Rubin 2005; 87 percent, Mahlstedt, Labounty, and Kennedy 2010; 77 percent, Jadva et al. 2010) and also the identity of any halfsiblings (89 percent, Scheib, Riordan, and Rubin 2005; 78 percent, Jadva et al. 2010). The parity between the desire to know their progenitors and half-siblings exhibits the value that offspring put into all biological connections. Disc**ussion regarding offspring's right to genealogy has typically focussed on the donor and only rarely has included consideration of the entire genetic family, which has been shown to be equally important to DC offspring**. The search and desire for biological family is not borne out through poor sociological parent relationships (Mahlstedt, Labounty, and Kennedy 2010), thereby also highlighting the importance of genetic kinship to offspring. If the importance of biological kinship is indeed profound and an intrinsic component of who we are as humans—as suggested by the NHMRC and SLCAC —then surely the deprivation of this kinship is a failure to accept the child and the biological kin that make up the child's "complete" family, the entirety of who that child is. However, I argue that this is not necessarily a failure on the parents' part but rather one that has been forced upon them to a certain degree. As a general rule in Australia, a child will not be able to access identifying information on a donor until the age of 18, provided that the child has been informed of the conception and chooses to seek out this information. For offspring that may eventually know and meet their donor, the knowledge and interactions obtained may not completely erase their trauma. They may still suffer a lingering loss of not having shared a life together, of not having the intimate knowledge of each other that family members do, and of still feeling disconnected (Walker 2006). This deprivation of interaction with the donor(s) and associated

> kin (donor family) during a child's formative years has reduced the ability for that child to form relationships with them that would be analogous to those normally associated with the immediate family.(..).Parents who wish to provide their children with knowledge of the donor family are being prevented from doing so through bureaucracy (..)' (Adams, 2013, pp.373).

Opgroeien met elkaar is even belangrijk als in het geval van 'normale' broers en zussen. Ik stel dan ook voor dat er geen minimum leeftijd wordt gehanteerd voor relaties met halfjes – zo heb ik ALTIJD al mijn halfjes willen kennen (ik wist dat er (maximaal) 8 waren – was er gezegd door dokter Karbaat tegen mijn moeder). Hoe jong ik ook was, ik wilde het weten. En ik fantaseerde over wie het waren. Daarbij had ik als tienermeisje enorm veel angst om met jongens te daten, omdat ik gewoonweg niet wist of het straks mijn halfbroer zou zijn! (En die angst bleek terecht!). Daarbij heb ik op mijn 25ste een halfzus gevonden, die voelt als een zus. En we zullen nooit 25 jaar in kunnen halen. Dit voelt voor mij als een heel groot verlies.

> 'Loss of Identity
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> Loss of kinship can equate to a loss of heritage and is also associated with identity loss (Weigert and Hastings 1977). Adolescence is a critical time for a person in terms of identity formation: It is the transition to adulthood and is often highlighted with confusion (Erikson 1968). The absence of one or both biological links clouds this process by removing the mirror in which we see ourselves, our looks, our personality and behaviour that are evident in our progenitors and our kin. When approximately 41 percent of our behaviour is inherited (Malouff, Rooke, and Schutte 2008), this is a substantial mirror missing from these offspring's lives. The right to an identity is as much about not being deceived as it is about knowing the truth of one's origins (Freeman 1996). **Discovering and even meeting one's progenitor(s) after the age of 18 is potentially too late to avoid the damage associated with forcibly removing vital components of a person's identity. These factors contribute to genealogical or genetic bewilderment (Sants 1964), resulting in a person whose own identity and place in the world remains unclear to him or her, putting that person in a perpetual state of identity limbo**. The genetic void created by lack of information about biological parentage is not in a person's best psychological interests (Cooper and Glazer 1994). Not only do most offspring feel a strong need to know the identity of their donor(s) but, according to Mahlstedt, Labounty, and Kennedy (2010), 62 percent would also like to meet him and/or her at least once. Curiosity concerning donors appears to slightly outweigh the need for identification, with 96.6 percent of offspring studied by Scheib, Riordan, and Rubin (2005) desiring a picture of their donor and 89.7 percent wishing to know other non-identifying information such as vocation, marital status, and children. Since this study focused on teenage offspring, findings suggest that curiosity about donors is intrinsically a component of the identity-construction process during adolescence. It could be postulated that the discrepancy between figures of curiosity about donors and actual knowledge of their identities is the result of the imprinting onto and conditioning of many offspring under current and previous ideological climates as to having to feel grateful for their existence, to carry an existential debt (described by Rushbrooke 2004 and Rose 2009), not wanting to interfere with a donor's life, and for fear of hurting the feelings of their raising parents (Lorbach 2003). **One assessment of the harm of identity loss is that it runs in parallel with the harm of kinship loss. The two harms are linked through the lack of knowledge and interaction with the child's donor family**, (..). An alternative approach is that if the parents let the child's identity develop freely rather than wilfully force an identity construct on the child (i.e., tell the child early about the DC), then they are being accepting of who the child chooses

> to become (..), even though the identity and the paths the child may choose to take may be different if they had access to the donor family.’ (Adams, 2013, pp.374)

Wat heel erg mist in de nieuwe wetswijziging is dat donorkinderen nog steeds compleet afhankelijk zijn van hun ouders om hen in te lichten (en de overheid dus gegevens over je heeft verzameld waarvan je nooit op de hoogte gesteld wordt dat zij deze hebben). Het kind MOET op de hoogte worden gesteld van zijn/haar conceptie naar mijn idee – bijvoorbeeld door een vermelding op de geboorteakte en zelfs met een verplicht informerend gesprek met de schoolarts/psycholoog (?) op de basisschool. En het kind MOET in contact worden gebracht met halfjes en informatie over de donor krijgen, zowel over zijn achtergrond als medische achtergrond (en dat moet up to date zijn!).

> ‘Deception of Their Origins
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> Current practice in Australia centres around identity release donors and encouragement of the recipient couple to tell the offspring about their conception and to tell them early (Johnson and Kane 2007). **Yet studies (Golombok et al. 2002; Broderick and Walker 2001; Brewaeys et al. 1997; Rumball and Adair 1999; Lycett et al. 2005) reveal that the majority of parents are unwilling to disclose and prefer to keep the secret**. Nondisclosure is typically coupled by a belief that the child does not need to know and that keeping the secret protects the child (Murray and Golombok 2003). During the infancy of DC practice, the trend was to use anonymous donation and for recipients not to tell. Irrespective of the period in which they were conceived, the majority of donor-conceived people will therefore not be aware of their DC status. **The freedom for parents to parent as they see fit, which also includes the choice to disclose, is something that governments are extremely disinclined to legislate.** Certainly the Victorian Law Reform Committee (VLRC 2012), in its inquiry into donor conception, was reluctant to recommend the forcing of parents to inform their children of their DC status, even though the committee felt that such knowledge was in the child’s best interest. **Under current practice, most offspring will never seek information about their progenitor(s) because they will be deprived of and shielded from the truth**. Parents who have initially decided not to tell may change their minds in the future, disclosing their child’s method of conception (Daniels, Gillett, and Grace 2009). Parental attitudes toward disclosure over the years has changed considerably, with the majority during the 1980s and 1990s intending not to tell (Leeton and Backwell 1982; Milsom and Bergman 1982; Klock, Jacob, and Maier 1994; Durna et al. 1997) while more recent evidence has seen a reversal in this view (Godman et al. 2006; MacDougall et al. 2007; Shehab et al. 2008). Intent, however, does not always lead to actual disclosure, even within families that support truth-telling (Blyth and Ryll 2005), and the majority are still not disclosing (Freeman and Golombok 2012). The freedom of parents who choose not to inform and, thus, deceive their offspring about their conception potentially creates a psychologically and socially harmful environment that is ethically unacceptable (Landau 1998), as well as a level of dysfunction in the family (Paul and Berger 2007). While improvements are being made in the realm of disclosure, at the ethical and moral heart of the matter is that if children are deceived then “they are being wrongly treated” (Warnock 1987, 151). There is an argument that if the children are deceived about their origins then there will be no harm caused to them. Cowden, however, argues that the concept of “no harm, no foul” (a term she uses to describe this) should not apply and that openness facilitates the respect that offspring deserve (Cowden 2012, 122). **When donor-conceived people have been asked whether they believe they should be told the truth of their conception, the majority do feel this way** (Jadva et al. 2009), suggesting that not only should openness be practiced as a matter of principle but also that it is how donor-conceived people wish to be treated. The origin of a person is central

> to who they are. It is the story of their coming into being. If parents choose to deceive the child of his or her origins, I postulate that they are not entirely comfortable with the notion that the child is not biologically related to one or both of them and therefore they have not completely accepted the entirety of the child and everything the child represents. The child may be seen as a reminder of their infertility (..). (Adams, 2013, pp.372-373).

En waarom heb ik het over basisschool leeftijd?

> ‘Late Discovery
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> A compounding aspect is late discovery, whereby offspring who find out in adulthood—through open disclosure or extreme circumstances such as arguments or after the death of a parent—have altered perceptions of identity and family, creating great distrust, confusion, feelings of deceit, and possibly anger between themselves and those who withheld the truth from them (McWhinnie 2000; Turner and Coyle 2000). **It has been reported that less damage may occur if the child is told of his or her conception at an early age** (Hewitt 2002; Jadva et al. 2009), **before the identity-construct window of adolescence occurs** (Kirkman 2003). The emotional trauma associated with late discovery is similar to that occurring in the adoption community and may remain unresolved for several decades post-disclosure (Riley 2009). It is clear that some offspring have difficulty assimilating this newfound information and dealing with the changed family and identity constructs that they had previously formed. A substantial argument is that if the donor-conceived person wasn’t told of his or her conception then the harm would be avoided; however, this fails to satisfy Cowden (2012) and the offspring themselves. (..)’ (Adams, 2013, pp.374).

In de wetswijziging wordt de werkwijze rond medische gegevens veranderd (niet meer basisgegevens aandragen maar wel meer verplichting om te melden en alle betrokken ouders in te lichten). Hier wil ik aan toevoegen dat de medische gegevens MOETEN worden aangedragen aan het KIND (en diens medisch achtergronddossier bij de huisarts) en up to date moeten zijn. Zo is een halfzus van mij jarenlang bezig geweest met uitzoeken wat er medisch gezien met haar aan de hand was. Pas toen ze ons gevonden had (en er een stuk of 6 halfjes mee werkten aan het onderzoek bij de klinisch geneticus) kon ze een diagnose krijgen. Daarbij heb ik zelf ook een hele heftige auto-immuunziekte – en graag zou ik mijn andere (1000) halfjes ook op de hoogte willen stellen van dat ze deze ziekte(s) met zich meedragen. Deze verantwoordelijkheid moet niet bij de donor liggen om door te geven – onze donor claimt ‘kerngezond’ te zijn en ontkent alle genetische ziekten.

> ‘Incomplete Medical Histories
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> All offspring have incomplete medical histories in some form. Believing that a nonbiological parent is in fact one’s progenitor is disadvantageous in any clinical setting and can result in poor diagnosis. **Even when offspring are aware of their conception, an incomplete medical history through either having no access to a progenitor’s medical history or access to one that is outdated also creates problems for any consulting physician.** This lack of knowledge has serious implications for early diagnosis (Hastrup 1985; Centers for Disease Control and Prevention 2004) as well as lifestyle choices for the offspring. Reports of how this can adversely affect a person’s health prospects were highlighted in the VLRC inquiry, which showed that in 2011 there were three incidences of a donor or DC person unable to pass on medical information to those directly affected and, in one instance, a person was diagnosed with a terminal illness that possibly could have been screened and treated at an earlier stage if a health history had been available (VLRC 2012). Theoretically and evidentially there is a strong case for the provision of medical information to DC individuals. This is also mirrored in data

> that show that the majority of those conceived through DC desire updated medical history of their donor(s) for their own physical health (Hewitt 2002). For those who are unable to obtain medical information, some are resorting to expensive and, in many instances, inconclusive genetic health analyses to provide some familial health history and enable lifestyle and other choices to be made (Adams and Lorbach 2012). Some dispute that the previously mentioned harms are sufficient grounds for altering the current paradigm. For example, one argument is that nondisclosure will not lead to negative outcomes provided that the child never knows about his or her conception and is raised in a loving home. The nondisclosure effect postulation is difficult to determine empirically from studies of offspring unaware of their conception, due to the problem of unethical treatment of study participants who are unaware of why they are being studied. Additionally, in psychological and emotional well-being studies there can be a wide range of outcomes, thus raising doubt. It is difficult to envisage, however, that the deprivation of a medical health history can ever be viewed as justified in light of current understanding of how genetics can influence our physicalwell-being. (..) as the child's ability to flourish and remain in a physically healthy state can be severely hampered without knowledge of a complete familial health history. Interestingly, while the majority of donors have for some time agreed to the release of medical records (Robinson et al. 1991; Mahlstedt and Probasco 1991),there is yet to be a system put into place to ensure that these records are updated and that vital information is disseminated to offspring and recipient parents (..)' (Adams, 2013, pp.375).

Verder is het nog maar de vraag of donorconceptie – de medische ingreep – wel goed is in zichzelf. Dit inzicht komt niet terug in de wet(swijziging) en stip ik graag nog even aan.

> 'Physical Harms
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> Robertson (1983) describes conception as usually not being harmful in itself and therefore it could be argued that DC should be a procreative freedom if it is not harmful. However, Robertson's argument was written during a period where our medical knowledge of conception was rather limited compared to now. For example, preeclampsia (hypertension during pregnancy) is a leading cause of foetal and maternal morbidity and mortality (Backes et al. 2011). **There is an increased risk of preeclampsia among in women who have become pregnant with the assistance of donated gametes or embryos (**Smith et al. 1997; Salha et al. 1999). These studies show that there is an underlying immune response to becoming pregnant with an oocyte that is not one's own and to being impregnated with sperm that is not from one's partner. This is supported by additional evidence whereby further exposure to the same donor sperm reduces the risk of preeclampsia, as the immune system has become tolerant of the novel antigen (Kyrou et al. 2010). Current DC practice involves the use of frozen gametes so that appropriate screening of donors for transmissible diseases and certain genetic conditions can be undertaken. The mere manipulation of sperm in the laboratory introduces DNA fragmentation (Toro et al. 2009), as do cryopreservation (Zribi et al. 2010) and the thawing process (Gosálvez et al. 2009). This sperm DNA fragmentation results in poorer embryo quality as well as poorer fertilisation and pregnancy rates (Simon et al. 2011). In some instances, sperm DNA damage can be repaired after fertilisation but it can also persist (Yamauchi, Riel, and Ward 2012), suggesting that these changes can be carried on into the resulting embryo or child. As cryopreservation induced DNA damage is primarily mediated by oxidative stress (Thomson et al. 2009), and oxidative stress-induced damage is linked with childhood cancer and may make male offspring infertile themselves (Aitken and Krausz 2001), there is considerable cause for concern. Large-scale DNA damage may result in either

> nonfertilisation or failure of the embryo to develop properly —therefore not being carried to term (Robinson et al. 2012).However, given that single base changes in DNA (single nucleotide polymorphisms) can result in increases in the incidence of outcomes such as autism spectrum disorders and schizophrenia (Kong et al. 2012), the effect that small-scale DNA changes can have on the resulting child should not be underestimated. The physical long-term health effects on people conceived using donated gametes is somewhat unclear and further research needs to be conducted. What is apparent is that Robertson's broad procreative freedom is too broad, because his assumption that conception usually causes no harm and that the risk is speculative is flawed, as the aforementioned potential physical harms occur during the conception processes associated with DC. While outcomes such as preeclampsia can be treated, the incidence of preeclampsia occurring in the next generation is also increased (Esplin et al. 2001), and the resultant child has an elevated risk of developing cardiovascular disease and diabetes in adulthood (Simmons 2009). The effects of conception can have far-reaching and longterm effects with what is now a widely accepted concept known as the foetal origins of adult disease (Barker 1990). (..).' (Adams, 2013, pp.375-376).

Aanvullend wil ik de gevolgen van draagmoederschap – in het geval van eicel en/of sperma donatie en dat het donorkind gedragen wordt door een draagmoeder – aanstippen, zoals is besproken in de vierdelige documentaire serie De Babyindustrie (KRO/NCRV). Wat sowieso een goede serie is wat betreft de praktijken van wensouders en de gehele fertiliteitsindustrie erachter https://www.npostart.nl/de-baby-industrie/KN_1697684

En dan hebben we het nog niet gehad over de steeds meer (neuro)wetenschappelijke gronden en onderzoek naar ***genetic memory*** over het doorgeven van trauma's etc. die niet kunnen worden geplaatst in het geval van het niet kennen van (de helft) van je sociale achtergrond. Het is ook niet enkel je donor die donorkinderen wordt ontnomen. Het is zijn (of haar in het geval van eiceldonatie) hele stamboom! Je opa en oma van donorskant en diens familiaire achtergronden.

Wil ook graag het internationaal kinderrechtenverdrag nog even aanstippen! We hebben dit als Nederland niet voor niks ondertekend. In mijn redenering gaat donorconceptie geheel tegen artikel 9 bijvoorbeeld in. Donorconceptie is het scheiden van het kind van zijn biologische ouder nog voor de verwekking!

> **Artikel 9: Scheiding van kind en ouder**
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> **1. De Staten die partij zijn, waarborgen dat een kind niet wordt gescheiden van zijn of haar ouders tegen hun wil, tenzij de bevoegde autoriteiten, onder voorbehoud van de mogelijkheid van rechterlijke toetsing, in overeenstemming met het toepasselijke recht en de toepasselijke procedures, beslissen dat deze scheiding noodzakelijk is in het belang van het kind.** Een dergelijke beslissing kan noodzakelijk zijn in een bepaald geval, zoals wanneer er sprake is van misbruik of verwaarlozing van het kind door de ouders, of wanneer de ouders gescheiden leven en er een beslissing moet worden genomen ten aanzien van de verblijfplaats van het kind.
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> 2. In procedures ingevolge het eerste lid van dit artikel dienen alle betrokken partijen de gelegenheid te krijgen aan de procedures deel te nemen en hun standpunten naar voren te brengen.
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> 3. De Staten die partij zijn, eerbiedigen het recht van het kind dat van een ouder of beide ouders is gescheiden, op regelmatige basis persoonlijke betrekkingen en rechtstreeks contact met beide ouders te onderhouden, tenzij dit in strijd is met het belang van het kind.

> 4. Indien een dergelijke scheiding voortvloeit uit een maatregel genomen door een Staat die partij is, zoals de inhechtenisneming, gevangenneming, verbanning, deportatie, of uit een maatregel het overlijden ten gevolge hebbend (met inbegrip van overlijden, door welke oorzaak ook, terwijl de betrokkene door de Staat in bewaring wordt gehouden) van één ouder of beide ouders of van het kind, verstrekt die Staat, op verzoek, aan de ouders, aan het kind of, indien van toepassing, aan een ander familielid van het kind de noodzakelijke inlichtingen over waar het afwezige lid van het gezin zich bevindt of waar de afwezige leden van het gezin zich bevinden, tenzij het verstrekken van die inlichtingen het welzijn van het kind zou schaden. De Staten die partij zijn, waarborgen voorts dat het indienen van een dergelijk verzoek op zich geen nadelige gevolgen heeft voor de betrokkene(n).

En vanuit artikel 9 samen met artikel 35 kun je ook niks anders concluderen dan dat het (wereldwijd) verhandelen van (bijvoorbeeld Deens) zaad of (Roemeense) eicellen eigenlijk een pre-conceptuele vorm van mensenhandel is.

> Artikel 35: Ontvoering, verhandeling en verkoop van kinderen
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> De Staten die partij zijn, nemen alle passende nationale, bilaterale en multilaterale maatregelen ter voorkoming van de ontvoering of de verkoop van of van de handel in kinderen voor welk doel ook of in welke vorm ook
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> Bron https://www.kinderrechten.nl/verdragstekst/

Met alle bovenstaande punten rijst de vraag: kan het überhaupt wel ooit goed gereguleerd worden? Nationaal denk ik niet – de mensenhandel in eicel en sperma is dusdanig internationaal dat enkel een Nederlandse wet hier niet veel in gaat borgen. De wetswijzigingen zoals nu opgeschreven zijn in mijn ogen ook niet verregaand genoeg. Maar is het verder internationaal tegen te houden? Ik denk dat eerlijk gezegd ook niet. Het blijft dat er kinderen opgroeien zonder hun roots te kennen - met alle psychische en soms ook medisch lichamelijk schadelijke gevolgen van dien. Mijns insziens moet donorconceptie daarom in zijn geheel verboden worden.

> ‘(..) Somerville (2007) argues that children from reproductive technologies such as DC have been failed by the processes that create them, in that many of the possible consequences to the child have been neglected because children are desirable objects and a component of big business. This argument shows how freedom of procreation coupled with deep-rooted desires to procreate can be utilised for commercial gain while ignoring the actual “product” that they create. When balancing the opposing rights of individuals or parties, ethically we should provide protection to the party that is most vulnerable. In donor conception this is the child, as recognised through legislation and regulation. In the issue of welfare, the child’s rights must take precedence and override those of the adults (Gollancz 2001). While it may be argued that some children are naturally born into scenarios where they may be equally disadvantaged, this does not automatically provide ethical approval of harms or the justification of children being a means to an end in a state-sanctioned manner (Laing and Oderberg 2005). Chisholm (2012) describes this means-to-an-end argument as being in conflict with the Kantian principle—the principle of humanity—in which people should always be treated as ends in themselves. Privacy concerns and other agendas of the adults involved should be outweighed by the possible negative consequences of withholding such information, which also violates the offspring’s autonomy (McGee, Brakman, and Gurmankin 2001). Such a moral countenance supports reconceptualisation of the donor conception paradigm. While some legislative efforts have been enacted to cater for the welfare of offspring and their right to a genetic heritage and knowledge of their progenitors, these efforts have been suppressed to cater for the

> desires of the infertile (van den Akker 2006). Public funding of fertility treatments imposes a greater level of responsibility than would otherwise occur due to the community investment and the intentionality of the process; thereby, the principle of duty of care and the welfare of the child should indeed restrict freedom of choice in DC reproduction. It could be argued that, no matter how much the paradigm was reconceptualised toward a child-centric model, there will always be some children who will be unhappy or harmed by their method of conception and that therefore the whole practice of DC should be banned and this procreative freedom/choice be prohibited. Such arguments are counterproductive, as DC has been in practice for a long time, has been accepted by a large portion of Australian society, is entrenched as a common fertility treatment, and is enshrined in legislation and regulation as an acceptable procreative freedom. However, due to the child welfare paramountcy principle, these freedoms do not have to follow the broad Robertson definition with an "anything goes" approach, but rather there is an intrinsic legal obligation of the states to ensure that an appropriate paradigm is implemented that acknowledges this freedom but constrains it, not only in the interests of child welfare but also in the interests of the parents to allow them to be as virtuous as possible. As such, a child-centric model has the potential to improve the outcomes for not only the child but also the parent' (Adams, 2013, pp.378).

Op dit punt ben ik het niet helemaal eens met Adams (2013). Ja er moet een child centered approach komen om naar te streven als eerste (en broodnodige) stap. En dit mist in de nieuwe wetswijziging. Het draait nogsteeds om het 'recht' van de wensouders voor een kind en het belang van het kind staat niet (genoeg) voorop. En dat iets zo moet blijven omdat het 'normaal' is en omdat er veel mensen achter staan, wil nog niet zeggen dat het niet verboden moet en kan worden. Alleen al denkend aan slavernij bijvoorbeeld, hoop ik dat wij ook in de toekomst anders gaan kijken naar de praktijken rondom donorconceptie.

Literatuurverwijzing

Adams, D. (2013). Conceptualising a Child-Centric Paradigm. Do We Have Freedom of Choice in Donor Conception Reproduction? Bioethical Inquiry, 10, p.369–381. DOI 10.1007/s11673-013-9454-7