Fertilize-this: framing infertility in Quebec, Ontario and England between 1990 and 2010

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À ma famille qui me donne des racines et des ailes.
Grâce à vous, cette aventure aura été une belle histoire.
Je vous aime infiniment

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ABSTRACT AND KEYWORDS

Infertility politics implies a role for the state in regulating the relationships between different parties involved in the medicalized process of reproduction, namely would-be-parents (infertile couples or individuals), gamete donors, surrogate mothers, fertility specialists, etc. Policies adopted by the Canadian federal government in 2004 as regards assisted reproductive technologies (ARTs) were largely inspired by British regulations. Despite this similar start, Canadian policies never lead to implementation; the province of Quebec rapidly contested the federal Assisted Human Reproduction Act before the courts; and many issues of assisted conception were regulated in a heterogeneous manner by the provinces. Meanwhile in Britain, the implementation of the policies created many disparities among the regions of the country; the principle of the law was thoroughly contested and scrutinized; and the sites of deliberation were multiple in spite of the existence of a national regulatory agency. First, the author argues that assisted reproduction technologies cannot be taken as one policy domain, but is an umbrella label for a variety of policy issues. In that context, ARTs are unpacked in order to study, at the system level, the practices related to the overcoming of infertility. I focus on three sub-issues: access to fertility treatments, including the question of public funding and access criteria; gamete and embryo donation, including the question of filiation and donor conceived children's right to know their biological origins; and surrogacy or the enforcement of pre-natal gestational surrogacy arrangements. Second, by mapping the variety of discourses and arenas mobilized by a range of actors, this study shows how framing and reframing dynamics influence public policies and their implementation. Third, by comparing frame mobilization and discursive dynamics between Quebec, Ontario and England this analysis demonstrates how frame alignment can be a necessary condition for a frame to be performative and influence policy outcomes. Depending on the context in which it occurs, frame transformation, amplification, extension or bridging can induce stability or trigger a cascade of events that will lead to policy change or to a change in the implementation of a policy.

Key words: infertility, assisted reproductive technologies, access to fertility treatments, gamete donation, surrogacy, donor-conceived children, framing, frame alignment, frame reflection, policy implementation, policy-making process, discursive mechanisms, epistemic communities, frames performativity, policy arenas, Quebec, Ontario, England, Canada, United Kingdom.

RÉSUMÉ ET MOTS CLÉS

Les politiques de l’infertilité impliquent l'État dans la gestion des relations entre les différentes parties impliquées dans la procréation médicalement assistée (PMA), à savoir les parents d’intention, les donneurs de gamètes, les mères porteuses, les spécialistes de la fertilité, etc. La loi sur les technologies reproductives adoptée par le gouvernement fédéral canadien en 2004 a été largement inspirée par la réglementation britannique. Malgré ce point de départ semblable, la loi fédérale sur la procréation assistée n’a pas été mise en œuvre, la province de Québec l’a rapidement contesté devant les tribunaux, et de nombreuses questions en lien avec la PMA ont été réglementées de façon hétérogène par les provinces. Quant à elle, la mise en œuvre des politiques en Grande-Bretagne a créé de nombreuses disparités entre les régions du pays, les pratiques ont continué d’être scrupuleusement examinées, et les sites de délibération se sont avérés multiples en dépit de la présence d’un organisme national de réglementation. Tout d'abord, l'auteur affirme que la PMA ne peut pas être considérée comme un seul domaine politique, mais consiste plutôt en une variété de questions de politiques regroupées sous la même étiquette. Ainsi, la PMA est sectionnée afin d'étudier les pratiques qui participent à résoudre l'infertilité. Trois sous questions sont étudiées en détail dans cette thèse: l'accès aux traitements de fertilité, y compris la question du financement public et les critères d'accès, le don de gamètes et d'embryon, y compris la question de la filiation et le droit des enfants de connaître leurs origines biologiques, et la maternité de substitution et l'exécution des contrats de gestation pour autrui. Deuxièmement, en cartographiant les différents discours et arènes mobilisés par les communautés d'acteurs, cette étude montre comment les dynamiques de cadrage et de recadrage peuvent influencer les politiques publiques et leur mise en œuvre. Troisièmement, en comparant le contexte de la mobilisation des cadrages et les dynamiques discursives au Québec, en Ontario et en Angleterre, cette analyse démontre comment l’alignement des cadrages peut être une condition nécessaire pour qu'un cadrage soit performatif. Selon le contexte dans lequel il survient, la transformation d’un cadrage, son amplification, son extension ou sa combinaison avec un autre cadrage, peut provoquer de la stabilité ou bien déclencher une cascade d'événements qui mèneront à un changement de politique ou de mise en œuvre.

Mots clés: infertilité, procréation médicalement assistée, accès aux traitements de fertilité, don de gamètes et d’embryons, cadrage de politique, alignement des cadrages, mise en œuvre des politiques, processus de prise de décision, mécanismes discursifs, performativité des cadrages, arènes de politique, communautés épistémiques, Québec, Ontario, Angleterre, Canada, Grande-Bretagne.

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LIST OF ABBREVIATIONS AND ACRONYMS

ACIQ – Association des couples infertiles du Québec
ADQ – Action Démocratique du Québec
AHRAct – Assisted Human Reproduction Act
AMLQ – Association des mères lesbiennes du Québec
ART – Assisted Reproductive Technologies
BAAF – British Association for Adoption and Fostering
BASW – British Association of Social Workers
BICA – British Infertility Counselling Association
BMA – British Medical Association
BMI – Body Mass Index
CCSO - Coordinating Committee of Senior Officials
CEST – Conseil de l'Éthique des Sciences et de la Technologie du Québec
CFAS – Canadian Fertility and Andrology Society
CLRA – Children Law Reform Act
COTS – Childlessness Overcome Through Surrogacy
CSFQ – Conseil du Statut de la Femme du Québec
DCC – Donor-Conceive Children
DCN – Donor Conception Network
ECHR – European Convention of Human Rights
eSET – Elective single embryo transfer
GP – General Practitioner
GRO – General Register Office
HA – Health Authority
HFEA – Human Fertilisation and Embryology Authority
HFEAct – Human Fertilisation and Embryology Act
IAAC – Infertility Awareness Association of Canada
ICSI – Intra-cytoplasmic Sperm Injection
INUK – Infertility Network United Kingdom
IUI – Intrauterine Insemination
IVF – In vitro fertilization
NDP – New Democratic Party
NHS – National Health Service
NIAC – National Infertility Awareness Campaign
NICE – National Institute for Clinical Excellence
OHIP – Ontario Health Insurance Plan
OHTAC – Ontario Health Technology Advisory Committee
OMA – Ontario Medical Association
PCP – Progressive conservative party
PCT – Primary Care Trust
PET – Progress Educational Trust
PLQ – Parti Libéral du Québec
PQ – Parti Québécois
Progar - Project Group on Assisted Reproduction
RAMQ – Régime d'Assurance Maladie du Québec
RCOG – Royal College of Obstetricians and Gynaecologists
RVIC – Royal Victoria Hospital
SOGC - Society of Obstetricians and Gynaecologists of Canada
SPUC - Society for the Protection of Unborn Children
UK – United Kingdom
ULCC – Uniform Law Conference of Canada
VSA – Vital Statistics Act

FERTILIZE-THIS: FRAMING INFERTILITY IN QUEBEC, ONTARIO AND ENGLAND BETWEEN 1990 AND 2010

INTRODUCTION

Popular stories of assisted reproductive technologies (ART) often take as their starting point the birth of Louise Brown, the world's first "test-tube baby" born July 1978 in England. Her birth ushered a new debate about conception, one that raised a series of ethical questions and courted political controversy. Infertility politics appeared as families created through medically assisted reproduction increased in number and visibility, and as narratives of reproduction, conception, biological ties, and family began to be questioned, destabilized, and reported through individual and collective experiences (Franklin, Edwards et al. 1999; Luce 2010).

Infertility politics is the term used here to describe a politics in which "people move from the private world of 'trying for a baby' to the public world of seeking… assistance with conception" (Crawshaw 2009, p. 271). For many years, adoption was the only option available to single parents, same-sex couples and infertile heterosexual couples wishing to have children. Collaboration was needed between the intended parent(s), the biological parents and national and\or international authorities to overcome infertility and lead to the formation of a family unit. Collaboration stressed a role for the state in regulating the creation of families through national and international adoption policies and programs. Informal surrogacy and conception arrangements were alternatives to adoption and took place mainly in the privacy of homes and families. With the social recognition of same-sex unions and the lesbian baby boom of the 1990s, the need for legal acknowledgment of same-sex family units pushed decision-makers to reopen family laws to include families created through assisted reproduction and establish new parentage rights. Thus, family building is considered to be part of the state's responsibilities both in terms of managing access to parenthood and legislating parentage rights and responsibilities.

By creating alternative forms of relationships and by supplanting sexual intercourse as the sole means of reproduction, assisted reproductive technologies have unleashed a series of political questions, which in turn have influenced the regulation of these technologies and the management of their related social effects. ARTs have their own logic of collaboration, underline different moral challenges, and demand distinct policy solutions other than adoption or homemade assisted conception arrangements. The movement of reproduction into clinics and the routinization of practices by physicians changed reproductive behaviors and the very process of having a child. Today, all the different medical procedures available to infertile individuals and couples - from artificial insemination to the more complex and intrusive in vitro fertilization - come with their own policy challenges.

Medical practices around assisted reproduction are becoming more advanced and complex. Each year, the technology is changing and thus producing new kinship options. Live birth rates following infertility treatments are increasing as well, offering to different types of intended parents a better chance to create families. Moreover, assisted reproduction creates the possibility that a child ensuing from such medical practices has more than two legal parents, and thus reconfigures family and social structures (Franklin and Ragoné 1998; Fine 2002). The traditional categories of "mother" and "father" can no longer be universally applied, at least without reservation as to the meaning of those words and/or without creating new categories such as "surrogate mother, "donor" and "co-parents", for instance. In that context and as a result of social norms and public policies, sociologists came to argue that reproduction is stratified[1] (Ginsburg and Rapp 1995) and the representations of infertility reconfigured (Franklin 1990).

Assisted reproduction is an issue for which meaning-making is crucial, as it confronts us with a series of political issues and social representations that are increasingly debated. On the one hand, the way we grapple with technology, science and medicine provides us with some insight into how society values life. On the other hand, the reconfiguration of family units is revealing of how we organize our society and reproduce or pass on social norms and principles that are embedded in policies and practices.

Infertility Politics in Interesting times: the end of 2010 in Canada and the UK

This dissertation originates from an empirical observation; a little more than thirty years after the birth of Louise Brown, the United Kingdom and Canada were in the midst of intense political debates about infertility. Many political events and debates were (re)emerging at the end of 2010, producing similar discourses but still different policies

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[1] Stratified reproduction means that reproduction is structured across social/cultural boundaries, that some people are empowered with the ability to reproduce and others not. In each society some reproductive futures constructed around social representation are being valued and others despised.

were implemented in the two countries. By the end of 2010, Quebec, Ontario and England were at a turning point in the regulation of assisted reproduction.

Following the adoption of the Assisted Human Reproduction Act (AHRAct) by the Canadian government in 2004, the government of Quebec asked the Court of Appeal to review the federal law to determine whether it exceeded provincial powers over health care in the matter of assisted reproduction.[2] Six years later, in December 2010, the Supreme Court of Canada finally allowed the appeal in part, stating that some provisions intruded on provincial powers to regulate health care as ruled by the Quebec Court of Appeal[3] earlier in 2008. However other articles were ruled still constitutional. The judgment refers to the extent to which provincial and federal powers overlap in the case of assisted reproduction.[4] Most interestingly, it refers several times to the tension that exists between morality, health, and security in the management of assisted reproductive technologies.

In the meantime, David Johnston used his first official visit to Ontario's Queen's Park as Governor General of Canada to implore provincial representatives to make it easier for women to get pregnant and for families to adopt children. On the heels of his prior role as president of Ontario's Expert Panel on Infertility and Adoption[5], he used his reputation as well as the extended research conducted by the panel to cast a spotlight on the hard battle fought by Ontario's advocates for easier access to fertility treatments. Being the grandfather of adopted children and children born through assisted reproduction, Johnston spoke of the importance of offering infertile couples secure health care services structured around ethically responsible practices (Benzie and Monsebraaten 2010).

On the other side of the Atlantic, a discussion panel consisting of experts and political figures was gathering at the Royal Society in London to debate whether the new conservative government of David Cameron was "throwing the baby out with the bathwater"[6]. A few months after an historic election victory, the new Conservative government introduced the Public Bodies Bill. In an attempt to decrease state spending, the Bill was projected to abolish many quasi-autonomous non-governmental organizations

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[2] Reference by Quebec's government on the constitutionality of articles 8 to 19, 40 to 53, 60, 61 and 68 of the Assisted Human Reproduction Act, L.C. 2004, ch. 2, 2008 QCCA 1167.

[3] These are ss. 10, 11, 13, 14 to 18, 40(2), (3), (3.1), (4) and (5) and ss. 44(2) and (3) of the AHRA.

[4] Reference re Assisted Human Reproduction Act, 2010 SCC 61, [2010] 3 S.C.R. 457.

[5] The final report was issued August 2009.

[6] Progress Educational Trust, « The End of the HFEA: Are We Throwing the Baby Out with the Bathwater? », Royal Society, 6-9 Carlton House Terrace, London SW1Y 5AG, UK, 17 January 2011 - 6.30pm-8.30pm

(Quangos), the Human Fertilisation and Embryology Authority (HFEA) among them. Several commentators drew attention to the questionable benefits of dismantling the fertility regulator. Most of them discussed the value of the ethically bounded and medically relevant decision-making process at the HFEA. Others talked about the essential role of the HFEA as a licensing agency; as it maintained secure services for would-be-parents, surrogate mothers and gamete donors.

At the same time, in very different circumstances, actors involved in the debate mobilized medical, legal and moral arguments to describe the politics of infertility. However, this similarity in discourses does not carry over when examining the implementation of legislation, practices and policy strategies in the two countries; variation within Canada and the UK figure prominently. As shown in Table 1[7], Quebec, Ontario and England adopted very different policies in regard to access to fertility treatments, gamete and embryo donation and surrogacy.

Table 1: Variation in the policies over access, donation and surrogacy in Quebec, Ontario and England in 2010

Sub-issues of ARTs	**Related Policies**	**Quebec**	**Ontario**	**England**
Access	Public Funding	X	X	X
	Coverage criteria		X	X
Donation	Parentage	X		X
	Same-Sex union	X	X	X
	Right to know			X
Surrogacy	Arrangements		X	
	Parentage			X

In Canada, Ontario and Quebec made different policy choices in terms of access to fertility treatments and practices even if the federal government took the lead in debating and regulating ARTs. The provincial prerogatives over health care and family laws granted the provinces greater autonomy than what is normally suggested by scholars and observers. In the last twenty years, regulatory regimes have been created in the Canadian provinces,

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[7] X indicates that there is a policy or program addressing the issue.

meaning that people treated for infertility in Ontario can expect a very different experience in terms of state support and legal recognition than their Quebec counterparts. In the UK, constituent countries like England provide a set of services and implement medical practices in a variety of ways, thus granting access and parentage rights to specific types of intended parents only.

While Quebec, Ontario and England each provide varying degrees of public funding for infertility treatment, policies in the three sub-national units differ in terms of who has access and what is covered. Donation policies are similar in terms of restricting commercialization of gametes and embryos. Nevertheless, clinical procedures to acquire and transfer gametes and embryos are regulated at the regional level and vary in Quebec, Ontario and England. Quebec and England created a specific legal framework to structure parentage in cases of assisted conception, while Ontario has not specified statutory principles to apply when a child is born through assisted reproductive technologies. Same-sex partners have access to fertility treatments and to parentage rights in the three spaces, but there is variation in the implementation procedures and in the timing of their adoption. Donor-conceived children have the right to know their origins only in England; the two Canadian provinces barely discussed the issue of donor anonymity. Surrogacy arrangements are enforced only in Ontario; they are null but not illegal in Quebec and England. Hence, the two countries prohibit surrogate mothers from receiving compensation.

The UK was one of the first countries to introduce legislation providing a framework for the systematic regulation of assisted reproduction in the world, one that has been identified as providing a model regulatory system that other countries could usefully emulate (Blank 2004). The British model has long been labeled as the global "gold standard" of regulation as regards ARTs (Franklin and Roberts 2006, p.40) because of its comprehensive nature and the fact that the country was an early mover in the domain. That reputation pushed the Canadian federal government to refer heavily to the British policy while drafting its own regulatory framework in the 1990s. Canada ranked third after the British and the Americans in the global biotechnology market, and its position in the "big leagues" implied that Canada had to align with the regulatory frameworks of the big two to stay competitive in terms of scientific innovation and service provision (Montpetit 2007a).

In 2004, the policies adopted by the Canadian federal government were largely inspired by the British regulations (Montpetit 2007b).

Thus, we might have expected more convergence between Canada and the United Kingdom given that they have many common national characteristics. At a national level, Canada and Britain have similar legal frameworks in which a regulatory body is in charge of monitoring scientific developments and the social impact of assisted reproductive practices. This similar starting point is treated in the political science literature as a case of policy transfer (e.g. Jones and Salter 2007; 2010). Despite the addition of a few more restrictive principles in Canada, the two countries' acts did not restrict access to ART, nor did they restrict embryo and gamete donation. Both Canada and the UK began their deliberations on new assisted reproductive technologies at the same period; fertility clinics in both countries are funded through a mix of public and private funding. In addition, the policy communities involved in the policy area – such as women's groups and the medical community - were similar in the two countries. Given the national umbrella framework in the two countries and the common institutional context within Canada, it is reasonable to expect much more uniformity in the policy practices and in the implementation of legal standards at the sub-national level.

At the beginning of 2011, after years of non-action in Canada and intense policing of assisted reproductive technologies in the UK, the two countries were about to turn the page on the regulation of assisted reproductive technologies. Hence this dissertation explores the processes that led to the regulation of assisted reproduction in Quebec, Ontario and England in order to identify and analyze the influence of ideational factors on public policies.

Research question and argument

This thesis asks: Why, despite national institutional similarities, did Quebec, Ontario and England develop and implement different policies with regard to assisted reproduction? In light of the literature (see chapter 2), I argue that the variation in outcomes can be explained by the frame mobilization and the articulation of policy frames in a given context of deliberation. Previous research anchored in neo-institutionalism tried to explain policy variation (e.g. Young 1998; Barnett 2003; Bleikie, Goggin et al. 2004; Barnett and Steuernagel 2005; Montpetit, Rothmayr et al. 2007), but faced the challenge of identifying the relevant networks, targeted population and institutional structure influencing the global regulation of assisted reproductive technologies.

Here, I argue that it is possible to explain variation between Quebec, Ontario and England by focusing not solely on the institutional context, but rather the constructed image of the constitutive issues of assisted reproduction. Issues of conception in the era of reproductive medicine are linked to social representations and norms. This dissertation will show how the meanings constructed around questions of infertility, assisted conception, gestation, medicine, morality, family and state responsibilities over them, influence policy decision-making processes and thus, policy outcomes.

This dissertation has three main objectives. First, I convey that assisted reproductive technologies cannot be regarded as one policy domain, but is composed of many different policy issues. The technologies themselves are a means to an end; assisted reproductive technologies help people to conceive when social or physical circumstances prevent a couple or an individual from doing so. I argue that to understand the path on which Ontario, Quebec and England embarked, we need to unpack assisted reproductive technologies and consider the issue not as one policy domain but as three overlapping issues. Differences in the nature of the sub-issues, I argue, are an indicator of change and stability in public policy, but also in the process leading to the formulation, adoption and implementation of these policies in Ontario, Quebec and England. The sub-issues associated with ARTs are defined by very specific political dynamics. Access to fertility treatments, gamete and embryo donation and surrogacy unleash very different questions of law, governance and advocacy, group a range of diverse actors in the policy debate and bring about varied definitions and conceptions of the policy problem. In 1964, Theodore Lowi claimed that "for every type of policy there is likely to be a distinctive type of political relationship" (Lowi 1964 p.688). Depending upon the issue at stake, the public priority on the agenda can change. Moreover, the ideas, values and arguments that underpin the issue can influence how decision-makers will receive and/or be oppose to a policy alternative. These elements are essential to understanding why and how a state regulates.

Second, I compare frame mobilization among the three sub-national units in order to understand how frames emerge, are articulated, by whom and where, and to what extent they influence policies in Quebec, Ontario and England. I consider that after unpacking ARTs the implementation of policies should be viewed as the ‘real’ policy outcomes of decision-making, thereby justifying their study at the sub-national level as well. When taking a closer and more systematic look at the three sub-issues of ARTs, the policy system becomes clearer. At the system level, it is easier to identify the distinct dynamics of mobilization as well as the factors influencing the decision-making processes for each issue. Assisted reproduction is constructed around many routines and practices that cannot be regulated independently. While policies and regulations are important, the way in which actors implement them in clinics, courts and families are as critical in understanding why Ontario, Quebec and England are so different or similar after all. To do so, the level of analysis must be changed. The implementation of public policies is neither fixed in time nor resistant to social dynamics, meaning that it is more likely to be responsive to changes in the social conceptions of an issue than public policies themselves. That is why the implementation of legislation must be compared instead of only national legislation or regulatory frameworks. It is at the sub-national level that the implementation of regulatory regimes and practices of assisted reproduction can be observed as well as how the issue/s were constructed, which actors mobilized in the debates and to what extent the state gave in to some of these pressures.

In the political debates over the regulation of ARTs, participants vary in the amount of time and effort they devote to the policy domain. Political actors of all types participating in policy processes are often ephemeral – would-be-parents, for instance, tend to step away from advocacy when they achieve pregnancy; while others lack the necessary resources and shop for different policy venues. Also, groups and activists sometimes represent voiceless clientele (children, for instance) that gives them less leeway for action, and still, some of them are not acting in their own self interest but the well-being of others. However, this erratic and uncertain participation does not necessarily mean that there will be less participation. On the contrary, the number of short-lived and/or single-issue organizations and activists render issue networks complex and multiply political discourses. Moreover, rather than worrying about attempting to influence the policy decisions made by legislatures or political executives, a greater share of political activity is becoming directed at influencing the behavior of bureaucracies, mostly at the street level (Pressman and Wildavsky 1973). In the case of assisted reproductive technologies and their social impacts, it was demonstrated that multiple arenas at the implementation level have been invested in order to modify and challenge legal frameworks that are not in line with social practices. Among others, lower courts (L'Espérance 2012) or clinics (Cussins 1996) have become implementation bodies by allowing would-be parents to be treated and to acquire rights over their children, well before the parliamentary arena granted them the same rights.

Finally, the third objective is to assess the performativity of frames and the influence of discursive mechanisms on the development and implementation of public policies, examining the conditions under which policy discourses contribute to policy change. I attempt to contribute to debates on the role of ideas in policy analysis and how they can, as frames, play a constitutive role in explaining policy outcomes. I illustrate the importance of framing and frame alignment in the area of Assisted Reproductive Technologies more generally and show how these factors affect public policy change and policy implementation. Shifts in elite attention shifts, I suggest, are linked to the rise of new frames or the reconfiguration of frames' mobilization and alignment. 'Tipping points' can be reached and changes in public understanding begin to induce changes in policy and/or their implementation, which in turn reinforce those same changes in public understanding. In some cases, a particular judicial decision, the rise of a social group, the enterprise of a policy entrepreneur or the deliberation of an issue in a specific arena, can foster frame reflection and trigger a discursive mechanism.

Unpacking the policy domain: assisted reproductive technologies as three issues

I define medically assisted reproduction as any procedure undertaken to support conception, gestation, and birth when natural processes do not function normally. Unpacking the issue of assisted reproductive technologies means untangling the different questions related to its regulation. In using the three sub-issues of infertility, I intend to emphasize the collaborative nature of assisted reproduction, particularly the use of medical procedures and assistance of multiple parties to achieve conception. The particular techniques of assisted reproduction I address are artificial insemination, in vitro fertilization (IVF), and gestational surrogacy. In deviating from the traditional model of reproduction, assisted reproductive technologies become politically problematic along three lines:

identification of legal parents, control over one's biological information, and state regulation of access to ART services.

Access to infertility treatments

In spite of what happens in other parts of the world[8], a large part of the discussions around infertility treatments in Canada and the UK concerns access. Quite often this leads to discussions about the ethical acceptability of the various forms of assisted conception. But there is also debate about the patients themselves, as well as the treatments they seek. Participants in conflicts over access to infertility treatments call on the state to reallocate the costs of various reproductive procedures from the individual to the societal level, or they call on the state to compel fertility service providers to make services available to those individuals whom clinics refuse to treat or admit. This raises a number of questions: Who can be treated for infertility in clinics? Are there criteria for refusing to treat patients (e.g.: age, health considerations, etc.)? Is medical care available only to the financially privileged?

Resource allocation towards infertility treatment has been debated extensively in countries where health care is publicly funded in whole or in part, as it is in Canada and the UK. Medical, social and ethical aspects have to be evaluated prior to the allocation of resources. Analysis of cost-effectiveness, risks and benefits, success rates, but also social values and norms have led to restrictions on fertility treatment for all sorts of patients such as single mothers, same-sex partners, surrogates, unmarried, obese, older, women who smoke, couples who already have children, etc.

In the global debate over health care, the issue of access to fertility treatments inevitably leads to debates about the place of these services within a redistributive politics of the welfare state. Access has been taken as synonymous with the availability of financial and health system resources as much as it has been associated with the characteristics of the delivery system. In that context, the policy decision-making process with regard to access to fertility treatments raised issues about commodification, medical definitions, system organization and distribution of resources among citizens.

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[8] Although access to ARTs is the first step in assisted reproduction, it receives considerably less attention than issues of parentage or authority over reproductive materials in the United States. For a detailed analysis, see Ackerman, E. (2007). Reproducing Law: ARTS, Judicial Policymaking, and Reproductive Rights. Baltimore, Maryland, Johns Hopkins University. PhD. thesis, Law.

In a sense, this sub-issue of infertility politics is the main entry point to the other two issues discussed in this dissertation. How access is regulated in Quebec, Ontario and England enables different medical practices which have their own outcomes on parentage. Hence, access is also the main, persistent issue debated by groups and individuals interested in the regulation of gamete and embryo donation and surrogacy.

Gamete and Embryo Donation

When a man is unable to produce enough healthy sperm, his partner can be inseminated with sperm provided by a donor to help the couple to have a child. Where a woman is unable to produce healthy eggs, eggs from another woman can be fertilized in the laboratory using the woman's partner's sperm (or sperm from a donor) and the resulting embryos transferred to her so that she can carry the pregnancy herself. Occasionally there will be reasons why the donation of embryos (using both eggs and sperm from third parties) will be appropriate. Those are the different options of donation that enable medically assisted conception.

This issue raises two series of questions: the first is associated with donation itself and the meaning of genetic relatedness, and the second is related to kinship and the parental links that are created by in-vitro fertilization (IVF) or insemination. Is the donor known or unknown? Can more or less than two parents share parenting responsibilities? What are the basis to which we refer when legally creating the link between the child and its parent(s)? What kind of agreement is arranged before the procedure and does it compel the intended parents/donors to fulfill it?

In contrast to the traditional family, families created through medically assisted reproduction are no longer defined by the legal principles of marriage, heterosexuality and binary parenthood. Family now goes beyond the logic of nature to a conception where private and relational aspects of reproduction play a bigger part. Fiercely attached to the bonds of blood because of its clear way of establishing parentage, legal structures placed this indisputable evidence of a link between an adult and a child at the center of kinship law. However, assisted reproduction negates the earlier obvious relation between the social role of parents and their biological relationship to the child (Iacub 2002, p.212-213) and asks for the redefinition of family law.

Marriage was the second foundation for creating a link that could not be previously justified by blood. The presumption of paternity, however, is not a cure in all cases, because the use of medically assisted reproduction, in a tangible way, supports the separation between the parental project and marriage (Belleau 2004, p.13). In the context of assisted reproduction, the best interests of the child[9] are undoubtedly paramount when deliberating best practices of donation and lead to wide policy variation when it is time to settle which family configuration will be recognized legally.

In addition to questions of parentage, in recent years the interests of donor-conceived offspring came to the forefront of the debate over assisted conception. The first generation of donor-conceived offspring is now becoming young adults who are beginning to share their unique perspectives. Many tell stories of psychological distress. They describe a strong need to know where they come from; to know their genetic origins as an essential part of constructing their identities. They are at the center of a lively academic debate as well as a driver for support networks, educational campaigns, and sometimes, legislative changes. The debate surrounding disclosure of donor identity is typically framed as a tension between the rights of donors and parents on one hand, and those of donor-conceived offspring on the other. Donors, it is argued, have a right to maintain anonymity in order to avoid potential future liabilities, intended parents have a right to keep the circumstances of conception private, while offspring have a right to know their genetic origins. Consequently, these arguments serve as justification for different policy options for the oversight of the practice of gamete donation and future disclosure of information.

Many aspects of the questions are at play when deliberating the issue of the right of donor-conceived children to know their origins. First, the medical aspect points to the importance of knowing the full medical history and by extension, to know medically relevant genetic information about the donor. Second, the identity argument asks for personal information about the donor as a person who would assist offspring in overcoming identity issues. Third, the relational option tends towards the disclosure of the full identity of the donor in order to contact him or her and attempt to establish a relationship between the

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[9] In England, the "best interests of the child principle" is called the "welfare of the child principle". The English principle refers much more to a socio-psycho-economic relationship between guardian(s) and child and is strictly interpreted by the courts, while the Canadian principle refers to a flexible standard of support by the guardian(s) and can be defined in accordance with the case studied by the courts.

child and its genitor. Finally, the parental disclosure debate relates to the full disclosure of the circumstances of the child's conception in order to integrate truth in the extended family unit. Each of these aspects is based on a different understanding of the meaning of genetic relatedness from a narrow biological sense to a wider social-environmental one. Accordingly, this sub-issue can be addressed by different policy solutions, from full anonymity of donors, to disclosure of medical history and genetic information, through disclosure of de-identified personal information, all the way to disclosure of donor identity and to legal enforcement of truth telling within the family.

Surrogacy

Surrogacy involves a simple premise: a woman gives birth to a baby that she will not parent. In practice, surrogacy is divided into two forms: genetic or traditional surrogacy and gestational surrogacy. In the first form, the surrogate gestates her own inseminated eggs and the resulting child is genetically related to her. This kind of surrogacy often occurs privately as it may not require much reproductive technology. In contrast, gestational surrogacy requires specialized professional assistance and so the thesis primarily deals with this practice. The gestational surrogate is implanted in a clinic with an in vitro-created embryo. The embryo may be created with the reproductive material of donors or of the intended parents, or with a mix of the two. In either case, the pregnancy occurs with high levels of medical intervention. By occurring under the care of medical personnel, gestational surrogacy is more easily regulated by the state than homemade arrangements.

What distinguishes surrogacy from other reproductive technologies is not the technology itself but the circumstances of its application — an arrangement whereby one woman bears a child for another, with the intent of relinquishing the infant at birth. The surrogate arrangement is often made between a couple (where the wife is infertile) and a surrogate mother. In the contract signed by both parties, the surrogate agrees to be implanted with an in vitro-created embryo, to bear a child, and at birth to give up all parental rights and transfer physical custody of the child to the commissioning couple. Although contracts vary, they usually include provisions concerning the rights and responsibilities of all parties, both before and during pregnancy and after the birth of the child.

In these circumstances, the state can decide that the surrogacy arrangement's contract can be enforced by courts or considered null. When considered enforceable, different principles will be established as paramount in the establishment of parentage, such as the welfare of the child, the need for a father, intentionality, consent, etc. Finally, declaration of parentage can be granted through an administrative procedure (administrative form such as the birth certificate and/or parental orders application) or litigation (judicial procedures).

Plan of the dissertation

The first chapter will present in detail the policy variation in the three political-institutional contexts as regards the three sub-issues identified earlier. This chapter will show precisely the similarities and differences in the policies and their implementation in the three cases across issues. This will provide the basis for understanding the puzzle this dissertation addresses and to what extent the three issues are regulated in a variety of ways.

Chapter 2 will discuss how the literature that has addressed the puzzle of national variation in the regulation of ARTs. Examining a range of relevant literatures, including the public policy literature related to biotechnologies and assisted reproductive technologies; anthropology and sociology literature that studies the social impacts of technologies such as in vitro fertilization; and the public health literature on the public management of health care and the medicalization of reproduction, I attempt to point to some possible answers that might account for this policy variation.

Chapter 3 will elaborate the theoretical framework that combines elements of the frame reflection and frame alignment literatures, and how framing itself can influence policy outcomes. This dissertation identifies and maps the variety of discourses mobilized by communities of actors in diverse policy arenas in order to change the political status quo. From a framing perspective, a dominant meaning consists of the argument or discourse with the highest probability of being noticed, processed, and accepted by the most people. To identify a meaning as dominant or favored is to suggest a particular framing of the situation that is most heavily supported by the involved actors and is congruent with society's representation of the issue. Actors and communities of actors are able to influence the policy process by making information more noticeable, meaningful, or memorable to policy elites. Accordingly, this chapter assesses that utterances and the performance of frames in different spaces of deliberation enable actors to alter the policy image, the meaning of a policy issues or the sense attached to a specific practice. This chapter will also discuss methodology and the different sources gathered in the course of this research.

Chapter 4, 5, and 6, will outline the evolution of decision-making between 1990 and 2010 respectively on access to fertility treatments, gamete and embryo donation and surrogacy. The three chapters will demonstrate changes and stability in frame mobilization and in the ways in which governmental officials constructed the problem of infertility. In doing so, it will be possible to show how the different dynamics of frame alignment and frame reflection influenced policies and their implementation within the nine cases (three sub-issues in three sub-national units).

Finally, chapter 7 provide a comparison of the findings by issues and by jurisdiction. In doing so, this chapter gives a better understanding of the emergence of dominant frames, the meshing of discursive mechanisms and their influence on policy processes and outcomes. This comparison will present the theoretical contribution of this dissertation as well as a conclusion in which I outline the key empirical findings from this dissertation. Finally, the conclusion will provide an overview of the contributions of the dissertation as well as reflect on key developments following 2010 in England, Quebec and Ontario.

CHAPTER 1

POLICY VARIATION AMONG THREE SUB-ISSUES OF ASSISTED REPRODUCTION

This dissertation tries to understand why Canada and the UK developed such different policies regarding ART in spite of the policy transfer that occurred at the end of the 1990's and, why there is such variation amongst sub-national units despite their similar national framework. In order to set the stage for the next analysis, this overview of the policies and regulations in Quebec, Ontario and England and their implementation will provide the basis for understanding the empirical puzzle this dissertation addresses. This chapter shows that depending on the issue, the similarities and differences between cases vary greatly, and that sometimes, the similarities between cases have nothing to do with institutional circumstances, national regulatory frameworks or agency.

National similarities

The study of assisted reproduction at the sub-national level does not preclude the important influence of national legislative and regulatory framework on policy development, the policy communities and their discourses. In fact, many aspects of the national framework influence the processes of Quebec, Ontario and England respectively. The fact that the early stage of the policy process in the United Kingdom and Canada has so much in common does not mean that they had the same influence on policy development at the sub-national level. As will be outlined in the empirical chapters, depending on the issue, time and space, the national context had a variable influence on the representation of infertility and policy image. This section will highlight that particular context to situate the next study in time and space.

United Kingdom

In the mid-1980s, after considerable study and debate, the Committee of Inquiry into Human Fertilisation and Embryology, chaired by philosopher Mary Warnock, issued a voluminous set of legislative recommendations. Contrary to the Committee's expectations, another five years passed before the Government brought the Human Fertilisation and Embryology Bill to Parliament (1989). The measure became law the following year. Subsequently, only minor changes were made until 2008, when Parliament substantially overhauled the regulations and introduced new provisions addressing filiation and rights of donor-conceived children.

In the United Kingdom, in the 1990s, skepticism about the wisdom and moral acceptability of assisted conception and research on embryos led to several attempts to foreclose embryo disposal and thereby effectively prohibit treatments. Since embryo research is an essential precursor of infertility treatment, the anti-abortion movement objected vociferously to reproductive technologies' reliance on embryo destruction. In the debate in the House of Lords following the publication of the Warnock report, the overwhelming majority of Lords who spoke against the report were supporters of the Society for the Protection of the Unborn Child (SPUC) (Abse 1986, p. 210). Given its religious roots, the anti-abortion movement was understandably critical of the Warnock Report's failure to insist that fertility treatments should be available only to married couples (Mulkay 1997, p.17).

Michael Mulkay (1997) points out that, initially, those opposed to embryo research were much better organized and appeared to have both public and parliamentary opinion on their side. A few scandals also influenced the parliamentary process, leading to the adoption of the 1990 Human Fertilisation and Embryology Act (hereafter HFEAct) and regulations that quickly followed, enough to create what some people called a campaign against maverick doctors and risky behaviors (Interview with NHS manager, Region of London, February 17th 2011). For instance, in 1987, septuplets were born to a woman in Liverpool who had used ovulation-inducing drugs; the longest surviving child lived for only 16 days.

Between 1985 and 1990, the scientific and medical community campaigned to sway public and parliamentary opinion, largely by stressing the potential health benefits of embryo research (Jackson 2001). An organization called the Progress Educational Trust (PET) was set up in 1985 to work for increased public understanding of embryo research and the benefits of fertility treatments. Prior to the parliamentary debates on the Human Fertilisation and Embryology Bill, PET arranged for members of the House of Lords to be visited by families affected by genetic diseases (Mulkay 1997). Arrangements were also made for representatives and members of the House of Lords to visit clinics and talk to patients and clinicians (Franklin 1993). The passing of a relatively liberal statute in 1990 has been attributed, in part, to the fortuitous announcement five days before the House of Commons voted on the Bill, that doctors and scientists working at the Hammersmith Hospital had successfully performed pre-implantation sex diagnosis in order to prevent the birth of a child suffering from a sex-linked genetic disorder. That in vitro fertilization (IVF) could be used to prevent serious disease and severe suffering significantly advanced the case for facilitated regulation.

As a result, the UK has a moderate system of regulation whereby an oversight body, the Human Fertility and Embryology Authority (HFEA), issues licenses to fertility clinics and provides recommendations in the form of a code of good practice. Petersen and Johnson described the UK legislation as being “relatively permissive, containing a limited number of express prohibitions, but is otherwise facilitative of a flexible regime administered by the Human Fertilisation and Embryology Authority.” (Petersen and Johnson 2007, p.241) The HFEA is made up of medical professionals and lay people (including religious officials, social workers, reporters and individuals who have experienced infertility) who consider the regulation of ART twice yearly (based on changes in technology and the evolving ethical landscape), and inspect and license ART clinics. However, the UK statutory framework is not overly prescriptive, enabling the HFEA to exercise regulatory control in a flexible manner. The HFEA therefore plays a significant role in the collection of data, but also has a number of other general functions, such as increasing public awareness.

Additionally, one of the HFEA’s key responsibility is to produce and maintain the Code of Practice (hereafter the Code). The Code facilitates the practical application of the Act, as well as allowing for minor updates if specific problems or issues are identified. Furthermore, the HFEA must grant a license before any clinic can use human gametes and embryos for treatments or research. This license will be revoked if the clinic does not conform to the rules laid out in the Acts and the Code of Practice. This system not only enables clinics to be ‘policed’ but also allows the HFEA, through the Code, to retain a level of flexibility, which is considered essential in this area where both technology and public opinion continually evolve. The advice contained in the Code goes beyond the statutory provisions outlined under UK legislation. It elaborates on the statutory provisions, providing clinics with advice as to what constitutes good practice. The provisions contained in the Code are not legally binding, but if ART clinics fail to observe the Code, such conduct may be heavily counted against the provider should it be liable to civil and/or criminal action. Furthermore, the HFEA is empowered to revoke or refuse to renew a license in light of any deviations from the Code.

In 2010, the eighth edition of the Code of Practice was still in effect. Currently the Code of Practice specifies that clinics should not transfer more than three eggs or two embryos in any treatment cycle if the woman is to receive treatment using her own eggs, or embryos created using her own eggs and the woman is aged under 40 at the time of transfer. In other cases, clinics are advised not to transfer more than four eggs or three embryos in any treatment cycle (HFEA 2009, guidance 7.2-7.3). Moreover, the quality of care provided by fertility specialists and fertility clinics' staff is guided by good clinical practice guidelines produced by the Royal College of Obstetrics and Gynaecologists (RCOG) and the British Medical Association (BMA) and commissioned by the HFEA, but which are not legally binding (implementation is discretionary).

The amendments to the HFEAct received Royal Assent on November 13th 2008. Most of the changes took effect on October 1st 2009, although the revised definitions of parenthood contained in Part 2 of the Act have been effective since April 2009. A final stage of amendments implemented parental orders in 2010. The 2008 Act amends the HFEAct of 1990 and the Surrogacy Arrangement Act of 1985. The Act covers any fertility treatment that involves the use of donated eggs or sperm (gamete donation) or embryos created outside the body (in vitro fertilization). It also provides a legal framework for everyone involved in fertility treatments. It defines the rights of donors, patients and the children who may result from the treatment. The rights of the child are paramount, and treatment cannot be offered without proper guidance to the patient and donor.

Section 8 of the 1990 Act, which sets out the general functions of the HFEA, was amended by the 2008 Act to include an obligation to maintain a statement of general principles that applies to both the activities regulated in the Act and the Authority's own functions. Its duties were enlarged to include the express acknowledgement of the Better Regulation principles[10]. The objective of the HFEA is thus to minimize the burdens imposed on clinics concentrating on a risk-based approach to compliance with, and enforcement of, the relevant regulation. It is also required to promote compliance with both the Act and the Code of Practice. Compliance with the Code should result in more effective, efficient and

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[10] The UK government with the aim of streaming all public services' work for good governance, adopted the five Better Regulation principles in 2006. The Better Regulation Commission, a non-governmental public body of the British Government, is in charge of advising the government on action to reduce unnecessary regulatory and administrative burdens, and ensure that regulation and its enforcement are 1) proportionate, 2) accountable, 3) consistent, 4) transparent and 5) targeted.

cost-effective regulation, because the Code maintains the principle that regulation is effectively administered by a risk-based outcome. Also, the Code of Practice builds upon general ethical principles of fairness and non-discrimination of patients undergoing fertility treatments.

Canada

In 1993, after four years of controversy over the Commission's internal affairs and significant public consultation, the Royal Commission on New Reproductive Technologies issued a report entitled Proceed with Care (Baird 1994). Among the 293 recommendations, the report called for the regulation and oversight of reproductive technologies throughout Canada. It relies on a framework for federal legislation that would use the criminal law to prohibit certain practices and establish a regulatory agency to develop guidelines and implement regulations. In comparison with the British HFEA, Assisted Reproduction Canada was created in 2006 to police clinics, infertile individuals and donors rather than to oversee practices of assisted reproduction. The focus was on emerging reproductive technologies, such as prenatal diagnosis, and the regulatory emphasis was on the safety of women and children. The report raises the complexity of jurisdictional issues pertaining to ARTs. The report states that leaving the issue to the provinces would result in an unsatisfactory statutory patchwork.

As a result of this report, a series of federal bills was put forward, starting with Bill C-47 in 1996. This law died as a result of the calling of the federal election in 1997. After a legislative hiatus, the issue resurfaced in May 2001 when the government released the Proposals for Legislation Governing Assisted Human Reproduction. The unusual step of releasing draft legislation was meant to stimulate national debate and serve as a framework for discussion and analysis by the House of Commons Standing Committee on Health. The Committee heard submissions from interested parties, ranging from academics to professional associations. Its report, titled *Building Families*, was submitted in December 2001 and recommended that legislation be introduced on a priority basis. On May 9th 2002, the government introduced Bill C-56, "An Act Respecting Assisted Human Reproduction" in the House of Commons. After the summer break of the Canadian Parliament, this bill was re-introduced as Bill C-13 but died again when an election was called. Finally Bill C-6, a virtual replica of Bill C-13, was introduced and passed first, second, and third reading in the House of Commons on the same day, February 11th 2004. It also rapidly passed in the Senate and received Royal Assent on March 29th 2004. Bill C-6 became the Assisted Human Reproduction Act (AHRAct).

The main debates in Parliament, therefore, occurred after the introduction of Bill C-56. The press frequently referred to the legislative proposal as the "cloning and stem cell bill" (Greenaway 2002). The Bill was mostly thought in terms of cloning and stem cell research and rested on restrictive criminal law instruments while most of the day to day practices affecting citizens directly are related to medical assistance of infertile individuals and couples. While the proposed legislation dealt with all aspects of assisted reproduction, from commercial surrogacy to regulation of IVF clinical practices and storage of human reproductive material, human reproductive cloning and embryonic stem cell research dominated the political debates.

The literature on assisted reproductive technologies in Canada and the legislative and regulatory initiative of the federal government since the Royal Commission has identified the constitutional division of powers as being in part responsible for the regulatory void and the non-implementation of the few regulations adopted after 2004 (Cameron and Gruben Forthcoming). Many claim that Quebec's judicial review of the AHRAct and the length of legal proceedings contributed to the vagueness surrounding the practices of assisted reproductive technologies in Canada. Quebec's review process arguably slowed down enormously the implementation of the law and its principles, stopped almost any attempt of regulations at the federal level and limited the provincial margin for maneuver in this domain. In this context, private clinics had to self-regulate and autonomously establish who would be treated and how.

In December 2010, the Supreme Court stated that the management of clinical practices and related activities was a provincial prerogative. For example, licensing and clinics' inspections were thereafter a provincial competence[11]. Medical and personal information gathering is now a provincial responsibility and relies on the clinics' and

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[11] Most of Assisted Reproduction Canada's responsibilities revolved around licensing and policing clinics. In 2012, the federal government announced through the annual budget that they would close the agency and transfer the remaining federal responsibilities upon ARTs to Health Canada.

professional association's archiving systems[12]. Some likened the new situation to an "unregulated nightmare" (Guichon, Giroux et al. 2008). Gruben and Campbell (Forthcoming) worried that provinces would be incapable of protecting women from the risks of assisted reproduction and the commodification of their reproductive capacities. The concern over inter-provincial fertility tourism was especially pronounced, with the Toronto Star reporting that the prospects for would-be parents "depend on where they live or how easily they can get to a province with a more lax regime" (Unsigned Editorial 2010).

The Assisted Human Reproduction Act in its current form forbids remuneration for surrogate mothers[13], defends the marketing of gametes[14], and requires informed consent of donors[15]. Donor anonymity is de facto maintained in spite of the absence of laws or statute in this regard since the judicial review of 2010. This principle, formerly included in federal law, is maintained today through medical practice in Quebec and Ontario and has been recently submitted to judicial scrutiny in British Columbia[16]. The purchase of gametes is not permitted[17], although reimbursement of all donor's expenses related to their donation is legal. Egg, sperm and embryo donation are all legal in Canada. The respective rights and obligations of the intended parents and the donor are consistent regardless of whether the donor is known or anonymous.

In April 2010, the Society of Obstetricians and Gynecologists of Canada (SOGC) and the Canadian Fertility and Andrology Society (CFAS) jointly published their Clinical Practice Guideline for elective single embryo transfer (eSET) following in vitro fertilization (2010). The guidelines promote the use of eSET in order to optimize live birth rates and

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[12] The Canadian Fertility and Endrology Society is in part responsible of gathering clinical information from clinics all over Canada. Clinics are now guardians of all personal information of donors and patients.

[13] Section 6(1) of the AHRAct of 2004

[14] Section 6(2) and 6(3) of the AHRAct of 2004

[15] Section 8 of the AHRAct of 2004

[16] Olivia Pratten, a donor-conceived child, now 28 years old, initially launched a judicial challenge against both the province of British Columbia and the College of Physicians and Surgeons in British Columbia (CPSBC). In 2010, an agreement was reached between Pratten and the CPSBC, stating that the college would amend its by-laws in the case of a Pratten victory. In return, Pratten's action against the CPSBC was dismissed, and her case focused solely on government action. In May 2011, Justice Elaine Adair of the Supreme Court of British Columbia struck down much of BC's Adoption Act and Adoption Regulation, claiming that the provincial government's adoption policy unfairly discriminated against children born through assisted reproduction. The provincial government was given 15 months to rewrite the legislation to grant equal information access to donor-conceived offspring. Just as importantly, Justice Adair granted a permanent injunction "prohibiting the destruction, disposal, redaction or transfer" of gamete donor records from BC. Shortly after the decision, the BC government announced that it would appeal the Pratten ruling to the BC Court of Appeal. Unless the provincial government wins on appeal, donor anonymity in British Columbia has come to an end.

[17] Section 7(1) and 7(2) or the AHRAct of 2004

minimize multiple pregnancies. Clinicians are not legally bound by this one-baby-at-a-time practice guideline.

In keeping with the anti-commercialization spirit evident with respect to eggs, sperm and embryo donation, the AHRAct prohibited commercial but permitted altruistic surrogacy. The Act does not exactly regulate who may or may not enter into a surrogacy arrangement, but it forbids payment to a surrogate mother. Section 2(f) states that “trade in the reproductive capabilities of women and men and the exploitation of children, women and men for commercial ends raise health and ethical concerns that justify their prohibition” (Canada 2004). In addition, the Act forbids the payment of another person to arrange the services of a surrogate mother. It is an offence to counsel or induce a female under the age of 21 years old to become a surrogate or to perform any medical procedure to assist such a person to become a surrogate. A surrogate mother may only be reimbursed for expenditures incurred in relation to her pregnancy and may be financially supported when loss of work-related income occurs.

Parentage was left out of the AHRAct of 2004. Ottawa’s decision to steer clear of this policy area – which was included in the British model on which Canada otherwise relied – is due to jurisdictional separation of powers. Family law differs from province to province due to a longstanding provincial variation in legal systems. It seems that the legislation regarding parentage and assisted reproduction is often viewed as inadequate and considered as leaving legal loopholes around the filiation of a child born through such practices (e.g. Giroux 1997; Tahon 2004; Roy 2005). For instance, while the Act created a criminal prohibition for commercial surrogacy, it contained no discussion of surrogacy contracts, which are considered provincial jurisdiction and are often decided on a case-to-case basis. This vagueness is created on one hand by the dislocation between federal and provincial law on assisted reproduction and the provincial family laws, and on the other hand by the inadequacy of family law with the reality of families resulting from assisted reproduction (L'Espérance 2012).

Sub-National specificities

Variation in policy and their implementation among provinces are not only observable within Canada, but also within the constituent countries of the United Kingdom.

Fertility services provision, gamete and embryo donation and surrogacy arrangements are susceptible to differential implementation depending on the region studied. This variation is most striking when looking at each issue independently.

Access

As presented in Table 2, the most striking difference in terms of access to fertility treatments in Quebec, Ontario and England are access criteria. The three sub-national units fund fertility treatments, IVF in particular, to a certain degree. The biggest difference resides in Quebec's full coverage of fertility treatments, Ontario's strict limitation of access to medically necessary cases of female factor infertility, and England's regional variationd in the implementation of a variety of eligibility criteria.

Table 2: Status of Access to Fertility Treatments in Quebec, Ontario and England in December 2010

	Coverage	Coverage information	Additional information
Ontario	Restrictive	<u>Eligibility Criteria</u> Restricted to women with two blocked fallopian tubes. <u>Number of IVF Cycles Covered</u> Three cycles <u>Number of Embryos that Can Be Transferred per Cycle</u> Not reported but CFAS and SOGC jointly practice guidelines recommend elective single embryo transfers	The Ontario Health Insurance Plan (OHIP) covers the cost of IVF for women meeting the eligibility criteria, excluding the cost of drugs.
Quebec	Comprehensive	<u>Eligibility Criteria</u> All women (regardless of sexual orientation) of child-bearing age <u>Number of IVF Cycles Covered</u> Three stimulated cycles or six natural cycles. <u>Number of Embryos that Can Be Transferred per Cycle</u> Promotion of best practices: One embryo per cycle. The physician may, under exceptional conditions, transfer a maximum of 2 embryos if the woman is 36 years of age or younger, and a maximum of 3 embryos if the woman is 37 years of age or older.	The Public Prescription Drug Insurance Plan covers the medications used for the purpose of assisted procreation. Quebec also offers a refundable tax credit for expenses related to the treatment of fertility, including IVF. The credit is equal to 50% of all eligible expenses with a maximum credit of $10,000 per year. To be entitled to the credit, the applicant must have been a Quebec resident as of December 31, 2008.

England	Partial	Eligibility Criteria Women aged 23 to 39 years at the time of treatment One or both individuals have been diagnosed with a fertility problem (such as having no sperm or both fallopian tubes being blocked) Couple has experienced infertility for at least 3 years Number of IVF Cycles Covered Three Number of Embryos that Can Be Transferred per Cycle Two embryos per cycle	Coverage is based on the National Institute for Health and Clinical Excellence (NICE) guidance for infertility treatment. The Code of Practice address clinical issues. The HFEA provides a code of practice for both private and publicly funded IVF cycles, which covers egg and embryo transfers and the prevention of multiple births.

Quebec

In the fall of 2008, the government of Quebec made a commitment to discharge the costs of assisted reproduction for couples and women wishing to have children. "An Act respecting Clinical and Research Activities relating to Assisted Procreation" —which aims at ensuring that the practice of assisted procreation in Quebec is of high quality, safe, and ethical—was passed by the National Assembly on June 18th 2009. The government adopted two regulations for the bill to come into effect: the "Réglement sur les activités cliniques en matière de procréation assistée" which defines clinical practices and the "Réglement modifiant le réglement d'application de la Loi sur l'assurance maladie" which specifies the procedures covered. The bill and both regulations have been in effect since August 5, 2010. Since that time, services were completely subsidized by the province.

The choice of which fertility treatment to apply depends on the cause of the infertility. The most appropriate treatment for each person or couple is determined through discussion with the attending physician, based on the cause of the procreation difficulty and its clinical features: ovarian stimulation, donor insemination, in vitro fertilization (IVF), or embryo transfer are then privileged. All women of childbearing age—including lesbians and single women—can have access to services. All costs related to medical procedures and medication for ovarian stimulation, artificial insemination and three cycles of in vitro fertilization are defrayed by the public plan. This includes the services required for retrieval of eggs and ovarian tissue, in vitro fertilization, transfer of a fresh or frozen embryo and sperm extraction via medical procedure. The plan covers three stimulated cycles of in vitro fertilization, which produces several ova and embryos, and one-by-one implantation of each embryo for as many times as there are embryos. On the other hand, the plan covers up to six cycles for natural or modified natural cycles, which generally produce a single embryo. The public plan does not pay for services for in vitro fertilization beyond three stimulated cycles or six natural cycles. The Public Prescription Drug Insurance Plan, in accordance with the normal provisions, covers the medications used for the purpose of medically assisted reproduction. Private insurers cover individuals with access to a private plan.

Furthermore, the government wanted to reduce the number of multiple pregnancies from in vitro fertilization from 30% to 5% with the aim of reducing the costs of neonatal treatments. Multiple pregnancies are, among other things, a source of premature births, entailing their own complications, some of which are permanent. The approach fosters not legally binding but mostly applied best practices such as modified natural cycle and implantation of one embryo at a time. The physician may, under exceptional conditions, transfer a maximum of 2 embryos if the woman is 36 years of age or younger, and a maximum of 3 embryos if the woman is 37 years of age or older. Although the plan must ensure fair access to all Quebec couples, at the outset, in 2010, only four clinics (McGill Reproductive Center, Montreal Fertility Center, OVO, and Procrea) were providing fertility treatments in Montréal and Quebec City, resulting in long waiting lists.

Ontario

Ontario is the first province to have built and organized an ART services delivery system in Canada. In the late 1980s, the Ontario government promoted that service delivery would essentially be provided by university hospital centers throughout the province. Fertility treatments were included de facto in public health insurance. The medicalization of the issue of reproduction as well as the desire to dominate this new knowledge economy contributed to provincial funding of ART from its first appearance in the mid 1980s. However, circumstances that will be analyzed in Chapter 4 changed the province's approach to funding fertility treatments.

In 1994, Ontario faced intense economic restructuring and a turbulent political climate. The province thus decided to limit its funding and to cover IVF exclusively for women whose both fallopian tubes were blocked, a diagnosis that represents only 1% of the cases of infertility[18]. The Ontario Health Insurance Plan (OHIP) covers the first three treatment cycles. A treatment cycle includes preparation, oocyte retrieval and embryo transfer. In cases where IVF is covered, the blood work, ultrasounds and medical procedures are insured in all hospital and non-hospital community-based fertility clinics in Ontario. When insured IVF is provided in hospitals (that is, in the Mount Sinai Hospital Reproductive Biology Unit, London Health Sciences Fertility Clinic) or in the Ottawa Fertility Centre, associated embryology services are funded (in addition to the blood work, ultrasounds and medical procedures noted above). Patients cannot be charged for such services provided in those three facilities. The ministry does not fund fertility drug costs, intracytoplasmic sperm injection (ICSI) or costs associated with the freezing and storage of sperm, eggs and embryos, regardless of where insured IVF services are provided. Donor insemination is covered by OHIP. Assisted reproduction services are provided in 14 specialized clinics and several fertility centers and private physicians' offices in Ontario. Most of the 14 clinics are private and situated in the Toronto, London and Ottawa corridor.

England

England has a nationalized health system, the National Health Service (NHS). However, fertility treatments provision and their funding varies significantly across the UK, a situation that is often referred to as a "postcode lottery". This disparity of access is due to the regional autonomy of England regarding the UK and regional funding bodies (Primary Care Trusts (PCT)) within it. The PCTs vary regarding their ART policy in the absence of an adequately forceful central directive. Individual clinics – in co-operation with PCTs if the NHS funds them – make decisions about which clinical services they choose to offer, and about access to those services. Thus PCTs in England have divergent definitions of infertility and waiting times also differ markedly (Infertility Network UK 2008) – See appendix A.

The National Institute for Clinical Excellence (NICE) issues guidelines on patient access to ART in the NHS. These guidelines, however, are only recommendations. NICE has defined infertility as "failing to get pregnant after two years of regular unprotected sex"

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[18] IVF is not covered by OHIP except in the limited circumstances listed in Regulation 552 under the Health Insurance Act: "In vitro fertilization other than the first three treatment cycles of in vitro fertilization that are intended to address infertility due to complete bilateral anatomical fallopian tube blockage that did not result from sterilization."

(NICE 2002) though it has not explicitly defined infertility as an illness. Each PCT in England decides the scope of its ART funding and associated eligibility criteria. NICE's 2004 guidelines include funding for three full cycles of IVF to clinically eligible couples: that is, where the woman is aged between 23 and 39, and the couple have been having regular unprotected sex for three years. NICE recommends that it is appropriate to fund IVF treatment when the chances of success are more than 10 per cent. In February 2004 the government announced that all women with appropriate clinical needs should be provided at least one cycle of treatment paid for by the NHS, starting April 2005. In fact, a survey commissioned by the Department of Health in March 2009 found that 30% of PCTs were adhering fully to NICE guidelines by offering three full cycles of treatment, 23% were offering two cycles, 25% one full cycle and 22% one fresh cycle (Department of Health 2009).

Despite local differences in who is eligible for public funding of ART, there are some requirements common to all PCTs. Until recently, all Primary Care Trusts required applicants to be in stable relationships for at least two to three years and have no existing children. The 2008 Act deleted the duty imposed on treatment providers to have regard for "the need of the child for a father"[19] when considering children welfare. The amended Act directs them instead to simply have regard for the child's "need for supportive parenting"[20]. Whether this reform makes a major impact in practice depends largely on how the requirement of supportive parenting is interpreted by medical practitioners. 'Stable relationships' is frequently cited as a criterion for child welfare, which usually includes the proven ability to provide a caring environment for the child and an absence of child-related convictions or offences related to domestic violence. There is no absolute prohibition upon the treatment of single or lesbian women either in the 1990 Act or 2008 Act. However, keeping the welfare of the child principle in the 2008, even without the "need for a father" requirement, was hotly contested because of the possible discriminations it entailed.

Additionally, PCTs across the nine regions of England have different eligibility social and medical criteria for access to funding. These can include: limits on a patient's Body Mass Index, whether or not the patient already has children, the number of previous fertility

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[19] s. 13(5) of the 1990 Act

[20] s. 13(5) as amended by 14(2)(b) of the 2008 Act

treatment cycles taken, age of women and/or male partners, whether women and/or partner is a non-smoker, whether either partner had a previous sterilization. (See **Appendix A** for a full list of coverage criteria for all PCTs and NHS service providers in England) The HFEA does not regulate the cost of treatment set by private UK fertility clinics. Prices can vary from clinic to clinic. However, since the 60 clinics are in competition with each other for patients, prices tend to be similar.

Donation

The variation in gamete and embryo donation policies and regulation is somewhat more intricate. As presented in Table 3, in regard to parentage of donor-conceived children, the definition of who is their parent and if same-sex couples can be recognized as such was debated at very different time and through different channels in Quebec, Ontario and England. However the process in the three sub-national units resulted in similar outcomes, i.e. the definition of intended parents as legal guardian of the child and the recognition of homoparentality as a legitimate family form. As for the right of donor-conceived children to know their biological origins, only England regulated the issue while Quebec and Ontario implemented donors' anonymity through practice and law.

Table 3: Status of Gamete and Embryo Donation in Quebec, Ontario and England in December 2010

	Parentage	Same-sex parents	Right to know
Ontario	Mother: woman who gestates and gives birth to the child, regardless of their genetic origins Second parent: presumption that a husband, civil partner (male or female) or de facto partner is the other parent Multiparentality: Granted by court declaration only	Legal Parenthood granted to second parents by means of parental orders or birth certificate. (Administrative and Judicial procedures)	Donor anonymity
Quebec	Mother: woman who	Legal Parenthood	Donor anonymity

	gestates and gives birth to the child, regardless of their genetic origins Second parent: presumption that a husband, civil partner (male or female) or de facto partner is the other parent OR participant in parental project Multiparentality: Not recognized	granted to second parents directly through birth certificates. (Administrative procedures)	
England	Mother: woman who gestates and give birth to the child, regardless of their genetic connection Second parent: presumption that a husband or civil partner is the other parent OR consents to treatment with partner Multiparentality: Not recognized	Legal Parenthood granted to second parents by means of parental orders. (Administrative procedures)	Age 16: access to non-identifying information about the donor(s) + Access to information about number, sex and year of birth of half siblings Age 18: access to identifying information about the donor(s) + identifying information about half siblings if all siblings consent to the disclosure of this information by registering on sibling contact register

Quebec

In 2002, Quebec decided to recognize legally homosexual parents (Pratte 2003, p.543). In addition, these changes have opened the door to chosen single parenthood as the biological father is completely removed from the filiation system (Noreau 2002, p. 145-148). In this context, the new standards of filiation of a child born of assisted procreation helps lesbian couples and single mothers "by choice" to assert their rights as parents (Phillips-Nootens 2005). Quebec has become a pioneer in Canada in institutionalizing these principles through articles 538-542 of the Civil Code.

The parental project is the paramount principle in this new legislation. It defines that “the parental project involving assisted procreation exists from the moment a person alone decides or spouses by mutual consent decide, in order to have a child, to resort to the genetic material of a person who is not party to the parental project.[21]" Contributing genetic material for the purposes of a third-party parental project therefore creates no bond of filiation between the contributor and the child born of such donation[22]. Two innovative features are crucial. First, by stating that a single woman may have a child with the genetic material of another, the regime envisions chosen monoparentality as a possible familial model. Second, spouses may be of the same sex[23]. The legislation provides a basis for a birth mother's same-sex spouse to establish a bond of filiation between herself and the child. It states that, if both parents are women, the mother who did not give birth to the child assumes any rights or obligations legally assigned to the father[24].

It is worth situating participation in a parental project as a basis for establishing filiation in relation to the interests of the child and to the conventional view of filiation. The civil code provides that every decision concerning a child shall be taken in the light of the child's best interests. The code specifies that no adoption may take place except if it is in the best interests of the child. Indeed, while the regime refers primarily to the intention of the parties to a parental project, the rules also, secondarily, set up a rebuttable presumption in favor of the birth mother's legal partner on the basis of that status. If a child is born of a parental project involving assisted procreation between married or civil union spouses during the marriage or civil union, or within 300 days after its termination, "the spouse of the woman who gave birth to the child is presumed to be the child's other parent[25]". The presumption of paternity towards a birth mother's husband in the case of filiation by blood is now, in the case of assisted reproduction, a presumption of parenthood[26] towards her spouse, whatever that spouse's sex.

Finally, personal information relating to medically assisted procreation is

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[21] Art 538 Civil Code Quebec
[22] Art 538.2 para 1 Civil Code Quebec
[23] Articles 521.1 and following of the Civil Code of Quebec. The effect of subsequent federal legislation is that married spouses too may be of the same sex (Civil Marriage Act SC 2005 c 33). 'Spouses' additionally includes de facto spouses, who may also be of the same sex (Interpretation Act RSQ c I-16 s 61.1)
[24] Art 539.1 CCQ. The contemplation in this part of the code of two mothers, but not two fathers, reflects the legislature's maintenance of the nullity of surrogacy agreements (art 541 CCQ). In other words, the legislature seems to understand that two men are not to have a child conceived for them by means of a parental project. See the following Quebec surrogacy laws section.
[25] Art 538.3 para 1 CCQ
[26] When the spouse of the mother is presumed to be the second parent of a child. In case of a married couple, the child has de facto two parents. This was modified to include same-sex partners in a civil union.

confidential, subject to a serious harm exception[27]. Information collected by clinics and physicians provides access to the donor's genetic profile and health history, but preserves the individual's anonymity if that is his or her choice. A donor may choose to be identified or not; confidential information cannot be released without the donor's consent.

Ontario

Ontario's response to new technologies of reproduction was made mostly by judicial mobilization and jurisprudential modification to family law. Legally establishing parentage is done through the framework of the Children's Law Reform Act (CLRA). Part II of the Act sets out who is presumed to be the father. It also provides the scheme whereby a person can make an application for a declaration that he or she is the father or mother of the child. Additionally, the Vital Statistics Act (VSA) establishes who can be registered as parents on a child's birth certificate. Following the CLRA, only two models of legal parentage exist: natural and adoptive parentage. The first consists of the legal bond connecting a child to its birth mother and to its genetic father. It assumes that all children are born from one man and one woman and these are the child's intended and actual "real" parents. The mother is defined as the woman who gestates and give birth to the child, regardless of her genetic link to the child she carried. The general law governing the establishment of parent–child relationships has also been based on presumptions which determine that a child's father is the male spouse of the birth mother, even where the latter conceived with sperm donated by a third party. The second model is adoptive parentage and is mostly sustained by the interest of the child principle. In applying for a parental order, the parents declare their intention vis-à-vis the child. In this case, the same presumptions are applicable for the second parent as the ones taken into consideration in a natural parentage case.

In the Rutherford case[28], a judge allowed a constitutional challenge to Ontario's VSA. The judge accepted that the differential treatment of non-biological intended fathers and non-biological intended mothers was unconstitutional. It discriminated, contrary to Section 15 of the Canadian Charter of Rights and Freedoms, on the bases of sex and sexual orientation. Following the decision, since January 2nd 2007, the VSA permits that two lesbian mothers

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[27] Art 542 CCQ

[28] Rutherford v Ontario (Deputy Registrar General) (2006) 81 OR (3d) 81 (SCJ)

may register their child's birth as parents, but only if the father is unknown and conception is by assisted reproduction.

The courts were also instrumental in creating parentage between one child and its three parents. AA v. BB v. CC[29] involved lesbian mothers who were spouses and who wished to acknowledge their child's father as a parent without denying the co-mother's rights. In the first instance, they were unsuccessful. The parties appealed and asked to advance constitutional arguments for the first time. On January 2, 2007, the Ontario Court of Appeal granted the lesbian co-mother status as the parent of her child. The court ruled that the CLRA did not permit declarations in favor of two mothers as a matter of statutory interpretation and declined to rule on the constitutional arguments. Instead, the court granted the co-mother status as a parent using its parens patriae jurisdiction. The court held that the drafters of the CLRA had not contemplated the realities of modern family forms. There was no intention to exclude lesbians, or other non-biological parents, from parental recognition. Rather, the legislative gap had become obvious now as a result of changing social circumstances. The decision was, however, not referring to the need for legislative change. As a result, the CLRA recognizes only the nuclear family, excluding other family forms from legal recognition. In other words, the 'ABC family' was granted the legal status of a multiparental unit without opening the law for other similar families. Families who would like to acquire the same status need to pursue litigation to know if they could be granted that legal status.

England

Amendments with regard to donation made to the previous Act in 2008 can be grouped into two categories. The first category of statutes concerns the impact of fertility treatments on the family. Changes to the determination of parenthood in Part 2 of the HFEAct of 2008 are significant and expand the range of those who will legally count as parents. Section 42 recognizes same-sex couples as legal parents of children conceived through the use of donated sperm, eggs or embryos. The new provision enables, for example, the civil partner of a woman who gestates a child conceived via IVF to be recognized as the child's legal parent, whereas the 1990 Act tacitly assumed that the partner of a woman giving

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[29] 2003 (Ont. S.C.J.) 38 R.F.L. (5th) 1 and 2007 ONCA 2, 83 OR (3d) 561

birth would be male. Section 33 preserves the legal definition of the mother contained in section 27(1) of the 1990 Act, which defines the legal mother as the woman who gestates and gives birth to the child, regardless of their genetic connection. The Act also stipulates that maternity is restricted to one woman and that there can only be one other legal parent. There is a rebuttable presumption that a husband or civil partner[30] is the other parent[31]. If a couple who has undergone fertility treatment is not married or in a civil partnership, then the mother's partner may be deemed to be the other parent, given that either the "agreed fatherhood conditions"[32] or "agreed female parenthood conditions"[33] are met.

The second category of statutes concerns access to data collected by the HFEA and held on its register. In this regard, section 24 of the HFEAct of 2008, which replaces section 31 of the 1990 Act, confers certain new rights to information and confirms one of the most significant prior regulations that was the end of donor anonymity in 2004[34]. The 2008 Act lends further credence to this shift by allowing donor-conceived children to request non-identifying information about their donor at age 16 and confirms the existing position that at age 18 they have access to identifying information about their donor(s)[35]. This provision also permits donor-conceived children at age 16 to access information about the number, sex and year of birth of half siblings conceived using gametes donated by the same donor. At 18 years old, identifying information about these half siblings can be provided if all siblings consent to the disclosure of this information by registering on a new sibling contact register. The statute also allows a person over 16 to find out whether they are related to a person they intend to marry or with whom they intend to enter a civil partnership or to begin an intimate physical relationship, provided the prospective partner gives written consent. Donors are also entitled to information about whether their donation has been successful, the number of children born as a result of their donation, their sex and year of birth.[36]

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[30] In 2004, the UK has given legal recognition to same-sex relationships in the form of civil partnership. This legislative change was influential in the revision of the Human Fertilisation and Embryology Act in 2008.

[31] Sections 35 and 42 of the HFEAct

[32] Section 37 of the HFEAct 2008

[33] Section 44 of the HFEAct 2008

[34] The Human Fertilisation and Embryology Authority (Disclosure of Donor Information) Regulations were adopted in 2004 and implemented in April 2005.

[35] Section 31ZA of the HFEAct 2008

[36] Section 31ZD of the HFEAct of 2008

Surrogacy

The variation among Quebec, Ontario and England comes from their views on surrogacy pre-conception arrangements or the legal enforceability of contracts. As Table 4 shows, Ontario is the only unit that executes these contracts when the time comes to establish parentage of a child. Quebec legislated on the nullity of gestational contracts and made sure that the courts – that establish parentage in such cases – are not bound to take them into consideration when establishing parentage. England made changes to legislation in 2008 that enabled compensation for surrogates - strictly regulating the amount and circumstances of the payment – and that defined a clearer process to establish parentage.

Table 4: Status of Surrogacy in Quebec, Ontario and England in December 2010

	Arrangement	**Parentage**	**Additional Information**
Ontario	Enforceable	Mother Gestational carrier and birth mother until she declines her rights over the child, and the child can be adopted Genetic link needed Partial genetic link to intended father highly recommended How Parental order application	Interest of the child principle and protective services are used to screen the parties involved in the agreement. No precedent on the application of a gestational agreement in Canada. The courts are free to decide if the contract is enforceable in the eventuality of a surrogate deciding to keep the baby.
Quebec	Invalid	Mother Gestational carrier and birth mother until she declines her rights over the child, and the child can be adopted Genetic link needed Partial genetic link to intended father highly recommended How Parental order application	In cases of surrogacy, courts decide whether or not the process was ethical and legal – if there was retribution, if the interest of the child is protected – and can in such circumstances create filiation between intended mother, biological father and child.
England	Restricted	Who “Two persons who are living as partners in an	Administrative process overseen by children’s protection agency.

▨		enduring family relationship” Genetic link needed Partial genetic link How Parental order application	

Quebec

Since 1992, the Quebec Civil Code has explicitly stated that surrogacy agreements are null and have no legal standing. So far only a few cases in Quebec have specifically tackled article 541 of the Civil Code of Quebec, and it was given a very strict interpretation. In the eyes of the law, the surrogate mother is the child’s real mother and she cannot be replaced unless the child is later adopted. Thus, the intended parents can request a declaration of parentage when the father is genetically related to the child. It is therefore a very risky contract to make because the surrogate mother can decide to keep the baby and in that circumstance create a custody dispute between the genetic father and the surrogate mother. The genetic link with the egg donor/intended mother has not been yet recognized as a legal link between the child and the genetic mother.

Ontario

Ontario recognizes the surrogacy arrangement contracts to the extent to which the parties involved can be screened by the child welfare principle and the protective services requirements. In gestational surrogacy, in Ontario, it is possible with legal assistance to have the Statement of Live Birth sealed and to have only the intended parent(s) name(s) listed on the child’s birth certificate. First, the intended parents need to delay the completion of the birth registration. Legally, parents have up to 30 days after the birth of the child to complete this paperwork. Most intended parents with a genetic link to the child will conduct genetic tests to prove that the intended parent, or one of the intended parents, is genetically related to the child. Then, the intended parent application for a declaration of parentage under the CLRA is the only procedure required to legally seal away the Statement of Live Birth. Family courts then make the decision and create filiation.

The lack of clear legislative framework in Ontario bears out the risky nature of the procedure as well. A contract for a traditional surrogacy arrangement is likely to be unenforceable if the surrogate changes her mind. However, she would have to be proven unfit for the child to be removed from the birth certificate. If she did change her mind, she would have all rights to the child at birth whether a contract was signed or not. Since there is no precedent, it is difficult to determine the outcome for certain as it would depend on the judge presiding over the circumstances. The intended father would most likely have legal rights to visitation if pursued since he would be the genetic father, but he could also be required to pay child support.

England

The law on surrogacy in the UK is contained in the Surrogacy Arrangements Act 1985, which restricts the arrangement of surrogacy in the UK, and in the Human Fertilisation and Embryology Act 2008, which deals with parenthood and parental orders[37]. The family courts implement the law. The 1985 Surrogacy Arrangements Act seeks to regulate surrogacy so that there is no commercial dimension: advertising is forbidden for both parties and commercial third party brokering is illegal as is the case in Canada. Voluntary surrogacy agencies do, however, exist in the country such as Childlessness Overcome Through Surrogacy (COTS).

Surrogacy arrangements (involving heterosexual couples, single men and same-sex couples) are legal, although the law bars arrangements being brokered on a commercial basis and makes it an offence to advertise for a surrogate mother. Under English law, the surrogate mother is always treated as the legal mother of a child at birth. If the surrogate is married or in a civil partnership, her husband/civil partner is treated as the child's second parent, and this excludes the intended father from having any legal status at birth. If the surrogate is not married or in a civil partnership (at the time of conception), the biological father will usually be treated as the child's legal father. The eligibility preconditions for seeking a parental order following an uncontested surrogacy arrangement were widened by the 2008 Act. Section 54 extends the category of couples who can apply for these orders, which effectively bypasses the need for adoption in such cases. In addition to married couples, civil partners and "two persons who are living as partners in an enduring family relationship and are not within prohibited degrees of relationship in relation to each other" (United Kingdom 2008) may

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[37] See sections 33 to 55 of the HFEAct

apply. It remains the case that only couples are eligible to apply for these orders and that the child must have at least a partial genetic link to the couple.

Couples who enter into a surrogacy arrangement may apply to the court within six months of their child's birth for a parental order in order to acquire parenthood. Parental orders are designed specifically for surrogacy situations and have the effect of extinguishing the status of the surrogate mother (and her husband/civil partner) and conferring full parental status instead on the applicants. Following the grant of a parental order, the child will be issued with a new birth certificate naming the applicants as the child's parents.

As of April 2010, same-sex couples are also eligible to apply. Whether or not they are civil partners, but they must be in a relationship; single men remain ineligible. To obtain a parental order, the court will have to be satisfied that the following conditions have been met: one of the applicants is the child's biological father, the applicants are over 18 and are applying as a couple within six months of the birth, at least one of the applicants is domiciled in England, the child is in their care at the time of the application, the surrogate mother (and her husband or civil partner) consent fully and freely to the order being made, and the surrogate mother has not been paid more than reasonable expenses, or alternatively the court agrees to authorize any payments which have been made.

Conclusion

This chapter laid out some basic facts about long-term trends and public policies relating to assisted reproductive technology, and more precisely access to fertility treatments, gamete and embryo donation and surrogacy. By providing an overview of the current laws and practices, this chapter showed how the three sub-issues of assisted reproduction are managed differently in Quebec, Ontario and England. This policy variation justifies an in-depth study of the policy processes that led to their adoption, moreover one that estimates the influence of ideas and discourses on the policy outcomes.

In the next chapter, it will be discussed how when looking at the various studies published in other fields of research, such as sociology or law, one can have a better sense of how fundamental the making of meaning can be in the field of assisted reproduction. Scholars of disciplines outside political science have extensively studied social conceptions and representations of reproduction and technologies. The discourses underlined in these studies tell us a lot about the various political ideas created in the policy processes. Framing infertility influences the way we think about access, donation and surrogacy and accordingly influences the policy outcomes.

The next chapter also critically approaches the studies of policy variation that were recently undertaken by political scientists. Thus I aim at understanding the factors that have already been taken into consideration in the studies of the regulation of assisted reproduction in order to draw from their findings and learn from their limits. That will provide an opportunity to understand and identify the different ideas that came into play in the regulation of access, donation and surrogacy in Quebec, Ontario and England and put them in their context in order to assess the performativity of frames and the factors that trigger discursive mechanisms or not. On the other hand, the next chapter takes a close look at the different conceptions of infertility the literature studied in the last years and tries to reach their importance for the study of policy processes.

CHAPTER 2
LITERATURE REVIEW

From the study of paradigms (Béland and Hacker 2004; Jenson 2009), the analysis of cultural framing (Stryker and Wald 2009), the impact of discourses (Bhatia and Coleman 2003), and discussions about the potential interdependence of causal factors (Padamsee 2009), the relationship between ideational processes and social policy has been well presented by political scientists. Despite their common interest in acknowledging the role of ideas in the policy process, each considers a different angle when analyzing policy change; some consider the broader ideational context in producing new political rules of the game while others analyze discursive interactions in policy sub-systems leading to policy (re)formulation. Few scholars have paid attention to the role of ideas at both levels simultaneously even if it is generally recognized that they are not mutually exclusive.

When looking at the regulation of ARTs, the multiple ideational levels influencing the debate are one of the first things scholars interested in this policy domain observed and discussed. The area and its constitutive sub-issues are located at the intersection between science, society, psychology, law and politics. From the conception of the welfare state to the expression of medical risks, from the notion of "good parenting" to human rights, an array of ideas are mobilized by communities of actors seeking state support. Drawn as much from their individual experience than from their social context, ideas are selected, interpreted and mobilized by political actors in their endeavor to influence public policy. Perceived mainly as a private problem a few decades ago, infertility is now seen as a social problem in Canada and in the UK, one that requires some form of state intervention. Following Ginsburgh and Rapp's (1995) work, I see the politics of infertility as merging the two perspectives – universal and particular - into the multiple levels on which reproductive practices, policies, and politics are defined.

ART is a policy domain where preferences are multiple, intertwined and/or blurred. Hence, I treat political decision-making in this field as based in bounded rationality. As Olsen (2001) convincingly puts it, many political scientists already found "great diversity in human motivation and modes of action" (p. 195). Actors may be driven by practices, emotions, and values. When confronted with the immediate and future effects of infertility and the restorative power of reproductive medicine, behavioral logics are even more changeable. Preferences are sometimes incompatible among the participants of the policy process and/or vaguely defined by policy communities. Some preferences are even subject to limited discussion because of the political difficulties that their moral/ideological character generates within the political system. The point here is that preferences held by individual or collective actors may well be reliable and could be well claimed, but the same preferences within the decision-making structure might not be consistent with the context of the political struggle. In other words, the ideational and institutional context of claim making is instrumental to its resonance in the broader political milieu of political deliberation.

ART is a policy domain that is not always understood by its own members[38]. The very fact that the technologies are always evolving and that uncertainty is growing, accordingly makes global understanding difficult, and this in turn pushes political actors to specialize their knowledge and limit their activity to one medical technique or one social issue brought about by assisted reproductive technologies. Because of this constant technological and social evolution, "adaptation rather than comprehensive strategic planning from the center" structures the system (Peters 2002, p.7). Thus, the goals and means of governing tend to emerge from practice rather than being imposed by the law.

Assisted reproductive technologies often raise intractable policy controversies (Schön and Rein 1994), or as Deborah Stone called it, a paradox (2001). Logically, "two contradictory interpretations cannot be both true", but as Deborah Stone (2001, p.1) argued, political life is full of situations where the same facts can be interpreted differently or used with a distinct purpose. In addition, the governance of assisted reproductive technologies is complex because it is unexpectedly "resistant to resolution by appeal to evidence, research, or reasoned argument" (Schön and Rein 1994, p. xi). Policymaking in such areas tends to be subjected to considerable uncertainty and ambiguity (Shapiro 1999). Despite the very technical aspects of the technologies and the importance of scientific information for policy-making in the domain of biomedicine (Jasanoff 2003), the regulation of ARTs is characterized by a vast array of facts, logics and emotions that are at times complementary and at times competing for attention. I argue that depending on their definition of the issues,

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[38] Basen, Eichler and Lippman's book titled *Misconceptions : the social construction of choice and the new reproductive and genetic technologies* (1993, Hull : Voyageur Publishing) is based on this idea that reproductive technologies have a multiplicity of meanings and effects, all of which lead to greater ambiguity.

political actors differ as to what facts they regard as relevant, and even when they focus on the same facts they do not necessarily give them the same interpretation.

By reviewing the broad scope of literature on assisted reproductive technologies, assisted reproduction and kinship, this chapter presents two sets of studies informing the understanding of the policy debates and the way the problem of infertility can be constructed. First, the effort of political science to identify the factors influencing the regulation of assisted reproduction and biotechnologies challenged me to reflect on the level of analysis used by political scientists and the need to unpack ARTs. While providing great comparative insights on the first wave of legislation following the emergence of ARTs (period between 1970 and 1990), this literature is limited in terms of identifying common explanatory factors and explaining of sub-national variations. Second, this observation led me to identify studies about the many discourses and social representations of infertility, reproduction and kinship and the impact these constructions have on law and society. This review led me to identify and define key frames that have been mobilized in the policy process in Quebec, Ontario and England between 1990 and 2010. Therefore, a short list of frames will guide the comparative analysis that supports this dissertation.

Policy variation among countries and political science

With the aim of explaining national variation in the regulation of ARTs, the existing political science literature has focused on studying the influence of three major factors: the institutional configuration, actors' configurations and ideational factors. To begin with, the literature shows the differing influence of national institutions on the regulation of reproduction. In their comparative public policy study of assisted reproduction, Rothmayr and al. (Rothmayr, Varone et al. 2004, p. 238-245; Varone, Rothmayr et al. 2006; see also, Montpetit, Rothmayr et al. 2007) find no clear trend in explaining differences in regulation between countries according to the types of policy systems. The policies in this area are neither similar in federal states nor in unitary countries. For instance the United States (Goggin and Orth 2004; Garon and Montpetit 2007) and Canada (Montpetit 2004) have taken a permissive approach,[39] while Germany and Switzerland have developed highly

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[39] In *The Politics of Biotechnology in North America and Europe: Policy Networks, Institutions, and Internationalization*, Montpetit, Rothmayr, and Varone established three ideal-types for the design of

restrictive regulations. In contrast, France has taken an intermediate response to conflicts over the development of new reproductive technologies by regulating the medical use of ARTs as well as restricting patients' access to treatments (Engeli 2004), while England has treated technological development liberally, providing significant autonomy to the medical community (Blank 2004).

Mixed findings about the influence of institutional structures on the regulation of reproduction have encouraged researchers to turn to the logic of policy sectors and actor configurations (Bleiklie, Goggin et al. 2004). Their findings are nevertheless incomplete and contradictory. In terms of political parties, studies show that the regulation of assisted reproduction is a challenge to the left-right cleavage that characterizes politics in a number of countries, even when a faith-based political party is involved (Fink 2005). The literature has emphasized the importance of specific players in the regulation of reproduction, such as the medical community and the feminist movement. Comparative studies on the politics of assisted reproduction have given a central role to the medical profession, considered the main target of this type of policy (Bleiklie, Goggin et al. 2004). This focus has led to the formulation of explanations focused on the autonomy granted to the medical profession in accordance with their mobilization. Montpetit (2004) even proposed that non-decision in Canada safeguarded the autonomy of the medical profession. He stressed a symbiosis between the power of physicians' networks, the Canadian division of responsibilities in health care and new managerial ideas. He argued that a combination of these factors explained non-decision in Canada, and as a result, protected medical autonomy and self-regulation by the medical body. Moreover, feminist movements were identified as being instrumental in underscoring the ways in which these technologies redefined prevailing social practices and values, such as reproduction, parenthood and family (Stanworth 1987; Scala, Montpetit et al. 2004; 2005). Then again, the direct influence of these movements on policy development seems to be different depending on the context of their action. For example, Scala, Montpetit and Fortier (2005) revealed how, in Canada, the National Action Committee on the Status of Women's capacity to influence and participate in the formulation of policy regarding ARTs was challenged by its inability to resolve competing demands, by

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Biopolicies in the Assisted Reproductive Technologies and Genetically Modified Organisms sectors (Table 1.1, p.8). The permissive type was defined as *"everything is allowed with some exceptions*".

the institutional context of politics which called for professional advocacy, and by the internal demands for deliberation and participation originating from its grassroots member groups. Again turning to actors was informative in studies that restricted their analysis to one particular moment of deliberation in one country. That limited explanatory capacity led political scientists to turn to the study ideas, sometimes in configuration with institutions and interests, and assess their influence on policies.

The impact of framing and discourses, or more generally ideas, was illustrated in five studies of political science. The first focuses primarily on reproductive issues related to biomedicine and compares discourses in the United States and Canada. Alison Harvison Young (1998) argues that the dominant discourse of individual rights led to a correspondingly minimalist government role in the USA. In Canada, she proposes that the dominant discourse has been social democratic, assuming and expecting that the government can, should and will seek to improve the welfare of citizens. In other words, the dominant discourse in a country is an indicator of the government's willingness to act upon a policy issue, explaining why Canada regulated the issue more extensively in the 1990s than the United States. Harvison Young's comparison of the different discourses heard at the Royal Commission on New Reproductive Technologies in Canada and the different American court cases heard at the same period are not sufficient to fully show how discourses emerged and influenced policy-making in the two countries. This snapshot of a very intense, but still short period of time does not offer enough empirical rooting to encompass the vast array of discourses that never had access to these specific and elite-driven political arenas. Besides, Harrison Young somewhat restates, in the particular context of the regulation of assisted reproduction, well-known assumptions about differences between Canada and United States in terms of political culture and values, which were heavily criticized and challenged by Canadian scholars.

The second study by Gottweis (2002) focuses on research issues related to biomedicine. He shows that differences in the regulation of stem cell research in Germany and the United States can be explained by the discourses on embryo research. The American discourse legitimized state funding of stem cell research by building a national imperative to ensure the country's leadership in scientific research. The market-driven discourse then explains the involvement of the state in the field. In contrast, the German human rights discourse contributed to the restrictive nature of its regulation. Again, this study shows how discourses are important in the determination of policies whilst stressing the differences between research and reproduction issues brought about by assisted reproductive technologies. Gottweis's discourse-analytical perspective is based on the long-term tracking of the policy narratives in the two countries. To do so accurately, Gottweis studied only one sub-issue of ARTs, which affirms the importance of unpacking policy areas in order to fully perceive the distinctive discursive dynamics and their effect on policy outcomes.

The third study, by Montpetit, Rothmayr and al. (2005), similarly showed that social representations of health care issues and the medical community, together with the institutional context, help to shape ART policies. They argued that policy makers' understanding of the actor networks concerned with ART can be tinted by perceptions of social groups in specific institutional contexts. They have shown that this is particularly the case in jurisdictional federations where discourses to increase the legitimacy of medical actors' policy options are prevalent. Trusted physicians and researchers in Canada and Belgium benefit from permissive ART policy designs. In contrast, functional federalism encourages policy makers to rely on types of discourses that construct target populations independently of widely held perceptions. Montpetit, Rothmayr and Varone showed that restrictive policies resulted from such discourses in Germany and Switzerland. As far as ART policy are concerned, cooperative discourses prevailed in both the United Kingdom and France. In both cases, the target populations situated in the shadow of hierarchy initiated the coordinative discourses. The latter's aim was to convince policy makers to legislate moderately. Here, Montpetit, Rothmayr and Varone showed that different types of discourses paired with a specific institutional context led to a particular policy outcome. Conversely, this study and all the others studying the role of ideas in the definition of ART policies, concentrated on a macro level analysis of public policy, leaving aside the policy debate taking place within the countries in constituent nations, provinces, states, lander, etc. Also driven by the impulse to understand the national variation as regards biopolicies, Montpetit, Rothmayr and Varone were confined by the national structures.

The fourth study (Engeli 2007) examines to what extent public controversies with a moral dimension, such as abortion and access to assisted reproductive technology, lead to significantly different policy design in France and Switzerland. The study demonstrates the importance of taking into account the configurational impact of institutional interests and ideational factors to explain the evolution of public policies on controversial issues. Her neo-institutional approach led Engeli to argue that feminist movements played contrasting roles in the public controversy over regulation of the assisted reproductive technology sector. While adopting a similar critical discourse, the feminist problematization of the issue actually achieved its ends in very different ways in France and Switzerland. In France, feminist movements were faced with a public controversy mainly focused on the legitimacy of the desire to have children. In Switzerland, the alarmist feminist discourse on reproductive technology coincided with the critical stance adopted by left-wing parties and to some extent, pro-life movements. This discursive resonance, Engeli argues, gave the Swiss feminist movements greater leverage in the public debate. Despite Rothmayr, Montpetit, Varone and Engeli's important conclusions on the connection between types of discourses and national systems, their findings need to be nuanced through the analysis of the many policies that are implemented at the sub-national level and the distinct discourses brought about by sub-issues of ARTs.

Finally, the fifth study by Kettell and Cairney (2010) argues that the reform of the 1990 Human Fertilisation and Embryology Act in 2008 was a battle of ideas between two sides: the supporters of the medical frame and the claimants of the human rights frame. They consider that the only way to appraise the role of ideas in the policy process is to mesh ideas with power. This research article is compelling and shows the intertwined nature of actors and discourses. However, the empirical analysis proves to be oriented towards the issues of embryo research, accordingly excluding the various and intense debates on access, donation and surrogacy the reform of the HFEA unleashed. As well, Kettell and Cairney's study rest upon notions of power and ideas that are not specifically defined. The most important challenges in operationalizing the concept of ideas is to define them, show the interrelated but singular influence of ideas and power on the policy process and identify their effect on the policy or their implementation. Despite their interesting attempt "to take the power of ideas seriously", this last study does not produce a comprehensive account of the ideas, actors and arenas mobilized when the HFEAct of 2008 was debated.

The political science literature has demonstrated that assisted reproductive technology is a complex policy domain, one that is influenced by various institutional contexts, actors' constellations and ideas. However, the limited amount of public policy and political science research especially on sub-issues related to the medicalization of reproduction demonstrates a need for more detailed analysis of the influence of ideas in this specific policy area and its constitutive sub-issues (access, donation and surrogacy). The literature shows very different and sometimes contrasting conclusions about the impact of discourses on policy development, depending on the sub-issue they were studying more closely and the level of analysis they favoured. Most of the studies consider the influential character of ideas in a combined manner with other factors such as institutional arrangements, actors' configuration or both. Furthermore, the lack of clarity regarding which ideas, conception or frames influence policy processes in regard to assisted reproductive technologies prompts a reflection on the policy domain as studied by political scientists, on the level of analysis they privilege, and the explanatory factors they study or put in relation to one another.

ART: one policy domain?

Beginning in the 1990s, technological advances created a number of controversies, thus increasing attention to the challenges associated with biotechnology. In some countries during the early stages of public debate, all types of biotechnology applications were folded into a general discussion of the risks and benefits of what we called genetic engineering (Abels and Rothmayr 2007, p.154-157). The focus soon shifted to the specific applications of biotechnologies such as assisted reproduction. Developments that raised awareness included the first successful in vitro fertilization (1978); pregnancy after cryopreservation of oocytes (1986); gene therapy treatment (1990); intracytoplasmic sperm injection (1992); genetic testing (1995); cloning (1997); and embryonic stem cell research (1998). That specialization of issue regulation also had its effects on political science studies. During the same period, academics segmented their object of research and deepened their analysis of one aspect of biotechnology at a time. Hence, depending on the precise issues being studied, medical biotechnology policies have been defined in a number of ways, including being framed in terms of health policy and regenerative medicine (Gottweis, Salter et al. 2009), as family and parenting issues (Luce 2010), within gender policy (Engeli 2009), as value-driven issues (Banchoff 2005), and as policies on scientific research (Harvey 2009). Some of them raised some legal and social implications, including ownership rights over embryos and parental rights of gamete donors and surrogates. The complexity of the issues brought about by biomedical advances and practices asks especially for a reflection on "what" is precisely the policy domain at stake.

Bearing in mind that studies of assisted reproductive technologies, medically assisted reproduction and biomedicine analyzed a wide range of issues through diverse analytical angles, I want to argue that what are broadly called ARTs are, in fact, many different political issues that all bring about their own logic of public action. For instance, stem cell research and kinship were already taken outside of the ART box by researchers in social sciences without any criticism; they unleashed specific questions of scientific research, ethics and legal formulation, which were considered unique by peer researchers. What has never been questioned by social studies of sciences and technologies was the specificity of all sub-issues of ARTs and how particular fields of research classify these issues in their own ways. This dissertation aims to further unpack medically assisted reproduction with the aim of exploring the political sub-issues related to reproduction. However, this dissertation does not claim to be a comprehensive study of all sub-issues or to provide a blanket classification of ARTs sub-issues. In fact, the specific angle of this work is driven by citizens' experience and their relationship to the state. In other words, this analysis unpacks ARTs from the angle of infertility.

Whether future parents need medical assistance for conceiving or are "diagnosed" with social infertility[40], assisted reproductive technologies are one means to their ends. As discussed, the medicalization of conception led to the increasing involvement of the State in the private life of citizens. This involvement took multiple forms – legislation, regulation, code of practices, etc. - and was implemented in courts, clinics, bureaucracy, and professional associations. In the interests of unpacking this broad policy domain, I identified three different issues brought about by the medicalization of reproduction: 1) access to fertility treatments; 2) gamete donation; and 3) surrogacy. These three reproductive issues bring about their own dynamics of political mobilization, discourse definition, policy preferences and implementation, consequently awarding them the status of policy area. Far from rejecting the public policy literature on ART conducted by the previously referenced

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[40] Luce (2010, p.162) talks about the progressive access to clinics lesbian acquired in the 1990's as a process by which lesbians inseminations has passed from being considered a special request to a fully recognized medical necessity.

authors, I am adding to their findings. Analysing the three sub-issues of ART as unpacked policy areas is the only way to really understand the impact of ideational factors on policy outcomes as well as their needed combination with institutional and interest-based factors in given contexts.

As demonstrated previously, the regulation of assisted reproduction is not just a dispute over medical autonomy or the scientific market, but also a conflict involving gender, rights, health management and values over life and family. This complexity has led to various studies in other disciplines, such as sociology, science and technology studies, anthropology and law. These studies reveal different ways of understanding the social and political impact of assisted reproductive technologies and the way societies manage their practice. In unraveling processes of construction of meanings over time and in different spaces, authors of other social science disciplines granted me singular tools to understand the politics of infertility. They led me to understand medically assisted reproduction as three distinct policy issues, therefore pointing to new ways of considering contextual factors and actors' participation in the public debate, but first and foremost, to identify relevant social representations and discourses.

Social representations and public action

For instance, a few studies reveal the influence of social representations on public action rationales. In their study of IVF coverage in England, Mladovsky and Sorenson (2010) present the current state of knowledge regarding the cost-effectiveness of IVF, arguing that the limitations of economic evaluation put into doubt the justification of employing such evidence as a sole determinant of public financing decisions. The study examines the merits and limitations of five alternative rationales to justify the reimbursement of IVF, which might more fully account for the social, political, ethical, and philosophical considerations embedded in notions of infertility and technology driven reproductive treatments. The five different rationales they identified are used to claim funding and access to fertility treatments. First, they noted that some patients felt IVF should be publicly funded because, for them, infertility is a disease or a medical condition. As a counterargument, it has been argued that infertility is not a disease, but that much like other discomforts or malfunctions, it is rather a symptom of a possible underlying disease. Mladovsky and Sorenson convincingly show that the term ‘infertility’ covers a range of disorders from sterility to possibly normal fertility if the period of non-conception used to define infertility is short in duration. It is not clear how long involuntary failure to conceive must continue before ‘infertility’ is attributable. As they show, in the clinical context, a threshold of 1 year has become the norm, while in epidemiological studies, 2 years is the standard.

The second rationale for access and public funding is one of eligibility. Who is eligible for treatment is widely debated. Rationales of medical necessity, worth and personal development have been competing in the social debate. An important policy issue relates to the use of the clinical definition of infertility to exclude single and lesbian women (‘socially infertile’) from coverage eligibility. A general point that can be drawn from the above is that where reimbursement policy excludes certain patient groups from receiving publicly funded services, public providers may take decisions into their own hands and provide these services regardless of the criteria. “Providers’ incentives for doing this are unclear, but presumably the criteria used by public authorities in these cases could not comply with providers’ own views on eligibility.” (p.118)

Third, there are two possible arguments that are advanced to support public funding of IVF based on the general rationale of human rights. The first argument relates to the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The second human rights related argument claims that everyone has a right to have children.

Fourth, the inequalities can be considered inequitable if they violate the principal of ‘equal access for equal need’ and instead relate to other characteristics, such as place of residence or ability to pay of infertile individuals. Gender, income, geographical access, etc. become the foundation of the inequality narrative, which relies not on a general rational of human rights but rather to the individual right to opportunities.

Finally, the natalist discourse argues that IVF should be publicly funded because it will increase a country’s total fertility rate and reduce population ageing. Family building is thus considered to contribue to state building and to the construction of human and economic resources. In that sense, the state should invest in reproduction in order to facilitate family building that could provide many socio-economical tools to the nation in the future. This narrative has also been studied with a cultural angle as we sill see later.

The five rationales identified and described by Mladovsky and Sorenson (2010) echo various other studies of sociology, law, anthropology and psychology that studied the multiple dynamics brought about by infertility and assisted conception. Drawing on this work, I contemplated the wide range of rationales discussed in the literature to come to identify the few that are mobilized in the political processes in Quebec, Ontario and England.

New conception of reproduction and kinship

The emergence and development of assisted reproductive technologies highlighted a very interesting debate on the naturalization of the in vitro embryo and the denaturalization of reproduction. Others discussed the fact that in vitro embryos were almost naturalized through the rapid spread of assisted reproduction in western countries. "As long as they are implanted into the mother's womb they seem hardly different from embryos produced by reproduction." (Jasanoff 2011, p.62) The medical intervention is seen as procedural - to a certain extent normal in cases of infertility - and excluded from the reproductive experience as soon as pregnancy is achieved. That way, as long as the procedure is successful, the couple that went through in vitro fertilization is no longer different from the couple that conceived naturally. Jasanoff argues that the western conception of genetic and medical technologies links scientific practices to a citizen's notion of rights. Interestingly, the studies of the denaturalization of reproduction came to similar conclusions as regards citizens' experience with pregnancy and parentage. The search for normality seems to occupy an important position in the experience of infertile individuals seeking medical assistance with conception.

With the rise of assisted reproductive technologies, other social science disciplines began to rethink the meaning of reproduction as a response to the fact that reproduction had lost its natural quality. The denaturalization of reproduction drove a wide range of studies that attempted to draw attention to the different social experiences related to procreation in this new scientific era. Biology took the place of nature and increased the impact of culture on our perception of the prevalence of biological facts in the production of kinship (Rapp and Ginsburg 1991; Ginsburg and Rapp 1995; Franklin, Edwards et al. 1999). As a result, not only did our ways of having children and the social relations that lead to conception changed, but structures institutionalizing the process of reproduction and parenting underwent profound change, as well.

Since the 1990's, ethnographic and sociological studies have documented the ways in which new technologies of assisted reproduction have transformed understandings of conception, pregnancy, and parenthood. Kinship studies related to reproductive technologies examine the tensions around family configuration produced by the use of new reproductive technologies. Thus, kinship is an ambivalent and shifting category, closely related to cultural and social contexts. The consistent finding by anthropologists studying egg donation (Bestard 2004; Orobitg and Salazar 2005), surrogacy (Roberts 1998; Ragoné and Willis 2000; Delaisi de Parseval and Collard 2007), and lay and governmental views of reproductive technology (Edwards 1999; Franklin, Edwards et al. 1999) suggests that people engage in a cultural negotiation, integrating new meanings of kinship parallel to traditional ideas of family relations based on blood and law. Assistance introduces a new order of facts that destabilize this foundation: i.e. the natural facts produced by technology (Franklin 1995, p.336).

The established authority of science in western countries facilitates ideational proximity between genes, identity and family. "Genetic links today seem to have a symbolic value similar to the relation of blood. Genes thus seem to play a more prominent role in the conceptualization of kinship" (Lebner 2000, p.373). By showing how kinship is redefined by scientific and technological developments, social scientists showed how difficult it is for political actors to obtain consensus on the legal and social vision the family should have in a given country.

If our perception of kinship is culturally bound and our way of conceiving family relationships was influenced by technological advances enhancing the importance of genetic links and parentality, it is unsurprising to see our former filiation scheme pressured to respond to new conceptions of infertility and parenthood. In the debate over assisted reproduction, bonds of blood, law and now genes propose new ways to reproduce and to create a child's filiation. As a result, we have to consider culture as a factor that influences debates over family law redefinition in the era of assisted conception. This literature signals a need to take into consideration the ways in which dominant images of reproduction, the family, technology and kinship can shape both political action and public policy in this field. On the one hand, the way we understand conception in a technological world influences our understanding of family and filiation. On the other hand, the way would-be-parents and donors conceptualize their relationship to the child, their contribution to the family and their role vis-à-vis their partner and children influences the rights and responsibilities they could claim. Reproduction is no longer an act of nature and involves new dimensions of self, which transform the ways in which families are conceptualized and rights and responsibilities are legally defined. The life course is thus altered by the use of technologies and science.

Infertility as a medical condition

In recent years, infertility and reproductive impairments have been transformed from private problems into social concerns (Scritchfield 1989, p.99). Significant changes in social patterns and values might reasonably be expected to have affected constructions of infertility. These include changing gender roles, increased rates of divorce and single parent families, and an apparent increase in sub-fertility. Indeed, the emergence of controversies around infertility and its treatment can be linked in part to the social construction of infertility as a problem requiring medical treatment (ibid, p.111). In western societies currently, there are tensions between seeing infertility as a medical condition or as a social problem. The medical framework seeks to understand difficulties in conceiving in terms of bodily malfunction, with a view to repairing or circumventing the malfunctioning part (Crawshaw 2009, p.273-274) while the social problem framework views infertility as a product of life choices influenced by the wider societal context. The increasing importance and prevalence of biomedicine added to the discomfort and taboos associated with infertility is said to contribute to the further medicalization of infertility in the western world.

Reproductive technologies can be situated in a broad set of inquiries that explore the links between science and society in general and the special role of genetic and reproductive science and technology in contemporary society in particular. “It provides an opportunity for exploring the interaction between science and power, the exercise of social control over knowledge, and the cultural authority of expertise in general.” (Scala 2007, p.212) Scientists have become influential actors in the policy-making process by way of scientific advisory boards and regulatory agencies. Governments increasingly rely on scientific knowledge to advise them on technology and science policy, especially in the biotechnology area. “[M]edicine and science never stop imposing their biological truth on us. Sustained by genetic tests, they tell us [among other things] who is the father…"[41] (Gavarini 2002, p.94). Still, the questions raised by the practices of ART are not only science-based, which means other types of knowledge challenge the authority of science and medicine in the public sphere. Giandomenico Majone (1989) used the term "trans-scientific" problems to describe issues which arise from technological or scientific developments but which cannot be resolved through a recourse to science. Interest groups, social movements and experts in the social sciences also contribute to define and structure the debate over the governance of infertility politics.

Thirty years after its first successful application, IVF became accepted both as a research discipline, a specialized medical field and as a common medical procedure (Van Dijck 1995). Media and government attitudes toward ARTs have contributed to further medicalize the issue of reproduction (Scala 2007); scientific research and technologies tend to be romanticized[42](Franklin 1990) while governments are inclined to promote self-regulation by the medical community (Rothmayr 2003). In Quebec, Ontario and England, the medical frame has been applied to many different areas of life as numerous types of health conditions, social statuses, and behaviors have been relegated to the health care system; infertility thus is one of many conditions that is discussed through the language of medicine.

In addition, considering medically assisted conception in relation to questions of parentality inevitably raises questions about the relationship of reproduction and maternity to the public management of health care services. Health has become one of the key ethical values in western societies. The responsibilities of states have expanded from the collective measures to ensure health that were widely adopted in the nineteenth century to the active encouragement of healthy regimes in the home and interventions in the rearing of children (Rose 2007, p.22). The literature focusing on the governance of health care issues related to reproduction and infertility highlighted the process of medicalization in place since the birth of the first test tube baby. Some commentators would say that the medicalization process was one aimed at tempering the fear attached to these technologies when they were first

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[41] Translation from French to English by the author.

[42] Headlines often talk about "miracle babies" or a "reproductive revolution", and also treat clinicians as saviours or technological magicians. "Reproductive… engineering news is often covered as a series of dramatic events with the stress on technological miracle, magic, and mystique. Today, reproductive… engineering as become a national symbol of progress…" See Raymond, J., 1993, *Women as Wombs: Reproductive Technologies and the Battle Over Women's Freedom*, San Francisco, Harper Collins Publishers, pages. p.110

practiced; others proposed that the medical sciences were able to create a rationale that helped decision-makers to provide efficient services to their population.

The work of Peter Conrad (2007) is key to understanding the nature and effect of medicalization on social processes. He explains that the medical nature of a condition resides much more "in the eyes of the beholder or in the realm of those who have the authority to define a problem as medical." (p. 4) In this sense it is the dominance of the designation in time rather than the reliability of the diagnosis that is significant for sociologists. An entity that is regarded as an illness or disease is not necessarily a medical problem; rather, it needs to become defined as one and keep its medical designation in time. Medicalization appears when a "problem is defined in medical terms, described using medical language understood through the adoption of a medical framework, or "'treated" with a medical intervention. [...] Medicalization describes a process." (Conrad 2007, p.6) This process is social, political, individual, etc. This dissertation is interested in the political influence this medicalization can have on policies and practices. In a political context, medicalizing an issue can limit the scope of the other ideas mobilized in the polity.

As Conrad notes, however, there are degrees of medicalization. A condition may not be medicalized, competing definitions may exist, or a previous definition may resist. There are also constraints on medicalization, including competing definitions of a condition, absence of support in the medical profession, limits on clinical treatments, and so on. Interestingly, Conrad argues that medical categories can shift on the continuum toward or away from more complete medicalization and shows that medical categories can also expand or contract in part because of the elasticity of medical categories. "While some categories are narrow and circumspect, others can expand and incorporate a number of other problems" (Conrad 1992, p.221). In that way, the medical frame can be crucial in the deliberations without producing the medicalization of an issue. That way, the medical frame is still subject to reframing attempts.

According to Conrad, a range of factors, including declining interest in religion, an abiding faith in science, rationality, and progress, the increased prestige and power of the medical profession, have facilitated or impeded medicalization (p.8). These factors set the context in which the medical frame is mobilized and medicalization occurs. The rise of the medical profession as an authoritative voice in public policy debate is one contextual element common to Quebec, Ontario and England. As seen previously, the power and authority of the medical profession, whether in terms of professional dominance, physician entrepreneurs, or, in its extremes, medical colonization was discussed as a very important factor in the determination of biotechnology policies. In addition, new or developed arenas of medical knowledge became dominant. Adele Clarke and colleagues (2003) argue that medicalization is intensifying and being transformed. They suggest that in the mid-1980s, "dramatic changes in both the organization and practices of contemporary biomedicine, implemented largely through the integration of technoscientific innovations" (p.161) created what they call biomedicalization.

The definition of infertility was changed by assisted reproductive technologies, but increasingly with the transformation of our understanding of reproductive medicine. Steinberg convincingly argued:

> The way in which 'childlessness' is seen as a physiological 'dysfunction' locates it firmly (and only) within the domain of medical science. It posits not only the state of "childlessness", but those individuals who are childless (defined as "infertile") as appropriately, even necessarily, medical territory. In so doing, the classification "infertility" sets up a categorical imperative for medical intervention. "Infertility" is set up as a medical problem, which, therefore, necessitates a medical "solution". (Steinberg 1990, p.91; p.91)

In this literature, it is clear that the medical profession and physicians themselves are not the only ones involved in the management of diseases and the search for medical solutions to medicalized conditions. Social movements, patients' organizations, and individual patients have also been important advocates for medicalization (Broom and Woodward 1996). The relationship between patients and physicians is one of many mechanisms leading to the medicalization of a condition. However, medicalization is not just an outcome of advocacy, but can also produce changes in individual behavior. Inlander (1998) showed how in the 1980s health policy shifted from concerns of access to cost control, and how the management of care became central with this shift. Accordingly, large numbers of patients began to act more like consumers, both in choosing health insurance policies and in seeking out medical services.

Accordingly, these technologies lead to new dilemmas of choice and new ways to act as a patient and as a parent (Rapp and Ginsburg 1991; Franklin and Ragoné 1998; Rapp and Ginsburg 2001), and by extension, to new ways of being a citizen. In their discussion of biological citizenship, Rose and Novas (2008) argue that citizenship has been shaped by conceptions of the specific vital characteristics of human beings, and has been a target of medical practices that not only simply changed our relation to health and illness but has modified the things we think we might hope for and the objectives to which we aspire.

A good illustration of this change in citizen behavior was made by Charis Thompson (2005, p.238) who showed how infertile would-be parents activists feel that they cannot afford not to be involved in medical science by influencing treatments, medical practices and public policy. In this regard, even though treatment of infertility is elective, the option to "just say no" to treatment does not address the needs and interests of most patients. From this perspective, "the diagnostic and treatment options and knowledge about human reproduction are mutually dependent. The frames of reference and modes of practice that at once enable infertility to be understood, and diagnosis and treatment to be performed, are various." (Cussins 1996, p.80) The lay involvement not only related access to and quality of care in terms of political and personal involvement, but also in the scientific and protocol development. The stratified nature of ART coverage has been a major focus of patient and physician activism, but its mere existence makes it hard to describe patient activism in the case of ART as particularly democratic.

The message medicine delivers to the debate over infertility can be compared to other politically charged health issues – namely euthanasia, HIV/AIDS, abortion, autism, etc. – that changes states' involvement in citizens lives as well as citizens' action in the polity. By using science to democratize knowledge production, contested illnesses (Brown, Morello-Frosch et al. 2011) struggles engage in effective policy advocacy, challenge aspects of the political economy, and transform traditional assumptions and scientific lines of inquiry regarding disease causation and prevention (p.6). What this literature makes clear is that the experience of the body is now a growing factor in the policy debates partly because political power has to increasingly engage with its citizens' body (Rose 2007) and partly because citizens are politically mobilizing around their health (Orsini and Smith 2010). A plethora of medical and philanthropic organizations engage in campaigns of health education and promotion, and make demands on political authorities in the name of health. Additionally, actual or potential patients and their families and advocates became key actors in the economics, politics and ethics of health. As consumers, they actively choose and use medicine in order to maximize and enhance their life, while as citizens they draw on legal discourses in order to challenge authorities when things go wrong.

Infertility as a socially constructed experience

Because it involves an inability to achieve the desired social role of becoming a parent, infertility is often associated with psychological distress and social stigmas. About 10 years ago, Greil and colleagues (2010) published a review of the literature on the socio-psychological impact of infertility. They found support for the conclusion that infertility is a fundamentally different experience for women than for men, but most importantly, argued that the psychological distress literature showed little regard for the social construction of infertility, treating infertility instead as a medical condition with psychological consequences.

As discussed earlier, most medical sociologists agree that health and illness are best understood, not as objectively measurable states, but as socially constructed categories negotiated by professionals, patients and others in a sociocultural context. Decisions as to what constitutes infertility, how to define infertility and what steps, if any, should be taken to deal with this conditions are all made within a social context. How other members of society see infertility and how infertile couples and individuals come to see themselves are both products of processes of social definition.

Greil, Slauson-Blevins and al. (2010) consider that the medicalization of infertility began in earnest with the development of fertility drugs in the USA in the 1950s but has proceeded even more rapidly since the development of such assisted reproductive technologies (ART) as in vitro fertilization (IVF) and intracytoplasmic sperm injection (ICSI). The social construction of health and illness is perhaps even more striking in the case of infertility than it is for other conditions. First, no matter how medical practitioners may define infertility, couples do not define themselves as infertile or present themselves for treatment unless they embrace parenthood as a desired social role. Secondly, while the biomedical model treats medical conditions as phenomena affecting the individual, infertility is often seen as a condition that affects a couple regardless of which partner may have a functional impairment. Thus, defining oneself as infertile involves not simply negotiations between the individual and medical professionals but also negotiations within the couple and, possibly, larger social networks. Third, the presence of infertility is signaled, not by the presence of pathological symptoms, but by the absence of a desired state increasing the sense of uncertainty. Finally, it is more obvious in the case of infertility than it is for other medical conditions that other possibilities exist rather than pursuing a ‘cure’. Possible alternatives to treatment include self-definition as voluntarily child- free, adoption, fostering or changing partners. In sum, infertility can be understood as a socially constructed process whereby individuals come to define their ability to have children as a problem, to define the nature of that problem and to construct an appropriate course of action.

The literature on infertility emphasizes the importance of the sociocultural context in shaping the lived experience of infertility. The degree of availability of reproductive technology was identified as playing a major role in shaping perceptions of and responses to infertility by patients (Kirkman and Rosenthal 1999). According to Letherby (2002), ambivalence toward motherhood may have been more socially acceptable before the advent of assisted reproductive technologies than today. Ulrich and Weatherall (2000) suggested that women experience infertility as an unanticipated life-course disruption.

Another well-studied characteristic of the sociocultural context that influences infertility was pro-natalism. While all societies are pro-natalist, some emphasize the centrality of motherhood to women’s identity more than others (Ulrich and Weatherall 2000; Parry 2006). For example, the case of Israel was extensively studied for its intensely pro-natalist society with state subsidies for IVF and surrogacy (Kahn 2000) and peculiar practices of assisted reproduction (Nahman 2006).

However, infertility has not only been increasingly medicalized in the last decades, it also has been narrated as a new socially constructed experience. Psychology provided many insights into the way infertility is lived and felt. For instance, Williams (1997) extracted eleven themes from interviews with infertile women: negative identity; a sense of worthlessness and inadequacy; a feeling of lack of personal control; anger and resentment; grief and depression; anxiety and stress; lower life satisfaction; envy of other mothers; loss of the dream of co-creating; the ‘emotional roller coaster’; and a sense of isolation. But, more convincingly, studies of psychology worked on the different social contexts influencing childlessness and/or infertility. Depending on the country of residence, infertile patients did not experience the same emotions, stigmas and pressures (Inhorn and Van Balen 2002).

Sandelowski and de Lacey (2002) showed how infertile individuals represent themselves as patients, as emotionally distressed, as socially handicapped, as consumers, as cultural dupes and foils, and even sometimes as heroic sufferers. Sandelowsky and de Lacey's assessment of fertility patients is quite informative on the way would-be-parent tell their stories of infertility and treatment and how that narration can become a source of political assertion.

They argue that when infertility is problematized as a disease or symptom of one or more organic dysfunctions or hormonal abnormality, the infertile are viewed as patients, that is, as persons in need of medical diagnosis and treatment. Failed body functions are the targets of intervention, and the infertile are categorized by diagnosis, treatment or physical responses to treatment. Following their study the representation of the infertile as patients is arguably the least objectionable and the most culturally resonant. Infertility is thus problematized as a constellation of negative or unhealthful behavioral and or emotional response to the inability to reproduce and, more often, to the medical means to resolve it. Infertility can be seen as a social disability and in this context the infertile are viewed as socially handicapped by virtue of their childlessness and therefore in need of social supports for living without children. According to Sandelowsky and de Lacey, infertility can also be narrated as a consumer issue; hence, the infertile are viewed as buyers in need of customer satisfaction. Moreover, when infertility is problematized as a cultural problem, both infertility and the infertile almost completely recede from view as pronatalism, patriarchalism, capitalism, and the technological imperative take center stage and are targeted for harsh criticism and reform.

What needs to be reassessed, though is the influence of this changing relationship on decision-making processes. One of the changes that will be considered in this dissertation is that political actors are now talking more and more about their experiences as disabled or as parents/relatives of a disabled person. These patients' associations are changing the ways the politics of health are dealt with at the political level. They introduce to the debate lay knowledge and experience-based facts that would otherwise have been brought in indirectly by medical practitioners, for instance, or political representatives speaking on behalf of their constituents. Associations actively intervene in the redefinition of health care priorities, in securing funding for treatments, or in the production of knowledge about situations and conditions about which scientific production is needed (Epstein 2000). In that context, the dominant political image of infertility has radically changed by the addition of this kind of actor in the policy process.

Edwards referred to the experience of infertile individuals and their families saying: “People interpret what they see as the implications of ARTs not through what they know of the techniques and philosophies of reproductive medicine, but through what they know about the practice and predictabilities of kinship.” (Edwards 1993, p. 63-64) Political actors increasingly refer to their personal and social experience as a form of expertise in the public debate. Collins and Evans (2002) called for a study of experience-based expertise in social studies of science. They discussed the debatable definitions given to experience and expertise in the literature and the importance of excluding ideas of truth and scientificity from public policy debates. This interesting perspective prompts a reflection on the narration of individual and collective experience in public debates and their influence in the interpretation and use of technical language and scientific findings in the state’s institutions. The psychological and social experience of infertile couples and individuals is narrated in public space and can be interpreted as one political discourse among others. The voice of citizens enhanced by their stigmatization and suffering has a place in the arenas of public deliberation. To what extent it has an influence is part of the puzzle of infertility politics. However, this particular form of expertise becomes increasingly important in Quebec, Ontario, and England and can be traced in the media as well as in more formal political institutions.

ARTs and gender

Culture and representation of infertility are not the only factors influencing the experience of infertility. Gender is another factor that was closely studied and which involved the personal as the political. The rights and autonomy of women in reproduction and in particular in their special and diverse roles in assisted reproductive technologies encouraged legal scholars to study the extent of the autonomy principle in law and in the judicial decision making processes. The arguments revolve around interaction between reproductive autonomy and self-determination, since it is at this interface that the law tends to intervene to limit choice. Also, the uncertainty surrounding the definition of parenthood and more specifically the definition of motherhood when a child is conceived with the help of assisted reproductive technologies, pushed legal scholars to study the various alternatives taken in the arbitration of parental links and to understand the linearity of parental rights in law.

Luce (2010) argues that women mediated technology and played an active role in its constitution. According to her, they were not simply pawns in a patriarchal game in which science had the upper hand, but they were in fact becoming knowledgeable about new reproductive technologies in their attempt to become pregnant. The story demonstrates the reframing of what might once have seemed unacceptable within, for example, the language of consumption and the exchange of money for treatment value or safety. The processes of imagining parenthood and literally setting out to find information that could make that possible have changed over time, informed by new communication technologies, transitions in usual modes of social networking or social engagement, and the emerging visibility and changing status of alternative family forms.

The influence of family law (that presumes a heterosexual union) on lesbian motherhood illustrates further dimensions of biology and sociality. Procreation by gay and lesbians is also affected by the expansion of fertility treatments and sperm banks that result in greater degrees of medicalization in “queer reproduction” (Mamo 2007). For example, the practice of providing lesbians with access to artificial insemination with tested anonymous donor sperm or any pro-fertility technology is presented not only as acting in a non-discriminatory manner, but also as extending necessary protection to lesbians who might subject themselves to health risks due to the difficulty of accessing fertility and adoption programs.

The legal status of women and donors in relation to children is a question and a concern for women at various stages of their experiences of medically assisted conception. Most resources concerning legal parental status following assisted conception still cite ambiguity with respect to the recognition of a sperm (or egg) donor as parent. Thus, women employ emerging legal techniques to record their relatedness to a child or children. Practices of various kinds are discussed by the literature aiming at showing how they shaped women’s anticipation of the formalization of parentage. It also points to the limited scope of interactions in the legal spheres and to what extent it produced negotiation between women, partners, children, donors, and formal institutions.

Studies on the recognition of parenting by same-sex couples show how the discourses mobilized over legal acknowledgement of this issue were organized around two frames. On the one hand, the case for reform was made in terms of equality. Despite the successes of equality claims on the marriage front, this discourse has been charged with failing to take relevant differences of same-sex couples in matters of reproduction into account (Leckey 2009). Thus, on the other hand, the case for reform was made in terms of appropriateness of law's reflecting existing "family practices" (Morgan 1996). Legal and sociology studies structured around the idea that laws should reflect social practices both focus on the realities of familial relationships (Ettelbrick 1993; Bala 1994; Shapiro 2006; McCandless and Sheldon 2010). This approach was presented as accommodating a variety of family forms, irrespective of the extent to which they mirror heterosexual nuclear families (Polikoff 2008; Jakobsen 2010).

Three lessons stand out from the bulk of this work. First, practices among couples and women's experiences as intended single mothers of homosexual partners shaped in many ways the process leading to their formal access to fertility treatments and the legal recognition of their parenthood. Second, considering that the recourse to assisted reproductive technologies is different for lesbian couples and male same-sex couples, gays and lesbians do not speak with the same voice. Hence, they are not necessarily involved in the same sub-issue of medically assisted reproduction and will not frame their claims the same way. Furthermore, equality and rights debates associated usually with LGBT movements cannot be taken as granted in the debates over filiation and access to fertility treatments. Third, the role of women in reproduction cannot be considered and expected to be the same in regard to the issue of assisted conception than it was when studying issues like contraception or abortion. Women engaged pregnancy differently when given a diagnosis of infertility or when dealing with social pressures related to their sexual orientation. Pregnancy in this context is framed less as a question of choice, but rather in terms of control over their body and their lives.

Reproduction and law

"When human beings could do little to control their fertility or infertility, law was of comparatively little importance," said Emily Jackson (2001, p.1). The advent of biomedicine and reproductive technologies increased the importance of legislations and likewise the legal study of the phenomenon. Like social science studies, legal studies were invested in the evolution of birth control policies and women's bodily power - namely abortion laws or access to the contraceptive pill - when assisted reproductive technologies appeared to be the new cure for infertility and accordingly, a new subject of law. Normative in greater part, the legal studies of ARTs and their regulation questioned principles of rights, autonomy, privacy, justice and liberty.

Legal concepts and argumentation widened significantly in the 1990s in parallel with technological developments and social movements. For instance Sheila Jasanoff's book *Reframing Rights* (2011) shows that prospects of genetic testing and gene therapy fed worries about information privacy and discrimination through the creation of a genetically stigmatized class with reduced access to employment, health care, insurance, and other social goods. "Unifying this first generation of constitutional thought was an underlying certainty, or taken-for-grantedness, about the nature and meaning of rights." (p. 9) She claims that concerns about the need to regulate the disruptive potential of biological manipulation were apparent almost from the moment when genetic engineering became feasible in the 1970s. And with the emergence of concerns came the emergence of the legal frame. This frame is not a mere representation of an issue in terms of law, but also a relationship to law in conceptualizing values, identities and preferences. That is why the legal frame reaches well beyond the judicial interpretation of formal legal documents. As she has argued in many other publications, definitions of individual and collective rights both influence and are transformed by changes in the biological status of the human (Jasanoff 2003; 2005). The products of technoscience not only influence but also incorporate and reaffirm social values and institutional practices. They also manifest particular ways of imagining futures, creating social order and ratifying moral judgments. The legal frame are more than constructs understood by judges or lawyers trained in legal reasoning and articulated in legal language. As Jasanoff argues, for a legal frame "to have social meaning, it must become embedded in people's imaginations and understandings and worked out in their practical dealing with one another, with the products and processes of technoscience and with governing institutions."(p. 15)

In Canada and Britain, legal scholars reassessed a stumbling block of law: namely its assumption that a child can have only two legal parents. Legal parenthood has been an indivisible and exclusive status. In that context, the question stays clear: what are the defining features of parenthood favored by society or by governments? A mother can be identified when she 1) gave birth, 2) contributed the egg, or rather when she 3) intended to raise a child, sometimes even all three. A father can be identified when 1) contributing the sperm, 2) intending to raise the child, 3) is being married to the birth mother, or rather when he is 4) being registered on the child's birth certificate. In all filiation cases, the definition of what the parent is can change significanty. Adoption and assisted reproduction made that very clear by blurring the role of the parties involved in collaborative reproduction.

Because the law has been blocked by the principle of parental exclusivity, "its response to the spotting of the normal incidents of parenthood has been to try to identify a hierarchy of criteria which will result in one putative parent's claim trumping the others" (Jackson 2006, p.60). Which of these criteria will be put upon the others in the case of children born through medically assisted reproduction? The literature points to some of the courts' privileged criteria, such as intention of would-be parents, consent among parties, the need for a father, and the best interests (welfare) of the child. However, like any other public policy instrument, legal criteria are questioned, put to the test of implementation and reformulated through time and experience. In cases presented by different authors, the courts seems to present their decision as a question of judgment rather than facts (Campbell 2007; L'Espérance forthcoming). Legal language is depicted by critical jurists as having simply insufficient elasticity to accommodate the cultural disintegration of the biological nuclear family (among others, Leckey 2009), perhaps even more when adding to this legal ambiguity new genetic and social relationships brought about by ARTs.

This context poses serious challenges to the policy processes. Considering that the law needs to follow the social changes brought about by technology and social evolution, the political actors consider questions of parenthood as one very important feature of the debate over the regulation of ART. The debate is also very much influenced by development in other public policy areas like marriage, divorce, adoption, etc. What the literature emphasizes on is the importance of cultural and policy legacies to the debate on filiation of children born through medically assisted conception. These former debates - resolved or not, legislated or not – impede or enable the emergence of ideas and frames and according legal criteria.

Furthermore, the reported need for, or right to, information about the truth regarding one's genetic origins has significant purchase in the legal discourses, mostly within the specific context of donor conception (Jones 2009). Many question the extent to which facts of genetic relatedness should inform the basis of legal relationships (Strathern 1993). To assess the perspective of the child before and after he or she is born, legal scholars studied the rights of children in the context of assisted reproduction. This literature is concerned about how the law has an impact on whether the child conceived through assisted reproductive techniques will be reared in a good environment and will be sustained morally and economically by responsible parents. Laws on assisted reproduction have demonstrated two different ways of handling the welfare of the child. On the one hand, the welfare of the child is assured a priori in the regulation of access to assisted reproduction. In other words, to make sure that the child that will be conceived in fertility clinics will be supported and nurtured, the law establishes criteria and procedures that enable state personnel to evaluate the future parents before treatment. Emily Jackson (2002) notes that the vast majority of people who reproduce through heterosexual sexual intercourse are free to do so without any interference or scrutiny by the state, and that to monitor such decisions would be "unreservedly condemned as an unacceptably intrusive abuse of state power" (p.177).

On the other hand, the welfare of the child had been regulated by some countries a posteriori, which means that the child conceived through ART is assured of a minimum sustenance in a variety of ways after he or she is born. That type of regulation deals with the establishment of parentage and fulfillment of parental responsibilities after the child is born, but it also deals with the demands of donor conceived children, for instance in relation to their genetic origins. The way to ensure that the child's best interests is paramount in the establishment of its filiation is to attach a legal test to its determination. Dealing with questions of access to information about one's genetic origin, the court added to the child's (and now adult) best interests test, a reflection about equality and privacy.

In these contexts, the judiciary arena becomes the site of implementation of such criteria. Accordingly, new frames influence the discourses on infertility, parenthood and genetic links. Frames are then structured around law and the aforementioned legal criteria and produce new ways of defining problems and resolving legal issues brought about by medically assisted conception. Further, this literature proposes that these criteria and ways of implementation differ from one state to the other, sometimes depends on legal frameworks and heritage, and may or may not be flexible enough to open to new conceptions of the family[43].

Framing infertility, redefining public action

The review of the literature concerned with assisted reproductive technologies and its social implications touches a wide range of issues more or less related to the regulation of access, donation and surrogacy. On the one hand, political science studies stressed the importance of unpacking ART as a policy domain and looking at the three sub-issues more specifically. Moreover, by staying at a national level of analysis and by accordingly leaving aside much of the explanation, this discipline has not been able to appraise the many practices managed by different types of policy – soft and hard law, programs, codes of practice – in many implementation sites. On the other hand, other domains show the importance of the variety of representations - of science, medicine, kinship, conception, legal criteria to establish filiation, to name a few - in understanding actors' discourses, decision-making processes, and their outcomes. The literature points at different ideational, but also institutional and actor-oriented factors influencing policy processes and outcomes.

Without a doubt, what these two types of literature show is the importance of ideas, discourses and frames in understanding the practice of medically assisted reproduction and the experience of infertile would-be-parents from their desire to conceive to their legal recognition as parents. Without considering the new meanings given to pregnancy, health, parenthood and relatedness, it becomes impossible to make clear why Quebec, Ontario and England established such different policies as regards access to fertility treatments, gamete and embryo donation and surrogacy.

The construction of infertility in the three cases and among the three sub-issues influence the way they are debated politically by policy communities in the diverse arenas of political deliberation. This dissertation is an attempt to appraise the role of ideas by developing how infertility was narrated in each of the 9 cases and try to understand how the performance of these politically formatted ideas influenced the policy process, and

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[43] Among others, we can think of multiparentality or homoparentality.

ultimately, the policy outcomes.

CHAPTER 3
THEORETICAL APPROACH AND METHODOLOGY

One of the main aims of this dissertation is to understand how ideas influenced the policy outcomes in Quebec, Ontario and England in regard to access to fertility treatments, gamete and embryo donation and surrogacy. The influence of ideas on public policy is central to the contemporary studies of political science. Ideas shape how we understand political problems, define preferences and policy objectives, and give political debates a sense and a purpose. As a result, they convert policy processes and shape the outcomes that derive from them. Peter Hall (1993) reminded us that we need to ask not whether ideas are important, but when and how these ideas influence public policy. The challenge is to tackle differences of conceptualization of ideational elements in order to clarify causal mechanisms (Béland and Cox 2011) and understand how they can become drivers of policy change and stability and thus influence policy outcomes.

Introducing ideas and discourses

In the growing literature on ideas and politics, some scholars design ideas as being dependent on the interests of actors, others as determined by them. Some theoretical approaches conceptualize ideas as previously defined individual actions. Other approaches have ideas as producing interaction processes of collective action. Between these positions, there are undertakings that capture ideas as subject to a constant process of redefinition in an interdependent relationship with the interest and the institutions, and this is where my study rests. This dissertation will focus on the ideational dynamics influencing decisions and political outcomes. Well beyond considering ideas as a simple explanatory factor, I acknowledge the interactive dimension of ideas, which attaches them to different institutions and actors who carry forward discourses into the political realm. Discourse is not only what you say; it includes to whom you say it, how, why, and where (Schmidt 2008).

Ideas are the products of our own cognition that are then connected to reality via the interpretation of our surroundings. Ideas have the power to connect things and people. They establish relationships, in formal and informal ways, between events, individuals, and even between other ideas. Thus, meaning is relational, associative and derived through contrasts between linguistic terms (Saussure 1959). Ideas provide guides for action in determining problems and defining solutions in the polis[44]. They are, indeed, performative[45] since they allow alliances and oppositions, adaptation and innovation, continuity and change. "Ideas, after all, are a medium by which people can imagine a state of affairs other than the status quo and such imaginings might plausibly spur them to act to try and make changes. " (Lieberman 2002, p.698) Starting from this perspective, it becomes possible to define politics, as did Deborah Stone (Stone 2001, p.11) and others, "as a struggle over ideas".

However, ideas cannot become a central point of analysis in political science without assessing their performativity. Considering that ideas by themselves influence policy processes would lead to the same abyss that caused the evacuation of ideas from political science at the outset. Therefore, I argue that the power of ideas resides in utterances, in the expression of ideas, or discourse. To cite Maarten Hajer (2005) discourse consists of "ideas, concepts, and categories through which meaning is given to a phenomena" (p.300). Hence, it is in the communication between actors in multiple institutional contexts where ideas acquire their influential place in policy processes.

Discourse can be conceptualized at two levels. Fists, discourse is present in the way a given issue is cognitively structured. The policy image of a policy issue is the common meaning given to an issue. This image is in part constructed through the deliberation of experts in the area and the interested people gravitating around institutional venues dealing with the issue. Policy images are a mixture of empirical information and emotive appeals according to Baumgartner and Jones (2009). They can be subtle or strong. Constructed mostly by experts or public opinion they give the tone of the debate.

To identify a policy image, the context in which discourses emerge and the policy domain to which they relate must be determined. Concepts like the universe of political discourse (Jenson 1989), policy paradigm (Hall 1993) and the latest return to culture (Geertz 1977; Kane 1991; Steinmetz 1999; Padamsee 2009) all defined this environment as systems of meaning and practices in which ideas are embedded (Steinmetz 1999). These systems appear to be like umbrellas over a policy domain. More or less hegemonic depending on the

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[44] This is a reference to the two concepts of society defined by Deborah Stone. We consider that the Polis Model is more adapted to our vision of the governance of ART as an "organised anarchy". See Stone, 2002, Policy Paradox : The Art of Political Decision Making, New-York : W.W. Nortons & Company, p. 33.

[45] "Designating or relating to an utterance that effects an action by being spoken or by means of which the speaker performs a particular act." as defined in the Oxford English Dictionary, retrieved online 15th March 2011.

case and the areas studied, culture seems to account for a set of concepts or ideas which are both the product of a social context and a key determinant in the articulation of political discourses. As Padamsee states it, the impact of culture arises from its inscription in the "institutions, routines, purposes, and language of policy making" (Padamsee 2009, p.428). Cultural elements are expressed in specific policy proposals; ideas about the social problems, groups, and solutions to which those proposals relate; and discourses through which policy debates and decisions take place. Several ideas are both the result of discipline and of the context in which this discipline is brought to life. They are then expressed in a range of symbols that represent and guide the thinking, feeling and behavior of members of a society. Social practices express and reproduce them in daily life. "Actors are then simultaneously subjects of structures and acting subjects carrying in their practices and meaning systems the possibilities of social stability and change" (Jenson 1989, p.236). This "nested context" (Rein and Schoen 1993, p.154) describes the broader context – in time and space - in which policy issues arise and are (re)solved.

Second, discourse can also be conceptualized as a performance. Through utterances, political actors challenge, support or add to the policy image of a specific issue. In order to produce change or in a search for equilibrium, political actors continue their deliberation within and outside institutional venues. Ideas are interesting as soon as their interconnectedness with actors and the milieu in which they are staged are addressed. Following Cohen, March, and Olsen (1972) an organization "is a loose collection of ideas [rather than] a coherent structure; it discovers preferences through action more than it acts on the basis of preferences" (p.1) In other terms, discourse supplies actors that interact in a given context with substantive arguments, both cognitive and normative (Schmidt 2008). These arguments provide the logic and premises of a particular policy discourse, including statements of its appropriateness in terms of social values. They serve to define or redefine the actors' perceptions of both their interest and the general views of society (a.k.a. norms).

To use Hajer's formulation (2009), "policy-makers and politicians use all the tools that are available to them, from the power of narrative to the employment of the very context in which they speak" (p. 54) to influence the political process. In a public space, communication produces sense and concurrently sets power relationships between actors. "One important form of interaction, then, is when an actor can make others see the world according to a preferred frame and thus generate the legitimacy for preferred course of action." (Hajer 2009, p.55) In doing so, actors generate public support for specific policy ideas. Ideas require actors to continually re-enact certain patterns of behavior (practices), thoughts (ideas), and social intervention (action) in their political actions, and they are doing so mainly through frames. They then generate public support for specific policy ideas (Béland and Cox 2011, p.11).

Framing and reframing discourses

Although this dissertation takes discourse as a central point of policy analysis, I base this analysis on the concept of policy frames. The study of frames and framing dynamics helps us understand the policymaking process in times of equilibrium and policy change. The specific "ideas, concepts and categorizations" referred to by Marteen Hajer offer a clear understanding of the issue definition, the policy preferences and the arguments used by political actors. The practices and discourses that people engage in and embody, and a focus on the actual ways people produce these practices and discourses within socio-cultural constraints which themselves are subject to reproduction and change are examined here.

Frames are the channels through which communities and entrepreneurs structure meanings and express their claims, blames, and preferences. "To frame is to select some aspects of a perceived reality and make them more salient in a communicating text, in such a way as to promote a particular problem definition, causal interpretation, moral evaluation, and/or treatment recommendation for the item described" (Entman 1993, p.52). Actors use social representation and common beliefs and values to make their discourse persuasive and legitimate. They attempt to make their discourse resonate among a certain audience or access a certain arena by bringing in previously muted themes or expressing old ideas in new ways.

Practices appear to provide the space that sets the stage for framing and reframing dynamics. As Laws and Rein (2003) put it, practices open the way for reflection and reframing (p. 205). "The discursive interactions prompt them (i.e. the actors) to refine, reframe, and reinterpret these ideas" (Béland and Cox 2011, p.10). The prevailing image of a policy defines the position of political actors and their relationships with one another. The actors thus have to place their own discourse with regard to, or in relation with, recognized discourses (Hajer 1995). As a result, the frames represented by the policy status quo themselves remain subject to re-framing attempts, which might lead to breaking up a dominant image and initiating policy change. In many cases, what happens is not the collapse of an older policy but, rather, simply the rise of a new set of considerations that make a different set of policies appropriate for approaching the issue area.

> A frame indicates which elements become more meaningful and consequently… can more easily be noticed by the audience. Through the frame's link to familiar cultural symbols, both material and discursive, communication is not only facilitated, it is literally made possible. (Fischer 2003, p.144)

Framing is a particular way of representing knowledge, and the reliance on (and development of) interpretative schemas that create boundaries and order a chaotic situation facilitate interpretation and provide a guide for doing and acting (Laws and Rein 2003, p.173). By definition, frames are almost always partial; they never tell the whole story. They focus attention on one aspect of the political problem and privilege one form of solution rather than the multiple others available. Frames can also be used to stigmatize groups of people as undeserving of government assistance or public attention. The stigma of infertility can also be used in a positive way to benefit would-be-parents. In this sense it is a stigma that is politically productive. Positive stigma create frames that can become a strategic tool for action in policy debates. Thus, frames can be performed in a rational, strategic and voluntary way as well as in a diffuse and unconscious manner. It is difficult to isolate one source of a new frame. New frames are contested or repressed because status quo or other frames are performed at the same time. Frames compete with each other in the polity and some political issues involve more policy frames than others. This is also true for different nations; different spaces imply different policy frames.

Furthermore, frames are quite stable in time, stemming in part from the difficulty of reframing issues. Redefinition of frames is rare and uncommon. In this way frames are durable, altered only incrementally over time or when a tipping point is reached. Issues are reframed mostly because of the rhetorical skills of individual policy entrepreneurs and advocacy groups or because of surprise events beyond the control of any actor. Reframing or what others call frame transformation (Snow, Rochford et al. 1986) can be partial or can also mean that a frame is amplified. Reframing does not mean direct policy change, but it shows discursive changes and a redirection in the policy debate. When reframing occurs, by means of political action or the investment of a specific arena, a shift in attention over an issue can occur. This can produce what Baumgartner, De Boef and Boydstun (2008) have called a tipping point[46]: “a point at which the cumulative cause finally passes a threshold and leads to a rapid change in the outcome” (Capoccia and Kelemen 2007, p.351) or in other words, an ideational mechanism driving a cascade of events pushing towards policy change (Baumgartner, De Boef et al. 2008, p. 9-13). Reframing can also occur without producing any events. In that context, by who and where the framing is performed can explain its influence on the policy process. A tipping point in that sense involves the performance of (a) specific frame(s) at a threshold. Without this particular context, framing and reframing dynamics can contribute to status quo, to the slow construction of a new frame, and to the amplification or extension of an old one. In other words, if a frame or an ideational mechanism does not consist of a tipping point inducing a cascade of events, it can consist of frame reflection, hence influencing the policy process by other means.

Presenting theoretical objectives and main concepts

This dissertation asks two theoretical questions in an attempt to contribute to the literature on ideas and their influence on public policies. First, the literature indicated that the scope for reframing is strongest when the ideas, concepts and theories that reframing draws on derive from the experience, understanding and active involvement of actors in concrete social situations. “The felt needs and experience… of the agents involved animate the process and ground it in a stubborn persistence that leads, over time, to an increased capability to act effectively that involves adjustments in action that spill over into reframing beliefs.” (Laws and Rein 2003, p.173) Also, the appeal to science and rationality, technical knowledge, and scientific expertise are central to the understanding of assisted reproduction in English and Canadian society and are portrayed in the literature as the new rationale for public action as presented in the previous chapter.

Not surprisingly, as will be demonstrated, the medical frame is adopted not only by medical players and bureaucrats, but also by would-be-parents and donor-conceived

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[46] For a discussion about the difference between tipping points and critical junctures, see p. 351 of Capoccia, G. and D. R. Kelemen, 2007, "The Study of Critical Junctures: Theory, Narative, and Counterfactuals Historial Institutionalism", *World Politics,* 59, April, p.341-369.

children. The medical frame is the most mobilized[47] frame in Quebec, Ontario and England in all of the different arenas invested to debate the politics of infertility over the two decades studied. Medicalization is often viewed as an attempt to professionalize social problems. The medical frame is also attributed with a degree of authority because of the disciplinary provenance of its utterances and the expertise that it underlines. As well, the medical frame consist of many types of ideas, from very technical and sharp to more broad and comfortable. The medical frame has been characterized as malleable in the way in which it is at the same time is assumed to be morally neutral, dominated by expert knowledge, individualizing social problems while engaging societal questions, and depoliticizing behaviors all of which help temper the emotional questions at stake in the debate over assisted conception.

I therefore ask if certain ideas, particular frames, are more performative than others? In other words, I want to know if framing infertility in a particular way can induce change and produce a specific policy outcome. The common and persistent mobilization of the medical frame seems to have an influence on the different sub-issues of assisted reproduction. Is that an indicator of the medical frame influencing public policy and practices? Are there any other frames that are as performative?

The second theoretical question asked in this dissertation is whether one mechanism is more likely to trigger a social cascade than another. The literature emphasizes that a policy frame needs a certain degree of appropriateness to be effective in the political spheres and to trigger a social cascade. Rationality, science, numbers and administrative articulations are perceived as providing more reliable political arguments than emotions or experiences. However, the meaning attached to a problem is not unidirectional, and most of the time the conception of a problem and its solution is perceived differently depending on the position of actors in the political debate. Following the work of, among others, Baumgartner, De Boef and Boystun (2008), policy change is most likely to occur when a reframing attempt succeeds and shifts both the attention of the public and the decision-makers – sometimes one increasing the shift of the other group. Considering that public attention is driven by different considerations than state decision-makers', we can argue that different frames can be effective to shift their attention in given situations. For example, public attention can be more attentive and cognizant of discourses mobilizing individual and collective events and

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[47] In quantitative, not necessarily in qualitative value.

emotions thereby providing a sense of self-involvement in society while decision-makers are seeking arguments providing a sense of good governance. In that context, frames can be extended or amplified with the aim of acquiring more sustainability and appropriateness instead of being reframed totally. However, bridges between two frames can be built through discussion, negotiation and public action, and can provide a wider range of acceptance and tractability to a discourse. This new double frame has the feature of appealing to the public as well as to the state decision-makers. Thus, I ask if one type of frame is more likely to trigger one or more of four mechanisms of frame alignment and what mechanism is more likely to consist of a tipping point in the policy process.

This theoretical chapter will present the concepts supporting this analysis. Drawn from the literature on frame reflection, frame alignment and policy analysis, I maintain that ideas are framed by communities and actors in order to be performed in different policy arenas. In doing so, ideational mechanisms such as frame bridging, extension, amplification and transformation can occur and as a result trigger a social cascade of events that will produce change and influence policy practices.

Agency: policy communities and entrepreneurs

As Béland and Cox (2011) explain it, "the discursive interactions prompt them (i.e. the actors) to refine, reframe, and reinterpret […] ideas." (p.10) Actors try to achieve dominance in a discursive space and in doing so form discourse coalitions or epistemic communities. Lobbyists, legislators, and administrators with a shared interest in the same public-policy problem interact on an ongoing basis to shape relevant statutes and regulations (Baumgartner, Berry et al. 2009, p.61). Policy entrepreneurs are also important in the game of politics. In promoting frames, entrepreneurs form communities, convince elites and/or support the status quo.

An important element of postpositivist policy analysis is its emphasis on the manner in which political actors form discourse coalitions (Hajer 1995; Fischer 2003). This happens, for example, when members of interest groups, public servants, politicians, journalists, or academics use the same frame in order to participate in a policy debate.

Policy communities have been conceptualized in many ways, from the close-knit subgovernmental communities (Berry 1990), to the more expert-driven advocacy coalition

(Sabatier 1988), passing through Heclo's (1978) larger, open and cooperative issue network concept. Authors talk about two subsets of actors present in the policy universe (Howlett and Ramesh 1995). The larger set of actors is composed of those who have some knowledge of the policy issue and who collectively construct a policy frame within a "policy community" (Haas 1992). The second subset within the larger one, called knowledge-based policy communities, is composed of those who participate in relationships with each other to further their own ends or policy goals (Wilks and Wright 1987). Policy communities can be close-knit or fragmented, which can affect the number and quality of discourses, acceptance and dominance of a frame and/or authority of a type of actors in the political debate. It is not so much that the network shapes policy as an institution, but that participants within a network join together and work together to try to shape policy by framing and reframing issues. Subsystems are not devoid of conflict and indeed are often organized around fundamental issues of disagreement. Thus, coalitions are "shared knowledge groups" (Heclo 1994).

However, the literature is dominated by very strict concepts of expertise and public action. Experts are depicted in the literature as coherent, rational, educated and well-informed political actors that access the policy process more easily because of their authoritative discourse. For some authors, the expert is "rigorously" scientific, for others, he or she is supposed to be a member of a professional association, thus granting authority and value to his or her discourses. An increasing number of authors argued that expertise could be practical, related to social and individual experiences that ground political actors in reality. I follow Haas's (1992, p.3) definition while broadening the notion of expertise to add experience and practices to its conceptual construction.

An epistemic community consist of individuals and group representatives from a variety of disciplines and backgrounds. They most importantly have: (1) a shared set of normative and moral beliefs, which provide frames on which the social action of community members will be based; (2) shared causal beliefs, which are derived from their analysis of practices or experiences leading or contributing to a central set of problems in their domain and which then serve as the basis for elucidating the multiple linkages between possible policy actions and outcomes; (3) shared notions of validity - that is, internally defined criteria for weighing and validating knowledge in the debate; and (4) a common policy enterprise - that is, a set of strategies associated with a set of problems to which their professional or personal competence is directed, presumably out of the conviction that human welfare will be enhanced as a consequence.

Thus, participants can come from inside or outside government. On the one hand, actors inside government benefit from veto points and prerogatives, from longevity and legitimacy, from relationships and expertise. Their power also lies in their ability to be part of the problem definition stream as well as of the solution construction stream, bringing to their frames a potentially higher consistency. Nevertheless, their constituencies, social groups, lobbyists and public opinion pressure them to make the best decision within the shortest time possible. In these conditions, framing and reframing problems and solutions can help them limit the boundaries of a political problem, limit access to the process of decision-making, divert attention and/or speed up the decision-making process. On the other hand, actors outside of government act as communicators within political communities, try to magnify movements and spread information. By their action, they might have indirect effects through public opinion. However, their access to the political process is not guaranteed and the problem definition is invariably the key to their way in. Framing or reframing issues can help them enter the decision-making process; and furthermore, it can assure them a place at the table.

Individual actors willing to invest their resources (time, energy, reputation, money) in hope of a future return for them or for significant others can become very important in a policy community. Kingdon (1984) defines a policy entrepreneur as an individual who initiates a change or the emergence of public policy by using his or her creativity, strategic thinking or its network in order to persuade, to provide ideas or promote a frame. It is an agent for change who is inside or outside government, elected or not. It can equally be an expert, a lobbyist, an informed layperson or a bureaucrat who wants to devote its resources to the development and promotion of a frame. The policy entrepreneur's activities include shaping the terms of a debate, defining problem, shopping venues, and/or building coalitions (Minstrom 1997; Pralle 2006).

For True, Baumgartner and Jones, the entrepreneur is part of a policy community. This actor attempts to reframe issues and provide new ideational dimensions to the debate. William Riker (1986) argues that policy entrepreneurs use argumentation as a "formidable political weapon" in their efforts to manipulate political debates. He writes that the political leader who is able to define the symbols associated with two sides of the debate will easily be able to dominate the outcome. The entrepreneur provides venues to promote values or influence the formation of public policy. Subsequently, if entrepreneurs are able to couple their preferred policy alternative with a definition of a salient issue for the political elite, the shift will take place quickly. The efforts of policy entrepreneurs are meant not only to privilege select policy solutions, but also to facilitate the construction of culturally specific public knowledge. For policy entrepreneurs in the modern era, success depends on framing knowledge to fit the characteristics of the culturally specific policy subsystem. Policy entrepreneurs, do not, however, operate in a vacuum; the context in which they operate mediates their actions. For Kingdon (1984), certain criteria help us to understand which ideas will emerge. According to Kingdon (1984, p.200), these include technical feasibility, congruence with the values of community members, and the anticipation of future constraints, public acceptability, and politicians' receptivity. Ideas that emerge most successfully are likely to affect how policy is made and how politics is conducted, even in the absence of direct pressure. As a result, policy entrepreneurs promote their ideas as brokers, and attempt to recombine and present their ideas in the context of the familiar.

Is it not necessarily easier for entrepreneurs to shape and manipulate frames than it is for other political actors or communities of actors. A range of actors can mobilize frames equally because framing processes do not privilege certain actors over others. However, the position of the entrepreneur, political actor or epistemic community in relation to the dominant policy image can create constraint or opportunity for the mobilization of their policy frame(s). As has been noted, the appropriateness of a frame can offer a better position to an argument, provide access to a specific arena to a group or an advocate, or help the construction of an epistemic community.

As explained by Baumgartner and Jones (1993), actors can also be involved in opening institutional windows of opportunity. The way a problem is defined influences the legitimacy of the actors who participate in the process of regulation. They showed that actors attempt to limit legitimate representations of problems to restrict access to the public policy arenas by means of discourse. The marginalized players are trying to develop and integrate competing frames, articulating them in other institutional arenas hoping to access the policy-making process. In that context, a definition framed in technical terms centers problem-solving in the hands of a small circle of players. In contrast, a definition in terms of a social issue opens the debate to a much wider range of interests (Rochefort and Cobb 1994). Actors do not only frame or reframe problems to access the policy process, they also group together with other actors, sometimes leading to a combination of frames or a reframing attempt what Schön and Rein (1994) call frame reflection: […] human beings can reflect on and learn about the game of policy making even as they play it, and, more specifically, that they are capable of reflecting in action on the frame conflicts that underlie controversies and account for their intractability. (p. 37)

Frame alignment in the policy process

Frames structure our language and create a pattern in a discussion among actors in political arenas. Frame analysis is the method of finding and illuminating that pattern, its mechanisms and its political effects. This part of my approach is inspired by the work of Maarten A. Hajer (2009), who analyses governance as performance and how actors articulate particular frames in a specific situation. The interest of that approach lies less in the determination of discourses, but rather in the way they are performed, enacted and embodied through a variety of means. The performativity of a discourse is its ability to change, to construct and reiterate a political issue. As Hajer (2009) notes, performance is "the way in which the contextualized interaction itself produces social realities like understandings of the problem at hand, knowledge, decisions, and new power relations." (p.66)

Hence, I argue that to appraise the role of ideas in the policy process and the impact of frames on the policy outcomes, the ideational drivers for policy change and policy stability need to be examined. The work of Snow and al. (1986) is mobilized, specifically their concept of frame alignment, which refers to the linkage of individual and social movement interpretive orientations, such that some set of individual interests, values and beliefs and movements activities, goals, and ideology are congruent and complementary. The concept of frame alignment can be extended to the discursive relationship that needs to be created between epistemic communities and the state in a context of public policy advocacy. Hence, frame alignment is not only important to produce and maintain participation in a community of actors, but also becomes primary in obtaining access to the policy subsystem. In that sense, frame reflection occurs in an attempt to influence decision-makers rather than in a context of contestation. Discontent is another term used in the literature to explain why actors mobilize. In the context of public policy formulation, discontent is not the only rationale for participation. In fact, some actors mobilize on a constant basis to assure that policy-makers in every sphere of a policy domain consider their interests. For instance, in ART the medical players are not necessarily discontent or contesting a policy option, but participate in the policy debates to make sure their voice is heard by the political and administrative elites.

According to Benford and Snow (2000), a frame is believable and credible only if it is congruent with the everyday experience of the target community, and conversely, frames can also bring shifting interpretations into play. Actors and communities reflect on their discourse and creatively model the frame they mobilize to adjust to the context - sometimes in a strategic enterprise, otherwise in simple reaction to their position in the debate. In this way, frames are relatively elastic packages of ideas that can be reinvented across a range of settings. This flexible character allows them to be easily performed in different contexts and to resonate in a variety of institutional conditions.

Borrowing from the frame alignment literature, I identified four mechanisms – amplification, transformation, bridging and extension - for the purpose of this study of the regulation of access to fertility treatments, gamete and embryo donation and surrogacy. These four discursive mechanisms have the power to produce change and stability, but only indirectly. As Baumgartner, De Boef and Boystun (2008) asserted in their study of the issue of the death penalty, it is virtually impossible to isolate the precise causes of the redefinition of issues. Rather, we know through their work that a cascade can occur and that attention accordingly tends to shift. In fact, because of social cascades, the issue tends to become salient and the new frame acquires resonance. Thus, the impact of framing, reframing – and I would add, frame combination – is to shift the topic of discussion. This shift is strongly related to changes in the configuration of actors taking part in the discussion and most probably leads to a shift in public opinion. If done in a relatively short period of time, it will have an impact on policy outcomes. Since framing effects are self-reinforcing, when a reframing attempt is successful, the frame tends to dominate and last. So, the four ideational mechanisms subsequently presented can contribute to a shift in issue attention and redirect public policy processes, and, by extension, increase the likelihood of policy change in accordance with the new dominant frame.

Frame amplification

By frame amplification, I refer to the clarification and invigoration of a frame that bears on a particular issue, problem or set of events. Because the meaning of events and their connection to one's immediate life situation are often cloaked by indifference, deception or fabrication by others, and by ambiguity or uncertainty, support for and participation in public debates is frequently contingent on the clarification and reinvigoration of an interpretive frame. Amplifying a frame can be an instrumental way to address small policy failures or inconsistencies or assess technological advances that were not previously included in a policy frame[48].

In the example of ART, the medical frame that was mostly mobilized around the idea of risks in the 1990's was amplified to assess the increasing success rates of clinics in the early 2000's. Success rates were invariably linked to the risk associated with fertility treatment; however, it reduced the negative perception the public had of ARTs whilst increasing the positive perception of the role of medical practitioners who were seen as guardians of women and children. The medical frame thus acquired a wider range of support in the medical community as well as in governmental communities. It also shifted attention on the good done by medically-assisted reproduction at a period of rapid development in medical practices.

Frame extension

Directed outwards, a discourse can be performed in a challenging manner seeking to persuade more diverse audiences both to think very differently about policy and to switch allegiances to those proposing new ideas. "One important form of interaction, then, is when an actor can make others see the world according to a preferred frame and thus generate the legitimacy for preferred course of action." (Hajer 2009, p.55) Indeed, when performed in that manner, discourse is empowered because it fits with the dominant frame in the broader

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[48] Also labeled as inducement in Stone, D. A., 1988, *Policy Paradox: The Art of Political Decision Making*, New York, W. W. Norton, p.5.

political debate. Thus, frame extension, means here the attempt to enlarge the pool of adherents to a frame by portraying the objectives or activities as attending to or being congruent with the values or interests of potential adherents. In other words, frame extension means that a community will try to reach a new set of supporters and/or to acquire access to the state by operationalizing its discourse or to adjoin new ideas.

The best example of a frame extension is the family-building frame in England at the end of 2000. The family-building frame mobilized the idea that a child needed a father and that fertility clinics were responsible for assuring that was the case, consequently excluding all lesbian couples as well as single would-be mothers wanting to have a child. After 2005, some English policy communities were attached to the family-building frame and needed to extend the frame to include this newly recognized clientele. Thus, these communities extended their frames by replacing the need for a father for the need for supportive parenting. This new policy idea still maintained the importance of considering the future children's environment when considering would-be parents' access to service provision. At the same time, the new extended frame included lesbian and single mothers in the set of potential supporters, changed the target of the policy, and gave the frame more acceptability.

Frame transformation or complete reframing

A discourse can be performed in a truth-seeking manner to challenge the moral appropriateness and authority of the underlying norms and beliefs of the policy frame and seek to develop consensus around a new set of broad, normative parameters for policy making. Discourses are then empowered through the language of policymaking (Hall 1993), or as Bhatia and Coleman (2003) would put it, through the marshalling of persuasive social facts in favor of a change. By frame transformation I consequently refer to the reframing of some set of conditions or ideas in the policy community. The objective contours of the situation may not change so much as the way the situation is defined and thus experienced. Consequently, it becomes important for the community to reframe and therefore reposition itself in the political game.

In communities of would-be parents, the legal frame was used as a call to arms in Quebec, Ontario and England. Mobilized around the right to have a child, the would-be parents' community organized and solicited attention though the discourse structured around the right to have a child. After a few years of mobilizing the legal frame, would-be parents' communities who were unsuccessful in getting public and political attention transformed their legal frame and adopted a medical frame, presenting infertility as a medical condition that needed medical treatments granted by the state for many more health conditions. Reframing their discourses in medical terms introduced them to discussions with medical players and ultimately with political decision-makers.

Frame bridging or combination of frames

Combination of frames in discourses can also be very influential in the game of politics. By frame bridging, I refer to the linkage of two or more ideologically congruent but structurally unconnected frames regarding a particular issue or problem. Such bridging can happen within a policy community through the alliance of two or more communities together, or can be facilitated by the institutional environment in which the frames are performed. The two frames are thus mobilized in relation to each other as if one was necessary or dependent of the other to produce a meaningful argument/discourse.

Frame bridging happened in Quebec during the access to fertility treatments debate in 2005. Through an alliance between the medical community with the would-be parents' community and the central work of a policy entrepreneur, the medical and the experience-based frames were bridged. Articulated for the first time in a policy draft produced in the context of an upcoming election campaign, the bridge between the medical frame – mobilized around the idea that infertility is a medical condition that needs to be overseen by medical practitioners aware of the risks associate with such practices - and the experience-base frame – mobilized around the idea that infertile individual and couple go through emotional pain, encounter monetary troubles and are driven by their desire to have child, a condition that thus needs governmental attention – triggered a cascade of events that led to the comprehensive funding of fertility treatments. That bridge produced enough support for public funding of fertility treatments to shift the attention of the health department and produce public support for change.

Arenas: spaces of political deliberation

Policy arenas are spaces for political deliberation that provide a milieu for frames to be mobilized, to compete with one another, to be reframed, extended, amplified or bridged, etc. Argumentation and discussion are the key processes through which citizens and policymakers assess a decision.

> Public discussion mobilizes the knowledge, experience and interest of many people, while focusing their attention on a limited range of issues. Each participant is encouraged to adjust his view of reality, and even to change his values, as a result of the process of reciprocal persuasion. (Majone 1989, p. 2)

This can be realized only in a context where rules and procedures exist and structure the discursive exchanges. That is why, in line with this framework, I picture institutional arrangement as political arenas. To define institutions as arenas enables us to understand them as a set of rules as well as a space where ideas are discussed. They structure ideas as well as permit them to be spoken, which contributes to their articulation as a discourse and their performativity.

Frames help actors associate with and learn about their opponents and create opportunities, but they cannot by themselves produce policy change. To do so, they have to be performed through discourse in a selected arena or venue. The arena in this context becomes more or less chosen, understood and integrated into the discourse of political actors. Jenson (1987) argued that an issue can spark protest only if it gains to a specific arena or to several arenas of public discourse and raises attention. To define institutions as arenas enables us to understand them as a set of rules as well as a space where ideas are discussed. They structure ideas as well as permit them to be spoken, which contributes to their articulation as a discourse and their performativity in the policy process. To use Baumgartner and Jones's (1993) formulation: "just as images may change over time, so may venues [...] Some types of image may be well accepted in on venue, but considered inappropriate when raised in another institutional arena" (p.32). In that sense, frames performed in an arena that enables the mobilization of messages, frames that link public and political benefits, can create an impetus to legislate or an access to institutionalized policy processes. Choosing one arena over another, or simply put, venue shopping, is closely related to framing for two reasons. First, issues may be assigned to a particular venue because of how they are framed. Second, different venues reinforce different ways of considering the issue.

Initial venue assignments, while not necessarily permanent, can have long-lasting policy consequences as they give a special advantage to those with greater access to that forum and to those ideas most easily accepted within it. Venues, like frames, have tremendous policy consequences. Venue shopping, like reframing, however, may be easier said than done. Just as is the case with framing, there are two sides to the venue-shopping coin. For most issues, most of the time, venues appear quite fixed. Similarly, issues initially assigned to one venue are not guaranteed to stay attached to that institution, forever and/or without competition. Venues work both ways. They are not only a cause of change; they are more often in fact a cause of stability.

Policy venues are institutional sites where framing of problems and solutions takes place (Baumgartner and Jones 1993, p.32). They are locations where policies originate, obtain support, and are adopted as binding decisions. Types of policy venues are formal political arenas such as legislatures, executives and the judiciary. The media can also be venues for shaping images of problems and solutions. Venues are sites of strategic issue control, and such control can be directed to stabilizing or destabilizing the policy status quo. I follow Arco Timmermans (2001) in the way he distinguishes two types of policy arenas: system arenas and subsystem arenas. For instance, legislatures, executives, and courts are all formal system arenas, while subsystem arenas are specific to a particular field of policymaking, for example consultations, parliamentary committees, specific administrative courts, quasi-governmental agencies, etc. How an issue gets assigned to a particular arena of policymaking is just as much a puzzle as how an issue comes to be associated with one set of frames rather than another. To use Baumgartner and Jones's formulation, just as images may change over time, so may venues. Further, just as an issue may at times have multiple images, so may it fall within the jurisdictions of several venues. Some types of images may be well accepted in one venue, but considered inappropriate when they rise in another institutional arena (Baumgartner and Jones 1993, p.32).

The logic of comparison

To identify and assess the impact of frames on policy outcomes, I will compare frame mobilization within three issues of assisted reproduction and between three national units studied. Hence, by comparing frame mobilization in these nine cases, this dissertation will highlight the influence of discursive mechanisms in the policy process, the context in which they are triggered and their effect on policy implementation. The comparison between the nine cases (three issues, three units) will help us identify, define and trace the frames; analyze their content and the way they are articulated in the actors'/communities' discourses; and the way they are performed (where, to whom and when). At the outset, this will allow me to show how particular discursive dynamics brought about stability or otherwise triggered cascades of events or incremental changes.

The comparison fulfills two efforts. First, by comparing the frame mobilization among three national units - Quebec, Ontario and England - and within three issues of assisted reproduction – access to treatments, gamete and embryo donation and surrogacy. I hope to be able to understand which ideas and discourses are products of the policy issue and to what extent they are common across the jurisdictions. In doing so, I will be able to sustain the importance of unpacking the policy area of assisted reproductive technologies in order to study effectively policy implementation at the system level. Then, mapping and comparing the context of the mobilization of frames by communities and actors in different arenas will create understanding of what led to change and stability in the different national units. Thus, the comparison will enable a better identification of discursive mechanisms as well s a clearer recognition of their consequence on policy development and the policy outcomes. Moreover, the comparison between frame mobilization and framing and reframing mechanisms enables a discussion on the competition and complementarity of frames when it comes to policy change and stability.

Short list of frames

Framing issues lead to the construction of narratives and contribute to express policy positions in decision-making processes (Howlett and Ramesh 1995). Following ideas leads us to understand how elites of the policy field frame their claims and where they are mobilized and by whom (Fischer 2003, p.89). Accordingly, policy communities and available political arenas produce a "short list of frames"[49], i.e. the frames that are prominent

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[49] See Kingdon, J. W., 1995, *Agendas, Alternatives and Public Policies*, New-York, Harper Collins, pages. Kingdon talks about a short list of ideas. I consider that his way of defining that short list relates to the concept of framing: "[…] a set of a few prominent alternatives has risen to the top of the policy primeval soup […] Ideas have been sharpened and changed, combinations have emerged that serve the purpose better than original

for a given issue. By identifying, tracing and mapping these frames, we will be able to understand how ideas influenced the policy process and contributed to the diverging policy outcomes in Quebec, Ontario and England. Table 5 presents the six frames that have been mobilized by policy communities and their opponents in the debate over access to fertility treatments, gamete and embryo donation and surrogacy between 1990 and 2010 : The 1) medical 2) experience-based 3) moral 4) legal 5) family-building and 6) administrative frames structure the way debates were constructed in Quebec, Ontario and England between 1990 and 2010. The table also presents the discourses that can be associated with these specific frames, or in other words, the different articulation of a frame mobilized by actors and communities over time and space.

Table 5: List of discourses coded across documents and interviews for the period between 1990 and 2010

Frames	Moral	Medical	Administrative	Legal	Family-building	Experience-based
Access	**100.** General **101.** Bodily integrity **102.** Medical supremacy over nature **103.** Uncertainty **104.** Sanctity of life	**200.** General **201.** Risks **202.** Success rates **203**.Security of patients **204.** Infertility as a medical condition	**300.** General **301.** Cost control **302.** Financial constraint **303.** Service provision (problem or incapacity of system) **304.** Efficiency **305.** Necessity **306.** Sustainability **307.** Universality	**400.** General **401.** Right to have a child **402.** Equality	**500.** General **501.** Natality **502.** Province building **503.** Helping families through legislation **504.** Equality with other citizens **505.** Social investment **506.** Family as State's responsibility	**600.** General **601.** Grief **602.** Monetary burden, **603.** Psychological aspects **604.** Desire

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proposals, people have been accustomed to thinking along certain lines, the list of alternatives under discussion has narrowed […]" (p.139)

Donation	**105.** Embryos and gametes as human life **106.** Dignity of life **107.** Objectification of human life	**205.** Means to an end	**308.** Shortage management **309.** One baby at a time **310.** Registration **311.** Auto-regulation **312.** Regionalization	**403.** Best interests (welfare) of the child **404.** Consent **405.** Agreement **406.** Intention	**507.** Need for a father	**605.** Equality between man an woman with infertility **606.** Identity crisis **607.** Truth **608.** Privacy
Surrogacy	**108.** Baby selling **109.** Commodification of reproduction **110.** Exploitation of women	**206.** Medical overview as protection for children and women	**313.** Comparison with adoption procedure **314.** Public/private divide	**407.** Contractual arrangement **408.** Privacy rights	**508.** Creating versus cheapening family building	**609.** Reproductive freedom of surrogates **610.** Altruistic relationship **611.** Gift givers

First, the medical frame refers to a tendency to ‘biologize’ or ‘medicalize’ political arguments. This submission of politics to the world of medical science (Jasanoff 2005) not only serves the immediate interests of social and political groups, but through the creation of new conceptual categories, opens the way for extending those interests to new or larger domains. Behaviors and conditions, medical and non-medical, are given a medical meaning. Hence they are defined in terms of health and illness. This is a sociocultural process that may or may not involve the medical profession, lead to medical social control or medical treatment, or be the result of intentional expansion by the medical profession. Medicalization occurs when a medical frame or definition has been applied to understand or manage a problem (Conrad 1992) over time in a persistent manner. Medical players often argue that they use a particular language due to the specificities of their particular knowledge, thus usually reinforcing the social image of medicine as the best scientific field with competence to regulate ART (Silva and Machado 2011). The use of such language is an important strategic tool not merely for scientists and political officials, but for all other societal interest groups, such as would-be parents and bureaucrats, who have a stake in the way in which power is distributed among centers of political authority.

Second, the experience-based frame is mostly related to a language of practical knowledge, constructed around infertility, the multiple facets of that condition, its overcoming and its impact on families. This frame emphasizes the social, emotional, and affective dimensions of ARTs. Again, this frame is not merely for would-be parents, but for other groups or experts involved in the policy process as well. Some feminist groups or would-be-parents used that frame to emphasize the role of women in reproduction and the emotional context in which they enter fertility treatments.

Third, the moral frame has been long discussed in the literature because of its prevalence in many other policy issues such as abortion, the death penalty or same-sex marriage. Moral frames make authoritative statements about what a polity holds to be fundamentally right and wrong. Hence, moral frames are expressions of societal values (Mooney and Lee 2000). Within the morality policy literature, there has also been explicit recognition that even the coalition threatened in their core values might develop non-morality framing strategies (Feld 2002) or that the coalition might simply not succeed in framing the policy debate in moral terms (Lewis 2006).

Fourth, the legal frame can be seen as the juridicisation of a set of political ideas. From structuring claims in terms of rights to the construction of utterances that fit the constraints of the legal language, legal frames are produced not just to be performed in the judicial arena but also to respond to legal rules and norms (McCann 1994). Each of these ideas is rooted in a symbolic framework organized around legal concepts and categories. A great deal of studies looks at actors' use of law to frame perceptions, actions, and experiences (among others: Sarat and Kearns 1993; Ewick and Silbey 2003). Since law provides political actors with key interpretative resources, framing issues in legal terms is one central way of constructing their claims, identity and objectives (Pedriana 2006, p.1724). Right-based claims are the most well-known legal frame, but many other claims framed around ideas of justice and injustice are mobilized in the policy debates.

Fifth, the family-building frame is centered on a holistic view of the family as a unit of socialization, sometimes enclosing conjugality and filiation to questions of reproduction. This frame somewhat places the family as the building block of society or as a unit of human organization for child (citizen) rearing, combining economic, social and psychological characteristics. This frame posits that family is a desired end not only for couples, but also for any individual, opening at its extremes to a link between family-building and provincial performance. The family-building frame also encompasses the idea of state building and nation building.

Finally, the administrative frame is used once again not only by public servants and elected representatives, but also other political actors in order to promote the "good governance" of assisted reproduction. In this context, framing the stakes in administrative terms confers a wide range of ideas over how to legislate and who to target. This frame is inked in a perspective of implementation even if it can be mobilized at any time in the political process. In other words, the administrative frame is linked to discourses of, to name a few, costs control, efficiency, equity of access, integration of good practices, regulation of behaviors, economic and administrative performance and evidence-based methods.

Quebec, Ontario and England undertook very different policy paths in the last twenty years, even though the same six frames were mobilized in the two provinces. The way they were articulated by epistemic communities and political actors and in which arena illuminates the driving action of ideational factors and the reasons why they adopted the policies and practices they did.

Methodology

"Frame analysis allows us to capture the process of the attribution of meaning, which lies behind the explosion of any conflict" (della Porta and Diani 1999, p.69). Frame analysis is a discourse analysis method that is principally concerned with dissecting how an issue is defined and problematized, and the effect that this has on the broader discussion of the issue. Frame analysis examines how reformers, activists, and politicians strategically bolster their messages in public domains (Benford 1997; Benford and Snow; 2000; Williams and Benford 2000).

This dissertation draws on the methodological tools developed by interpretive policy analysis and frame analysis "in which the focus is on the structure of language use among different groups of policy-relevant actors, sometimes pointing to the implications for actions of these various ways of thinking about the policy issue." (Yanow 2003, p.240)[50]. Four steps were undertaken to successfully identify and interpret the framing mechanisms at play in the three nations for the three sub-issues studied.

The first step in this frame analysis was to gather all legislation, regulations, governmental publications (expert reports, committees proceedings, Hansards, etc.) and court

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[50] Also see, Schön, D. A. and M. Rein, 1994, *Frame Reflection: Toward the Resolution of Intractable Policy Controversies*, New-York, Basic Books, pages.

cases with regard to fertility treatments provision, gamete and embryo donation and surrogacy-related debates in Ontario, Quebec and England. A variety of documents produced by groups working or advocating around the issue of access to fertility treatments, gamete and embryo donation and surrogacy were also identified. Frames and discourses are frequently found in texts. To be able to understand their political use as well as their dominance, these documents helped me trace frames in time and contextualize them. Over a hundred and thirty documents were identified and consulted, and eighty-seven of them were coded. In addition to these documents, forty-eight court decisions (see Table 6) were also analyzed and coded in order to identify the interpretation of the law and to evaluate their resonance in the political process and their impact on the implementation of the laws and regulations in place.

Table 6: Distribution of court decisions by issue in Quebec, Ontario and England

	Access	Donation	Surrogacy
Quebec	1	13	9
Ontario	1	10	4
England	2	1	7

The second step was to conduct a total of thirty-seven interviews in Quebec, Ontario and England with public servants, group leaders, experts and scholars who provided complementary information and interpretive validity (see Table 7)[51]. In the process of interviewing members of different constituencies, I discovered that the understanding of policy issues is vast, complex, contradictory and emotionally charged. Even in a single population group, meaning is not uniform and frames are hotly contested. Interviews helped me uncover which dominant frames and what underlying ideas are mobilized in debates over the three sub-issues of medically assisted reproduction. They will illustrate the case studies by supporting assertions of frame mobilization.

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[51] Research received approval from the Social Sciences and Humanities Research Ethics Board of the University of Ottawa, April 15th, 2010. Research approval number 12-09-14

Table 7: Distribution of interviews by type of actor in Quebec, Ontario and England

Type of actor → **State ↓**	Public Servants	Group Leaders	Experts	Scholars
Quebec	3	4	2	2
Ontario	2	4	2	2
England	3	5	3	4

I was also interested in the attention a frame received, thus, the third step consisted of analyzing media coverage of the different sub-issues. To do so, I gathered newspaper articles covering the period between January 1990 and December 2010 for the three jurisdictions (see Table 8). For Quebec, articles from *La Presse* and *Le Devoir* were consulted. For Ontario, the *Globe and Mail* and the *Toronto Star* were consulted. For England, the *Guardian* and the *Telegraph* was consulted. Each newspaper article in relation to the three policy issues were coded to reach a number of 286 articles.

Table 8: Media coverage by issues for Quebec, Ontario and England

Issue → **State ↓**	Access to treatments	Gamete and embryo donation	Surrogacy
Quebec	68	22	8
Ontario	38	29	15
England	44	37	25

Third, a coding scheme[52] was defined after a comprehensive literature review on assisted reproductive technologies in diverse field of research (sociology, anthropology, law, medicine) and a round of pre-analysis of the data set. I identified the relevant components of discourses (frames), actors to which these discourses can be attributed, and arenas where they were performed. I was looking for frames that clearly represented the most dominant ways of discussing the issues accordingly, excluding some arguments and classifying others. I traced the continuity of the frames over successive time periods. To capture the evolutionary nature of frames and their content, I wanted to identify sets of arguments that not only moved together within time windows, but were stable over time as well. For each

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[52] The six frames are related to diverse ideas identified through the first round of pre-analysis. The complete coding scheme is available on request.

frame, I identified the component arguments or ideas. I named each of the six major frames with a name reflecting the primary substance of the component arguments and what I knew of the history of the policy debate during that period in time.

The final step consisted of coding all documents, newspaper articles and interviews in relation with the coding scheme, revealing ideational patterns, epistemic communities, discursive strategies, identities, problem definitions and categorizations. In short, this process of mapping consisted of identifying the details of what the frames meant, the specific language used to articulate those meanings, the different groups for which it holds those meaning, and what the conflicting interpretations are.

The next chapters present the three issues through a specific question linked to the influence of the mobilization of frames on public policies and their implementation. First, chapter 4 asks why, despite that all three national units are funding fertility treatments, Quebec is the only one providing comprehensive access while Ontario and England implement very strict access criteria. Second, chapter 5 asks why England was so prompt to regulation filiation by assisted procreation and donor-conceived children’s (DCC) right to know their origins, while the policy development in Quebec and Ontario regulated filiation through different channels and scarcely discussed the issue of DCC. Finally, chapter 6 asks why Ontario was the only jurisdiction that did not regulate surrogacy in the period between 1990 and 2010 while dealing with the same moral predicament.

CHAPTER 4
ACCESS TO FERTILITY TREATMENTS

When examining the issue of access to fertility treatment, it is striking that despite the general dominance of the medical frame in Quebec, Ontario and England, there are still variations in the implementation of access criteria for public funding. The explanation resides in great part on the slow but steady progress in the issue's medicalization in Quebec. On the one hand, it contributed to sustaining the dominance of the Ministry of Health in policy development and keeping the parliamentary arena at the center of debates. Would-be-parents' coalitions aligned with the medical community's views and bridged their experience-based frame – based primarily on a discourse of grief and suffering - to the dominant medical frame – arguing for access to risk-sensitive health care services. In doing so they provided their discourse with public support and elite attention and thereby triggered a social cascade of events that led to universal public funding for fertility treatments. In Ontario, the successive mobilization of different policy frames over time by the close-knit would-be-parents' community and their allies failed to overturn the dominant medical frame mobilized through a discourse of medical necessity. The issue was mostly discussed in sub-system policy arenas and was debated in parallel with other issues of parentage (such as adoption) or government cutbacks (economic constraints) by small communities of actors. In England, the issue of access to fertility treatments was dominated by the problem of the 'postcode lottery' created by the health care system and the Primary Care Trusts' (PCT) preeminence in determining access criteria to treatments. The multiplicity of ways PCTs frame infertility limited the government's attempts to achieve a uniform provision of services throughout England. The issue was thus regulated through many guidelines and soft laws that produced competing definition of infertility. Over time, many acquired access to treatment by slowly redefining infertility at the central and at the implementation levels, for instance lesbian and same-sex couples.

Quebec

The story of fertility treatment provision in Quebec is that of unrelenting progress toward accessibility and public funding that began as soon as the first clinics opened in

Montreal in the early 1980s. The province's first in vitro baby was born on August 10, 1985 as a result of efforts by Dr. Jacques-Émile Rioux[53] and his team in Quebec City. Two years later a team at Saint-Luc hospital in Montreal performed the procedure as well. In 1989, the lack of space and funding from the public sector to develop medically assisted reproduction services forced the creation of the McGill Institute of Reproductive Medicine, which became Quebec's first private clinic. From 1990 onwards, IVF services for infertile couples would only be available privately.[54]

Uncertainty, medical necessity and infertility

Despite that treatments were only available privately, the government was nonetheless interested in regulating the issue. Fear that clinicians' autonomy would lead to maverick practices led Quebec to develop ethical guidelines and principles. In 1989, the Ministry of Health and Social Services adopted four orientations to guide the work of the ministry in the area of reproductive health and new reproductive technologies: 1) children conceived through medically assisted reproduction should have their interest and dignity protected; 2) human beings cannot be objects of commerce, in part as much as in whole; 3) the ministry should take clear action starting from the prevention of infertility to the use of technologies[55]; 4) access to clear, exact and comparable information (from one center to the other) is a fundamental right for users.

Many measures were defined in line with these four orientations. Priority was set on acquiring information on causes of infertility and its treatment; on contraceptive methods, their effectivity and their impacts on fertility and infertility; and finally, on alternative solutions to early voluntary sterilization. At that period, all stakeholders consulted identified sexually transmitted diseases as one cause of infertility. That led many of these stakeholders to recommend that the department implement an action plan having as a primary objective to decrease their occurrence. Moreover, the ministry proposed ensuring the regulation of

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[53] Encouraged by the success of his British colleagues, Dr. Jacques-Émile Rioux Professor at the Faculty of medicine of University Laval begun to propose some assisted reproduction techniques to his patients at the end of the 1970s.

[54] The IMRM became Procrea a few years later and developed an affiliated clinic in Quebec City in 1998. In 1995, McGill University recruited a group of doctors formerly working at Procrea and a few specialists from England who created the new private center hosted by the University: the McGill Reproductive Centre.

[55] That implies in part to prevent sexually transmitted deseases and increase awareness on the different causes of infertility.

assisted reproduction by limiting the sites of practice through an approval system for fertility centers. Such a project was never further elaborated because the federal government took the lead in developing legislation in that regard.

In 1990 and 1991, in accordance with the orientations previously adopted, the Ministry conducted a consultation on assisted reproductive technologies and planned parenthood aimed at gathering information on clinical practices, views on related legal questions and statistical information regarding infertility and its treatment. Around twenty groups were consulted, including the Conseil du Statut de la Femme du Québec (CSFQ). In November 1993, the delegated minister to the Status of Women, Violette Trépanier, asked different stakeholders to produce documents on the needed regulation and the role of the provincial state in the domain. This request was made in part because the Royal Commission, after long months of consultation at the federal level, had submitted its report detailing the high level of risks women assumed when seeking fertility treatments.

Driven by the federal pressure to "proceed with care" with assisted reproductive technologies, Quebec invested the debate over access to fertility treatments by embracing the bridge between the moral and the medical frames that dominated the discourses of the Royal Commission (Scala 1997). The medical necessity[56] said to be needed for a service to be provided and the uncertainty the medical players still contended was present, made the provincial government maintain its position and created the necessary incentives to let the market organize and auto-regulate.

The medical profession remained important in the development of assisted reproductive technologies at that period as Quebec tended to give much autonomy to its medical professionals. In a context where the health system was in crisis and where the province was to reorganize provision of services for all health services - aiming to be more effective and make important economies of scale - it was not the time to invest in a service targeting a very silent minority of citizens, especially for a medically unnecessary and still experimental treatment. To align their position, the province let the clinicians take care of the implementation of best practices and stable price lists until techniques were better developed and the market well implanted. For this reason, professional associations such as the Collège

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[56] We can think that at the same period vasectomy was covered by RAMQ even if medical necessity had never been defined in many cases of sterilization.

des médecins du Québec and the Association of obstetricians and gynecologists of Quebec (AOGQ) took the leadership in establishing working groups on ART.

In the 1990s, IVF was seen by many as a line of treatment that was inevitably accompanied by unacceptable practices. For those concerned – many of them being doctors - it was the state's responsibility to regulate the technology, in particular the transfer of multiple embryos. The scientific and market competition between providers of ARTs added to the lack of valuable information such as success rates, clinical information on treated patients, live birth rates, etc. contributed to stigmatize IVF. It also increased worries about risks undertaken by women and consolidated the taboos around infertility. In the early 1990s, interveners in the scarce provincial debates still linked medical innovation - which involved many risk-taking procedures in other countries[57] - with decreased attention to patients' needs, and accordingly, to bad medical practices.

> […] en effet, 'la pratique, par son côté spectaculaire, s'inscrit dans un contexte de concurrence internationale au niveau des savoir et des spécialités de pointe'[58]. Cette situation fait en sorte que les chercheurs n'ont pas avantage à se dissocier de la course qui existe dans leur champ de recherche, puisqu'ils courent le risque d'être exclus des cercles et des réseaux où se font les avancés scientifiques. […] La compétition qui se déroule dans le monde scientifique peut s'opposer aux valeurs d'ordre éthique. (Conseil du Statut de la Femme 1996, p.50, 54)

In terms of access to treatments, a survey conducted by the CSFQ in 1996 showed that a majority of people interested in ARTs considered that marital status was unimportant, but medical necessity or diagnosed infertility was an essential criterion to be taken into consideration. The result of the survey showed that a majority of people thought IVF should be covered by the RAMQ if conventional treatments did not work. Many kinds of medical conditions were cited, interestingly all related to female factor infertility: tubal blockage, endometriosis, idiopathic infertility or infertility after a disease or tubal condition (breast cancer, salpingitis, ectopic pregnancy)[59]. The only exception to public coverage was if

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[57] The United States was often described by practitioners in Canada and in the United Kingdom as the country of maverick doctors. It became and still is to a certain extent the bad example in the treatment of infertility. Most interviewees who discussed this issue related the dissenting behaviors of American clinicians to their will to dominate the ART market and to rapidly develop new technologies in order to compete with other countries.

[58] Quote from Bouchard, L., 1990, "L'institutionnalisation de la procréation artificielle, une monographie d'une clinique québécoise de fécondation in vitro", Maîtrise es Sciences en sociologie, Faculté des études supérieures p.141

[59] Note that about one third of male infertility is unexplained, i.e. that the cause of their incapacity to procreate stays a medical mystery therefore rendering diagnosis impossible.

women underwent a voluntary sterilization; in that case RAMQ should not cover the cost of treatment, according to survey respondents.

Between 1990 and 1998, the province of Quebec went from discovering new technologies to debating them at a very rapid pace. The few interveners in that very specialized and already multifaceted debate pictured embryologists and fertility specialists as being concerned by technological development more than women's needs:

> C'était probablement disproportionné de dire que la fertilisation in vitro était une intervention expérimentale à cette période, mais c'était tout de même le sentiement que les gens avaient. Si je suis honnête avec vous, on ne savait pas grand-chose sur les inconvénients et la game complète des effets sur la santé des femmes et des enfants. On savait seulement que la seule manière de parvenir à en savoir plus était de creuser davantage, de faire plus de recherche, et ça impliquait de traiter plus de femme. (Interview with Fertility Expert Qc-1, November 9th 2010)

The practitioners' uncertainty and the women's groups' worries pushed the involved communities to consider IVF as a last resort for medically infertile couples. In a context of scientific development many experts and policy-makers felt it was not the time for the Ministry of Health and Social Services to open the doors of clinics, endorse the practice and publicly fund a new procedure. However, the debate was started and the rapid development of biomedicine increased the need for further debate on access to fertility treatments.

The first community of would-be-parents

The Association Québécoise pour la Fertilité Déméter (hereafter Déméter) was founded in 1987 by a group of infertile couples with the help of Dr. Pierre Miron, director of Procréa in Montréal. Willing to share their experience and assist other couples struggling with the same situation, they organized around a telephone support line, and later a discussion forum on the Internet. This association was non-profit and did not belong to any clinic, despite Dr. Miron's help. The aim was primarily to diffuse information and support couples with fertility problems before, during and after their treatment in a clinic.

> Nos patients dans notre salle d'attente racontaient aux secrétaires et aux autres patients des discussions qu'ils avaient eu à la table à dîner familiale ou au travail […] l'opinion publique était plutôt d'avis que les personnes infertiles devaient adopter au lieu de passer à travers des traitements bizarres, expérimentaux et coûteux. C'était curieusement plus méritant d'être infertile et d'adopter à cette

> époque-là que d'être infertile et d'aller chercher de l'aide médicale en procréation assistée. (Interview Fertility Expert Qc-1, November 9th 2010)

In the spring of 1995, Déméter organized the first conference on infertility awareness in the province. The small-scale event helped introduce the association to couples who were seeking assistance with conception. In the fall of 1999, André Gosselin and Francine Corbeil, who became respectively, chairman of Déméter and webmaster of the forum, wrote a text entitled "L'infertilité et nous" that they sent to various media and ministers: "À l'heure où l'on parle de taux de natalité à la baisse dans notre pays et de mesure incitatives pour 'nous repeupler' […] J'aimerais apporter un point de vue oublié: celui des couples vivant un problème de fertilité."(Gosselin and Corbeil 1999) Interestingly, that sentence is how Francine Corbeil began her letter. It presents the family-building frame that she and her husband mobilized intensively that year. She speaks about the costs of treatments and the different approaches they have taken toward their first attempt with IVF. More importantly, Corbeil was the first layperson[60] in Quebec to talk publicly about infertility as a disease and access to treatment as a nation building strategy.

Social Investment, family building and the medical risks

Following the publication of their letter, TVA, a television broadcaster, invited Corbeil and Gosselin in November 1999, to discuss their situation and openly claim support from the state. Invited to the same talk-show, Louise Montreuil, a representative from the Minister of Health and Social Services, explained the government's concerns with regard to ethics, treatment-associated risks and the potential negative effects on women's health. Not long after the televised debate, Pauline Marois, then Minister of Health and Social Services, received a letter from Corbeil and Gosselin reporting their experience and claiming once again public funding:

> Comme il nous semble illogique de ne pas soigner l'infertilité comme on soigne n'importe quelle autre maladie, nous réclamons l'accès gratuit aux traitements appropriés, notamment la fécondation in vitro. Mais si votre ministère, ou le

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[60] The Association of Obstetricians and Gynecologists of Quebec defined infertility as an illness October 29th 1993 in an official policy statement by the board. "*L'Association des obstétriciens et gynécologues du Québec déclare que l'infertilité est une maladie et que les actes effectués pour la corriger, incluant la fécondation in vitro, sont des actes médicaux. Plus spécialement, la fécondation in vitro est maintenant sortie de sa période d'expérience médicale pour être une technique efficace de traitement de l'infertilité dans certaines circonstances bien précises.*"

> ministère du Revenu, constate que malgré le bien fondé de cette demande, l'argent n'est pas encore disponible, nous nous attendons au moins à avoir les mêmes droits que les couples ayant choisi d'adopter, c'est à dire avoir un crédit d'impôt de 3000$ sur les frais de nos traitements. (Gosselin and Corbeil 2000)

This second letter marks a shift towards a medical and an administrative frame. The dominant moral and administrative frames supported by the government and the medical community consistently challenged the new family-building frame mobilized in the first attempts to influence the decision-making process. Déméter and the Corbeil-Gosselin couple had to rearrange their claims around other ideas and when they did, they aligned with both the discourse of fertility specialists like Pierre Miron and the Ministry's administrative considerations. A turn towards a fiscal solution seemed convincing. A few months later, on March 14th 2000, in order to harmonize the support offered to adopting couples and to couples undergoing assisted reproductive treatment, Bernard Landry (Parti Québécois - PQ), Minister of Finance, presented a 25 per cent tax credit on expenses incurred by infertile couples for a maximum $15,000 total admissible fees. The fiscal measure was not the first choice of advocates. For a while before this decision, Dr Pierre Miron and Déméter were pressuring[61] the government to invest in the creation of families through full coverage of assisted reproductive treatments through the RAMQ. However, the fiscal instrument was a means for the PQ government to limit the scope of their action without opening a broader debate, already hard to untangle at the federal level[62], whilst continuing to invest in families as much as possible (Interview Public Servant Qc-2 – Ministry of Health and Social Services - October 23rd 2010). The measure was described in the media as a natalist policy ranking Quebec as the Canadian exception.

Nevertheless, it was not seen as the final word for would-be parents, even less for Francine Corbeil and André Gosselin. In a letter to Premier Bouchard, minister of Finance Bernard Landry and Minister of Health Pauline Marois, they welcomed the news, but mentioned what they really expected from their government: « En effet, considérant l'impact social du traitement ou du non-traitement de l'infertilité, et surtout, considérant qu'il s'agit bel

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[61] Many letters were sent to ministers and MPs by Déméter. Pierre Miron also used all available avenues to publicize about the need for public funding.

[62] At that time, more than six years passed since the Royal Commission report was issued, and already two bills had been submitted to the Commons.

et bien d'une maladie, notre objectif reste la gratuité du traitement médical requis. » (Gosselin and Corbeil 2000)

Nadine Filion, journalist at *La Presse*, published May 28th 2000 a series of articles on infertility that rapidly increased attention to questions of assisted reproduction and the situation of infertile couples. Again, Francine Corbeil and André Gosselin, in their testimony to the journalist, maintained the view that infertility was a disease and that IVF was the only treatment available. When asked why the state refused to cover the full costs of treatment, Pierre Michaud, representative of the general direction of service provision at the Ministry of Health, responded:

> Du point de vue éthique, plusieurs questions d'ordre médicale et sociale doivent être étudiées [...]. D'une part, la technique est récente et le ministère n'est pas en mesure d'évaluer les impacts sociaux et individuels qu'elle provoque. D'autre part, il est encore trop tôt pour mesurer les risques qu'elle pourrait représenter pour la santé de la femme et surtout pour celle de l'enfant." (Filion 2000)

The discourse of the government's health ministry was focused on the variable success rates associated with these technologies, and the multiple side effects of the treatments. In this view, since the technologies were not perfectly able to cure or overcome the diagnosed condition, the service could not be publicly funded. By contrast, the medical definition that would-be-parents were mobilizing was based on their experience in attempts to conceive regardless of the technology used. The psychological impacts of the condition were enough for would-be-parents to justify the definition of infertility as a disease.

In her last months as minister of Health, Pauline Marois released a policy strategy against sexually transmitted diseases, one of the causes of infertility identified in data gathered on reproductive health. In October 2000, the Association québécoise pour la fertilité Déméter received an invitation from the public servant responsible for the RAMQ to talk with him about policy solutions. However, because of the birth of their twins resulting from a successful IVF treatment, André Gosselin and Francine Corbeil were not able to meet with him and the lack of representatives at the association to fill in meant that the meeting never took place. In March 2001, Pauline Marois was moved to Finance and as soon as she presented her first budget, she increased the tax credit dedicated to infertile couples from 25% to 30% for a maximum of $20 000 admissible fees. A few months before the release of the PQ budget that year, the would-be parents' community reacted vociferously to the increase of fees for artificial insemination and infertility related procedures. The attention of the decision-makers was clear from this quick move of the government to equilibrate the increase in cost and the governmental aid for families seeking assistance to conceive or adopt.

Between 1995 and 2001, the political discourse in Quebec changed drastically. From the claims of would-be-parents framed in terms of family-building and experience, to a dialogue that not only mobilized a medical frame, but took place between actors of the health policy domain, the story of social investment in Quebec[63] shows the slow tendency to think about assisted reproduction and infertility in medical terms. However, the fiscal engagement of the government as well as the formal discourse of the Ministry of Health over the years shows how controversial defining infertility as a medical condition can be. One frame that has been rarely contested from the government or other stakeholders is the family-building frame. The discourse on natality, the idea that the state should be helping couples to form families was accepted, valued and resonated with that particular government. In that discourse, adopting parents and parents seeking medical assistance with conception needed to be equal before the law, and accordingly, that led to the adoption of the first tax credits (Interview Public Servant Qc-1 – Ministry of Finance – June 18th 2011). However, the shift toward a medical understanding of infertility was perceptible through the constant references to infertility as a disease and IVF as a risky treatment.

Nothing else but actual access to services

For many years, lesbian couples and single women without a male partner who wanted to have children considered ‘homemade’ insemination as their first available option. Since their infertility was not caused by a medical condition, there was no need for a previous medical examination by a clinician; they could purchase sperm at the sperm bank[64] at low cost. The ability to do this in the comfort of their own homes made the process much less socially confrontational. In Quebec, there was no explicit exclusion of same-sex couples

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[63] For a discussion on the period of social investment in Quebec see St-Martin, D., 2002, "Apprentissage social et changement institutionnel: la politique de ‘l'investissement dans l'enfance’ au Canada et en Grande-Bretagne", *Politique et Sociétés,* 21, 3, p.41-67. ; Jenson, J., 2009, "Lost in Translation: The Social Investment Perspective and Gender Equality", *Social Politics: International Studies in Gender, State & Society,* 16, 4, p.446-483.

[64] Since 1990, ReproMed, the biggest sperm bank in Canada, has been providing sperm banking services throughout the country.

and single mothers from artificial insemination. Intra-uterine insemination was a medical act covered by the RAMQ in the 1990s. Only the cost of sperm sample and sperm screening was billed to patients at that time. The Ministry of Health had surprisingly issued no directive on artificial insemination. At that time, a clinic's internal politics prevailed; hence, some clinics treated married couples only.

The HIV crisis of the 1980s led same-sex couples and single women to see fertility clinics as a safer - and in many ways, their only – option for getting pregnant. It also compelled medical professional associations and the federal government to issue guidelines and eventually regulations on donor sperm. In 1986, the question regarding guidelines on donor insemination was raised at the Annual General Meeting of the Canadian Fertility and Andrology Society (CFAS) in Toronto. At that time, it was determined that the published guidelines of the American Fertility Society[65] were "in a number of ways, either inappropriate for Canada, insufficient, or, in one or two specific matters, incorrect" (Canadian Fertility and Andrology Society 1988). The American guidelines were structured around a patient-doctor relationship that was considered too commercial for the Canadian context. In addition, the screening and selection of donors were not consistent with medical practices in the different provinces of Canada. The CFAS considered screening and selection of donors essential and accordingly developed guidelines adopted in October 1988. The guidelines were again revised in 1992, 1996 and 2000.

Taking responsibility for the risks associated to donor sperm commerce in Canada, the federal regulation on the donation of semen samples for use in artificial insemination or in vitro fertilization, the Semen Regulations (The Processing and Distribution of Semen for Assisted Conception Regulations) of the Food and Drugs Act was issued in 1996. Donor sperm was thus a little more difficult to acquire and prices increased. Despite that situation, same-sex couples and single women were willing to pay for samples. However, mobilization against the psychological process required by RAMQ to cover services and the marital requirement of some clinics increased.

The claims of same-sex couples and single women have been described at the time as an extension of the "right to have a child" discourse, which did not resonate in the public and with institutional definitions of infertility and medically assisted reproduction. In this regard,

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[65] Now the American Society for Reproductive Medicine (ASRM).

three decisions of the Commission des droits de la personne of 1995 should be mentioned. Cases were brought by women against the Institut de Médecine de la Reproduction de Montréal, St-Luc Hospital and Sherbrooke Medical University Center[66]. Each complainant alleged that the clinic or hospital had refused her artificial insemination with donor sperm because she was single and had no spouse. Decisions of the Commission in these three cases concluded:

> Que les services d'insémination artificielle offerts par la Clinique d'infertilité, dans le présent dossier, ne sont pas des services offerts à l'ensemble du public. Ce sont des services offerts à un public restreints: les personnes qui sont confrontées à un problème d'infertilité. Dans les circonstances, le droit de la plaignante de conclure à un acte juridique ayant pour objet un bien ordinairement offert au public n'a pas été compromis, puisqu'elle ne faisait pas partie du groupe de personnes auxquelles le service offert par la Clinique d'infertilité était destiné. (Cases MTL 7464, MTL 7854, SHE 0431 -01/3, -02/1 and -03/9 of November 2nd 1995)

To address the situation, the Association des mères lesbiennes de Québec[67] (AMLQ) decided to lobby clinics directly, starting with Procrea[68]. The Fédération des Femmes du Québec and a few psychologists and sociologists participated in this exercise and tried to increase awareness of discriminations against same-sex partners and women's life choices (Interview Mona Greenbaum - November 11th 2010). Procrea became the first clinic to provide access to lesbians and single women, followed by other clinics such as the Montreal Fertility Clinics and OVO.

The Canadian fertility and andrology society (CFAS) 2000 revision of the sperm donation guidelines expanded the donor selection criteria and the testing requirements for transmissible diseases. The CFAS guidelines were then converted into the Technical Requirements for Therapeutic Donor Insemination by Health Canada and became effective on July 27, 2000. Sperm donors were then automatically anonymous and underwent rigorous screening for medical and genetic diseases and for all sexually transmitted and other infectious diseases, including AIDS and hepatitis. All donations needed to be quarantined for six months and the donor re-tested at this time to ensure samples were negative for the

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[66] Case MTL 7464, MTL 7854, SHE 0431 -01/3, -02/1 and -03/9 of November 2nd 1995.

[67] In 1998, the LGBT Family Coalition was founded as a result of a merger of two former non-profit community organizations: The Lesbian Mothers Association of Quebec and the Papa-Daddy Group.

[68] Procrea have a clinic in Montreal and one in Quebec, which necessarily meant that more couples would have been affected by a positive outcome.

viruses that lead to those diseases. The Semen Regulations also stipulate that if a donated sample has a high white blood cell count, it must be destroyed, as this is often indicative of a viral or bacterial infection. Lesbians hence needed to go through a physician to acquire sperm and/or be inseminated. Three out of the four private clinics in Quebec already responded positively to AMLQ's call for equal access to artificial insemination and public hospitals, and were required to proceed in accordance with the law[69].

Although sexual orientation was read into Section 15 equality rights of the Canadian Charter of Rights and Freedoms, discrimination still was part of same-sex couples' lives; their attempt to become parents did not make an exception. In 2001, after two ectopic pregnancies Helene Zylberszac found herself at the Royal Victoria Infertility Centre (RVIC) sitting and discussing her situation with a fertility specialist. The specialist agreed that because of the fertility issues that she was experiencing that she would be a perfect candidate for in vitro fertilization. When she left the doctor's office and went to the reception area to set up her appointment, the secretary asked her the name of her husband. When the secretary found out that she had neither a husband nor male partner, she refused to give Helene an appointment.

Shortly thereafter, Helene Zylberszac filed a complaint with the ombudsman of the hospital; she also spoke again with her doctor, as well as the head nurse of the clinic, who she said told her that the RVIC did not take lesbians as patients. In her testimony she stated that Dr. Tan, the chief of the department, also explained to her that gays and lesbians did not make good parents. Finally Dr. Tan recommended that she continue with regular inseminations outside of the hospital, despite the fact that another ectopic pregnancy could enhance health risks for her and the potential child. She finally decided to file a complaint with the Commission des droits de la personne.

During the time her complaint was under review, the situation of lesbians changed dramatically in the province. Full parental rights were granted to same-sex couples with the reform of the civil code in 2002. By adopting Bill 84, Quebec's legislature chose to expand access to artificial insemination for single women and lesbian couples. From that day on, the distinction based on marital status of women or sexual orientation was no longer admissible.

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[69] In 1996, the Canadian parliament enacted the Act to amend the Canadian Human Rights Act (Bill C-33),(11) which added "sexual orientation" to the Canadian Human Rights Act prohibited grounds of discrimination.

Bill 84 amended the Civil Code and replaced the old chapter on medically assisted procreation with a new chapter entitled "Filiation of children born of assisted procreation". Through that law, the legislature clearly stated that a single woman, whether in a same sex or opposite sex relationship, could not be prevented from seeking to use assisted reproduction.

At the end of 2003, the Commission had set up a mediation session with the Royal Victoria Infertility Center and Helen Zylberszac. Despite the new Civil Code articles, no solution was found. The hospital continued to insist that their decision was appropriate and acceptable, arguing that it was following its own internal policy. As soon as the federal Assisted Human Reproduction Act of 2004 was adopted, discrimination on the basis of marital status or sexual orientation in the provision of assisted reproduction was clearly prohibited, not just by the Charter or the provincial civil code of Quebec but also by the federal Act. Following the adoption of the federal Act, it was also illegal to compensate sperm or egg donors[70].

Finally, in March 2005, Zylberszac called the *Montreal Gazette* with her story. The Gazette ran an article entitled “Fertility Challenge was the First of Many” (Fidelman 2005). The article revealed that two lesbian couples had also also filed complaints with the commission after being denied IVF at the Centre hospitalier universitaire de Sherbrooke. Hospital officials denied allegations of discrimination while confirming that at least one doctor on staff refused to treat homosexuals because of his religious beliefs[71], but that six other doctors were able to perform the procedure. A telephone survey conducted in October 2005 by the Association des mères lesbiennes du Québec (AMLQ) had revealed that same-sex couples seeking fertility treatments were often turned away from hospitals because of their sexuality:

> We didn’t get beyond the secretary. They didn’t even want to give same-sex partners an appointment. And the answers were multiple. Good parenting was the worst of their arguments, the most illogical after the debate we had with Bill 84. Public clinics providing artificial insemination services were even arguing that their sperm banks were low and that was why they had to refer lesbians to private clinics. (Interview Mona Greenbaum - October 13th 2008)

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[70] Canadians have access to three Health Canada accredited sperm banks. Repromed collects sperm from men located in Toronto; Outreach and Can Am are Canadian offices that import sperm from American and international suppliers.

[71] The AHR Act of 2004 accepts that a clinician can refer patients to a colleague should she or he oppose treatment on the basis of personal or religious beliefs.

The counter argument of the lesbian community was that many women were turning to private fertility clinics, knowingly leaving aside their access to fully funded insemination, but in some cases they turned to unsafe practices. Mona Greenbaum, president of the AMLQ, argued to the Minister of Health and Social Services that women searched for donors via newspaper ads and that the alternative of having intercourse with a total stranger was putting women at risk. The group claimed that all women should have equal access to health care. Shortly after the *Gazette* article was published, the Commission des droits de la personne du Québec voted unanimously that the RVIC had discriminated against Helen Zylberszac and that damages should be awarded.

The mobilization of medical arguments around the debate over access to fertility clinics for same-sex partners and single women made possible discrimination against them in the 1990's (through a discourse of medical necessity), on the one hand, and their inclusion in the late 2000's on the other hand (through a discourse of equal access to health care and medical risks). Clinics used clinical guidelines and the medical necessity concept to sustain internal policies enabling only married couples to be treated. Even with the addition of sexual orientation to the Charter, same-sex couples had a hard time accessing fertility clinics. Through the 2000's, the change in the Civil Code, the federal act on assisted reproduction following in 2004, and same-sex marriage recognition in 2005 made it clear that discrimination was not an option. However, it was not a rights-based argument that changed the views of clinics. In fact, discourses maintaining that clinical practice was considered to have the responsibility to grant equal access to safe health services to any women seeking treatment won out over discriminatory criteria.

Bill 89: on the many ways of mobilizing a medical frame

With the multitude of critics of the federal government's poor management of the debate over ARTs and of the 2004 federal Act, the provincial level became the political space for deliberation. Ontario, which had been a pioneer in the field of assisted reproduction in Canada, was overtaken by Quebec in the race for policy innovation. Significant investments of the Société Générale de Financement in the development of Procrea in 2000, for instance, assured the continuous development of expertise in the province. Quebec specialists' leadership within the national professional associations made a difference. They urged the debates on ART to take place in the provinces, accordingly granting them the necessary resources for developing their market. The medical community needed to extend their medical market-oriented discourse to include ethical discourses built around good practices and success rates (Interview Fertility Expert Qc-2, December 19th 2010). In that sense, the introduction of Bill 89 meant both the amplification and the extension of the medical frame.

The Collège des médecins du Québec in 2000 and 2002 argued extensively for the necessity to regulate ARTs. The College also expressed concern about the rigidity of the federal bills and the inadequacy of criminal measures to regulate ART.

> Vous comprendrez que pour nous la régulation sociale exercée par les professions est tout aussi nécessaire que les lois votées par les Parlements. Quand une loi, criminelle de surcroît, se propose de venir contrôler tout un secteur d'activités sans égard aux encadrements qui existent déjà, alors rien ne va plus et il y a bien des querelles en vue. (Collège des médecins du Québec 2002)

The College asked the federal government first, and later the provincial government, for a framework that would overview the practice of assisted reproduction, although one that could be fluidly implemented through auto-regulation and a blueprint law. In addition, the Council for the Status of Women consulted again many experts and wrote to Philippe Couillard (Parti Libéral du Québec – PLQ) underlining to the new Liberal minister of Health the legal loopholes left open by the federal legislation and the lack of regulation at the provincial level. Considering their dissatisfaction with regards to the federal political process, Quebec medical bodies and feminist institutions each contributed putting the issue of assisted reproduction on the provincial government's agenda.

As Minister of health and social services, Couillard introduced Bill 89 to the National Assembly in December 2004 concurrently with Quebec's application to the Court of Appeal of Quebec for a judicial review of the Federal Law. The Assembly adopted the principle April 12th and 14th of 2005, leading to its review by a parliamentary commission. Ten briefs were submitted and nine oral representations were made before the Commission for Social Affairs on March 28-29-30, 2006[72].

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[72] Dr Seang Lin Tan, Centre de reproduction McGill; Dr François Bissonnette, Clinique Ovo, Montréal; M. Raymond Lambert, Centre de biologie de la reproduction CHUQ, Université [de] Laval; Société canadienne de fertilité et d'andrologie; Collège des médecins du Québec; Association des néonatalogistes; Mme Lucie Bélanger, Conseil du statut de la femme; Mme Nathalie Parent, Fédération québécoise pour le planning des

The Bill and the opening statement made by the minister were structured around a medical frame in terms of risk and best practices as well as an administrative frame based on sustainability. At first, Bill 89 was meant to attain two goals. The first goal was to sustain the province's prerogative in terms of health care practices by providing a regulatory structure to fertility clinics that the federal government had not been able to implement since 2004.

> Je tiens à souligner par ailleurs qu'un tel mécanisme est très important pour le Québec afin de lui permettre d'exercer ses compétences en cette matière, et cela, dans le respect des valeurs de notre société. À cet effet, le Québec ne saurait accepter un empiètement fédéral dans l'encadrement des activités de procréation assistée, qui relèvent du domaine de la santé. » (Couillard 2005)

In regulating the issue of assisted reproduction at the provincial level, the government was demonstrating to the federal government that provinces had the policy instruments and the administrative capacity – although not by creating a new bureaucracy but through the work of existing professional associations[73]- to adequately sustain supervision over the practice of assisted reproduction in case the law was declared unconstitutional by the appeal court. The federal agency had not been able to achieve this for two years because of its lack of authority and administrative capacity.

The second goal was to regulate the practice of medical players aiming at overcoming risk-taking methods and fostering best practices in the medical environment. Worried about protecting patients and the health of potential children, the Minister sought to reassure women's advocates: "Il vise donc à concilier les impératifs de la protection des personnes et la responsabilisation des professionnels pratiquant dans le domaine, et ce sont là deux valeurs primordiales à la mise en place d'une véritable culture de bonnes pratiques cliniques et de recherche." (Couillard 2005)

For Minister Couillard, the way to achieve protection of patients was to create a legal framework against which professional association could determine clinical practices

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naissances; Barreau du Québec; Mme Renée Turcotte, Solidarité de parents et de personnes handicapées; M. Réjean Tessier, psychologue et chercheur, Université Laval; Pr Édith Deleury, Droit de la personne et droit de la santé, Université Laval; Alliance québécoise des regroupements régionaux pour l'intégration des personnes handicapées; Me Michel Giroux, avocat et éthicien; and Mme Michèle Jean, Université de Montréal; were called for particular consultation by the Commission. Not all of them submitted a brief and/or made an oral presentation before the Commission.

[73] Philippe Couillard : « *vous ajoutez également la notion que l'agence fédérale proposée, ce serait une structure extrêmement lourde et bureaucratique pour encadrer une activité qui probablement n'a pas besoin de tant de lourdeur.* »

autonomously. The framework would have been protection against any kind of malpractice, and the code of practices established by professional associations would have been flexible enough to be modified in accordance with the rapid biomedical developments. In that sense, it was argued to be a more sustainable legal structure supported by a system already in place and ready to implement than a combination of soft and hard law.

Almost every intervener at the Parliamentary commission aggreed on the lack of social debate over assisted reproduction in Quebec. The first move from the provincial government was viewed as an inadequate response to an unanswered broad ethical question. Couillard was keen to remind participants that the legislative framework was not meant to be a comprehensive structure addressing social issues, but only the legal basis for medical practices and research activities. In that sense, he argued that the bill could become a regulatory foundation, while its opponents considered the bill as an empty shell trying to mimic the federal Act of 2004, this time with different policy instruments.

> Je crois qu'il faille, Mme la Présidente, en plus de cette vision médicale de la procréation assistée, je crois qu'il faut également faire appel à des comités d'éthique, cliniques et de recherche, aux associations de patients, aux représentants des familles, aux chercheurs. (Harel 2005)

Interestingly, the medical frame, which dominated the parliamentary commission, created an opportunity to advance women-centered discourses around reproduction. Women's health was not described as fostered through caution like it had been in the 1990s. Prevention took the place of precaution in the discourses of feminist groups and medical players. The frame was still medical, but the change of terminology showed the gradual switch made in the mind of actors in the debate compared to the anxious/moral discourses of the ten previous years. Technologies became further accepted and considered as a recognized way of overcoming childlessness; the fear and novelty of assisted reproduction tended to disappear with time. However, in the Quebec context, the lack of provincial data on infertility and medically assisted reproduction rendered impossible an evidence-based administrative approach needed to really engage in a preventive approach. Knowledge and data were still needed to define problems, social determinants of reproductive health and solutions to counter infertility upstream and minimize risks in the clinic. For Minister Couillard, the only way to structure the provision of services in the province was first to gather knowledge about fertility treatments provision, gamete donation and birth rates. The ministry had been trying to acquire that knowledge since 1990, but it had a difficult time collecting information because of the disconnection between the public sector and the private clinics.

What was possible to observe during the Commission hearings was the imposition of different themes in the province political spheres[74] and the creation of a limited space for debate. The first issue to hold sway over the debate was the medical risks undertaken by infertile couples. The argument focused on two particular practices: ovarian stimulation and multiple embryo transfer. For the first time in Quebec, risks undertaken by women when seeking assistance with conception were related to specific practices that were then related to funding problems. Clinicians talked extensively of the risks of multiple births created mostly by ovarian stimulation and/or multiple embryo transfer. What overtook the bill's mandate, was the association clinicians made between the patient-clinician relationship and these practices. For them, the fact that patients were also their clients encouraged the clinicians to increase the likelihood of a pregnancy by performing practices that could lead to riskier multiple pregnancy. Better public support would offer leeway to clinicians for better practices, mostly because, it was argued, the patient-clinician relationship would be less market-oriented. At that time, the recommendation was to upgrade the tax refund from 30% to 100%. A full tax credit would have been a better solution for clinics, as it would have preserved their monopoly on the sector and control on prices. The introduction of RAMQ funding was necessarily accompanied by the development of public clinics for greater cost control. The Ministry had already considered that option:

> Je vous rappelle que l'Association des obstétriciens et des gynécologues du Québec, dans le cadre de leurs rencontres de leur association, rendait publique une position à l'effet que c'était injuste de ne pas vouloir rembourser les frais de fécondation in vitro aux couples qui faisaient face à des problèmes d'infertilité. […] Selon le Dr Laberge, l'infertilité est un problème médical qui peut facilement être comparé à une grossesse non désirée […] c'était en octobre dernier, et la porte-parole du ministre de la Santé et des Services sociaux commentait cette déclaration du Dr Laberge en mentionnant qu'une telle mesure, comme celle des frais remboursés par la Régie de l'assurance maladie du Québec, pourrait, et je cite, «être éventuellement envisagée dans l'élaboration d'une politique familiale», et mentionnant que cela débordait les responsabilités du ministère de la Santé. (Harel 2005)

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[74] In opposition to the involvement of the private sector and the administration in the previous years.

Assisted reproduction was presented primarily as a doctor-patient relationship. Would-be-parents and clinicians were described by medical and feminist interveners as the only actors able to grasp the case-to-case nature of fertility treatments and their needs in terms of governmental intervention. “D'après nous, le but du traitement pour un problème de fertilité, pour nous, c'est un problème de santé. On va entendre que, pour certains, c'est un caprice de vouloir des enfants à tout prix. Pour nous, ce problème de santé là devrait être traité pour régler le problème.” (Janvier 2006)

The second issue that was made apparent through the representations at the Commission was the need for a holistic view of the medical practices around infertile couples, from prevention to childbirth passing through treatment and gestation. Minister Couillard and a few interveners - mostly medical and the planned-parenthood communities - connected infertility to women’s “behavior”. The social determinants of infertility, namely the age increase of the first pregnancy and sexually transmitted diseases, were depicted as the basic reasons increasing infertility in the population. Besides, women were often portrayed in the discourses as taking risks in their attempt to get pregnant under any conditions moreover taking into account the cost of treatments they underwent. This discourse intended to convince the Minister to enlarge the mandate and objectives of the bill, did not achieve its goal. The Minister mentioned many times to the Commission that the question was very important but needed to be addressed through other bills, regulations or programs, not necessarily related to the practice of assisted reproduction and certainly not through the regulation of research on embryos. From that perspective, to consider infertility and really tackle that problem, the government needed to go through other public policy channels.

> Donc, les deux actions préventives principales pour diminuer l'infertilité dans notre population seraient, d'une part, des efforts soutenus de prévention des maladies sexuellement transmises, donc de l'éducation essentiellement, et, deuxièmement, d'avoir des mesures, essentiellement des mesures de société, qui encouragent les gens à avoir des enfants tôt dans leur vie familiale. Disons que la question des disponibilités de services de garde entre en jeu, l'assurance parentale, tout ça, on voit un lien étroit avec ce dont nous discutons actuellement.[75] (Couillard 2005)

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[75] Dr. Pierre Miron, in a letter written to Minister Couillard in August 2008, is the only actor who participated in the specific debate that mobilized a family-building frame. He considered public funding as a natalist policy and claimed a political intervention to facilitate family building for infertile couples.

The population health framework was used to promote awareness campaigns and prevention programs that targeted women in the regulation of infertility. What could have become a family-building argument, constructed around education, work and family balance and family support programs, was actually expressed in moral terms. The discourse was constructed around women's reproductive behaviors and responsibility over their reproductive health as well as their vulnerability in the process[76]. The latter perspective was seen shortly after the commission as a stigmatizing way of treating women's choice and an insensitive way to treat the condition of infertile couples and individuals:

> Cette infantilisation des femmes qui sont en clinique est très mauvaise et abaisse le niveau d'information et de sensibilisation des couples lorsqu'ils vont vers des traitements de fertilité. Certains soi-disant experts entre autres ont une vision très mauvaise des traitements et sous-estime le pouvoir décisionnel des couples par rapport aux médecins. (Interview Caroline Amireault – July 18th 2008)

Experienced-based frames were rarely mobilized to illustrate the experience of couples undergoing fertility treatments. Even when they were, these narratives were presented via the testimony of their clinicians or via the recollection of media reports:

> On a surtout des témoignages et des anecdotes comme quoi il y a des personnes qui ont effectivement eu recours à ces technologies et qui ont sans cesse, après beaucoup de pertes d'argent, d'investissement d'argent, etc., ont vécu beaucoup de détresse psychologique à l'annonce continuelle d'un échec. C'est un peu un deuil à chaque fois quand on apprend qu'on n'est pas enceinte. (Parent 2006)
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> On a vu des témoignages aussi, dans le cadre de l'émission Enjeux, où est-ce que deux jeunes femmes, suite à avoir tenté ces procédures-là, qui n'ont pas porté fruit, se disaient: Bien, on aurait peut-être dû se tourner vers l'adoption, parce que, là, on aurait dépensé 20 000 $, mais on aurait été certains d'avoir un enfant en bout de ligne. Il y a un article de La Presse, tout dernièrement, qui parlait encore d'une femme qui disait: C'est un vrai parcours de combattante fait d'espoirs déçus et de souffrances, de décisions impossibles à prendre, aussi. On se rend bien compte qu'on met les technologies... place les femmes devant des choix parfois qui sont absolument déchirants et très difficiles à faire. » (Caron 2006)

Although the Minister never fully acknowledged a medicalized view of the issue and voluntarily bypassed any attempt by the interveners to make him concede a medical definition of infertility, Bill 89 linked for the first time the risk discourse to specific medical

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[76] Parental distress and the irrational desire to have a child are often related to each other in the discourse of interveners at the Commission.

practices contributing consequently to sustain the definition of infertility as a medical condition. Only the Federation of Planned Parenthood, through Abby Lippman's testimony, challenged the medical definition of infertility sustained by the medical interveners:

> Si, le problème pour l'infertilité, c'est un problème social, pourquoi utiliser une technologie médicale pour une réponse pour ceci? Et c'est dans ce cas où vous avez demandé si nous sommes contre. Je pense que nous pourrions supporter des technologies où il y a des données qui disent que c'est efficace, c'est sain et ça fait des choses nécessaires pour les problèmes qui existent, mais pas utiliser les technologies raffinées pour les problèmes sociaux. (Lippman 2006)

It was the last time in the story of the debate in the province of Quebec that an involved political actor questioned the dominant medical definition of infertility. The medical frame overtook the debate from then onwards to the extent that the issue in Quebec was colonized by a medical definition of infertility and structured around medical solutions to regulation.

The "baby lobby"[77]

Around the time Bill 89 was discussed at the National Assembly, would-be-parents organized and intensified their lobbying efforts. The would-be-parents community grew again slowly between 2004-2005 and organized around a shared experience of infertility. Clinics usually offered support services for couple undergoing treatments. Couples that had already gone through the process would make themselves available to answer questions of new patients in need of support and information. "Clinic waiting rooms are the best place to meet people living the same things you are. And most of our patients at the time were professionals or people with skills, networks or only the willingness to give back to other patients" (Interview Fertility Expert Qc-2, December 19th 2010). The community that formed as a result consisted of patients of fertility clinics, supportive relatives and clinicians that organized to become a politically relevant group attached to the Association des Couples Infertiles du Québec (ACIQ). That became possible mostly with the involvement of women lawyers and renowned media figures who chose to advocate for public funding after experiencing the stress and complications of fertility treatments.

On May 19th 2005, the Association des Couples Infertiles du Québec (ACIQ) was founded by Marie-José Joly, Caroline Amireault and Annie Dauphin, each of whom had

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[77] The would-be-parents community was sometimes refered in the media as the baby lobby.

been required to pay out of pocket to treat their infertility. In 2007, Caroline Amireault was elected as president of the board. Frustrated not to be involved in the debate around Bill 89, ACIQ wrote to many governmental representatives. Following the hearings in 2006, Jocelyne Caron (PQ) the official representative of the opposition party, requested and obtained the permission for ACIQ to produce a brief and be heard by the commission. In 2007, Caroline Amireault even wrote to Minister Couillard expressing her interest in contributing to the discussion if the commission resumed and her willingness that the Ministry hear the Association's claims. The Commission never resumed and the Bill died on the floor of the Assembly. The high ranking managers of the Ministry of Health convinced the Minister to delay the bill and conduct further discussions with the private clinics directors (Interview Public Servant Qc-3 - Ministry of Health and Social Services – May 25th 2011). Before the administration was able to brief the minister on the result of that consultation, the Prime Minister called for elections.

However, in the meantime ACIQ's president, Caroline Amireault's meeting with Julie Snyder[78], a public figure, contributed to strengthening and raising public attention on the issue. Airing on September 12th 2007 on the TVA network, a public affair program titled "Ça pourrait nous arriver" drastically increased public awareness of the process of medically assisted conception. The episode followed two couples that went through fertilization treatments, including Caroline Amireault and her husband. The episode gathered moving accounts and interviews from singer Céline Dion and producer Julie Snyder. Before the broadcast of the show, virtually no public debate was made in the public arena; only a few newspaper articles and one episode of Enjeux at Radio-Canada television network whad been broadcasted since 1999. After TVA put the show on air that September, the media attention on further policies and political debates increased considerably.

ACIQ and Julie Snyder contributed largely to changes in the image of infertile women treated before 2005 as people fretted about their desire for children. Through outreach work the image of women changed drastically to become an image of women in grief, constrained by nature and unfairly set aside by the system. The achieved goal of the would-be-parents' community was to decrease prejudices and taboos around infertility by showing couples of many classes and professional backgrounds dealing with the hard

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[78] They had met a few months before in the waiting room of Royal Victoria Hospital's clinic in Montreal.

challenge of being enabled to naturally conceive. They succeeded in portraying the Liberal Party, specifically Minister Couillard, as a stubborn figure inconsiderate of childless couples, the only party at the Assembly not willing to fund IVF. The Health Minister said he was ready to consider enhancing the tax program, but in times of budget cuts "il faut d'abord traiter les pathologies plutôt qu'aider les gens à avoir une vie meilleure […] C'est désirable de vouloir des enfants, mais ça ne fait pas partie des droits fondamentaux des individus" (Labelle 2007). That statement was rapidly publicized and accordingly, political blame was established for the first time in the debate over fertility service provision in Quebec.

Election, tax credit and policy objectives

The Liberal party was re-elected in March 2007, but this time with a minority government opposed for the first time in the National Assembly by the Action Démocratique du Québec (ADQ). After the Parliamentary Commission, the Liberal cabinet discussed the possibility of increasing the tax credit to 50% for the third round of IVF. Soon after the election, prevention of multiple pregnancies was prioritized by the adopted prenatal policy[79] of the Ministry of Health for 2008-2018 (Direction générale des services de santé et médecine univeristaire 2008) which compelled the Minister to consider options in order to decrease their numbers. IVF and ovarian stimulation were identified again as the primary cause of their high occurrence. Increasing the tax credit was one way of decreasing pressure on the clinicians when developing their line of treatment with their patients, but this measure was part of a broader program addressing issues of assisted reproduction (Interview Public Servant Qc-3 - Ministry of Health and Social Services - May 25th 2011). In line with this strategy, the Minister asked the Commission de l'Éthique de la Science et de la Technologie to conduct a thorough analysis of the ethical and societal values connected to medically assisted reproduction. The Commission mandate was to enlarge the work already under way at the Ministry of Health and Social Services and to present ethical considerations related to three practices: gamete and embryo donation, surrogacy and preimplantation genetic diagnosis (PGD).

> It was quite clear that the mandate was restricted to the three issues. Access, funding and so on were not to be discussed in the report. […] it was like… the

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[79] Québec's 2008–2018 perinatal policy, along with its 2008–2012 policy implementation plan promote good practices in regards to obstetrical interventions in the public sector.

> minister didn't want the Commission to jump into the debate, or complicate it any further. (Interview Scholar Qc-1 – June 8th 2012)

In fact, the report begins by stating that "[…] the Commission considers that there is no such thing as a "right to a child," and as a result the State is not required to satisfy the requests of all citizens where assisted procreation is concerned." (Commission de l'éthique de la science et de la technologie 2009), rejecting accordingly any possibility for the Commission to express recommendations on the related issue of access to fertility treatments.

Bill 23: the clash of many frames

Philippe Couillard submitted Bill 23, an amended version of Bill 89, December 18th 2007 during Canadian Infertility Awareness Week. The Commission for Social Affairs met in June 2008 to hear submissions. Three oral and written briefs were presented before the Commission after ADQ requested them: one by ACIQ; one by Julie Snyder, the last by Dr. Pierre Miron[80]. The Parliamentary commission for Bill 23 and the debates at the Assembly were a terrain where many frames clashed with one another. Even if most of the interveners at the Commission agreed on the need for public funding through the RAMQ, all of them did not support their claims with the same kind of arguments. The medical frame still dominated, but the experience-based frame became prevalent as well.

Philippe Couillard tried to reach out to infertile couples in his introduction, but made sure to argue that the bill did not aim at debating funding.

> D'abord, c'est que la solidarité que nous ressentons tous par rapport aux familles qui ont des difficultés à concevoir, des difficultés à avoir des enfants, cette solidarité dépasse les barrières partisanes et s'étend à tous les parlementaires présents dans cette Assemblée. […] il ne faut pas avoir, au cours de l'adoption de ce projet de loi, des débats sur les sujets qui n'appartiennent pas au projet de loi. Je sais, par exemple, que sur la question de l'inclusion, au panier de services de l'assurance maladie du Québec, des procédures il y a peut-être des différences d'opinions[…] (Couillard 2008)

The debates did not go as the minister had planned. Still, four themes took over and dominated further policy processes: the definition of infertility as a medical condition, the

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[80] Beverly Hanck of the Infertility Awareness Association of Canada was asked to participate, but the lack of time (people were contacted 48 hours before the hearings) to prepare made her decline the invitation. In a letter to the member of the Commission she says: «*Permettez-moi de vous dire, au nom des patients du Québec atteints de problèmes de fertilité, que je trouve tout à fait inapproprié d'être convoquée à une commission de cette importance à quelques jours d'avis.*»

difficulties couples encounter when seeking assistance with conception, the medical risks associated with ovarian stimulation and multiple embryo transfer; and finally, the family/province building path Quebec should promote.

First, the perspective of would-be-parents, instead of being represented by clinicians' testimony that time, was presented to the public and Parliament by the would-be-parents themselves. Most of the risk discourse heard previously was repeated but this time accompanied by a rationale why funding whould be provided.

> Well, that's the problem with people telling their lives in a public arena, we cannot frame their emotions in rational words, it's just sad stories lacking in expertise [...] well that time they had to listen even if it wasn't perfect 'public discourse' because parents linked funding to good practices and good practices to the relief of their struggle. (Interview Fertility Expert Qc-1, November 9th 2010)

The experience-based frame was created through the discourse of representatives for the two opposition parties as well as the would-be-parents community and allies such as Dr. Miron. For instance, Bernard Drainville quoted letters he received from citizens dealing with infertility before the National Assembly. For the first time in the parliamentary arena, the voice of the patients, the would-be-parents, was presented by means of their personal stories.

In Caroline Amireault's discourse that day, two frames were mobilized. She described in front of the Commission the situation of infertile couples; she put emphasis on the grief, stress, financial burden and suffering couples experienced every day after the diagnosis. The experience-based frame presented in her discourse resonated mostly with Bernard Drainville's speech.

The second theme came with ACIQ's attempt to have infertility recognized as an illness. ACIQ mobilized a medical frame that resonated in the discourse of the opposition representative Éric Caire (ADQ). Consensus over the definition of infertility was achieved at the commission. It was rapidly linked to best practices by Éric Caire:

> Or, nous pensons que le fait de reconnaître l'infertilité comme une maladie, le fait d'ajouter au panier de services de la RAMQ les remboursements de traitements de procréation assistée vont tout à fait dans ce que je viens de vous lire, sont tout à fait en droite ligne, en accord avec viser à favoriser l'amélioration continue des services en cette matière. (Caire 2008)

In addition, Caroline Amireault linked infertility as disease to a suffering experience: "On souffre d'infertilité. On souffre d'infertilité. Écrivez ça partout, dans vos mémoires, partout, on souffre d'infertilité. Le jour où l'infertilité sera reconnue comme une maladie, plusieurs conséquences néfastes seront annulées."(Amireault 2008) Philippe Couillard accepted the definition to further support the idea that defining a condition in medical terms did not mean that its treatment had to be funded by the State:

> Alors, lorsqu'on dit, par exemple, que l'infertilité n'est pas reconnue comme une maladie, avec respect, ce n'est pas exact. L'OMS reconnaît l'infertilité comme une maladie, le gouvernement du Québec également, et c'est la raison pour laquelle de nombreuses procédures d'investigation de l'infertilité, de nombreux traitements, tels que la stimulation ovarienne ou l'insémination artificielle, sont couverts dans le panier de services de l'assurance maladie du Québec, parce que justement c'est reconnu comme une maladie. Il est inexact de dire que, parce qu'on reconnaît une situation comme une maladie obligatoirement, on couvre tous les éléments ou les actes médicaux en relation avec cette maladie-là. (Couillard 2008)

The third theme that took over the debate over Bill 23 was the need for best practices and the burden that multiple births are for the health system. For the first time, medical risk had one name and one name only: multiple pregnancies. Multiple births were depicted as the cause of health problems for women and children, the cause of the impossibility of the Ministry to control costs, in neonatality even more, and fostering best practices was seen as the only way to colve that problem. Besides, finding was again linked to the solution, but this time not only by clinicians, but by members of the Assembly:

> Parce qu'on dit: Le coeur du problème, c'est le nombre de grossesses multiples. En ayant la fécondation in vitro dans le panier de services de la RAMQ, oui, on peut maintenant légiférer et réglementer sur le nombre d'embryons qui est implanté, dépendamment de certaines caractéristiques, n'implanter qu'un seul embryon, peut-être deux embryons, dépendamment de la qualité. (Caire 2008)

Ultimately, the family-building frame re-entered the political debate through the submission of the ADQ representative Éric Caire, and Julie Snyder[81]. They presented the decision of the government as illogical in a context where the Liberal party was describing their platform as family-oriented. They also suggested that a partial funding of IVF would assist in increasing the birth rate and thereby contribute to the development of Québec.

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[81] « *En fait, dans un contexte où le Québec vit un inquiétant problème démographique, de plus en plus de citoyens ? ou de contribuables, si on veut faire plaisir au ministre ? sont sensibles aux enjeux reliés à l'infertilité. C'est sûr que le remboursement de la fécondation in vitro n'est pas l'unique mesure pour augmenter le taux de natalité, mais c'est une mesure pertinente, qui a une réelle incidence sur ce taux.* » (Julie Snyder)

> On parle d'une société où on a un taux de dénatalité, hein? Et là on parle de gens qui veulent avoir des enfants. Mais, dans une société qui vit la dénatalité, là, parler d'un sujet qui touche des couples qui veulent avoir des enfants, moi, je pense que c'est fondamental, […] Mais est-ce que vous ne pensez pas que, dans une province qui a un taux de fertilité de 1,6 enfant par femme, donc un taux de dénatalité, vous ne pensez pas que soutenir les couples qui souffrent d'infertilité, ça s'inscrit en droite ligne avec ces mesures-là qui ont déjà été annoncées par le gouvernement et qui s'inscrivent très, très bien dans une politique... une politique nataliste, et que le Québec en a besoin, d'une politique nataliste? (Caire 2008)

However, the two dominant frames, medical and experience-based, were always discussed in parallel to each other in the interventions. Neither the would-be-parents' community nor the political parties in favor of funding were able to bridge the two frames or extend one of the two to align the interests of the two opposiung parties' representatives with those of ACIQ. The unwillingness of opponents's to seperate the issue of funding fertility treatments from legislation on clinical practice and the reluctance of the Minister to discuss both practices and funding issues further delayed deliberations and parliamentary procedures.

Party politics

Minister Couillard resigned June 25th 2008, two weeks after the end of the hearings, to pursue other professional goals. Yves Bolduc was named to replace him amid rumors of elections, which were already swirling in the province. Parties were thus prone to discussion to elaborate electoral platforms and the new Minister Bolduc was not completely closed to reconsider the issue of funding of fertility treatments (Interview Karine Joizil – November 1st 2010).

Yves Bolduc's first involvement in the development of the prenatal policy of the Ministry of Health for 2008-2018 (Direction générale des services de santé et médecine univeristaire 2008), nonetheless showed his attentiveness to assisted reproduction. The new minister sought to reduce the percentage of multiple pregnancies resulting from in vitro fertilization from 30% to 5%. The approach was said to foster best practices such as privileging modified natural cycles and the transfer of one embryo at a time. The physician could, under exceptional conditions, transfer a maximum of 2 embryos if the woman was 36 years of age or younger, and a maximum of 3 embryos if the woman was 37 years of age or older.

In parallel with the establishment of such medical guidelines by the Ministry of Health, Karine Joizil, a well established Montreal lawyer who underwent IVF procedures in 2007 and who had been vice-president of the Liberal Party since 2008, met with Julie Snyder at a fundraiser for the Little Miracles Fund[82]. Snyder convinced her to use her position in the Liberal party to change their position on funding IVF. Joizil worked on a policy draft for a few weeks, considering litigation as a possible strategy but quickly rejecting it after reading the Cameron[83] decision. This was the overruling by the Nova Scotia court of appeal of a couple's claim of discrimination on the basis of reproductive capacities. She provided the future government with a full policy draft, mixing medical and experienced-based frames at the National Convention in September 2009.

In fact, she proposed to regulate medical practices to engender fewer multiple births through assisted conception, while supporting the decision by addressing the psychological factors women were facing when getting their infertility "diagnosis". It is worth underlining the silence and non-representation of same-sex partners and single mothers in this policy statement, providing, accordingly, robustness to the medical definition of infertility. In that context, only medically treated couples, viewed as normally able to conceive, were considered in the debate and well represented in Karine Joizil's personal story. Bridging medical rationale with experiences of grief and psychological distress from women dealing with infertility led the Liberal Party to adopt the proposition in Assembly a few months before the election was announced. Frame bridging of the medical and experience-based frames by Joizil was intentional. She thought these two ideas would touch public sensitivities and match elites' expectations. Their performance in the political parties consolidated the different discourses into one policy solution accepted in part or in whole by all the communities of actors, governmental included.

In November, in the middle of the electoral campaign, Jean Charest promised to fund IVF and fertility treatments for infertile couples. As promised during the election, newly named Health minister Yves Bolduc introduced Bill 26 to the National Assembly in April 2009. The blueprint legislation was quite similar to bill 89 and bill 23. The submission of

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[82] The Fund is an initiative of the McGill Reproductive Center. Its mission is to provide financial assistance to low-income Canadians in need of IVF treatment, and fertility preservation to cancer patients about to undergo radiation or chemotherapy.

[83] *Cameron v. Nova Scotia [1999] N.S.J. No. 297* : An infertile couple claimed that fertility treatments should be covered by provincial health insurance plan. The claim was dismissed by the courts.

regulation drafts when the bill was discussed in parliament impelled the opposition parties to support the law. In fact, consensus was reached through the adoption of a double standard of best practice and public funding. Despite discussions on the issue in the detailed study of the bill, section 1 does not mention that infertility is a disease. The *Règlement sur les activités cliniques en matière de procréation assistée* and the *Règlement modifiant le Règlement d'application de la Loi sur l'assurance maladie* were further adopted and the full funding of fertility treatments begun August 5th 2010 in Quebec.

Conclusion

When Minister Bolduc announced the governmental measures to fund IVF and all fertility treatment August 5th 2010, he invited Julie Snyder and Caroline Amireault to join him at the press conference. Health Minister Bolduc vaguely linked the investment to a democratic choice but more convincingly, his office declared: « la base du programme, outre de permettre aux gens d'avoir des enfants, est de mettre en place les meilleures pratiques possibles et de diminuer le nombre de grossesses multiples". Julie Snyder commented on the decision in an emotional way by declaring: "Derrière chaque bébé-éprouvette, il y a une mère éprouvée [...] Le bonheur d'avoir des enfants quand on souffre d'infertilité ne peut être réservé aux seules personnes qui en ont les moyens." (Lacoursière 2010)

That day, the way the Minister and Julie Snyder, as a representative of the would-be-parents' community, presented the government's decision to fund IVF through the RAMQ, paid tribute in many ways to the bridge created between the medical and the experience-based frame in the last phase of the decision-making process in Québec. More importantly, I would argue infertility was medicalized in Quebec from the 1990's until 2010, leading to a consensus on the definition of infertility as a medical condition in 2008. Medicalization contributed to the normalization of the technologies, decreased fear and empowering of clinicians by providing political support for their recommendations. However, it also contributed to problematizing infertility, leading the population to see infertility as a "deviation of a normal life" granting relevance to the would-be parents' discourse structured around an experience-based frame. In consequence, the balance of power changed in accordance with the medicalization. Would-be-parents were given a moral authority over the issue. The cascade of events that produced policy change in the province is then largely due to the medicalization of infertility and the bridge between médical and experience-based frames it enabled. Finally, that bridge resonated with the discourse of actors mobilizing family-building frames, such as more natalist discourse engaging governments in provision of services for the sake of provincial development or demographic growth.

Ontario

The policy process in Ontario was considerably different in terms of frame mobilization and policy development. The quest to remove IVF from the Ontario Health Insurance Plan (OHIP) that marked the period between 1990 and 1994 cemented in many ways the frames mobilized in the debate over access to fertility treatment. For more than 15 years, the medical necessity rational dominated the discussion and prevented any other frames from competing convincingly. The fact that close-knit communities of actors mostly debated the issue in sub-system arenas is another major difference from what happened at the same period in Quebec.

Ontario was the first province to build and organize an ART public service delivery system in Canada in the 1980s. Competing for the leadership in the country, the province declared that service delivery would be provided by university hospital centers across the province. Accordingly, treatments saw themselves included de facto in the public health insurance program. The medical discipline’s dominance over the issue of reproduction as well as the will of the province to lead this new knowledge economy contributed to the provincial funding policy almost immediately. In Ontario, in vitro fertilization was fully covered by OHIP from 1985 to 1994 as long as the treatment was performed in a hospital setting rather than in a private clinic. The university hospitals in Ottawa, Toronto, Hamilton and London, as well as Toronto East General Hospital, developed IVF programs within their global budgets.

In the early 1990s, Ontario faced pressure from intense economic restructuring and a turbulent political climate. In December 1993, the New Democratic Party (NDP) government adopted the Expenditure Control Plan (Bill 50) that led to much discussion in all major ministries about reduction in public spending. The Health Ministry decided accordingly to amend the Health Insurance Act to delist medically unnecessary procedures. The province thus decided to limit its funding and to cover IVF exclusively for women with blockage of both fallopian tubes, a diagnosis which represents only 1% of the cases of infertility.

Deinsuring IVF from the Ontario Health Insurance Plan (OHIP) was intended to save $4.4 million through reduced physician billings, restriction of public billings to medically necessary care, apllying scientific evidence of effectiveness as a criterion for the medical necessity for a service and to take the first step toward applying the recommendations of the federal Royal Commission on New Reproductive Technologies[84] (Giacomini, Hurley et al. 2000).

<u>The would-be-parents' community</u>

The would-be-parents' community was just forming when the government began to consider delisting services from OHIP. Their effort to create support groups for infertile couples soon became an endeavor to keep IVF publically funded. Two major groups leaded the would-be-parents' community and voiced the claims of fertility patients in Ontario at that critical period and afterward. On the one hand, the Infertility Awareness Association of Canada[85] (IAAC) was founded in 1990 and originated from an Ottawa voluntary group called the Infertility Self Support Group, which began in 1983. IAAC is a national organization offering assistance, support and education to people experiencing infertility. The mission of the group changed through time and funding came from different sources[86]. IAAC is committed to increase awareness of the causes, treatments and emotional impact of infertility.

On the other hand, the Infertility Network became very active politically in an effort to stop the Ontario government de-listing IVF from OHIP. The Infertility Network is an independent, registered Canadian charity which strives to provide support and information to help people make informed choices about their family-building options; advocate for reform

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[84] Recommendations of the commission to withdraw IVF funding were largely based on findings of a systematic review of randomized controlled trials published before 1990. The review showed IVF was effective only in cases of bilateral tubal obstruction. Insufficient evidence existed to establish whether or not IVF was effective for nontubal causes of infertility.

[85] IAAC has a national vocation, however, its work was concentrated in Ontario for a short period in the early 1990s and then spread throughout Canada in the following years. IAAC was also involved in Quebec, but their anglophone leader had a more difficult time networking with other would-be-parents' groups such as ACIQ (Interview Beverly Hanck – July 2012)

[86] In 1993, IAAC's funding was personnal donations coming from fertility patients and their relatives. In 2010, IAAC's funding is provided in large part by pharmaceuticals and medical professional associations.

of gamete donation practices so that they may better meet the needs of offspring for medical and identity purposes; and develop public understanding and awareness of infertility, reproductive technology and related issues. In the course of the Ontario political debate on defunding IVF. The community organized an awareness campaign for the Ministry of Health, the opposition parties, and the Ontario Medical Association (OMA) through reporting stories of infertility. They met with the government and the opposition health critics of the time in an attempt to mobilize the needs of infertile couples. They presented written and oral briefs to the Joint Review Panel that took place in the realm of implementing Bill 50 Finally, they held a press conference at the Ontario Legislature which featured Diane Allen, Kathleen Taylor and Deborah Tennant, the three infertile women who founded the Infertility Network.

The two organizations joined forces to fight against IVF from being delisted. Because policy makers invoked the rationale of medical necessity, the would-be-parents community argued that infertility was a legitimate medical condition and IVF a legitimate treatment. Nonetheless, the very fact that IVF was put on the debated list of services provided by the Health Ministry and the Ontario Medical Association (OMA) meant that the definition of infertility and the effectiveness of IVF were being questioned.

> We genuinely thought that the only thing we had to do was to remind the decision-makers, OMA included, that infertility is a medical condition and that it filled all the required criteria to stay on the OHIP list of services. We never thought we had to sustain the technology that treated it as well, and at the time, IVF was still considered by many, many people as an experimental or tacky technology. We repeatedly told the government that medicine was the only response to the needs of infertile couples, but surprisingly medicine itself wasn't 100% sure about the help they could provide to infertile couples. (Interview Jocelyn Smith – December 8th 2010)

The Joint Panel

The Dean of Nursing at the University of Toronto chaired the Joint Review Panel that the Ministry of Health put together in order to decide on which services to de-list. Members included two representatives from the OMA, two representatives of the Ministry of Health and two public representatives. The Panel deliberated for three months, soliciting limited public input through one day of hearings in Toronto and through voluntary written submissions and letters. The Panel began with a list of nineteen services for possible deinsuring: eight services proposed by the Ontario Medical Association and eleven proposed by the Ministry of Health. When the list was published, it was difficult to determine who suggested what service should be cut.

The principles of the Panel's process were to address the cost effectiveness for each service previously listed as well as to maintain gender and age equity. The Panel relied heavily on information provided by the federal Royal Commission a few months earlier. The Royal Commission published the following recommendations regarding fertility service provision: 1) that IVF for bilateral fallopian tube blockage be an insured service under provincial medical programs within the regulatory framework recommended by the Royal Commission on New Reproductive Technologies; 2) that the province of Ontario discontinue coverage of IVF for indications other than bilateral fallopian tube blockage; and 3) that the resources be reallocated to fund clinical trials of unproven but promising techniques (Canada 1993, p.564)

Because 'medical necessity' was the basis for coverage mandated by the 1984 Canadian Health Act, this term had high currency in debates over which services belonged in provincial health insurance plans. The concept of medical necessity played an influential but highly ambivalent role in shaping both Ontario's deinsurance decision and stakeholders' interpretations of its meaning, whereas in Quebec this same idea of medical necessity was mostly absent from public debates. At the Joint Review Panel, medical necessity referred to various service characteristics: experimental status, effectiveness, legitimacy of infertility as a medical indication, coverage status in other jurisdictions and "as a Trojan horse for obscuring real decision criteria such as cost control" (Giacomini, Hurley et al. 2000, p.1497). The lack of an official definition and the ambiguity of the concept led to many different arguments against or in favor of de-listing IVF. Some insisted that infertility care was a medically necessary service for a physical or mental health problem – considering the psychological effects of infertility on couples. Some argued that it was a medical intervention but that the fact that it only circumvented the problem instead of curing the disease did not reach the definition of medical necessity. Others characterized IVF as more of a lifestyle choice or a luxury, depicting would-be-parents as already having options such as adoption available.

In the fall of 1993, the Standing Committee on Social Development discussed Bill 50 and heard testimony from the public, including the Infertility Awareness Association of Canada and the Infertility Network who mobilized medical frames in many different ways in order to support their claim and challenge the definition of medical necessity:

> Infertility is a medical condition affecting one in six couples of childbearing age in Canada, including me and my colleague with me today. […] Infertility has many different treatments, including in vitro fertilization, which has been considered non-experimental since 1985 […] The act defines "insured services" as "all services rendered by physicians that are medically necessary" and the Canada Health Act defines "insured health services" as "physician services provided to insured persons." "Physician services" means "any medically required services rendered by medical practitioners." (McNevin 1993)
>
> I think the other risk of delisting is that there is a real lack of standardization in terms of procedures, recordkeeping, the way drugs are used, and it really leaves the patients wide open to a lot of risks. There is also no certification program in infertility medicine. (Allen 1993)

However, Ruth Grier, Minister of Health, was more cautious regarding the technology. She argued that Ontario was the only province to fund and that the consensus around assisted reproductive technologies was to proceed with care.

> I would point out to her that Ontario is the only province where it is now an insured service. […] I have to say to you that I have some concerns about the process, and I await with interest the report of the Royal Commission on New Reproductive Technology […] There have been some recent studies that indicate that perhaps the chances of conceiving with that kind of treatment as opposed to some more conventional treatments are not that greatly different and that the side-effects are things that have yet to be evaluated. In coming to a conclusion as to whether or not this is a medically necessary procedure and one that should be covered by our insurance plan […] (Grier 1993)

Additionally, advocates of funding IVF in Ontario argued in part that people have a right to reproduce. The Infertility Awareness Association of Canada quoted in its brief to the Joint Review Panel the United Nations 1948 Universal Declaration of Human Rights, which “recognizes the right of everyone to have children” (IAAC 1994). IVF advocates delicately introduced the theme of rights to reproductive choices with the suggestion that provinces who offer the choice of abortion should offer the parallel choice of a full range of infertility interventions. The IAAC was not the only stakeholder to link abortion with assisted reproduction. Representatives of the Progressive Conservative Party (PCP) also addressed that inconsistency.

> You're certainly gung-ho on abortion services in this province, across the entire province, and I cannot see how you could possibly ever defend funding abortion services and not funding infertility clinics with whatever is needed, in vitro fertilization as part of that treatment. (Marland 1993)
>
> You have chosen to fund abortions and yet the funding for the opposite end of reproduction is possibly going to be withheld in the future. I don't personally believe it's fair and equitable, and my questions to you, Minister, are: What assurances are you prepared to give to the families that this service will not be delisted in Ontario? How can you justify funding one side of reproduction and not the other? (Witmer 1993)

Some clinicians agreed that deinsuring IVF impinged reproductive rights and choices, or constituted government interference in private family life; other fertility specialist argued access was not a right and that providers needed to assess the ability of patients to be good parents. The Joint Panel's consensus was that infertility is a medical need and infertility treatment necessitated medical care. The Panel recommended that, “In Ontario treatment of infertility [was] considered medically necessary and [was], therefore, covered by OHIP” (Ontario Ministry of Health 1994).

Despite that clear recommendation, in February 1994, the Ontario Ministry of Health announced that physician payment for IVF for indications other than completely blocked fallopian tubes would be removed from the Ontario Health Insurance Plan (OHIP) Schedule of Benefits. The Ministry stated:

> IVF is expensive and is not medically necessary. Furthermore, the medical community is divided on its efficiency. The government accepts the conclusions of a recently published federal governmental report which recommends that the IVF is not publicly financed except in cases of complete blocking of fallopian tubes (Ontario Ministry of Health 1994, p.1).

The medical framing of the issue at the provincial and federal levels of government offered the possibility to backtrack on the decision of the province to fund. The province bridged this medical frame to an administrative frame, stating the need for a cost-effective policy strategy for health before further funding of IVF would be considered again. The absence of real opposition at the time of the decision as well as the bridging with an administrative frame offered to the medical frame both resonance and robustness. This resulted in a two-tiered system of care, where private clinics began to open their doors, allowing wider access for patients who could afford the treatment cost.

Public payment for IVF then depended upon diagnosis. Nonetheless, women with two blocked fallopian tubes undergoing publicly insured IVF faced considerable out-of-pocket costs, including drugs and screening of sperm samples. The decision to delist IVF applies only to physician billings and IVF research remained publicly subsidized through operating budgets to university and hospital-based clinics (Giacomini, Hurley et al. 2000). Noteworthy, after 1994, in reaction to the failure of their medical framing of infertility, the would-be-parents' community framed its discourse in terms of rights until the mid-2000s. That "right to a child" discourse was used as a call to arms to increase the number of supporters and maintain a close relationship between patients and organizations like IAAC or the Infertility Network.

Jane Doe[87]and the medicalization of lesbian parenting

Providing lesbians with access to screened donor sperm, in early 2000, was presented not only as a non-discriminatory act but also as extending medical necessity to "social infertility". In fact, extending necessary protection to lesbians who might be subject to health risks in their quest to become pregnant invested the clinicians in lesbians' parental project and encouraged clinics to open their doors to single women and same-sex partners.

> Adoption and fertility programs can be difficult for lesbians to negotiate, so they may subject themselves to health risks to conceive, for example, intercourse with strangers or insemination with sperm from unscreened donors. No medical service should be restricted to an individual because of sexual orientation. (Davis 2000)

Despite this attempt to open the doors of fertility clinics to different kinds of potential families, the widest practice among lesbian couples was to purchase screened donor sperm through sperm banks directly and inseminate at home. Changes in legislation and interpretations of legislation between 1996 and 2006 have both facilitated and restricted the use of assisted reproductive technologies to same-sex partners (Luce 2010). For instance, Semen Regulation (1996), Health Canada quarantine on semen (1999), the updated Semen Regulation (2000) and the federal Assisted Reproduction Act (2004) have had particular consequences for women seeking to get pregnant without the help of an involved biological father. The greatest consequences resulted from the restrictions imposed on the importation

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[87] *Jane Doe v. Canada (Attorney General),* [2003] O.J. No. 5430 (Ont. Superior Court).

of semen from two California sperm banks, which had a long history of providing services to lesbian women and running donor identity-release programs. For many women, that meant the end of 'homemade' insemination and access to donor-identified (DI) sperm[88].

In many ways, in the 1990s the free market around assisted reproduction left space for same-sex partners and single women to purchase donor sperm directly from sperm banks and inseminate in the privacy of their homes. With the Royal Commission, a moral and medical frame was suddenly attached to artificial insemination, sperm donation and sperm banking. With the 1996 regulation and further legislation, same-sex couples and single women saw a restriction in their access to donor sperm, leading to increased mobilization from lesbian communities around IVF.

Despite the legislative changes, lesbians and single women in Ontario were able to obtain donor sperm without too many problems, and still, at an affordable price[89]. The situation was quite different when same-sex couples or single women relied on known donors to conceive. The legislative changes modified in many ways lesbian couples' and single mothers' access to their chosen type of family. With these changes, donors were necessarily anonymous, institutionally screened for diseases and legally inexistent[90]. The situation led to a famous litigation labeled Jane Doe v. Canada.

In 2003, the *Semen Regulations* and the *Health Canada Directive* were challenged as discriminatory under sections 7 and 15 of the Charter of Rights and Freedom. Jane Doe, a lesbian, wanted to conceive a child with semen donated by a gay friend, whom donated semen had previously been used to inseminate Jane's partner. Jane had experienced some problems self-inseminating due to a blocked fallopian tube and she required medical assistance in order for an intrauterine insemination procedure to be performed. Jane wanted her friend's semen to be used in the procedure in order for her family's children to be siblings. Two physicians refused Jane's requests because her friend was an excluded donor under the Semen Regulation and Health Canada's directive on sperm[91]. Jane argued that the Regulation contravened section 7 and 15 of the Charter because they "granted an exemption

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[88] Donor identity released program enabled donor-conceived children to obtain information about their donor on a voluntary basis. The release of information did not involve legal responsibilities and were provided at the child's age of majority. DI sperm was usually more expensive than non-DI sperm.

[89] Repromed in Toronto for instance was providing screened sperm to lesbian couples and single mothers. However, fees were higher than before 1996.

[90] The vocabulary changed at that period, passing from sperm donor to donor sperm.

[91] He was over 40 and he was gay.

to heterosexual women seeking to use semen donated by a spouse or sexual partner and not to lesbian women seeking to use the semen of a known donor."

Health Canada had agreed to allow Jane the use of B's semen, notwithstanding that B was gay and over 40, when a decision was reached under the Donor Semen Special Access Program. The program was intended to provide access, in exceptional circumstances, to donor semen that would otherwise be prohibited from distribution under the Regulations because they were not processed in accordance with all the regulatory requirements. Examples of exceptional circumstances included, among others, a woman or a couple who wished to have another child using semen from the same donor they used for assisted conception in the past to ensure the children would be genetic siblings or use semen from a donor with specific physical characteristics or use semen from a known donor. Before the action was initiated, Jane was able to conceive following an operation to remove uterine polyps and she gave birth to a son. Justice Brennan ruled the issue moot because Jane Doe no longer required the remedy sought. Yet, Justice Brennan also held that "the process should be the same for all "assisted conception" - by definition those which use donor semen not from a spouse or sexual partner." Justice Brennan assumed that the reasoning behind this exclusion was that a woman would already have been exposed to any communicable disease through sexual intercourse.

Reviewing the technology

In 2006, following both the inquiry of the Infertility Awareness Association of Canada (IAAC) and the help of the medical community[92] in gathering statistical and procedural information, the Ontario Health Technology Advisory Committee (OHTAC) met on October 19th and reviewed the health technology assessment report on the current role of IVF in the management of infertility and the potential for expanding IVF coverage by the Ontario Health Insurance Plan (OHIP). The review included a presentation by the Medical Advisory Secretariat, an evidence-based analysis of multiple pregnancies and in vitro fertilization, and a discussion on the clinical and cost effectiveness of IVF. The report recommendations point to the extension of the existing program, which originally limited access to female factor

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[92] The Canadian Fertility and Andrology Society and clinic representatives.

infertility[93], to male factor treatments (such as intra-cytoplasmic sperm injection (ICSI)) and called for more auto-regulation from the medical community with regard to best practices and clinical definitions of infertility.

Overall, the OHTAC concluded that savings from reducing multiple pregnancies did not justify universal coverage of IVF. Its report established the dominance of the medical and administrative frame at the governmental level and the recurrent incidence of the Royal Commission on the province's precautionary actions. The Secretariat, in its brief, portrayed the technology as more mature than at the time of the Royal Commission, but cost as being far higher than ever before (Medical Advisory Secretariat 2006). Nonetheless, there were two indications where OHTAC recommended additional access to IVF for patients with severe male factor infertility and for infertile women with serious medical contraindications for multiple pregnancy. OHTAC also recommended that the Society of Obstetricians and Gynecologists of Canada and Canadian Urological Association should be asked to develop the set of parameters that clearly define severe male factor infertility as well as a list of maternal medical conditions where multiple pregnancy is absolutely contraindicated. They also recommended that couples who wished to avoid the risk of multiple pregnancy could consider IVF with single embryo transfer as an option to IUI, which was already covered by OHIP. Again, despite the recommendations of the committee, Parliament has not address the issue in legislation yet.

Elections and Conceivable Dreams

During the 2007 election, the McGuinty Liberal Party platform committed to helping more Ontarians realize their dream of having a family by recommending ways to make infertility treatment more affordable. In July 2008, the elected Liberal government appointed an expert panel on fertility treatment and adoption to help find solutions for people who were trying to start or expand a family. The panel was to recommend ways to help make both fertility treatment and adoption more accessible and affordable in the province. Panel members included adoptive parents, people who had personal experience with infertility, and representatives from the medical and adoption communities. The panel reported back to the

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[93] OHTAC recommended additional access to IVF/ICSI for patients with severe male factor infertility and to IVF- SET for infertile women with serious medical contraindications for multiple pregnancies.

Minister of Children and Youth Services although the Ministry of Health and Long-Term Care was also present the day the Panel was appointed[94]. The joint responsibility of the ministries is an illustration of the turn towards family-building Ontario was about to make.

This initiative helped to transform government discourse on assisted reproduction from a dominant medical frame and a complementary administrative frame - which had been mobilized since the 1990s - to a new family-building frame. With the Expert panel, the government unintentionally widened the debate and hence complicated its disentanglement. The question of infertility was then not related only to the stories that were told by infertile couples and individuals throughout the report, but to the variety of ways within the province's reach to help them build families[95].

As a result of the Liberal government and the work of the Expert Panel, Conceivable Dreams was founded by infertility patients Joanne Horibe, Ashley Bulley and Kerri Stanford early 2009. They decided to use social networking tools, such as Facebook, to unite patients and their friends, families and supporters in hope of having funding reinstated. Contrasting with other would-be-parents groups such as Infertility Network and IAAC, Conceivable Dreams is not a charity nor does it provide support services for infertile couples. The sole aim of the association is to advocate public funding for IVF by OHIP and pressure governmental actions.

On Mother's Day 2009, two hundred people marched in Toronto in the Pram Push for IVF Funding, which sought to raise awareness for the issue of IVF and infertility funding as a lead-in event to National Infertility Awareness Week. Men and women were pushing empty strollers to symbolize emptiness in infertile couple's lives. At Queen's Park, Jan Silverman, former member of the Expert Panel on Infertility and Adoption, told the crowd that the Panel had heard the voices of infertile people. Jocelyn Smith, the president of the Infertility Awareness Association of Canada (IAAC), asked participants to take the time to tell their personal stories to people around them, but most importantly to their governmental representative. She argued that stories of infertility are the greatest tool to advocate for governmental support.

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[94] The presence of both Ministries was unsurprising given the overview of adoption policies – a responsibility of the Children and Youth services Ministry - in parallel to the access to infertility treatments – considered as a health care issue.

[95] Including homoparental and monoparental units.

Litigating access

In August 2009, Ana Ilha and husband, Amir Attaran, a University of Ottawa law and population health professor, filed a complaint with the Human Rights Tribunal of Ontario arguing that OHIP's policy was discriminatory because it covered IVF in only limited circumstances. In November 2009, Betty Ann Lobo and Robert William Mesher added their story to the Attaran case. They argued they were discriminated against on the basis of their gender and disability under section 34 of the Human Rights Code[96]. On December 2nd 2010, the decision of the Human Rights Tribunal of Ontario granted the right for four cases to be amalgamated because of their similarities[97]. This case takes the issue on the other side of reproduction, from a male perspective:

> In other cases dealing with questions of infertility, they had to deal with all the case law on reproductive health and women's rights over their reproductive health. Infertile individuals can use the argument of medical necessity to their own advantage; meaning that if women having a medical condition that disables them to have children OHIP should pay, the opposite should be also true. A man can have a medical condition preventing him from having children, thus OHIP should pay in this case as well. (Interview Fertility Expert Ont-2 - September 30th 2011)

The court has not ruled on this case yet, but the introduction of the medical frame in the judicial arena is quite interesting, given that the right-based discourse was rejected in the Cameron decision in Nova Scotia and that the OHTAC opened the debate of medical necessity to male factor infertility in 2006.

The Expert Panel Report and the increase in would-be-parents' mobilization

The Expert Panel finally released its report on August 26th 2009. Their conclusion is telling: "this Province can and should be the best jurisdiction in the world in which to build a family" (Expert Panel on Infertility and Adoption 2009, p.1). In fact, to consider childlessness as an experience and to connect the issues of adoption and assisted reproduction as two possible solutions to infertility widened the available policy alternatives. Among other things it integrated questions of family law in questions of health care provision (Interview with Fertility Expert Ont-1 - October 15th 2010). The Panel bridged this

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[96] Human Rights Code, R.S.O. 1990

[97] In 2011, the Lobo-Mesher couple withdrew their claim, further delaying the case.

wide family-building frame to an administrative frame pursuing cost-effective, cost-saving, cost-controlling, risk assessing, province-wide accessible measures. This administrative frame did cross the borders of the Panel to reach the governmental community, but did not manage to convince the ministry of the economic sustainability of funding IVF as had happened in Quebec a few months before. Even if the Panel was open to different approaches, the government welcomed the report favorably, but did not implement its recommendations because they were considered too expensive (Freed and Benzie on 2009).

> Obviously, costs remain an issue on every front. It's going to be difficult for us to embark upon any new initiatives. It'll call on us to make difficult choices […] The argument that the panel is making is that this, in fact, would save money in the long term. I have yet to see that (Freed and Benzie 2009)

To date, the government of Ontario has not followed up these recommendations that only touched on two different types of law and engaged the province in massive investments in health care services[98], but led governing parties in debating an issue considered "not [to be] a recipe for electoral success" (Expert Panel on Infertility and Adoption 2009, p. 1). However, following the Panel's work, governmental units transformed the medical frame and adopted a family-building frame that could lead to any kind of policy decision in the future.

On December 2nd 2009, in response, the would-be parents' community led by Conceivable Dreams planned a very special delivery for the Ontario Government. During their Virtual Rally for IVF Funding, hundreds of Ontario infertility patients simultaneously sent email messages of support for IVF funding to their provincial members of parliament and Premier Dalton McGuinty in a quest to raise elite attention on the issue.

> Hopefully our letters helped our elected officials to understand that infertility is a serious medical condition with devastating physical, emotional and financial consequences for its sufferers. (Interview Joanne Horibe – November 29th 2010)

Two months later, Conceivable Dreams built a huge structure out of building blocks on the steps of Queen's Park. It was inscribed with a message for Parliament saying that funding IVF would mean $550 000 000 in savings for Ontario taxpayers. Jane Evans (an infertility patient) shared her story about the financial strain on individual families in pursuing IVF in

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[98] In 2009, Ontario had 14 clinics in 8 cities providing more than 4 000 IVF cycles compared to 4 clinics in 2 cities providing around 1 500 IVF cycles in Quebec. The gradual integration of services and the simultaneous growth of the system with provincial funding was a great incentive in Quebec that was not possible to mobilize in Ontario because of the system already in place.

the absence of government funding. Dr. Art Leader (Fertility specialist) educated attendees about the work of the Expert Panel, focusing on the cost-savings to government of funding IVF. Lastly, Cheri DiNovo, the NDP critic for women's issues called on the Ontario government to implement the Expert Panel's recommendations as part of its March 2010 Budget.

In addition to this intensive advocacy, on Infertility Awareness Day, May 11th 2009, the legislative assembly of Ontario mentioned for the first time the issue of funding assisted reproductive technologies. Minister Deb Matthews (Liberal Party) maintained the government's position and mentioned the difficulties experienced by infertile couples. She learned of these difficulties through letters that were addressed to her office previously that year. The government's responsibility was depicted as support for starting families and decreasing the grief of infertile couples. Despite her engagement with the issue the opposition mentioned the months that passed without a legislative response to the Panel's recommendations. The opposition parties' positions were framed mostly in experience-based terms:

> Certainly, I've received letters from many of my constituents who have made this kind of comparison between the recognition and the opportunity provided by the Quebec government and the silence that we have in Ontario on this issue. As the minister mentioned, the government did make a promise in 2007. We certainly await those recommendations becoming public. (Munro 2009)
>
> Because right now, people seeking help always end up frustrated, exhausted and, most of the time, financially broke, we must ensure that families who have been searching for an answer to their infertility are not taken advantage of by the costly promise of yet another treatment that is not covered by OHIP. We must listen to the experts in the field and develop fertility treatment options that are tailored to and best for everyone in Ontario. (Gélinas 2009)

Joanne Horibe also represented Conceivable Dreams on February 2010 in front of the Legislative Assembly for pre-budget consultation. In response to the turn toward family-building on the part of the provincial government, the would-be-parents' community reacted by mobilizing a legally and medically framed discourse. "Everybody should have the right to a family" and "even more so when considering that infertility is a reproductive health disease" creating "terrible emotional anguish" (IAAC's position quoted by Wente 2010). But the message Johann Horibe tried to pass to the legislative assembly was that funding IVF could be a cost-effective measure considering savings made in case of multiple births.

> These less-than-optimal treatments significantly increase the risk of multiple, preterm births and the severe medical and developmental problems that result from these births. For moms, these pregnancies are also associated with an increase in medical complications such as gestational diabetes and hypertension of pregnancy. […] The McGuinty government's expert panel concluded that public funding of IVF will not only improve the health of mothers and babies, but it will also reduce hospital and other health care costs. I also want to highlight the expert panel's conclusions that Ontario is out of step with a number of other jurisdictions that fund IVF. (Horibe 2010)

Again, despite the insistence of the would-be-parents' community, the government stayed silent in regard to fertility treatments and infertile couples in their 2010 budget.

Conclusion

The increase in the infertility rates and the constant mobilization for funding pushed a change in the discourses of the few epistemic communities mobilized in Ontario. The political strategies of Quebec's political communities inspired the networks in Ontario that borrowed information and strategies from their campaign (Interview Joanne Horibe – November 29th 2010) Thus, the legal frame, which did not help the would-be-parents' community apart from acquiring support from would-be-parents and clinicians, was re-transformed into a medical frame used in parallel with an experience-based frame for a longer period. Instead of claiming their right to parentage, would-be-parents professionalized their discourse by adding statistics and medical facts to their claims in response to the cost-effectiveness strategy of the Ministry. They did so by telling stories of infertility at Parliament on the Infertility Awareness day or at time of pre-budget consultations, for example. However, in opposition to what happened in Quebec, the frames were mobilized alternatively and not simultaneously; in other words, they were not bridged. Even if the medical community extended its medical frame at the same moment to include the questions of best practices and services development, the alternation of frames by would-be-parents made real political support by clinicians and governmental officials fragile and momentary. The would-be-parents' community and their allies used all opportunities given to them to mobilize their claims. However, they reframed their discourse depending on the context of mobilization, sometimes using a family-building frame, sometimes a medical or an experience-based one. This voluntary strategy did not achieve challenge to the dominant medical frame mobilized early around discourses of necessity and risks, and later around the state responsibility to invest in family-building programs.

England

England's policy development was similar to Ontario in regard to the frames that were mobilized early by governmental authorities. The medical and the administrative frames dominated the debate over access to fertility treatments, albeit the difference resided in the bridge that was forged by Primary Care Trusts in England and never was consolidated in Ontario. In Quebec, the dynamic of frame bridging of the medical frame with the experienced-based frame triggered a cascade of events that led to policy change; likewise, in England the medical frame was bridged to an administrative frame. In contrast, that discursive dynamic contributed not to a definitive policy change but rather to the slow redefinition of access criteria at the implementation level.

There is nothing in the Human Fertilisation and Embryology Act (HFEAct) that expressly restricts access to fertility treatments. Instead, much is left to the discretion of the licensed clinics. There are several ways in which access to fertility treatment might be limited. The first is by the exercise of clinical judgment. In English law no person has a right to demand medical treatment. Consequently, if a doctor refuses to provide fertility treatment on the basis that it is not medically indicated, it is unlikely that his judgment could be challenged. In this context, many different medical criteria were used during the years to limit access to fertility treatments; amongst them were age, weight, medical history and preconditions such as smoking. The opposite problem is that fertility specialists, on the basis that accepting certain patients for treatment might prejudice the clinic's pregnancy rate, may reject difficult or uncertain cases.

Second, since the demand for fertility treatments often exceeded its availability within the NHS, other significant restrictions on access were social criteria. One of them was and is the presence of children in a couple's environment. For instance, if the couple have had a child from a previous relationship or adopted or already had children of their own, that could decrease their chances of having access to treatments considering that their desire to be parents is partly fulfilled by the presence of existing children. Despite the debatable nature of the "children clause" criteria[99], the welfare of the child's condition is still perhaps the most controversial means of limiting access on social grounds (Stern 1994). This condition compels clinics to make a value judgment about the patient's ability to parent in every case in which licensed treatment is provided.

> The most problematic issue is to establish a common accepted definition of infertility, child welfare, clinical success and determinants of the so-called success, etc. For instance, in the current situation, many criteria for access are validated by different views of what is infertility or childlessness. On their own, the two concepts are creating ambiguity in the management of access to and funding of fertility treatments in England. […] Ask yourself: Is it really different to be without children and to fail to conceive? Is success defined by pregnancy rates or live birth rates? What probability of success Primary Care Trusts should seek to attain to rationalize funding? What does a child need? What's the role of the clinician in the construction of a family? Depending on the answer you give to these simple questions, you will use your discretion and regulate access accordingly. That's exactly what our PCTs [Primary Care Trusts] are doing. […] You ask me what is the matter with access to fertility services in England? Well, my answer is: the definitions. (Interview Public Servant Eng-1, NHS manager, Region of London - February 17th 2011)

For instance, there is no clear distinction between the terms subfertility and infertility, neither in the Act of 1990 nor in the Warnock Report. The only definitions given to infertility in England were established through a time frame – e.g. three years of unprotected sexual intercourse without success if no reproductive pathology is known – or a medical perspective – e.g. fallopian dysfunction, endometriosis, disease process, etc. Between 1990 and 2010, the periodical and clinical definitions of infertility helped to exclude different patient groups from coverage eligibility, amongst others single and lesbian women (Mladovsky and Sorenson 2010).

Two discursive dynamics are observable through the study of the different phases of policymaking in England with regard to access to fertility treatments. On the one hand, when considering funding, what is striking is the inability of the central government and the would-be-parents' community to change the representation of infertility at the implementation level, here the PCTs. In the debate over medical criteria, the administrative

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[99] This is how clinics refer to the assessment of the family history of future patients.

frame (cost-effectiveness) was bridged through time to the medical frame (good practice) to the point where they dominated the broader political discourse. That situation limited the influence of the family-building frame (parental project and family construction) as well as the experience-based frame (feeling of lack of personal control; psychological impact of inability to conceive and of going through fertility treatments) mobilized by would-be-parents, governmental representatives and social sciences experts. On the other hand, when considering the universality of access, what is intriguing is the ability of the central government and the experts' community to incrementally change the representation of the family to include same sex couples and single women-led families in the British model. Hence, in the debate over social criteria, the moral (good versus bad parenting) and the family-building (parental project and family construction) frames kept their central position in the debate over time but were extended to new types of family structures which led to policy change in 2008.

The Warnock effect

In the late 1980s and early 1990s, a small number of National Health Services (NHS) clinics began to fund treatments as any other health procedure. The numbers steadily increased in the mid-1990s to include two thirds of Health Authorities in 1997[100]. The budget allocated by Health Authorities (HA) for infertility tended to be small and a majority of HAs were using eligibility criteria to select patients. At that period, no significant move from implicit to explicit rationing of IVF had occurred for the majority of treatments. In the 1990s, the administrative changes in the British Health Services led to a gradual restructuring in service provision. Resources were to be spent on "high quality, value-for-money services" through contracts with providers. Consequently, Health Authorities had to determine which services to prioritize. Rationing, which had previously, taken the form of patient selection at the point of service delivery, shifted to a meso level health manager who had the responsibility of distributing resources by ranking treatments on the basis of their clinical value and cost-effectiveness. Clinical effectiveness was introduced by the Conservative government in the early 1990s as a rationing tool in the drive towards an efficient, evidence-

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[100] NHS was reorganized in 2002: District health authorities were replaced by strategic health authorities (SHAs) and primary care trusts (PCTs). Strategic health authorities were created by the government to manage the local NHS on behalf of the secretary of state. There are currently 151 primary care trusts in England.

based health service.

In the 1990's, in opposition to the Canadian conception of IVF, the Warnock report showed how the reputation of reproductive technologies was changing in England: "It seems to us that the technique has now passed the research stage and can be regarded as an established form of treatment for infertility." (Warnock 1984, paragraph 5.15). The Warnock report is interesting for its establishment of childlessness as the basic reason for the existence of assisted conception techniques and the availability of these techniques to the public. The report states that childlessness is an important condition affecting couples and single people. The relationship between family building and society was rapidly introduced in the English debates, providing grounds for many definitions of infertility and the role of medicine in treating this condition:

> The family is a valued institution within our present society: within it the human infant receives nurture and protection during its prolonged period of dependence. It is also the place where social behavior is learnt and where the child develops its own identity and feeling of self- value. Parents likewise feel their identity in society enhanced and confirmed by their role in the family unit. For those who long for children, the realization that they are unable to found a family can be shattering. (Warnock 1984, paragraph 2.2)

Childlessness referred at that period not to the inability to conceive but rather to the failure to create a family; not only the inability to go beyond the simple status of being a couple or an individual, but rather the failure to completely integrate society by means of reproduction. It was clear for the committee that family-building was expected and that the State had responsibility in helping couples to conceive, even more so considering the availability of adoption and fertility services.

Considering childlessness as a social rather than medical condition did not prevent the Warnock committee from placing the NHS service delivery system at the center of the solution. Warnock herself considered that the right to treatment had been established ever since the introduction of the NHS in 1948 (Warnock 2002). However, she was clear that there were decisions to be made about what was reasonable to demand in terms of treatment. At that period, the right to access treatment was not established as a right to have children, but that did not stop the committee from supporting the idea that infertility was a "condition meriting treatment".

> […] the argument that the desire to have children is only a wish, not a need, and therefore should not be satisfied at the expense of other more urgent demands on resources can be answered in several ways. There are many other treatments not designed to satisfy absolute needs (in the sense that the patient would die without them) which are readily available within the NHS. Medicine is no longer exclusively concerned with the preservation of life, but with remedying the malfunctions of the human body. On this analysis, an inability to have children is a malfunction and should be considered in exactly the same way as any other. Furthermore, infertility may be the result of some disorder which in itself needs treatment for the benefit of the patient's health. Infertility is not something mysterious, nor a cause of shame, nor necessarily something that has to be endured without attempted cure. In addition, the psychological distress that may be caused by infertility in those who want children may precipitate a mental disorder warranting treatment. It is, in our view, better to treat the primary cause of such distress than to alleviate the symptoms. (Warnock 1984, paragraph 2.4)

The Warnock report was moving in the medical direction, suggesting that the inability to have children might unleash mental illness, another medical problem that would have to be treated. Despite the obvious intention to assist infertile couples and individuals, constraints on access to fertility centers were observable at that period in England. As with other medical services, the National Health Service (NHS) took charge of delivering fertility treatments in England from the start, first delivering Intrauterine Insemination (IUI) and gradually adding IVF to the list of services. Over 60 licensed clinics provided assisted conception treatment in the 1990's in England, most of them established in urban communities.

The Warnock report also expressed what it considered to be the best type of family. In this case, the opinion of the members was that a child should be born into a stable heterosexual relationship and that the creation of a child for a woman who is not a partner in such a relationship would be morally wrong: "[…] nevertheless, we believe that as a general rule it is better for children to be born into a two-parent family, with both father and mother, although we recognise that it is impossible to predict with any certainty how lasting such a relationship will be." (Warnock Report paragraph 2.11) That statement had a great effect on the different amendments that were proposed when the first bill on assisted reproduction was introduced to the House of Commons a few months later. The 1990 HFEAct was tainted by this gendered definition of the desired family structure in the British society. The welfare of the child section and the need for a father requirement are two of the best examples of the influence of that discourse in the policy process that led to the adoption of the HFEAct in 1990.

Another very important parameter that was established when the Warnock report was released was the need for clinician autonomy in the practice of assisted conception. The medical community was portrayed in the report as the guardian of patients' health and the protector against prejudices of defined as uncalled-for treatment. Their autonomy was not only a tool to establish an overview of the practice[101], but also a mean to regulate reproductive and parenting behaviors of patients.

> However, notwithstanding our view that every patient is entitled to advice and investigation of his or her infertility, we can foresee occasions where the consultant may, after discussion with professional health and social work colleagues, consider that there are valid reasons why infertility treatment would not be in the best interests of the patient, the child that may be born following treatment, or the patient's immediate family. (Warnock Report paragraph 2.12)

The influence of the Warnock report was tremendous on the policy process and on the legislation that followed in 1990, but in regard to access to fertility treatments it also indirectly established Health Authorities as the center for implementation of this legislation. The only way to implement access criteria without defining them too precisely in the law and by the existence of objective evidence restrict clinicians' practice, was to decentralize treatment decision-making to the Authorities as was the case for any other strictly medical conditions. This had implications for the uniformity and universality of access to fertility treatments around the nine regions of England.

The postcode lottery, cost effectiveness and local bureaucrats

Considering the important impact of the Warnock report on policy and clinical practices, the provision of fertility treatments, funded by the NHS, depended on the availability and willingness of clinicians to treat the condition. In the process of policy formation, the devolution of rationing decisions to local Health Authorities had resulted in a multiplicity of approaches which were not necessarily consistent with each other nor based on cost-effectiveness and clinical value. In a substantial number of clinics, social criteria played a significant part in determining access to treatment. Some of the criteria were

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[101] The overview was also made systematic through the creation of the HFEA and its constant policing of clinicians.

controversial and considered by many as discriminatory, since they operated in a manner that would systematically exclude certain categories of women and couples from funding. As mentioned above, the welfare of the child section provided room for many different social criteria, the only one being explicitly defined being the need for a father.

While the debate over the infringement of the welfare of the child principle in the HFEAct of 1990 was one mostly related to the protection of the child before its birth, this debate eliminated one very important impact of that article on service provision. Although Parliament discussed the validity of treatments, it was assumed that treatments would be available and would be acquired upon demand. What happened in reality was that NHS-funded treatments were difficult to obtain as funding was often targeted at establishing family units: a two-parent heterosexual family. Whether an applicant could obtain public funding or provide their own funding for treatment, decisions about the provision of treatment services rested within individual licensed treatment centers, guided by the Code of Practice (established by the Human Fertilisation and Embryology Authority) which set out guidance about the appropriateness of providing treatment or not.

The 'postcode lottery' has become the colloquial term for differing availability and standards of treatment offered to patients depending upon the NHS funding area in which they reside. The historical variation in NHS fertility service provision was argued to stem partly from the fact that professionals with different interests have been responsible for appointing commissioners within health authorities. Infertility Network UK (2004), a patients' organization, showed that these commissioners' background ranged from directors of public health or service development to heads of family planning or consultants in reproductive medicine. The differing professional and personal experiences, values and managerial goals of the commissioners greatly influenced the disparities in service provision among the Health Authorities.

It was common sense at that period to maintain that where resources were limited, as in the NHS, decisions were necessary to restrict admission to fertility programs. It has thus been argued that only deserving cases should be selected, namely those actually suffering from infertility. In this context, the medical definition of infertility helped some groups to access the system while rejecting others such as lesbian couples: "Fertility treatment was not created to sort out lesbians' problems of wanting to be whole by having children. How the

NHS can let lesbians use fertility treatment for what is not medical condition is beyond me." (Spokesman of the National Fertility Association cited by Blacklock 1997)

However, even in cases where pathologies were apparent/discovered, the access was not necessarily granted. In 1994, the decision in Seale[102] indicated that rationing policies resulting in the exclusion of patient groups, offering only limited funding, was not illegal when based on indicators of clinical effectiveness such as the patient's age. Mrs. Seale, aged 37, had received a letter from her Health Authority stating that due to her age, treatment was not offered due to limited resources and a high demand for IVF. The Authority had a cut-off point for treatment at 35 years old which was argued to make optimum use of resources by limiting treatment to those more likely to benefit from them. The decision relied on clinical evidence that estimated that IVF treatment was generally less effective for women aged over 35. The judge stated that it was not unreasonable for a Health Authority to adopt a general policy based on evidence about effectiveness of a treatment. The Seale decision became one of the first justifications to restrict access on the basis of administrative necessities. Cost-effectiveness and probability of success were about to become increasingly important in the discourse of decision-makers at the local level (PCTs).

The multiple sides of the welfare of the child's debate

When section 13(5) was debated in Parliament, the only matter of disagreement was the question of single or lesbian women's access to treatment. In contrast, the suitability of including a welfare principle was never doubted (Jackson 2002). When he introduced the amendment that became section 13(5), Lord Mackay, then Lord Chancellor, said:

> A fundamental principle to our law about children . . . is that the welfare of children is of paramount consideration. I think that it is . . . entirely right that the Bill should be amended to add that concept. (Mackay 1990)

The incorporation of a welfare principle was greatly welcomed by every intervener. Even Josephine Richardson (Labour), who was concerned that the needs of the clients of fertility clinics should also be relevant, agreed that the clinician ought to 'tak[e] account of the welfare of the child'.

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[102] *R v. Sheffield Health Authority, ex. p Seale* (1994) 25 BMLR 1

> […] they were all concerned with the welfare of the child – and most likely the population was as well – they needed to include a statutory direction to that effect in the Act. Well, we could have done it through various other channels […] clinical guidelines, the Code of Practice, increasing the role of fertility counselors, etc. They were convinced that the right thing to do was to protect the unborn, or in that case the children to be. It was a moral question. Who would have said it wasn't important to take care of the child? […] Perhaps the question was rather if we really could genuinely protect a child that wasn't even born yet, and most importantly if section 13 was the valid instrument to do that. (Legal Scholar Eng1 - February 2011)

The statute specifies that a child's future welfare must be taken into account when deciding whether to treat a particular patient or not. The British Medical Association (BMA) agreed that when health professionals assisted people to become parents, they had a special responsibility to protect the welfare of children born as a result. Considerations which commonly informed the welfare of the child assessments that clinics carried out before accepting anyone into their treatment program were: whether either prospective patient had ever had any mental health problems or received counselling or been prescribed anti-depressants; whether they have had a child taken into local authority care; and whether either of them had a criminal record, particularly relating to offences involving violence and/or children. Clinics could also have asked couples about the length of their relationship, the nature of their housing, and what arrangements they intended to make for their child's full time care. Practices varied, and not all clinics were this demanding in their assessments of parental suitability. It was, however, routine to ask for permission to contact each would-be patient's general practitioner so that he or she could confirm that there were no reasons why a particular person should be denied assistance with conception.

What detractors of section 13(5) considered the biggest problem was the welfare of the child was given various definitions depending on the position of the concerned actor. The welfare principle was accompanied by moral arguments, family-building principles, medical considerations and financial requirements among other factors. The Code of Practice also established different guidelines for practitioners in assessing the welfare of the child. Medical history has always been one of the criteria evoked in the Code, although discussions around the implementation of the statute rarely accounted for that criterion.

> The pre-conception welfare principle may be directed towards improving the quality of individual children's lives, rather than the health of society as a whole,

> but it nevertheless rests upon the assumption that it is the business of government to dissuade certain individuals from conceiving. (Interview Legal Scholar Eng-2 – January 22nd 2011)

In the House of Lords, when the amendment was debated, the moral argument came back repeatedly. It was argued that not to take account of the welfare of the child before treatments was unethical and that to adopt a provision would be the right thing to do for a responsible government.

> It is a nonsense and goes against experience to believe that giving everyone complete freedom to do exactly as they wish increases the strength of the family and human happiness. As we have seen in the cases of free and easy divorce and abortion, the pendulum swung too far in the direction of freedom. We are in grave danger of not making a contribution towards returning the pendulum to a more reasonable position when dealing with the Bill now before us. (Caldecote 1990)

In addition, the Lords debated the question of whether single mothers deserved the right to access treatments and hence to sustain and raise a child. Many feminist groups and expert witnesses saw this debate as paternalistic, the Lords continued to maintain that women needed to take their "situation" into account before seeking assistance with conception.

> … the single woman who will seek treatment under the provisions of this Bill will have thought deeply over the issue before deciding to receive treatment. Under the Bill she will receive counselling and will have satisfied herself that she is adequately prepared for parenthood and all its implications. That point should not be overlooked. (Prys-Davies 1990)

In this context, the discussion slipped quickly to the marital status of patients and the possibility that one deserving couple or individual would not fulfill all of the requirements the statute would encompass. In the House of Lords, an amendment stating that these services should be limited to married couples was lost by only one vote. Hence, the welfare of the child was, from the beginning, linked with the question of family structure. The need for a father requirement was supported in order to discourage people from having children if they did not at least have the family structure and financial support that they need to raise a child. The argument of parental support was used by many peers to oppose individual rights to become paramount:

> […] I did say that many single women were good mothers. But she could not offer the child the inestimable benefit of a father's loving care. All the arguments I have heard against my amendments put the interests of the woman concerned

> before those of the child. […] I am not really interested in morality, in the rights of women to have children, or in prevalent sexual mores. I am concerned with the best interests of the children. (Lady Saltoun of Abernethy 1990)

After all discussions, the welfare of the child principle was adopted in its broader sense. The only precise article related to the welfare provision required clinicians to assess the need for a father. The decision of whether or not to offer assisted conception was based on these broad principles, although there were no specific criteria of acceptance or rejection of prospective parents. In accordance with this discussion, the first Code of Practice stated (Human Fertilisation and Embryology Authority 1993, paragraph 3.14):

> Where people seek licensed treatment, centers should bear in mind the following factors:
>
> a. their commitment and that of their husband or partner (if any) to having and bringing up a child or children;
> b. their ages and medical histories and the medical histories of their families;
> c. the needs of any child or children who may be born as a result of treatment, including the implications of any possible multiple births, and the ability of the prospective parents (or parent) to meet those needs;
> d. any risk of harm to the child or children who may be born, including the risk of inherited disorders, problems during pregnancy and of neglect or abuse;
> e. the effect of a new baby or babies upon any existing child of the family.

In cases where there was to be no legal father, treatment centers were expected to consider the mother's ability to meet the child's needs and to investigate whether there was anyone else willing to share her responsibilities to do so.

The welfare of the child principle was an attempt to prevent children from being born into situations in which they might suffer serious harm. The adoption of the welfare provision was seen as a response to the case of R v. Ethical Committee of St. Mary's Hospital (Machester), ex parte Harriott (1988) in which the court considered the rejection of a woman on grounds of her way of life - specifically, her convictions for prostitution-related offences. The decision of the ethics committee was upheld by the court, which ruled that as long as a decision could not be described as one which no reasonable ethics committee could make, it would be acceptable[103]. The Warnock report referred to the "heavy burden of

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[103] Another court decision came to the same conclusion. In *R. Secretary of State for the Home Department, ex parte Mellor [2001] 2 FLR 1158*, the court found that it was legitimate to interfere to limit access to treatments

responsibility that go beyond the purely medical" for which the practitioners had responsibility (Warnock 1984, paragraph 2.13). Section 47 of the HFEAct of 1990 also made specific reference to the conscientious objections of medical staff. This provided doctors with one of the few situations in medical practice in which they were free to choose not to participate in activities to which they were opposed[104].

NIAC, NICE and the need for reform

The perspective of would-be-parents was almost absent from the discussion that preceded the adoption of the HFEAct of 1990. The situation changed considerably after the adoption of the law and the establishment of the Human Fertilization and Embryology Authority (HFEA). The latter is an administrative body in charge of sounding out public needs and setting up clinical practices. The National Infertility Awareness Campaign (NIAC) was formed in 1993 as an outgrowth of National Fertility Week, established with support from a wide range of organizations involved in the field of infertility, including infertility charities, patient support groups, healthcare professionals and the pharmaceutical industry. NIAC still campaigns for equal access for those with an established clinical need[105] to a full range of services for the investigation and treatment of infertility on the NHS. NIAC is funded through grants from different pharmaceutical companies[106]. After a few years, NIAC became the most important and involved patient group in England advocating for fertility clinics' patients. Clare Brown, Chair of NIAC, became a member of the HFEA in 2002. Her access to different consultations, parliamentary debates and stakeholders in the assisted reproduction domain secured NIAC's presence in debates over access, donation and surrogacy.

In 2000, the health system was restructured around a new set of priorities in order to control all fields of clinical practice. Scarce resources in the health field and the increase in prices for medical interventions amplified financial pressures on the NHS. This situation asked for a constant scrutiny of equity in service provision throughout England. This was

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because it *"is necessary in a democratic society in the interests of ... public safety or the economic well-being of the country ... for the protection of health or morals, or for the protection of the rights and freedoms of others."*

[104] Abortion was another medical activity in which doctors were free to choose to get involved in or not.

[105] Hence, they do not especially mobilize for gay and lesbian access to treatments or parentage rights.

[106] Ferring Pharmaceuticals Ltd, Merck Serono Pharmaceuticals and Pharmasure Ltd.

acknowledged by the setting up of agencies such as the National Institute for Clinical Excellence (NICE) whose purpose was to ensure that funding decisions were made fairly and consistently across the National Health Service (NHS). Denying patients treatments on the grounds of cost was widely believed to be regrettable but unavoidable. A patient never has the right to a particular treatment as mentioned earlier, and this was as true of assisted reproduction services as it was of any other medical procedure.

NICE was established by the Secretary of State for Health, Frank Dobson, in 1999. Its goal was to reduce variation in the availability and quality of NHS treatments and care. NICE established guidance in order to help "resolve uncertainty about which medicines, treatments, procedures and devices represent the best quality care and which offer the best value for money for the NHS." (National Institute for Health and Clinical Excellence) On July 31st 2001, NICE announced that its sixth work program would include the long-awaited review of infertility treatments. The problem of equity of access to effective infertility treatments, the 'postcode lottery', was well known at that period. However, many people felt that infertility should be viewed as a luxury service that the NHS could not afford. In 2002, the Health Secretary, Alan Milburn, acknowledged that infertility caused distress to thousands of couples, that NHS fertility services varied greatly around the country, and that the situation should be managed. Milburn said it was time to tackle infertility using some of the new funds being pumped into the NHS by the Labour government.

In 2004, NICE published its clinical guideline on fertility treatments. This guideline recommended that the NHS in England should provide three cycles of IVF/ICSI to couples where the woman was aged between 23 and 39 and who had an identified cause of their fertility problems or unexplained infertility of at least three years duration. In an accompanying statement, the then Secretary of State for Health, Dr. John Reid (Labor), stated that every Primary Care Trust (PCT) should provide eligible couples with at least one NHS funded cycle of treatment from April 2005, with full implementation expected to be offered in the long term. Aware of the significant investment required for full implementation, he went on to advise Primary Care Trusts (PCTs), that in the first round of implementation of the guideline, priority should be given to people without existing children living with them. Tony Blair, the Prime Minister at the time, told the Commons:

> The pain and distress infertility causes is very real and the variation in the level

> of NHS services is unacceptable. The Government is determined to change this. We hope very much over the next couple of years we will be able to see at least very substantial progress towards the implementation of the full NICE guidelines and they will allow us to end the current postcode lottery.

The contribution of the NICE Guideline towards improving equity of access to IVF in England remained limited, in that it gave solely clinical guidance and did not tackle social eligibility criteria.

> NICE guidelines were made to support health professionals. After the Warnock report and the parliament debates, it was the clinicians that had to deal with theoretical provisions. NICE was a medical version of the philosophy. Or should have been. […] It was based on clinical evidence not around the social values of whether it's appropriate to keep trying for a baby or not. It was reassuring for clinicians to know that they had grounds for decision-making. […] It was also a great regulatory tool to refuse a case if that case was against the clinician's morality. […] Yes, it was supposed to be medical, not social and after all, it became administrative and therefore political. (Interview Public Servant Eng-2 – HFEA member - March 4th 2011)

It was the moral and medical frames that explained most of the variation in service provision. The debate about publicly funding assisted conception was in essence a debate about values and medical priorities rather than a debate about what worked. Even with the guidelines it was unclear whether the government would ensure that appropriate resources were made available centrally. That is in part why the PCTs took so much responsibility in constructing an administrative framework relying on medical evidence.

The NICE Guideline was criticized for its lack of comprehensiveness. For instance, many stakeholders in fertility service provision said the guidelines included only the needs of some patients groups and that NICE didn't consult properly in order to provide the guidelines clinics and infertile couples and individuals actually required. One of the principal problems pointed by the critics of the guidelines – amongst others NIAC - was the definition of infertility NICE established. They defined infertility on a duration basis, namely the failure to conceive after regular unprotected sexual intercourse for three years in the absence of known reproductive pathology. While a heterosexual couple might conceive spontaneously within that period, a similar delay before treatment could be of no clinical benefit for another couple. This applied especially to lesbian couples or single women.

> NICE completely omitted these considerations and as a matter of fact cannot ensure that treatments are either clinically or cost effective. Take a lesbian couple

> for instance; it is way more cost-effective to treat them than treat any heterosexual couple having a reproductive pathology. By building clinical guidelines around a definition of infertility instead of the desired outcome of the treatment, NICE fails to provide tools that are as favorable for clinicians as for patients… all patients. And I would add that outcomes shouldn't be defined by number of pregnancies, because again if we define success as pregnancy rates, lesbian couples should definitely be included. (Interview former MP Liberal-Democrat party – April 26th 2011)

As mentioned in Chapter 2, the NICE guidelines are not compulsory for doctors and PCTs to execute. For many years, clinicians implemented their own clinical guidelines or followed the guidelines dictated by their professional associations instead of NICE's. Other clinicians argued against those, assuming that implementing the guidelines would lead England to fund fertility treatments; "as if playing by the rules would eventually get the system to be accessible and fair" (Interview Public Servant Eng-2, HFEA member - March 4th 2011)

In March 2005, NIAC conducted a survey of Primary Care Trusts (PCTs) in partnership with the All Party Parliamentary Group on Infertility[107] to assess the progress being made across England towards implementing the NICE guideline and the April 2005 deadline for one full cycle. The results showed that significant inequalities in access to NHS funding continued to exist, including wide variations in eligibility criteria. In addition to the parliamentary activities, in 2006, the Department of Health started funding a project with Infertility Network UK, a member of NIAC, to act as a go-between with PCTs to encourage implementation of the NICE guideline. The PCT Liaison Project sought to highlight barriers to, and share good practice in, the implementation of the guideline as well as to clarify the definition of a full cycle of IVF. Between 2005 and 2010, NIAC, the Department of health and the Secretaries for Health tried to mobilize a medical frame that would slowly advise PCTs to largely fund IVF as part of a good practice.

The One baby at the time policy: the rise of the medical risk discourse

As it was the case in Quebec, best medical practices became strongly connected to funding in the political debate in the 2000s. In fact, reducing multiple births resulting from

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[107] All Parties Paliamentary Groups meet together, relatively informally, to discuss a particular issue of concern, with members of both houses and of all parties. The APPG on Infertility was set up in 2003 after the National Infertility Awareness Campaign (NIAC) approached Labour MP Kevin Barron and other parliamentarians both to raise awareness in Parliament of infertility issues and to put pressure on the Government to implement the National Institute of Clinical Excellence (NICE) guidelines.

assisted conception became one of the biggest issues between 2003 and 2005. In the medical sphere, the only way to decrease multiple births was to introduce clinical practice guidelines and to make sure the guidelines applied to clinics. From 2003, the HFEA limited the number of embryos for transfer to two in women under 40, and to three for women over 40. Initially, more flexible guidance failed to achieve the desired effect of reducing the incidence of higher order pregnancies. Additionally, the decision of the HFEA to actively discourage multiple births for safety and health reasons had economic consequences and led to an increased number of cycles provided to infertile couples and individuals. Combined with a move towards elective single embryo transfer (eSET), this drastically changed access to IVF provision in England. The avoidance of multiple births is still today a serious cost consideration for the NHS and its funding of assisted conception.

In October 2006, an independent expert group, set up by the HFEA to look at reducing the number of multiple births from IVF recommended the introduction of eSET for appropriate patients. Because multiple births pose greater risks to mothers and infants than the birth of one baby, and give rise to higher NHS costs, the report recommended the introduction of elective single embryo transfer. The HFEA's intention was to reduce the number of multiple pregnancies without increasing the number of IVF cycles that do not result in a live birth. However, the group also concluded that failure to implement fully NICE guideline was the single greatest obstacle to its introduction in England. In other words, constraints to access and full public funding of IVF prevented clinicians from acquiring the needed autonomy and margin to uphold eSET.

The report *One child at the time – reducing multiple births after IVF* resulted in a policy change in 2007. The HFEA announced that it would be working with professional groups to develop guidelines to identify couples suitable for elective single embryo transfer and set a target for clinics to reduce their multiple pregnancy rates from the 2006 average of 23% to 10% by 2012. NIAC maintained that eSET was desirable but called for it to be accompanied by " fair and equitable access to NHS funded treatments":

> "If a PCT is only funding one cycle, without frozen embryo transfers, it is understandable that patients may be unwilling to accept a move that may reduce their chances of that one cycle being successful. We need to ensure that PCTs understand the connection between access to IVF and good medical practice." (Interview Clare Lewis-Jones – April 6th 2011)

Therefore, the debate on funding fertility treatments in England changed slightly during that period. Good medical practice and cost-effectiveness were no longer related to pregnancy rates and moral considerations only, but also to the global health of women and their children conceived through biomedicine. The medical frame was bridged to an administrative frame by the "one baby at the time" policy. In fact, the only way for clinicians to be medically appropriate was also to think about the global financial impacts of their practice. When considering a line of treatment, the clinician had to consider the potential risks for women and children, not only because it was their duty to protect them, but also because it was their responsibility to maintain the health of the system.

The second report of the All Party Parliamentary Group on Infertility highlighted again the need for greater funding for infertility treatments by the NHS in July of 2007. In their report title Infertility Treatment in the UK: Taking the Next Steps, the Group called for continued pressure for implementation of the NICE clinical guideline on infertility.

> There was, and still is political eagerness to provide greater access to treatments. The problem is in the social … medical conception and financial situations of the PCTs commissioners. We deal with many different medical cases requiring high cost interventions and many of us still don't consider infertility as a medical condition … or as a medical condition deserving as much attention and money as cancer or chronic illnesses. (Interview Public Servant Eng-1, NHS manager, London Region – February 17th 2011)

The following year, the HFEA Chief Executive wrote to directors of PCTs urging them to comply with NICE's clinical guideline. He pointed out that many couples were discouraged from accepting eSET because only one NHS-funded cycle was available to them, especially if that was only a fresh cycle. The matter was so important for stakeholders in the NHS system, medical professional associations, and patients' groups that many awareness campaigns were launched around that period. The One at a time website[108] was one of many efforts to increasing clinicians' and patients' awareness of the benefits of eSET and the risks of multiple pregnancies. The Human Fertility and Embryology Authority (HFEA 2007) backed the One baby at a time strategy and said they would be "monitoring clinics' performances".

In addition, Dawn Primarolo was appointed Government Minister of State for Public Health in July 2007. Upon her appointment, she announced that she would be continuing the

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[108] www.oneatatime.org.uk/ retrieved Octobre 29th 2012.

work of her predecessor, Caroline Flint, in introducing new measures to help the NHS improve childless couples' chances of gaining access to IVF treatment. As promised, on December 12th 2007, she addressed the House of Commons with her concerns over the level of services available through the NHS for those seeking fertility treatments. She announced that she was developing a program of work to improve the way in which NHS IVF services were provided; that the Department of Health had been funding the Infertility Network to work with the NHS to identify and share best practice in the provision of IVF; that this partnership was aimed at generating social criteria that she hoped would help PCTs develop a standardized approach across the country for providing IVF; that the provision of IVF was being monitored to assist in identifying where further work was needed to aid PCTs in evaluating the requirements of fertility patients and delivering services in a fair manner; and that she was setting up an expert group with the NHS and the Infertility Network to advise her on the issue. Following her nomination, Dawn Primarolo set out the definition of a full cycle of IVF in a letter to the NHS in July 2007. She established that one full cycle was "a fresh cycle[109] plus the transfer of frozen embryos where this is possible."

National Infertility Day, 30 years after Louise Brown

Thirty years after the birth of Louise Brown, the access debate was still highly salient, but changed rather slowly. The policy changes – the NICE guidance, the HFEA expert panel recommendations, the One baby at the time strategy and the nomination of Dawn Primarolo – gave better information and structure to medical practices but no financial incentives to open the doors of NHS fertility clinics to a greater number of people. Despite the willingness of the central agencies to inform the PCTs of the interest of good practices (now including eSET) in a cost-effective treatments provision (now including the good and bad outcomes of IVF pregnancies), the effect of their action was overturned. In fact, what happened is that many PCTs used the new information and guidance granted by the central agencies to sustain their non-funding policy. They argued that to maintain cost-effectiveness, eSET reduced the number of patients that could be responsive to this strict treatment procedure. To make sure not to increase the number of cycles, and thereby the cost, they had to choose carefully the

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[109] This means that there is no funding for the storage and/or transfer of any embryos resulting from, but not used in, the first cycle. This might lead to thousands of pounds of extra fees.

right couples. In that sense, limiting access through the establishment of new medical criteria (i.e. BMI[110]) was a way to instigate the strategies.

In Parliament, Dawn Primarolo continued to maintain the issue of public funding and PCTS responsibility upon access to treatments on the government's agenda. She stated June 17th 2008:

> By only considering the cost effectiveness of fertility treatment [PCTs] dodges the big question about publicly funded fertility treatment. Two additional considerations are the cost effectiveness and medical appropriateness of providing publicly funded fertility services. […] First, it is odd to think that a guideline [NICE guidelines] could be a useful prescription for what the NHS should do without considering the medical appropriateness of fertility treatment. It might be that the responsibility for this lies with the agency that determined the […] Second, by recommending that publicly funded fertility treatment should be available to heterosexual couples and not, by implication, to single women and lesbians, the guideline does make social judgments. […] Third, the guideline does discuss appropriateness as well as cost effectiveness. Infertility should, therefore, be considered to be a disease process worthy of investigation and treatment. (Primarolo 2008)

On National Infertility Day, July 19th 2008, in recognition of 30 years of IVF, the House of Commons noted that about one in six couples had difficulties conceiving, which could "cause profound psychological and emotional strain". Through a motion, the House deplored the fact that "huge inequalities in access" to NHS treatment existed despite the 2004 National Institute for Health and Clinical Excellence (NICE) clinical guideline on fertility. It also congratulated Infertility Network UK, ACeBabes and all associated organizations for organizing the largest one-day conference ever hosted by infertility patient associations. The House praised the work of the National Infertility Awareness Campaign in highlighting the need for greater equity in the provision of NHS-funded treatment. Finally it called for full implementation of the NICE clinical guideline to ensure that all those affected by difficulties in conceiving were able to receive equitable access to infertility treatment, regardless of location. The expert group on Commissioning NHS infertility provisions was established that same year by the Department of Health. Its mission was to identify the barriers to the implementation of the NICE fertility guideline in England, to help NHS commissioners in their decision-making on the provision of infertility treatment and to encourage all commissioners to progress towards the implementation of the NICE fertility guideline.

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[110] Body Mass Indice

As a result of the expert group's work, the policy developed in close association with both patient and professional bodies came into force in January 2009. The following February, the HFEA Chief Executive, Allan Doran, wrote to directors of public health, explaining that each clinic was now required to have a multiple births minimization strategy which described when eSET should be used. He wrote: "PCTs will wish to ensure that their commissioning strategies are consistent with the HFEA's new Multiple Births policy. [...] There is no 'one size fits all' policy that is evidence based." (Doran 2009)

The challenges associated with comprehensively implementing the national guidelines in a decentralized NHS was not specific to fertility services:

> If we compare service provision among different lines of treatments, we get to the conclusion that it is not just the system structure that blocks public funding of assisted reproduction. For instance, when NICE established guidance on pulmonary diseases [2004], PCTs were keen to implement them. [...] It's not an institutional barrier to implementation much as a different conception of health priorities. In the case of infertility, clinical necessity is a flexible if not subjective notion. That is explained by the failure of medical science to account for many cases of inability to conceive. For pulmonary diseases such as asthma we can define a strict diagnosis with specific symptoms and clinical observations. [...] not for infertility. (Interview Public Servant Eng-1, NHS manager, London Region – February 17th 2011)

The NICE guidance evaluation and update was due only in 2010 and this same explanation was also given to the long period of "application" of the guidance in a very changing medical domain. The definition of infertility was a contentious policy element in the central agencies and the debate on rather to outline the parameters of infertility or not was as much a political, financial and administrative question than a medical and/or social one. The medical frame and the administrative frame were thus intertwined in the public discourse to the extent that no other frames were able to compete with this robust discourse portraying medical best practices in relation to cost-effectiveness.

Review of the welfare principle: Tomorrow's children

The 2000 to 2010 period was one of redefinition of regulatory concepts in England. Not only did assisted reproduction service delivery changed at the implementation level, but the way the British representatives conceived of the family and children's needs had changed in comparison to the 1990s. In a debate that was far removed from the question of funding, the welfare principle was slowly but surely redefined. In the debate over social criteria, and especially the need for a father requirement, the moral (good versus bad parenting) and the family-building (parental project and family construction) frames kept their central position in the debate but were extended to new types of family structures such as same-sex couples and single mothers by choice. The welfare of child that was commonly linked to the ideal family structure changed to become a risk assessment related by and large to the clinical practices and probable harms to children. The risk evaluation strategy became part of the moral discourse and the inclusion of same-sex partners and single women was centered on the idea of sustainable parenting.

The Department of Health undertook a public consultation exercise during the summer and autumn of 2005 on possible changes to update the law and regulations relating to human reproductive technologies. This was part of a review intended to ensure that the law remained fit for its purpose in the early 21st Century. Likewise, the House of Commons Science and Technology Committee published its own review of the law in 2005 and the HFEA launched the welfare of the child consultation, Tomorrow's Children. These consultations built on a succession of reports, reviews, studies and surveys taking account of the rise of new technologies, international developments, and possible changes in public attitudes since the drawing up of the HFEAct of 1990.

A number of problems were identified and discussed at the House of Commons Science and Technology Select Committee hearings in March 2005. One problem mentioned by the written evidence was the inconsistency with which each clinic approached the ‘welfare of the child’ assessment. Sarah Elliston of the University of Glasgow told the Committee that: "this provision [was] notoriously open to wide variation in interpretation. The extent to which it allow[ed] arbitrary judgments to be made suggest[ed] that serious reconsideration of its retention, or at least a reconsideration of its scope and practical application, [was] required."(Elliston 2005)

Evan Harris asked in the House of Commons consultation[111] in 2004, why the HFEA had taken so long to limit embryo transfer if welfare of the child issues had been so obvious for groups involved in the fertility services provision. In other words, what these

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[111] Beginning in 2004, the House of Commons Select Committee started an inquiry on Human Fertilisation and Embryology and the Law in order to review and update the HFEAct in the following years.

interventions wanted to highlight was that section 13(5) placed a great burden on clinics to assess a notion that was neither defined nor consensually established throughout England. The difficulty was that, in overcoming the problem of definition, the guidance would have had to be extremely specific and possibly inflexible, unless the assessment was made with a checklist of different criteria[112]. The procedures that were somewhat easy to apply in the 1990s were much more complex in 2005. For instance, the clinics reported that it was difficult to get general practionners (GPs) to respond to the welfare of the child assessment form they asked them to sign and many GPs were uncomfortable with having to perform this policing function. Many of them were not aware of the personal history and family environment of their patients more than any other medical practitioner. The GPs' privileged position vis-à-vis a patient in the 1990s became as impersonal in the 2000's as the relationship between the new fertility doctor and his or her patient. The Progress Educational Trust testified to the committee and talked about the ambivalent nature of the provision.

> Whilst maximizing the psychological and social welfare of children is clearly, and rightly, a societal priority, this aspect of the welfare of putative children is in many ways an impossible assessment to make […] Clinicians should act in their patients' best interests. However, they should not be asked to second-guess those of their patients' putative children, whilst of course doing all they can do to ensure the physical health of future generations. (Progress Educational Fund 2005)

The Select Committee claimed for the welfare of the child a medical sense rather than a social definition. It maintained the moral frame first by arguing for the protection of the child then again in structuring the welfare assessment of clinicians with a risk framework. The clinics staff[113] had not to determine who was a good or bad parent, but rather what risk the child was potentially submitted to. It concluded in its report:

> The welfare of the child provision discriminates against the infertile and some sections of society, is impossible to implement and is of questionable practical value in protecting the interests of children born as a result of assisted reproduction […] The minimum threshold principle should apply but should specify that this threshold should be the risk of unpreventable and significant

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[112] For example, whether the parents appeared on police registers of violent offenders, if parents had a criminal record, etc.

[113] With time, the assessment passed from the doctor to the counselor (fertility psychologist) who undertook evaluation of the emotional capacities of future parents and their awareness of parental responsibility with no or almost no consideration of their marital status or gender. The counseling period granted to each patient became less a period of policing but more an effort to accompany the patients in their infertility and future parenting experience. (Interview Isobel O'Neil – March 2011)

> harm. Doctors should minimise the risks to any child conceived from treatment within the constraints of available knowledge but this should be encouraged through the promotion of good medical practice, not legislation. (Progress Educational Fund 2005)

The same year, the HFEA undertook a consultation on the appropriateness of the Code of practice's guidelines on the welfare of the child. The Select Committee questioned the Chair of the HFEA, Suzi Leather, in January 2005 on the goals of the consultation process.

> Clearly this is a very sensitive issue for patients. We have been doing some research with patients and with clinics, and there are some problems with the current legislation. We have also drawn attention to the tensions now between the current clause, particularly the child's need for a father, and other legislation that has been passed by Parliament, including the Adoption of Children Act and the Civil Partnership Act[114]. (Leather 2005)

Suzi Leather was identified as a very progressive chair of the HFEA (Interview Public Servant Eng-1, NHS manager, London Region – February 17th 2011). She reformed many of the clinical guidelines, launched many discussions on new technologies and consulted stakeholders in the advent of the HFEAct evaluation and update coming up in the second half of the decade 2000-2010. With the Tomorrow's Children consultation, she aimed at focusing the House of Commons' attention on the recurring problems lived on a day-to-day basis by clinicians and their confusion with regard to the welfare principle.

The HFEA reported other concerns in the report. All of them were based on the contradiction between medical requirements and social conceptions of family and parentage. One was that the time and cost of carrying out the welfare of the child assessment was disproportionate to any benefit gained. Professor Allan Templeton of the Royal College of Obstetricians and Gynaecologists argued that "It has been a distortion of clinical practice; it has been absolutely beyond any effect at all in terms of trying to enhance the welfare of the child" (House of Commons Science and Technology Committee 2005). He argued that there was no need for specific welfare of the child issues. Ensuring the child's welfare was protected was for him only a matter of good medical practice. Witnesses from the British Fertility Society and the Association of Clinical Embryologists stated that they had compared notes. Out of the four clinics they represented, they said that their "hit rate" for stopping

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[114] The Human Rights Act was also mentioned in the discussion as a potential legal challenge to the HFEAct of 1990.

treatment based on the welfare of the child was between 0% and 0.3%. The HFEA reported that while clinics sometimes made further enquiries to other agencies, they very rarely turned patients down for treatment. When they did, the most common reasons were medical, psychiatric or, occasionally, marital.

Moreover, the Tomorrow's Children report (Human Fertilisation and Embryology Authority 2005) established that the welfare of the child provision was seen as discriminatory[115] for two reasons. First, as the Royal College of Obstetricians and Gynecologists argued, it "discriminate[d] between those wishing to use licensed treatment to conceive and those who can conceive naturally". Mr. Tony Gilland, a contributor to the online consultation described it as "tantamount to licensing parenthood". Others, while conceding that there was discrimination, suggested that it was reasonable by referring to adoption procedures in which the background of prospective adoptive parents is carefully scrutinized. Alistair Campbell argued that:

> […] when the state and the professions are involved in parenting decisions (as they are in AHR [assisted human reproduction] and adoption), there is an obligation to avoid harm wherever possible. By preventing a pregnancy through regulation, no child is harmed (unless we believe in pre-existing souls!). Refusing to select parents could result in complicity in clear harm to children. (Campbell 2005)

On the other hand, potential parents were said to be harmed when they were denied the chance to conceive a child and/or were asked intrusive questions as to their suitability as parents. The parents' position in the clinic was discussed to shed light upon the already significant authority of clinicians over patients apart from their role in the selection of "good" parents.

The second basis of discrimination identified by the report was Section 13(5)'s demand that the welfare of the child should embrace the consideration of the need for a father. The Report discussed the imposition of an official view of an ideal family that was

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[115] Interestingly the "discrimination" discourse was not legally framed in England. Many interviewees talked about discrimination in a relational manner, as if the fact of being discriminated against prevented them to enter social structures. In comparison, in Ontario and Quebec, the discrimination discourse is related to a right discourse based on the idea of an individual having a right to access institutions. In that sense, the relationship of Canadians to law is clearer in their discourse. In England, the relationship to society, here through family structures, is established through acceptance. I would argue that equality of access to parenting was negotiated more than legally established.

considered as clearly intended to restrict the provision of IVF to lesbian and single women. The Royal College of Obstetricians and Gynecologists (RCOG) argued that:

> The requirement for a father does not square with the current view of what constitutes a family, and discriminates against single women who may have the financial and emotional facilities to cope with a child on their own or with other support systems, who may need to use donor insemination to conceive safely. (Royal College of Obstetricians and Gynecologists 2005)

PROGAR (Project Group on Assisted Reproduction), a multidisciplinary body under the auspices of the British Association of Social Workers, recommended that the child's need for a father in the Act be replaced by the need for a family.

In the written evidence, some maintained that consideringof the need for a father was important and should be retained because "as a general rule it is better for the children to be born into a two parent family with both father and mother" (House of Commons Science and Technology Committee 2005). They argued that requiring only the consideration of the need for a father was not discriminatory, since the HFEAct did not actually demand that there was an identifiable father. The fact that many practices of homemade assisted conception were high risk for lesbian couples and single women was echoed by members of the lesbian and gay community who worried about the medical and personal risks[116] undertaken to have children. However, the fit with the laws only just adopted[117] was considered also as a ground for a section 13(5) review. The HFEA's Chair was reported in January 2004 as saying that:

> It is absolutely clear if you think about the changes in society and the different ways that families can be constituted that it is anachronistic for the law to include the statement about a child's need for a father […] It seems to me a bit of nonsense to have that still in the legislation. (Fleming 2005)

The research of Professor Susan Golombok[118] supported this position. She testified that while there had been little research on the psychological outcomes for children born to single heterosexual mothers through donor insemination, there was a considerable body of research on lesbian mother families suggesting that there were no adverse outcomes for their children born using assisted reproduction. She argued that the requirement to consider whether a child

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[116] See Nordqvist, P., 2011, "Dealing with sperm: Compaing Lesbians' Clinical and Non-Clinical Donor Conception Processes", *Sociology of Health and Illness,* 33, 1,

[117] The Human Rights Act 1998, the Adoption of Children Act in 2002, the Civil Partnership Act 2004 among others.

[118] She is the director of the Centre for Family Research at the University of Cambridge, United Kingdom.

born as a result of assisted reproduction needs a father was too open to interpretation and unjustifiably offensive to many. "It is wrong for legislation to imply that unjustified discrimination against 'unconventional families' is acceptable." (House of Commons Science and Technology Committee 2005)

The age limit was also reviewed in the welfare of the child discussion. In fact, many considered that the principle should include or nonetheless debate the importance of an age cut-off for treatments. There were no upper limits set out in the HFEA's Code of Practice, even if the guidelines stated that, in considering the welfare of the child, clinics should assess the age, health and ability to provide for the needs of a child. It was widely recognized that as they approached the menopause, women's chances of achieving a live birth using IVF substantially reduced. Many had the deep-seated feeling that it was unnatural to give birth after a defined age. The majority of interveners in the consultation process agreed that if judgments were to be made about the health or age of parents, they should be applied equally to both parents (where there are two) and based on evidence of risk of significant harm.

The age cut-off seemed to be a reaction to the Romanian case[119]. Many comments following this news were based on ageism and sexism, neither of which was seen as a good basis for legislation for the HFEA. Some used the possibility of multiple pregnancies to argue that the welfare of the child provision be strengthened. Others considered that a better solution would be to ensure that doctors consider the impact of the treatments they provided on other areas of health services in general and in neonatal care in particular; in other words that fertility specialists appraise the global impact of treatments on the health of patients and future children. Given that a major known threat to the welfare of the embryo/fetus and any subsequent child is associated with multiple pregnancies, it was thought more desirable for legislation to specify that a regulator impose limits on the numbers of multiple births in licensed clinics. In that sense, the consultation was pointing towards a risk assessment of the patients and children's needs.

> However, the welfare of the child is much more important than simply a child's need for a father, or an age cut-off. I think that it has to be looked at in the round. […] One of the dimensions for the public consultation on welfare of the child

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[119] In 2005, a Romanian woman was set to become the world's oldest mother at the age of 67. Adriana Iliescu, a retired university lecturer, got pregnant with twin girls following ten years of fertility treatment. She also underwent hormone treatment for nine years to delay her menopause. Liz Buttle became the UK's oldest mother in 1997 when she had a son at the age of 60.

> that we issued last week touches on this issue about good enough, perfect, or minimal standard parenting. I think that it is an issue for this Committee. Are we going to say that, in order to be accepted for IVF treatment, you have to have shown that you will be an absolutely gold–plated, brilliant parent, or are we going to take the view that being good enough is good enough, or do we take the view that you simply want to ensure that there are not any gross risks? (Leather 2005)

The HFEA following the consultation set out new guidelines for clinicians, which incorporated a risk-based approach to assessing the welfare of children.

In August 2006, the British Fertility Society published recommended national criteria for NHS funding of assisted conception and stated that ‘single women and same sex couples should be eligible for six cycles of NHS funded Donor Insemination. If that failed or in the presence of an indication for IVF with donor sperm, treatments must have been allocated on the same basis as for heterosexual couples (British Fertility Society 2006). Dr Mark Hamilton, Chair of the British Fertility Society, said:

> Continued inequality of access to treatment is unacceptable in a state-funded health service and the source of considerable distress to a great number of people with fertility problems. We are presenting the recommendations to the PCT’s and Local Health Boards with the intention that they provide a basis for consistent application of social as well as medical criteria for access to State funded fertility treatment in England. (BFS Press Release 2006)

That declaration marks the first time the medical community aligned with the HFEA in describing the social criteria as discriminatory and as leading to broad inequalities. The BFS position helped the welfare of the child to be better defined in order to limit discrimination without leaving aside the need to assess the children’s interest.

White paper, nomination and consultation

On 24 March 2005, the House of Commons Science and Technology Committee published a report entitled Human Reproductive Technologies and the Law following a yearlong inquiry and collection of evidence. The Select Committee’s conclusions and recommendations were considered in the context of the Government’s own plans to review the Human Fertilisation and Embryology Act of 1990, announced on January 2004. The development of new procedures and technologies in assisted reproduction, the profound ethical issues associated with them, changing public perceptions, and international developments in the standards that clinics had to meet, were all issues that led the government and involved agencies to conclude that a review of the HFEAct was necessary. The report released by the Department of Health in August 2005 set out the Government's response to the House of Commons Committee's conclusions and recommendations.

Following the many consultations and a review of the law in 2005, the HFEA released a white paper in December 2006 updating its position on a number of controversial rules that had been part of its original 1990 charter. The white paper formed the basis for the Human Fertilisation and Embryology Bill 2008. The entire Act was reviewed by the House of Commons and the House of Lords Committees and discussed for a whole year between November 2007 and 2008.

During the Bill's progress through the two Houses and their Committees, the welfare of the child principle was again reviewed from all sides. This time the welfare of the child was also considered to be related to the "serious" issues of savior siblings[120] and access to biological origins (see next chapter). However, what gathered the most attention was in fact the issue of access to treatment for same-sex couples and single women.

Brazier and Cave observed that "a statute enacted in 1990 no longer meets the needs of scientific developments that were undreamed of 17 years ago" and that its "paternalistic structure of regulation is perceived as outdated and incompatible with a human rights culture" (2007, p.316). One of the most controversial changes to be announced was the removal of the need for a father requirement when assessing the welfare of the child. This cleared the way for lesbians and single women to have equal access to IVF through the NHS, a move acclaimed by many activists of the gay and lesbian community as an end to an unnecessarily moralizing stance on the part of the British government.

While religious groups were unequivocally opposed to allowing lesbian couples and single women to have access to fertility clinics, political opponents across party lines decried the move as having wider symbolic value as it endangered the wellbeing of children by marginalizing the role of fathers. Lord Northbourne resumed the argument for the conservation of the need for a father requirement:

> For most people, and especially for some fathers, the removal of that word will imply that the Government do not really think that the role played by fathers is

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[120] The Houses asked if they should prohibit the selection of embryos in the context of the creation of a savior sibling, a child who is born to provide an organ or cell transplant to a sibling that is affected with a fatal disease.

> important. It will also seriously downgrade the standing of the traditional family in the long term. It will downgrade the role of fathers to leave some children in limbo, not knowing their biological father—a point that has been made by many noble Lords. It will promote the idea that the mother's wishes are more important than the well being of the child and it will encourage single parenthood. (Northbourne 2007)

The amendment to retain the need for a father in the new HFEAct was proposed in the House of Lords and again in the House of Commons. In 2008, critics used the media to depict the removal of the need for a father as an attack on fatherhood, suggesting that women acquired the right to have children without fathers. Frequent allusions were made that this discourse sustained the inutility of men in childrearing and rejected traditional male roles in England (Watt 2008).

> Same-sex couples and single mothers can be successful parents, but if we enable a child to be born in circumstances in which a natural conception would not be possible, we have an ethical responsibility to ensure that the welfare of the child is fully protected. It is in the interests of every child to have a mother and a father, but if no father is present—as is, unhappily, the case for many children today—a male role model should be available. For that reason, I, personally, do not regard the substitution of "supportive parenting" for "father" as sufficient. The reference to the need for a father, which has not been reflected in the code, should be recast in the legislation as "the need for supportive parenting and a father or a male role model. (Lansley 2008)

The moral predicament attached to the need for a father was clear: the right way to sustain a child is to give him or her a mother and a father. But the welfare of the child was also debated in medical terms. For instance, the British Medical Association argued that a more specific provision only put more ambiguity into the application of the Law by clinicians and maintained the disparities between private clinics and PCTs.

> We have consistently rejected the idea of applying inflexible rules on access to fertility treatment, believing instead that each application should be considered on its merits. Assessments should be made on the individual factors in each case rather than on blanket restrictions applied to certain categories of people or family arrangements. (British Medical Association 2004; 2007)

As was the case in the HFEA consultation Tomorrow's children, the fact that lesbian couples and single women undertook risky endeavor to get pregnant came back in the discourses of the representatives as well as through the testimonies of women and lesbian co-mothers. The medical security of women and children were at stake, in their view, and the HFEAct should have been a tool to allow lesbians and single women to access legitimate services and thus protect the welfare of the future child.

> By allowing them to go to a licensed centre and both register as the child's parents we hope we would dissuade same-sex couples from carrying out unlicensed self-insemination at home. It also means that, in the event that something happened to the mother, there is another person who is the legal parent of that child. (Denham 2008)

In addition, a serious confrontation between supporters of the need for a father and supporters of its exclusion began, their valued weapon being research. Academic research studying the psychological, financial and social wellbeing of children raised in homoparental families and by single women were evoked many times at the House of Lords.

The work of Susan Golombok[121] was introduced once again by the Houses, sympathetic representatives using her studies as a means to reinforce the irrelevance of the need for a father provision and the validity of the new forms of families rendered possible and/or more visible by assisted reproductive technologies. This psychological appraisal of the welfare of the child resonated with the medical frames mobilized throughout the legislative process. In fact, it was easier to establish the wellbeing of children raised in non-traditional settings and the slowly increasing access to services bylesbians and single women since the 1990s than the opposite. That many clinics and PCTs put aside the need for a father assessment or used stratagems[122] to avoid doing so was illuminated by briefs and testimonies.

Despite the many arguments against the welfare of the child principle in its previous form, the common opinion of Lords and MPs was that the welfare of the child principle needed to be kept in order to prevent children from being raised in undesirable conditions. Thus, many Lords and MPs argued in favor of a 'supportive parenting' clause but against the observance of the need for a father. It was seen as a compromise to the total exclusion of the need for a father. It was seen as considering the importance of a good and fulfilling familial environment for children born by ART, without the conservation of the discriminatory effect of the need for a father clause.

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[121] Professor of Psychology at University of Cambridge, she works on new family forms with an emphasis on parent-child relationships and children's social, emotional and gender development in lesbian mother families, single mother families and families with children conceived by assisted reproduction.

[122] For example, some clinics asked the lesbian couple to have a sheet signed by a man testifying that he would be part of the child's life. That consent form was after all never corroborated by the staff and was used only as a proof that the assessment had been made by the clinician.

However, it was not as easy to envision how to implement supportive parenting as it was said to be by MPs who introduced the amendment. As for the HFEA earlier in 2005, it was a challenge to make clear to the many stakeholders in assisted reproduction what was the risk assessment presupposed by the supportive parenting clause.

The welfare of the child was finally kept in the HFEAct of 2008 but without the need for a father clause. The need for supportive parenting was included with a clear recommendation to the HFEA that the provision should be evaluated through an estimation of the risk for potential harms to the child, from its conception to its childhood. In that sense, for the first time, the welfare of the child principle really encompassed the medical, moral and family-building frames mobilized through the years in England.

Still muddling through

The Human Fertilisation and Embryology Act of 2008 had an immediate effect on same-sex couples and single women's access to fertility treatments. However, medical and social criteria that were applied to heterosexual couples still are applied to this not-so-new clientele. The postcode lottery is still a reality even with the new HFEAct. In 2009, NIAC developed a standardized set of access criteria for use by PCTs that led to the establishment by the Department of Health of an Expert Group on Commissioning NHS Infertility Provision, which produced a commissioning guide for PCTs in 2009. However, significant variations continue to exist in the number of IVF cycles funded, particularly criteria that fall outside the NICE clinical guideline. For example, on the issue of infertility, there is considerable variation around whether couples that have a child from a previous relationship should be excluded from funding. The majority of PCTs still do not fund the recommended three cycles of IVF NICE guidance suggests and there are parts of the country where treatment has been suspended or is simply not funded.

NICE began its review of the clinical guideline for infertility in 2010 and anticipated releasing them at the end of 2012. Many observers hope to see serious changes in the way NICE define infertility and the medical criteria for access to fertility treatments. "NICE seem to think that the best thing is to spend money on those with the best chance of a pregnancy; there is nothing fair about that at all." (as reported by Campbell 2010) At the time, in England, involved organizations clamoured for change in the access criteria. For instance, one access criteria was increasingly debated in 2010 despite many preceding debates: age limits. Many of the contesting groups proposed ovarian reserve testing as means to overcome the inability of the age criteria to answer the PCTs needs to enhance success rates. This ongoing debate is an endeavor to change minimally the way PCTs define infertility, deserving couples/individuals and medical good practices. Policy implementation changed and still changes every year in this regard, leading to broader or restricted access to fertility treatments.

Conclusion

In England, what was observed when considering the question of funding for IVF, is the inability of the central government and the would-be-parents community to change the representation of infertility at the level of PCTs. In the debate over medical criteria for access, the administrative frame (the cost-effectiveness, value for money treatments) was bridged through time to the medical frame (good practice) to the point where they dominated the universe of political discourse. That situation limited the influence of the family-building frame (parental project and family construction) as well as the experience-based frame (feeling of lack of personal control; psychological impact of inability to conceive and of going through fertility treatments) mobilized by would-be-parents, many governmental representatives and experts. When considering the debate around the access of same-sex couples and single women to treatments, what is interesting is the ability of the central government and the experts' community to change incrementally the representation of family to include same sex couples and single women. Influences from other policy debates from the late 1990s and in the first half of the 2000's are not estranged from this change in approach. Nevertheless, the LGBT and women's community took advantage of the large consensus of the medical community about opening the doors of clinics to new types of families. Consequently, in the debate on the welfare of the child, the moral (good versus bad parenting) and the family-building (parental project and family construction) frames kept their central position in the debate over time but were extended to new types of family structures which led to policy change.

Medicalization, frame bridging and entrepreneurs

Despite the dominance of the medical frame in the debate over access to fertility treatment and the public funding offered in Quebec, Ontario and England, the disparities in terms of access criteria and thus the scope of the coverage are diverse. Three factors contribute to explaining why there is so much variation between the three jurisdictions in this regard: medicalization, frame bridging and the role of policy entrepreneurs.

The process of medicalization in Quebec is one of the particularities of this case. Over time, many different communities of actors in diverse political contexts and arenas mobilized the medical frame to the extent that it became increasingly difficult to challenge. In addition to the persistence and salience of the medical frame, the problem itself was redefined in medical terms. Infertility was progressively regarded as a medical condition by would-be-parents first and later by the medical community. This contributed to establishing the Ministry of Health and Social Services and the parliamentary arena as central targets for advocacy by both the medical and the would-be-parents communities. Hence, the colonization of the issue by the medical frame was instrumental in helping same-sex couples acquire full access to fertility clinics by mobilizing their right to secure health care services.

Additionnaly, the medical frame showed its ability to be bridged to other frames in the process. Frame bridging mattered not only in Quebec –where it was bridged to the experience-based frame – but in England as well – where it was mobilized in concert with the administrative frame, albeit producing different outcomes in Quebec and England. In Quebec, this discursive mechanism proved to be a tipping point that triggered a social cascade of events influencing the formulation and adoption of a comprehensive public coverage of fertility treatments. In England, this same mechanism limited the influence of the broader debate on the implementation of access criteria by PCTs, which became central in the redefinition of infertility as a “deserving” condition for public support. Over time, PCTs changed their definitions of infertility and successful treatments in order to expand coverage to a larger clientele. The bridge between the administrative and the medical frames contributed to sustaining the PCTs power over implementation and justified their slow definition of more supple/or different criteria. In this regard, PCTs managers were influential in bridging the frames over time.

In fact, policy entrepreneurs such as the PCTs in England, the Minister of Health Philippe Couillard, and would-be-parent Karine Joizil in Quebec proved to be important in mobilizing, maintaining or meshing policy frames in time and space. The issue of access to fertility treatment is revealing in this regard; it showed that on many occasions the mobilization of frames and the influence they acquire is due to the work of individual or institutional actors who make sense of a policy problem and/or the range of available solutions. In other circumstances, policy entrepreneurs are the channel that allow frames to acquire resonance with elites of the system. For instance, Karine Joizil contributed to bridging the medical frame with the experience-based frame in drafting a policy statement through her position in the Liberal party that provided institutional resonance and public attention for her solution.

Quebec, Ontario and England all fund fertility treatment to some extent. The main difference resides in their implementation of access criteria. From a quasi-universal to a very narrow coverage, the politics of infertility treatments' provision is widely influenced by discursive dynamics and their performance in the policy system. Medicalization, frame bridging, and policy entrepreneurs explain in great part why Quebec developed such comprehensive coverage while Ontario covers treatment only in strictly medically necessary conditions, and England supports the application of access criteria that are seen as cost-effective.

Framing infertility proved to be influential in the development and implementation of legislations and regulations in regards to access to fertility treatments in Quebec, Ontario and England. With the same goal of uncovering the influence of discursive dynamics on policy outcomes, the next chapter will present the issue of gamete and embryo donation. In providing insights on the mobilization of the legal frame, Chapter 5 proposes a view of the multiple channels through which frames can be mobilized.

CHAPTER 5
GAMETE AND EMBRYO DONATION

England treats the legal status of donor-conceived children differently from Quebec and Ontario. Even if England was relatively late in recognizing homoparentality, the issue was debated concurrently with the issue of access to treatments. In addition, England regulated the issue of donor-conceived children's right to know their origins, while the Canadian provinces saw very little discussion on the subject. This chapter will explore the two sides of the issue of gamete donation and account for both the common mobilization of the legal frame in the three units studied and the singular development of regulatory regimes in regard to parentage of donor-conceived children. The mobilization of the judicial arena by individual litigants contributed equally to bridging and extending frames, which created changes in the implementation and regulation of gamete and embryo donation.

First, the issue linked to the establishment of parentage was legislated at different moments and through different routes in England, Quebec and Ontario. In England, parental orders were established as soon as the first Act was adopted in 1990. The Warnock report had already establish a clear link between the development of assisted reproductive techniques and family configurations. In that sense, they structured the 1990s parental orders around a heterosexual binary form of family. A particularity of policy development in England resides the lesbian and gay community's discussion of this precise issue at the same time they claimed equal access to fertility clinics. Indeed, the access debate and the redefinition of the welfare principle in 2008 led to the reform of the related parental orders. In contrast, processes in Quebec and Ontario were marked by a separate debate. The redefinition of family law was, however, consolidated through a legislative process in Quebec, whereas litigation incrementally redefined parentage of donor-conceived children in Ontario. Despite their different paths, England, Quebec and Ontario were invested with similar ideas of intention, consent and agreement when it became time to construct the filiation of donor-conceived children. The legal and family-building frames were mobilized in each case to give full legal recognition to same-sex couples and single parents.

Secondly, the issue of donor-conceived children's (DCC) right to know their biological origins was marked by different dynamics of mobilization and led to divergent policy outcomes. Despite this, Quebec and England share many arguments in regard to DCC rights. For instance, the DCC community usually argued the right of donor-conceived children in relation to adopted children's situation. Through that comparison, the actors mobilized for DDC rights sustained an equality-seeking discourse. Despite this similarity in the way the issue was discussed in the three sub-national units, England benefited from a sustained mobilization as well as the consolidation of a bridge between the moral and the legal frame via the Rose decision of the High Court of Justice in 2002, which will be discussed later in the chapter.

England

According to Caroline Jones (2009), in English legal discourse, the focus on genealogical information or genetic origins has traditionally and still tends to fall on paternity rather that maternity[123]. The Warnock report and the subsequent HFEAct of 1990 rapidly acknowledged the intertwined nature of gamete donation and parentage, but maintained the prevailing nature of paternity in English law. Therefore, the establishment and implementation of parental orders that followed the adoption of the Act particularly valued paternal linkage through section 13(5) with the "need for a father" clause. As will be discussed further in this section, the welfare of the child has always been the cornerstone of the HFEAct parental orders, but the definition that was given to its fulfillment changed over time and led to the amendment of section 13(5) in 2008. From the prevalence of donor anonymity and the maintenance of the traditional heterosexual nuclear family units in the 1990s, the British system changed to acknowledge homoparentality and the need for donor-conceived children to know their genetic origins.

The two frames battled in order to dominate the debate on lesbian and same-sex couples and single women's access to legal parenthood. The moral and the experience-based frames competed in the discourse of decision-makers in England despite the fact that they were built on the same idea: the welfare of the child. The mobilization of the experienced-

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[123] Jones presents an interesting argument on the continuous importance of the presence of fathers on the birth registration of children in England. Examples of the Deceased Father Act of 2003 and the "need for a father" clause in the HFEAct of 1990 are stated, but she also grounds her explanation historically to highlight the patriarchal character of parental orders in the UK. Jones, C. (2009). The identification of 'parents' and 'siblings': new possibilities under the reformed Human Fertilisation and Embryology Act. Rights, Gender and Family Law. J. Wallbank, S. Choudhry and J. Herring. Oxford, Routledge**:** 219-238.

based frame and its performance by different experts in social work, psychology, sociology and law gradually changed the minds of legislators and led to the comprehensive inclusion of same-sex couples and single mothers on the birth registration of their donor-conceived children. The importance of such expertise in the debate is one notable difference between policy development in Quebec and Ontario.

In addition, the discourse asserting the child's right to know his or her biological origins has had a crucial influence on the decision to lift donor anonymity. This legally framed discourse dominated the debate leading up to the 2004 regulations. The social context of adoption has been regarded as a morally and psychologically relevant model for approaching the need to find out about their origins claimed by some children born through donation. Social workers and parents of donor-conceived children continued to maintain that the only way the HFEA could be ethical was to acknowledge that the welfare of the child could not be satisfied without the disclosure of genetic information. The 2004 regulations endorsed the bridge between the moral and the legal frames by giving donor offspring and adoptees similar legal privileges.

Unlike its scarce mobilization in Canada, in the UK the legalization of the debate over access to genetic origins and the way it often surpassed the dominant medical view was due to a high degree of mobilization outside the courts prior to and following the Rose case. Despite the mobilization of the medical communities around donor anonymity, the work of Progar and their allies progressively changed the common view on genetic identity in the 1990s. The year 2002 was a turning point with the court's decision in the *Rose* affair, the cascade of events that led to the adoption of the 2004 Regulations, and the subsequent reinforcement of the government position in 2008 with the HFEAct.

Medical reproduction, natural families

The Warnock committee argued that absolute anonymity for donors should be maintained to ensure continued donation and to protect the recipient families (Warnock 1984, para. 4.22). While the Committee recommended that the birth mother should, for all intents and purposes, be regarded in law as the mother of the child, the discussion went it further when was time to establish who was the father. In England, the report marked the first formal confirmation of the widely accepted idea that donor conception was best conducted in secret.

Considering that the most practiced procedure at the time was donor insemination, concerns about who should access it arose from the recognition that lesbians and single heterosexual women could create fatherless families. “Moral and ethical concerns regarding masturbation, the question of whether the technique constitutes adultery (when used with a married couple) and fears that women may inseminate without their male partner’s knowledge” (Donovan 2006, p. 498-499) all cast a moral shadow over the issue of gamete donation. Non-heterosexual parenting brought out some of the most provocative responses from religious and right-wing groups.

Fox Harding (1999) called this community of actors the ‘family values lobby’. Baroness Warnock seemingly described them in her account of the commission (Warnock 2002). The arguments of the family values lobby construct children as vulnerable victims of selfish adult caprice and the immoral stance of individuals having the right to have a child. The assumed moral decision was thus to medicalize assisted reproduction and maintain the heterosexual nuclear family through the Human Fertilisation and Embryology Act and the work of the Authority to prevent any other kind of family arrangements.

Unease about children born of gamete donation has focused on whether or not they should be told about the circumstances of their conception; what impact the information may have on their emotional and psychological development; what information they should access; and fears that if one man’s donations result in many children, there may be cases of involuntary incest. The committee was very concerned about the potentially damaging impact of family secrets, stating “it is wrong to deceive children about their origins” (Warnock 1984, paragraph 4.12). However, the privacy rights of parents and donors, the development of the practice of assisted human reproduction and the maintenance of the traditional form of family ties prevailed over the children’s right to know.

It was no great surprise, therefore, that the Human Fertilisation and Embryology Act of 1990 institutionalized donor anonymity. From the first Code of Practice onwards, the HFEA advised clinics to counsel patients about potential questions on origins their children might ask growing up. This information was considered: “ the minimum necessary to allow the Authority to answer questions from children born as a consequence of treatment services about their genetic backgrounds…" (Human Fertilisation and Embryology Authority 1993) In the design of the data collection system great importance was given to avoiding unnecessary intrusion into the personal lives of patients and donors, and to avoid unnecessary costs to centers and to the Authority (p. 23). The focus on privacy rights thus favored the protection of parents and donors.

It was acknowledged that this recommendation could be seen as "legislating for a fiction" and so compromised the register of births "as a true genetic record" (Jones 2005). Informed consent to treatment became the means through which parents, primarily the father, supported their intention to assume full parental rights and responsibilities regarding the child. On one hand, as a potential alternative, the Committee proposed that "consideration should be given a matter of urgency to making it possible for the parents in registering the birth to add 'by donation' after the man's name"(Warnock 1984, paragraph 4.25). This was, however, never included in the HFEAct of 1990. The debates on this possible amendment in the House of Lords were very animated, many Lords considering this distinction to be comparable to the former "illegitimacy" label removed because of its discriminatory impact on children (Mackay 1990). On the other hand, worried about an eventual change of attitudes toward donor anonymity, Parliament charged the new Authority to maintain a Register of Information that included details relating to donors, recipients of donated gametes and embryos, and children born as a result of all donor procedures provided by a licensed clinic. The early implementation of this responsibility offered then and later the opportunity to open access to donor information or at least to issue some information upon demand[124].

The government took no action to produce new regulations until after the 1997 general election. Despite this long period of time, interested parties never shelved the issue. Between 1990 and 2001, many different associations organized. Communities of experts, families of donor-conceived children and would-be parents gathered to discuss and structure their claims.

Social Workers' contribution to the debate of access to origins

In the 1980's, Social worker's professional body, the British Association of Social

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[124] Such as providing for a person intending to marry to enquire whether any information held on the HFEA Register contained evidence of an existing genetic relationship with her or his intended spouse and – once they reached the age of 18 – to access unspecified non-identifying donor information.

Workers (BASW), submitted evidence to the Warnock Committee. Of fundamental concern to the BASW was the Warnock Committee recommendation that gamete donation should be anonymous, which was felt to be contradictory to the rights and needs of people to have access to their personal history. Thus commenced BASW's lobby for the right of donor-conceived people to attain equality with adopted people. In 1987 the government published a White Paper on the framework for proposed legislation. BASW was invited to provide further input at this stage and also gave oral evidence to a Parliamentary Standing Committee in 1988.

> [Adopted children] were the only other group of people at that time whose families had come into being as a result of professional intervention and whose access to information about their genetic relationships was regulated by statute. When subsequent legislation to regulate surrogacy (the Surrogacy Arrangements Act 1985) opted for parity with adopted people with regard to accessing identifying information from age 18, donor conceived people were further marginalized and BASW made strong representation about the inconsistency and resulting discrimination. (Wincott and Crawshaw 2006)

In 1988, Eric Blyth and Marilyn Crawshaw – an academic social worker and an experienced counselor in an assisted conception clinic (and ex-social worker) – were nominated as directors of the Project Group on Assisted Reproduction (Progar) of the BASW. During the 1990s, Progar decided to widen its membership to include those directly affected and their families, other disciplines, and key social welfare organizations including: two donor conceived people; Walter Merrick and his wife, parents of donor-conceived children who had set up a UK-wide network of parents of donor conceived children called Donor-Conceived Network; a representative from the Association of Directors of Social Service, the body which represents all statutory social services in England; a lawyer specializing in children's law and adoption; a representative from the British Infertility Counselling Association (BICA); and representatives of three major UK children's charities. This extended membership gave Progar links with wider networks, thus enabling it to promote and influence wide-ranging and diverse debates. It also undoubtedly afforded it greater clout in its own campaigning and ensured greater coverage of its views in the media and amongst political and other influential figures. During the 1990s, Progar's links and dialogue with the HFEA developed, which included giving evidence to a number of public consultations run by the HFEA. Progar members made increasingly diverse contributions to the work of the Authority; three members of Progar became members of the HFEA's teams of clinic inspectors. Though they were appointed independently of their role in Progar, the views of the community were diffused through their work. In the late 1990s a liaison group was set up between the HFEA, the British Infertility Counselling Association (BICA) and Progar.

In addition to the networking work of Progar, during the 2000's, growing numbers of written contributions[125] were published in professional and academic journals and in the media. The discussion about the use of evidence reflected the growing preoccupation with evidence-based policy and practice in Britain. Along with the professional work of Progar and its allies, the Children's Society, one of the biggest children-centered charities in the United Kingdom, started to mobilize for the right of children and the protection of their welfare from their childhood to their adulthood. The Children's Society runs children's centers all over England. Through lobbying and research, they seek to influence child protection policy and perceptions at all levels. In November 1998, the Children's Society called for a change in the law so that people who were born by sperm or egg donation could access the same information about their donors that adopted children could access about their natural parents. According to the Children's Society, donor anonymity creates identity problems for donor-conceived children who have similar needs to adopted children, and denying access to their identity infringes their rights.

> For example, the arguments were variously presented with a primary focus on the impact of secrecy on psychological well being, the primacy of children's rights over the rights of infertile adults to found a family, the impact of inadequate or inaccurate medical history on an individual's health or the moral rights of people to access information held by the state. (Interview Marilyn Crawshaw - April 18th 2011)

Stonewall and Pink Parenting

As seen in chapter 4, access to fertility treatment became one of the most important battles for gays and lesbians. With single would-be-parents, their aim was to be granted the right to access fertility treatments, publicly funded or not, without barriers. In Quebec and

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[125] In 1998, Progar decided that the time had come to update that publication and a fuller book was produced, edited by three Progar members. BASW published a booklet that included a mixture of personal and professional accounts and aimed to reflect the diversity of arguments for openness including social work, medical, genetic, sociological, psychological and legal. See Blyth, E., M. Crawshaw, et al. (dir.), 1998, *Truth and the Child 10 Years on: Information Exchange in Donor Assisted Conception.* , Birmingham.

Ontario, the issue of gamete donation was part of the debate in which gay and lesbian couples attempted to secure equal access to parentage. In England, the debate on access to fertility treatment was the first definitive step toward access to parentage rights. The first HFEAct's acknowledgement of the relationship between access and filiation created a bond between the two issues. Despite the dominance of the debates over access to fertility treatments in the regulation of parental orders for gay, lesbian and single would-be-parents, the issue of gamete donation in this regard still brought about discussions on the parentage capacity of single-led or homoparental families. Two organizations became important in this debate in the early 2000, Stonewall who played a key role in lobbying for securing equal adoption rights for same-sex couples – the Adoption and Children Act 2002 - and negotiating parental rights for lesbians in civil partnerships conceiving through artificial insemination. Second, Pink Parents mobilized, through the work of Lisa Saffron in particular, for the protection of lesbian couples in their quest to become parents and the equal recognition of their families.

The New Labour

The advent of the New Labour government in 1997 saw a renewed policy focus on the role of parents (Gillies 2005) and investment in children's welfare (Turgeon 2010). This approach derived from a perception that families had been left unsupported by the state through a period of sustained social change. Transformations in contemporary family relationships and, in particular, increases in cohabitation, divorce and separation, lone parenting and people living alone, were viewed as destabilizing family values and identities that undermined the practice of good parenting. New Labour policy thus contains both a commitment to upholding the traditional family and an acknowledgement that the diversity of contemporary family forms demands a more pragmatic approach.

This renewed focus on the family contributed to reorienting the issue of gamete donation and assisted reproduction out of the medical scheme to bring it back to filiation and supportive parenting. In the late 1990s and early 2000s, arguments about the development of technologies and the sustainability of service provision were likely to be traded for arguments about the need to redefine the role of parents in the child's development, and hence, the welfare of the child's principle. Parents are portrayed as in need of education and advice from 'experts', under conditions of social change, therefore aligning with Infertility Counselors' work and Social workers discourse. While its main emphasis is on the protection of children, children and their parents are also required to exercise responsibilities, one of them consisting of contributing to the child's identity building and self-development.

Litigation and consultation

In 2001, after two years of hesitation, the Department of Health launched a public consultation on the information to be provided for donor-conceived people requesting information from the HFEA Register. The consultation document reiterated the Government's view that it was not planning to impose a legal obligation on parents to inform their donor-conceived child of he or she was conceived:

> This paper is not concerned with the question as to whether donor offspring should be told by their family about the means of their conception (which is a matter for the parents themselves to decide) (Department of Health 2001, paragraph 1.10)

The right to privacy for parents was again very clear and simple in the mind of decision-makers. This very right to private conception was about to be challenged by Joanna Rose and another donor-conceived child's litigation.

Joanna Rose and an unidentified donor-conceived minor sought judicial review of the Secretary of State's response to their requests for further information about their donors submitted in June 2001[126]. At the English High Court Queen's Bench Division, their arguments included the assertion that donor anonymity breached their right to private life within the meaning of Article 8 of the European Convention on Human Rights (ECHR)[127]. The claimants also invoked Article 14[128] in conjunction with Article 8, arguing that there should not be discrimination between donor offspring and adoptees or between donor

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[126] *Rose v. Secretary of State for Health and the HFEA* [2002] EWHC 1593

[127] Article 8 of the European Convention on Human Rights states that: 1) Everyone has the right to respect for his private and family life, his home and his correspondence. 2) There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

[128] Article 14 of the European Convention on Human Rights states that: The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.

offspring born before the coming into force of the 1990 Act and those born thereafter.

Justice Baker agreed that Article 8 was engaged, but adjourned further deliberation on whether there had actually been an infringement in order to enable the Government to complete a planned public consultation and review of the arrangements for providing information to donor-conceived people and that Article 8 was engaged both with regard to identifying and non-identifying information. Justice Baker concluded:

> It is to my mind entirely understandable that AID children (sic) should wish to know about their origins and in particular to learn what they can about their biological father or, in the case, of egg donation, their biological mother. The extent to which this matters will vary from individual to individual. In some instances, as in the case of Joanna Rose, the information will be of massive importance. I do not find this at all surprising bearing in mind the lessons that have been learned from adoption. A human being is a human being whatever the circumstances of his conception and an AID child (sic) is entitled to establish a picture of his identity as much as anyone else. (paragraph 47)

The welfare of the child principle which is paramount in the British law on Human Fertilisation and Embryology (section 13) was not formerly considered by the court in its ruling. However, the decision is based on the idea that access to origin is needed for a child to develop in a proper manner. Justice Baker's judgment says nothing nevertheless about whether there had been a breach of Article 8 in this case: it focuses only on the fact that Article 8 is engaged.

Through the language of law, the arguments of the parties involved were modified and structured by the courts. In turn their decision bridged a rights-based frame mobilized by donor-conceived children to a moral frame claiming for the state the responsibility to protect the welfare of children born of assisted reproduction. In Rose, this bridge was visible through the principle of privacy right used to justify the decision of the High Court. In the decision, Justice Baker proposes that the way that right was interpreted in the past is due to values that were redefined through law practices since. In that context, what was seen as preferable in the 1990s – at the time of the adoption of the Human Fertilisation and Embryology Act – is now inadequate to the experience of donor-conceived individuals. In that context, the right-based claim of DCC is bridged through the principle of privacy to a moral frame dictating what should be good governance in today's circumstances.

> Private and family life is a flexible and elastic concept incapable of precise definition. Respect to private and family life can involve positive obligations on the state as well as protecting the individuals against arbitrary interference by a public authority. Respect to private and family life requires that everyone should be able to establish details of their identity as individual human beings. This includes their origins and the opportunity to understand them. It also embraces their physical and social identity and psychological integrity. (para. 45) […] We live in a much more open society than even 20 years ago. Secrecy nowadays has to be justified where previously it did not. (paragraph 47)

In February 2002, the Department of Health published a consultation paper after the first round of consultations in 2001. The paper proposed three main alternatives: non-identifying information on existing donors should be provided on request, more comprehensive non-identifying information should be collected on future donors and made available on request, or identifying information should be collected and provided. The consultation paper did not address the question of whether donor offspring should be told by their families about the means of their conception, which was considered to be a matter for the parents themselves to decide (Department of Health 2001). Of the 237 responses to the public consultation, 132 favored making identifiable information available, 70 were opposed, and 23 were undecided. There was widespread agreement[129] that more non-identifying information about donors should be made available to people conceived as a result of gamete donation.

Following public consultation, the Department of Health sought further information from clinics and donors. Responses were received from 140 donors and 42 clinics. Most clinics were opposed to the removal of anonymity because they were concerned that fewer donors would come forward at a time when there were already not enough. In addition, it was pointed out that removing anonymity would have no effect on secrecy since many parents chose never to tell their children that a donor was involved in the conception. Twelve donor offspring wanted non-identifying information and eleven wanted identifying information. Fifty-eight parents of donor-conceived children advocated for the availability of non-identifying information and 38 the availability of identifying information. Twenty-two of the donors agreed with the provision of non-identifying information but only eight agreed with the provision of identifying information (Lawford-Davies and Forsyth 2004).

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[129] 211 responses out of 237.

In response to the consultation paper, the British Fertility Society (2002) recommended that the regulations allow only for non-identifying information. The BFS claimed that it was not the right time for a radical change aiming at removal of anonymity because the majority of donors and recipients were not ready for this. The Society also suggested a new framework under which donors could choose to be either anonymous or identifiable. Other major professional groups (e.g., Royal College of Obstetricians and Gynaecologists and British Medical Association) were also opposed to the disclosure policy on the grounds that this would have an adverse impact on donor supply.

The changing of the guard

The year 2002 was an important one for donor-conceived children and their advocates. In addition to the decision of the courts in *Rose* and the consultation launched by the Department of Health, a changing of the guard' at the HFEA facilitated an opening to the rights discourse mobilized by the Progar community and their allies. The first change was the nomination of Suzi Leather as chair of the Authority[130]. Between 2002 and 2006, her leadership brought about many contentious debates and "brought the HFEA away for medicine and law" (Interview Legal Scholar Eng-3 – March 15th 2011). Another nomination to the HFEA offered privileged access to the decision-making process to donor-conceived children and their advocates. Walter Merricks[131], founder of the Donor-Conceived Network (DC Network) was appointed by Health Minister Hazel Blears in December 2002.

Progar undertook its campaign in a variety of ways, including running a conference in May 2002 generously funded by the internationally recognized Nuffield Foundation. Invitations were drawn up on the basis of influencing a wide range of professional and political opinions. The conference explored the importance of lifting anonymity from the point of view of donor-conceived people and social parents and from a medical, genetic, legal and social work perspective. Baroness Warnock, with whom Progar had developed a dialogue and who had joined its campaign to lobby for policy change, gave the keynote

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[130] Many observers consider her formation in social work and politics to be the grounds for her interest in Progar's work and for her sensitivity to donor-conceived children's welfare.

[131] Walter Merricks was the father of one of the five families of donor-conceived children that founded the DC Network in 1993. The DC Network is a support group for families and friends of donor-conceived children and for donor-conceived children as well. They created many workshops aimed at supporting families of donor-conceived children throughout the different events in their family live.

address, which ensured high national media coverage. She used this platform to announce publicly that she had changed her mind about donor anonymity and why. She stated her belief that withholding identifying information represented "the denial of a fundamental moral right for every donor conceived person" and that she and the Warnock Committee had not foreseen their acceptance of donor anonymity would lead to parents withholding vital information from their children about the circumstances of conception (Wincott and Crawshaw 2006).

In England, adoption became regarded as a morally and psychologically relevant model for dealing with come children's need to find out information about their origins. Studies of adopted children have found that a child's knowledge of his or her background is crucial to positive and non-confused self-identity. On this basis, it is argued that disclosure is in the best interests of the child. Using the adoption analogy, the Children's Society, Progar and DC Network identified the emotional and psychological needs of children conceived by donor conception and construed the need for identity as a familiar quest with which the public could identify. From 2002 to 2004, a rights-based approach seems to have trumped an evidence-based one[132], assuming, in Melanie Johnson's words, that ' donor-conceived people should not be treated so differently from adopted people'.

Legalizing the children's welfare

Several significant policy initiatives were undertaken by the government following the consultation (Department of Health 2003). Cautiously accepting the case that a donor-conceived individual should be able to learn the identity of her or his donor, the government also acknowledged widely expressed fears, especially from service providers, of the likely negative impact of such a move on donor recruitment.

In January 2003, the government announced at the HFEA Annual Conference that they accepted in principle the need for openness and for the paramountcy of the welfare of the children affected, but also said that they needed more time to arrive at a final decision about the lifting of anonymity and set up an additional six month research period. In the same speech, the Minister of Health provided financial support for the establishment of a voluntary

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[132] Consultation and stakeholders' arguments were pointing rather towards the maintenance of donor anonymity.

register, UK Donor Link (Crawshaw and Marshall 2008), to assist those involved in a donor procedure undertaken prior to 1991 who wereseeking information about their biographical and genetic history. The UK DonorLink was established and launched in April 2004, with Marilyn Crawshaw acting as Adviser and Chair of the Advisory Group in her professional capacity.

The HFEA undertook a review of its own policies and practices with regard to the 1990 Act's 'welfare of the child' requirement under Section 13(5). It adopted a proactive position regarding parental disclosure, advising clinics to "encourage and prepare patients to be open with their children from an early age about the circumstances of their conception" (Human Fertilisation and Embryology Authority 2005a; 2005b). In a parallel development, the HFEA explicitly began to encourage clinics to "respond as fully as possible to patients' requests for non-identifying information about the donor or donors used in their treatment" (Human Fertilisation and Embryology Authority 2004). Both policy developments were later encapsulated in the HFEA's revised Code of Practice. Similarly, the HFEA decided to provide parents of donor-conceived children with details of their children's donor codes.

During the spring of 2004, the HFEA conducted a survey of clinics to develop a detailed understanding of the current demand for, and provision of, treatment using donated gametes or embryos, as well as to identify relevant trends. 5 Sixty-two of the 99 surveyed clinics responded. Findings indicated that many practitioners expected the removal of donor anonymity to have a negative impact on the provision of treatment services with donor gametes.

Starting in May 2004, Parliament underwent the study of the Human Fertilisation and Embryology Authority (Disclosure of Donor Information) Regulations specifying non-identifying donor information to be collected by the HFEA that could be made available to a donor-conceived person seeking information from the Register. It went into effect from 1st April 2005, requiring all new donors to agree to their identity being disclosed to any donor-conceived individual aged at least 18 years requesting this information from the HFEA.

Medical against legal

On 18 May 2004, Melanie Johnson (Labour) opened the debate on the draft of the HFEA (Disclosure of Donor Information) Regulations. She pointed out that the regulations were strongly supported by the Donor Conception Network, the British Association for Adoption and Fostering (BAAF), other children's organizations, and the HFEA itself. Not being in possession of genetic capital was then portrayed as an intolerable deficit for children born of donated gametes by proponents of the regulations. In her opening speech at the House of Lords on June 4th 2004, Baroness Andrews explained the reasons that made this provision seem so necessary. Some of the issues that she raised were: that the secrecy and even stigma surrounding assisted conception had faded; that public attitudes towards information and rights to information had changed dramatically (referring to the Rose case); and that such openness had worked successfully in recent years in relation to adoption.

Interestingly, in the 2004 debates on the removal of donor anonymity, the ways in which egg and sperm donors were discussed differed considerably. The fear that "donor will be deterred by what has been rather dramatically described as the threat of a knock on the door in 18 years' time" (Baroness Andrew June 9th 2004) in the context of the preceding discussion were primarily aimed at sperm donors. However in 2004, it was egg donors who were considered especially vulnerable. Concerned MPs and members of the House of Lords presented the vulnerability of would-be-parents as the major problem created by the regulation. The egg sharing programs and egg donation were increasingly occuring in the practice of clinicians in England and thus questioned in many ways the principles of maternity and women's privileged relationship to the child. The would-be-mothers were seen as more likely to find it difficult to see someone else conceived with her eggs without thinking of herself as related to the child. A debate that was mostly masculine in the 1990s became extensively feminine in 2004, showing how the representation of women's gametes was very different and somehow more "connected" to the child's life than the donor sperm. Outside of this small consideration of women's sensitivity, the debate did not present the would-be-parents position more extensively. The would-be-parents themselves were absent from the debates in 2004 and 2005[133].

Given that the government had discounted their views, the BFS, the BMA and the Royal College of Obstetricians and Gyneacologists (RCOG) used the review of the

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[133] For a discussion of the silent would-be-parents' community in the debate on the children's right to know, see Turkmendag, I., R. Dingwall, et al., 2008, "The Removal of Donor Anonymity in the UK: The Silence of claims by would-be-parents", *International Journal of Law, Policy and the Family,* 22, 3, p.283-310.

HFEAct[134] undertaken by the House of Commons Science and Technology Select Committee during 2004 and 2005 to reinforce their objections[135]. The BFS, for instance, urged reconsideration of the 'double-track' system which would allow a donor to choose to be either anonymous or identifiable and recipients to chose whether to use gametes from either an anonymous or identifiable donor. Dr. Evan Harris (Liberal-Democrat), a MP member of the Committee who was deeply involved in the debates on assisted reproduction and health, suggested the removal of donor anonymity would be disastrous for the system, reinforcing the medical community's view. The latter argued it would be inappropriate to take a risk in relation to gamete supply unless it could be shown there was a clear overriding principle in the law or that there would be a significant benefit that would outweigh such a disbenefit for the provision of services. The medical professional associations all considered that the removal of donor anonymity would adversely affect on donor supply. Another concern was related to parents' unwillingness to inform their children that they were conceived using donated gametes even if the legislation allowed them access to their origins. The culture of secret needed to change well before the law, they argued.

Since lack of information about the donor was cited as a reason for not telling children about their conception, it seems counter-intuitive to suggest that access to the donor's identity could discourage parents from doing so. The government representatives used Susan Golombok's research with families that had used donor conception. Despite her established reputation as a Cambridge University scholar, her studies were criticized for being too anecdotal and based on the experience of a few individuals. The statistical analysis brought to the committee by the BMA on the percentage of families not disclosing the nature of their child's birth was presented as more accurate than Golombok's long-term qualitative study.

In their response to a consultation on the HFE Act in 2005, the British Association for Adoption and Fostering (BAAF) demanded that donor conception should be incuded in a child's birth records. They expressed their dissatisfaction with the new law and advocated for an open donation system. They portrayed donor-conceived children not only as victims of a

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[134] The review of the HFEAct started in parallel with those on the disclosure of information regulations. Different communities had the opportunity to contest and question the new regulation with the aim of changing the government's decision through that venue as well.

[135] Despite having supported the law, the National Gamete Donation Trust – a charity involved in the development of awareness regarding gamete donation - expressed concern about the donor shortage. The patient organization Infertility Network UK (INUK) also drew attention to the declining number of donors, leaving patients with no choice but to go abroad for treatment.

policy which infringed their right to identity, but also as victims of their parents, who violated moral standards by denying this information to them. Not only did BAAF present donor conception as a form of adoption, it also suggested that there was a conflict of interest between parents and children about disclosure. The law should not support parents unwilling to disclose the truth about a child’s birth. Asimilar moral framing is present in Baroness Warnock's discourse: “There can be no moral justification whatever in deceiving a child about the circumstances of his birth. It is a very awkward doctrine to enunciate, considering the number of children born by adulterous relationships. Nevertheless, it is deeply morally wrong to pretend that a child is the son or daughter of a father or mother who is not his or her real biological parent.”(Warnock 2004) In this discourse, concealing a child's biological origins is understood as an immoral act. Such discourse attributes moral aims to the donor conception law and suggests that the government's reluctance to compel disclosure sends a half-hearted message to parents.

The donor anonymity controversy indicates that during the debate that led to the 2004 Regulations, without any significant objection from would-be-parents, the donor anonymity problem came to be owned by advocates of the child's right to know. The final decision suggests that the decision to abolish donor anonymity was strongly influenced by a discourse that asserted donor-conceived children's right to personal identity. The view that donor-conceived children have a right to access identifying information was legitimized by two principal claims: that genealogical knowledge is central to the development of personal identity; and that the position of donor-conceived people should be aligned more closely with that of adopted people with access to identifying information about their biological parents. Nevertheless, the medical community and the patient support group performed counter-claim activities. However, the fact that would-be-parents would be affected by the donor shortage could find little sympathy when weighed against the child's welfare arguments raised by advocates of the child’s right to know.

Stepping back or going further?

Answering the increasing concerns that the 1990 Act had become outdated in the light of changing social attitudes, legislative changes in allied social policy and technological development, lawmakers (Science and Technology Committee 2005) and subsequently the government (Department of Health 2006) undertook a wide-scale review culminating in new legislation, the Human Fertilisation and Embryology Act 2008[136]. The issue of access to genetic origins was raised in many occasions while defining the new statutes. In the preceding period of preparation and evaluation of the act and its attached regulations, many venues of consultation and parliamentary scrutiny committees were at the disposal of the different actors involved in the debate over access to information. Two main questions came to the forefront: first, if the government should back up in order to reverse the gamete shortage induced by the 2004 Regulations, or conversely if the government should go further and register the biological parents of the child on the birth certificate.

Although the Joint Parliamentary Scrutiny Committee on the Human Tissue and Embryos (Draft) Bill[137] believed that it was in the best interests of the child to know of their donor conception, the Committee did not support those who called for a statutory duty on parents to tell their child of his or her biological parentage (paragraph 272). The Government's response to this recommendation was that it is preferable that parents are educated about the benefits of disclosure rather than forcing the issue through the annotation of birth certificates. However, the Government considered this a sensitive area be kept under review: "We believe that the issues need to be considered carefully, including constructive dialogue with stakeholders, and we will keep the matter under review" (paragraph 69 and 70).

Some of the witnesses suggested the draft Bill should be amended to give donor conceived people a legal right to know and the parents the legal duty to tell. It was argued as the state was involved in assisted conception, "the State has a moral duty not to be party to a deliberate deception about a person's genetic history" (Key 2008). Related to the arguments about a legal right to know, the Joint Committee considered whether donor conception should be registered on the birth certificates of donor-conceived people. A donor-conceived person argued a man or woman whose gametes are not used to create a child should be

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[136] This act took effect from 1st October 2009

[137] The Government also announced, in 2004, as part of the Department of Health's review of its arms-length bodies, that the Human Fertilisation and Embryology Authority and the Human Tissue Authority would be replaced by the Regulatory Authority for Tissue and Embryos. It was decided this would be most appropriately achieved by the legislation introduce the proposed changes to the Human Fertilisation and Embryology Act. After a long period of deliberation, the Human Tissue Act was amended to specify that all relevant material except gametes were regulated by the Act, granting accordingly full power over gamete and embryo donation to the HFEA.

referred to not as a parent but as an adoptive parent or a stepparent. The Government's response published in October 2007 rejected the Committee's suggestion of putting 'by donor' on birth certificates of donor offspring, but decided to keep the matter under review. The Government's response to this recommendation was it preferred parents to be educated through counselling about the benefits of disclosure rather than forcing the issue through the annotation of birth certificates. This idea was introduced in the reforms of the Code of practice following the adoption of the regulation in 2004 and later the adoption of the HFEAct of 2008.

After the adoption of the regulation, many detractor of the disclosure of information pressured the HFEA to go back on its decision before the revision of the HFEAct announced for 2007-2008. In 2006, Professor Sir Colin Campbell, founding chair of the HFEA, called for the restoration of anonymity for sperm donors. In his view, the putative interests of a person not yet conceived should not take precedence over the legitimate interests of would-be parents. He was supported by his successor, Baroness Deech, who had been chair of the HFEA between 1994 and 2002. She argued the mobilization for the removal of anonymity asserted a misleading parallel with adoption. Medically, she considered the argument one needs to know one's father in order to address certain health issues is also false because medical predictions can be made just as accurately from one's own body, given technological developments. Advocates of the child's right-to-know joined the debate. Eric Blyth reaffirmed the legal and moral framing of the issue by claiming human rights for donor-conceived children and the duty of the government vis-à-vis donor-conceived children, thereby closing the door to medically-framed arguments.

Conclusion

The way the issue of gamete donation was debated in England is interesting for two main reasons. First, gay and lesbian access to parentage was mostly debated as an issue of access to treatment. This is quite striking when compared to Quebec and Ontario's stories. The debate over the welfare of the child principle and the exclusion of the need for a father from the 2008 Act was accordingly conducted to the adoption of parental orders to establish parentage for lesbian co-mothers and gay co-fathers. It suggests assisted reproductive technologies has always been considered a multifaceted policy domain addressing both medical practices and the social impact of assisted conception.

The second observation is the legalization of the debate over access to genetic origins and the way it surpassed on many occasions the dominant medical view observed in the debate around access to treatments. Despite the mobilization of the medical communities concerning donor anonymity, the work of Progar and their allies progressively changed the common view on genetic identity in the 1990s. The year 2002 became a turning point with the court's decision in the Rose affair and the cascade of events leading to the adoption of the 2004 Regulations and the subsequent reinforcement of the government position in 2008 with the HFEAct. The question of registering the genetic parents of a donor-conceived child's birth certificate was still debated in 2010, but the HFEA and the Department of Health decided to involve BICA in the construction of a Code of Practice for fertility counselors in order for them to help parents in developing a sustainable strategy to tell their child about their conception and to sustain them in their development to adulthood.

After the release of the Rose decision in England, the bridge between the legal and the moral frame performed in many ways against the dominant medical frame mobilized by supporters of donor anonymity. The argument that disclosure of donors' identity would limit the provision of infertility treatments was very important before 2002 and is still mobilized by many public representatives and the medical community. The bridge between the legal and the moral frame consolidated through the *Rose* decision contributed increasing elite attention on the need of children at a time when the redefinition of the welfare of the child principle was discussed in organizations concerned with assisted reproduction. It granted to the disclosure option legal and administrative justification through the rights-based arguments and the call for responsible public action sustained by the court. In that way, the judicial mobilization contributed to bridge two frames that were then able to compete a dominant medical frame in the broader political debate.

Quebec

In 1987, the Conseil du Statut de la Femme (CSFQ) was the first institution to release a formal working paper on the issue of assisted conception. The report, entitled *Mémoire portant sur le droit de connaître leurs origines pour les enfants adoptés ou conçus par au* *moyen d'une technique de procréation assistée*, was released after the CSF undertook the study of the impact of assisted reproductive technologies on women and children in view of the Royal Commission's work at the federal level. The CSF account is one of the very few reports issued by the government of Quebec that addresses the issue of donor-conceived children's (DCC) right to know their biological origins. Despite this early interest in the question, the issue of the right of offspring to know their biological origins was rarely discussed between 1990 and 2010. In general, the issue was raised indirectly when debating parentage rights and responsibilities in the context of assisted conception. When introduced by different political actors, the right of donor-conceived children to know their biological origins was generally framed in medical or legal terms. Today, the rights discourse produced by experts (legal scholars) and parents of children conceived by assisted reproduction is still minimal in the province of Quebec. However, in that period, Quebec defined who would be the parents when a child is conceived with the help of a donor and redefined the family structures recognized as such by the states and public institutions.

The filiation debate and the establishment of parentage rights when children are conceived with the help of a gamete donor were catapulted into the political arena by reform of the Civil Code in the early 1990s and the broader debate on same-sex unions and lesbian and gay rights at the turn of the century. The reform of the Civil Code became a valuable moment for addressing the influence of new technologies on family structures. The medical frame dominated the part of the discussion interested in securing parenting rights and responsibilities after a child was born from assisted conception. At that time, donor insemination was the most practiced procedure. As well, through their fight over equality, the lesbian and gay community's discourse changed slightly to become a broader claim for the recognition of their families discussed through the ideas of sameness, parental project and family building. Lesbian couples, eager to show the "normality" of their households and to argue the importance of protecting their children's welfare by securing legal parentage, introduced this new family-oriented discourse. It challenged the medical frame attached to assisted conception institutionalized in the early 1990s through the Civil Code. Thus, the 2000s were period of abundant debates on assisted conception, on the role of the medical technologies to help create families, and on the legal structures needed to secure the relationship between parents and donor-conceived children.

Civil code reform and medically assisted reproduction

Between 1955 and 1990, the province of Quebec undertook a comprehensive reform of the Civil Code, including changes to the definition of family and filiation to adapt them to the new realities of Quebec's familial and marital relationships. In 1994, when the new Civil Code was first implemented, the document proposed a chapter titled "De la procréation médicalement assistée". In cases of medically assisted conception, the medicalization of reproduction made it easier to trace the intention of parents and their involvement in the planning that inevitably precedes medically assisted conception. When discussed in a parliamentary commission, medical intervention created the possibility to introduce in the Code new principles otherwise excluded from family law, such as intention to parent, arrangement between parties (donors and intended parents) and consent to treatment.

> Ça arrive qu'il y a tout un processus médical qui est en cours et qui fait en sorte qu'avant on a dit: Écoute, oui, est-ce que tu es d'accord que je prenne du sperme qui vient de quelqu'un d'autre, qu'on puisse faire en sorte qu'on ait un enfant ou que je prenne ton sperme et qu'il soit procédé d'une autre façon? Peu importent les techniques modernes, mais il y a un mécanisme médical qui est là et qui fait en sorte qu'il y a, médicalement donc, une décision à prendre et que, par conséquent, il y a une préparation qui s'impose. [...] Ce qui veut dire qu'il y a une responsabilité qui est engagée d'une façon plus évidente que dans le cas d'une procréation normale. [...] Pour nous, ce qui est important dans ce cas-là, c'est: Protégeons l'enfant, protégeons la mère. [...] Le mot qui est utilisé par l'article 536.3, c'est "engage sa responsabilité". Donc, le conjoint dit: Oui, tu vas avoir une grossesse médicalement assistée. Par le fait même, il engage sa responsabilité. (Rémillard 1991)

The debate introduced to the parliamentary arena a notion that would become very important in Quebec law on filiation by assisted reproduction: the parental project. When seeking assistance with conception, unlike natural reproduction, would-be-parents need to plan and organize the realization of their project to become parents. This project involves the would-be-parents' consent to the contribution of an anonymous third party as well as their intention to take responsibility of the child to come. The Civil Code institutionalized the first version of this idea by putting consent at the center of the chapter on filiation by medically assisted conception.

During this period, the ‘genetic forces’ of the third party were considered to come from a sperm donation[138] through which the mother was inseminated. However, members of the commission spoke exclusively about medically-assisted conception, shutting out the possibility of ‘homemade’ inseminations. This wording was justified by the context in which medical insemination was considered to take place. It was easy to establish the legal relationship between the child born as a result of such a process with his/her mother. The Civil Code was modified to extend the presumption of parenthood to the spouse of the mother who was medically inseminated. Legal union, consent to treatment, and donor anonymity were hallmarks of fatherhood in cases of medically assisted conception. In that sense, the legislator needed to exclude donors and establish parentage through other considerations than blood. With medical intervention, it was easy to identify the intended father and create the filiation. Despite the changes, the new version of the Code was still firmly attached to the biparental heterosexual family form.

Article 522 of Quebec’s Civil Code states that all the children have the same rights and duties whatever the circumstances of their birth. When the issue of access to biological information is considered, this statement is not as clear in reality as it is in law. Whilst reforming the Civil Code, the Parliamentary Commission on Institutions considered the donor-conceived children’s rights in a strictly medical sense. Article 542 of the Code established donor anonymity except in special cases, where it permits the disclosure of medical information if the child has a medical condition requiring such information. In this context, they have to ask the tribunal for non-nominative medical documents, which means that the medical history of the donor might be disclosed, but no identifiable information would be available to child or his or her parents. This article expressly links the “right to know” to the idea that children have a right to health rather than a right to know their biological parents. This medical dominance continued to be important in the issue of DCC rights from that moment onwards. Despite the low salience and the spontaneous attention given to the issue of DCC access to their origins, it is interesting to see public arenas seemed more responsive to the issue in Quebec than elsewhere in the country.

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[138] Egg donation was very rare in the early 1990s. The technology to preserve eggs made donation complicated and onerous.

Almost ten years of silence

Common to all Canadian provinces, the almost ten years of silence on the impact of assisted reproductive technologies on filiation and parentage rights was due to the establishment of donor anonymity by the clinics and gamete banking establishments; by the Royal Commission's ignorance of the issue of parentage and biological origins; and finally by the federal government's Assisted Human Reproductive Act (AHRAct) in 2004 which institutionalized anonymity. Donor anonymity and consent to treatment created a legal shield protecting patients against any filiation dispute. In fact, the donor was completely excluded from the parental project and the consent to treatment was proof of the intention of the parents to be dedicated to the child/children beyond pregnancy. The medical frame dominated the practice, and regulation of sperm, eggs and embryo donation produced a sense of structure and helped maintain the practices and secure them through the federal AHRAct.

Anonymity was a way to secure sperm provision while prohibiting retribution for donors. Otherwise, the federal government had no authority over family law, which is a provincial prerogative. Indeed, the separation of issues of health and parentage and the prevalence of anonymity not only in law but also in practice rendered any debate difficult and somewhat unnecessary for many users of assisted reproductive technologies. In fact, the provinces already had procedures to establish filiation. To seek assistance with conception did not change most of the couples' legal efforts to become parents. For heterosexual couples that were physically infertile, the exclusion of the donor from the parental project and the presumption of paternity contributed to normalization[139] of the establishment of parentage. Things were different for same-sex couples who came to publicly discuss the difficulties they experienced in attempting to protect not only their partner's rights and responsibility for them, but also for their child/children.

Again, the medical frame which was mobilized prevented the question of homoparentality from being raised and potentially created political turmoil. When Quebec's legislature decided to open up the question of same-sex unions, it was not surprising to see the issue of family-building emerge. The PQ government was sensitive to the situation of families in the province at that particular period. The exclusion of children from full legal

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[139] Parentage was established the same way any other couple who conceived naturally would, i.e. through the declaration of the child's birth and its brith certificate.

security was considered as important as the inequalities same-sex partners faced. In 2002, when the legislature decided to recognize same-sex couples, they opened the doors of the National Assembly to questions of parentage and to issues of assisted reproduction.

Lesbian and gay rights, families and medical assistance

After a decade of political struggle constructed around discourses of equality and rights, Quebec's lesbian and gay community achieved sustained political pressure[140] to the extent that the government decided in 2002 to create the institution of civil union to offer equality to same-sex couples[141]. In February, the Parliamentary Commission on Institution met for the first time to gather opinions and information that would help them draft a first bill. That Bill was intended to create a provincial institution meant to provide the same marital rights and responsibilities to same-sex and opposite-sex couples. During the hearings, many talked not only about inequalities for same-sex couples, but more importantly for lesbian-led and co-parented families.

> Nous savons que le ministre de la Justice, en présentant son avant-projet de loi sur l'union civile, n'a pas eu l'intention d'élaborer de nouvelles règles sur la filiation ou de favoriser un débat de société sur l'homoparentalité. [...] même si toutes ces hypothèses deviennent effectives, les règles de filiation n'auront pas pour autant subi un rajeunissement complet exempt d'hétérosexisme et de discrimination. Pour ce faire, il faudra procéder à un réaménagement des règles de filiation biologique ou d'adoption, il faudra repenser les règles qui sous-tendent des notions comme la présomption de paternité du mari de la mère biologique, la contribution au projet parental ou les règles d'adoption. (Coalition québécoise pour la reconnaissance des conjoints et conjointes de même sexe 2002)

The issue of same-sex marriage at the federal level and most of the provincial litigation between 1995 and 2005 was dominated by images of gay male couples. Among others, in Quebec, there was extensive coverage of the long-term relationship of Michael Hendricks

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[140] For a broader discussion on the gay and lesbian movement and its political action in Quebec and Canada, see among others, Smith, M., 2008, *Political Institutions and Lesbian and Gay Rights in the United States and Canada*, New York, Routledge, 244 pages. ; Larocque, S., 2005, *Mariage gai: Les coulisses d'une révolution sociale*, Québec, Flammarion, pages. ; Rayside, D., 2000, "Lesbian and gay rights in Canada: Social movements and equality-seeking, 1971-1995", *Canadian Public Administration-Administration Publique Du Canada,* 43, 1, p.120-121. ; Smith, M., 2005, "Social movements and judicial empowerment: Courts, public policy, and lesbian and gay organizing in Canada", *Politics & Society,* 33, 2, p.327-353.

[141] Marriage being a prerogative of the federal government, the claims for and againt same-sex marriage were, in general, aimed at the federal government. However, the provinces had a very important role to play in the incremental establishment of equality rights between 1995 and 2005. See op. cit.

and René Leboeuf (Larocque 2005). The aim was to show how same-sex couples were as dedicated and "normal" as opposite-sex couples. During the hearings for Bill 84, likewise, lesbian couples intended to catch the attention of the representatives in charge of the commission. They viewed this governmental debate as a political opportunity to introduce the issue of parentage through Parliament instead of courts[142], an issue that was as important to them as the recognition of their unions.

In 1998, Mona Greenbaum and Nicole Paquette founded the Association des mères lesbiennes du Québec (AMLQ). With the birth of their son, the couple discovered that no non-biological lesbian or gay parents in Quebec had ever asked to become legally recognized. Mona and Nicole thus began a legal battle that spanned years and involved four lawyers, three courts, three expert witnesses and the Government of Quebec. In parallel with their litigation process, in October 1999, Nicole, Mona and other members of the AML organized the first meeting of their political action committee. The four priorities of the committee were: parental rights, access to parenting (fertility clinics and adoption agencies), marriage between same-sex couples and the fight against homophobia in schools. In January 2001, the AML joined the Coalition québécoise pour la reconnaissance des conjoints et conjointes de même sexe who coordinated the battle in Quebec for the rights of same-sex couples and families.

Members of the AML submitted eleven briefs to the Parliamentary Commission on Institutions in order for the Commission which studied Bill 84, an Act instituting civil unions and establishing new rules of filiation. Their aim was to open the Bill to issues of parentage argued to be intrinsically related to civil union.

> Et, de plus, je pense que, si ce projet de loi n'est pas bonifié, il risque de décevoir profondément les aspirations légitimes de nombreux couples de même sexe et de nombreuses familles homoparentales qui attendent de lui la réalisation des objectifs d'égalité promus par les chartes québécoise et canadienne. (Coalition québécoise pour la reconnaissance des conjoints et conjointes de même sexe 2002)

The equality discourse was powerful at that period, even more so when considered in the context of the Canadian Charter of rights and freedoms. However, tension existed between individual rights and family-building incentives in the province of Quebec. The government

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[142] The judicialization of same-sex unions' recognition has been extensively studied in Canada. See the seminal work of Miriam Smith on the question. Op. cit.

was determined to invest in family-oriented policies and thus more keen to protect families than individual rights. The lesbian and gay community used this particularly favorable political context to reorganize their discourse around their experience as parents in claiming equal access to institutions[143]. Accordingly, transforming their discourse meant framing their claims in experienced-based terms, meaning that lesbian mothers narrated their stories before the commission, as male couples did in the media in the previous years.

> Motherhood is viewed as natural and the desire to become a parent for a woman is considered normal or even inevitable. We agree, in our society, women that don't want children are questioned much more on their life choices than women who desire to become mothers. […] So, when we talked about our families, we made sure to let people know about our day-to-day normal life and it was easy to make them relate to our lives … make connections between their experience as parents and ours. It is the same after all. We take kids to school, cook dinner, help with homework, etc. (Interview Mona Greenbaum – October 13th 2008)

"Je pense que nous, comme lesbiennes, nous sommes dans la même situation que les couples hétérosexuels qui utilisent les banques de sperme." (Paquette 2002) Without being expressed in these words, the discourse of sameness merged the concept of social and medical infertility together. The desire to form a family became a common ground for infertile heterosexual couples and same-sex couples. Sameness was expressed through experiences of life, family dynamics, and parental responsibilities. The experience-based discourses lesbians mobilized drew attention to the various effects of inequalities and the importance of social recognition for children raised in homoparental and monoparental settings.

> […] le souci de la famille et des enfants, ce n'est pas quelque chose qui est nouveau. […] Et ce n'est pas parce qu'on est d'une orientation sexuelle différente qu'on est des humains si différents que ça dans le fond. On partage les mêmes inquiétudes, les mêmes aspirations, on a les mêmes rêves, on achète aussi des 6/49 comme tout le monde, on a aussi les mêmes préoccupations concernant

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[143] The discourse of LGBT community in the 1990s and 2000s mobilized ideas such as the "creation of second-class citizens" and "equal access to institutions". For a comprehensive discussion, see among others, Smith, M., 2008, *Political Institutions and Lesbian and Gay Rights in the United States and Canada*, New York, Routledge, 244 pages.; Smith, M., 2007, "Framing Same-sex Marriage in Canada and the United States: Goodridge, Halpern and The National Boundaries of Political Discourse", *Social and Legal Studies,* 16, 1, p.5-26.; Goldberg-Hiller, J., 2002, *The Limits to Union: Same-Sex Marriage and the Politics of Civil Rights*, University of Michigan Press, pages, Brandzel, A. L., 2005, "Queering Citizenship? Same-Sex Marriage and the State", *GLQ: A Journal of Lesbian and Gay Studies,* 11, 2, p.171-204, Smith, M., 2005, "The politics of same-sex marriage in Canada and the United States", *Ps-Political Science & Politics,* 38, 2, p.225-228, Hull, K. E., 2006, *Same-sex Marriage: The Cultural Politics of Love and Law*, New-York, Cambridge University Press, pages.

> l'éducation de nos enfants et la fin de la discrimination sous toutes ses formes. (Coalition Gay et Lesbienne du Québec 2002)

The Commission reacted positively to the introduction of new filiation dispositions in the Law and introduced a larger bill in April 2002. The testimonies of many lesbian partners, lesbians and gay interests groups and children of homosexual parents had a lot to do with the direction the government took between February and April (mentionned by Lamquin-Éthier 2002[144] and mentioned as an important factor in the decision in an interview with Scholar Qc-2 – June 26th 2011).

> On a on a recueillis des témoignages de familles homoparentales ou d'enfants qui ont des parents gais. […] Le but ce n'était pas de mettre la larme à l'œil des députés, c'était davantage de leur faire voir l'impact des discriminations sur les couples et sur leurs familles; parents, frères, sœurs et enfants inclus. Finalement, c'était de faire comprendre à ceux qui voulaient reconnaître les couples gais que pour les hétéros le mariage c'était pas juste une affaire de couple et donc que pour les couples de même sexe non plus. Le mariage c'est aussi la base de la famille et les couples de même sexe ne sont pas différents des autres, ils veulent aussi des enfants. (Interview Mona Greenbaum – November 11th 2010)

For instance, in February 6th 2002, three young adults, two sisters and one brother, talked to the Commission about their own experience as children of a parent that came out after she had been married to an opposite-sex partner for many years. In addition, lesbian mothers' testimonies revealed the situation of many lesbian couples that relied on a "vieil ami" to get pregnant. That reflected on the position of many Commission members in the process that followed. After the preliminary work session, the Parliamentary Commission on Institutions talked about the importance of homemade insemination in the practice of assisted conception by lesbian couples, and indeed had to discuss filiation in clinical and home settings as well. Testimonies talked much about the "vieil ami" or the known donor who provided sperm for many couples who wanted to have children without going through the anonymous process of sperm banking and self-insemination.

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[144] Michèle Lamquin-Éthier, Parti Libéral : « *On a eu des témoignages où des gens sont venus nous dire, des lesbiennes, à quel point il était important pour elles, et je pense que vous pouvez en convenir également, de s'unir et de former, d'entretenir un projet de parentalité. C'est donc une rencontre de deux volontés qui a un seul objectif, avoir des enfants. Et ce projet-là, ce qu'il veut, c'est de donner de l'amour aux enfants. Il y a des enfants qui sont venus nous dire qu'ils aimaient leurs parents et il y a aussi des parents qui sont venus nous confirmer l'amour qu'ils avaient pour leurs enfants, et c'était extrêmement important qu'on en tienne compte, et c'est ces préoccupations-là que nous avions plus particulièrement quand nous avons abordé les règles de la filiation.* »

The Barreau du Québec was worried about the inclusiveness of the Law as well as the uncertainty of fundamental legal principles such as “procréation assistée”, “techniques” or “parental projet”. The distinction between having a child through medical procedures or homemade insemination was important to establish for the Barreau. It meant that the medical mediation, considered until now as the oversight of third-party reproduction, was not a necessary condition to establish filiation. In that context, the rules needed to be clearly stated:

> Donc, la procréation assistée, ça change pas mal, parce que, comme je l’ai dit tantôt, à l’heure actuelle, si, moi, je décide de fonder un projet d’union avec un autre femme et que je veux avoir un enfant puis que par ailleurs j’ai des relations sexuelles avec un de mes bons amis qui, lui, m’aime bien, mais, moi, je ne lui parle pas de mon projet, bien, normalement, en droit actuel, là, le mâle, si je peux dire, peut déclarer sa paternité dans l’acte de l’état civil. Mais, avec le projet de loi [84], il y a une présomption qui est créée en faveur de ma conjointe. Alors, ça nie à mon homme masculin, à mon géniteur, le droit de concrétiser sa volonté, lui, d’être père, puis ça, ça fonctionne[…] (Barreau du Québec 2002)

Therefore, the exclusion of donors and fathers from parental projects as well as the possibility of opening the law to multiparentality were broadly discussed. At the Commission, the different communities tried to reshape their discourse; the government and the gay and lesbian community tried to limit the types of families the law would recognize; the opposition leaders (backed by the Barreau du Québec) attempted to restrict the establishment of filiation to cases involving medical assistance only; the legal experts tried to make sense of family and couples’ experiences.

The exclusion of donors/biological fathers from the construction of filiation in the law was even visible in the exclusion of the possibility of two gay fathers to be recognized in law. In fact, the law extended the presumption of parenthood to the co-mother, but to be able to create the same link for same-sex male partners, the legislature would have had to open dispositions on surrogate motherhood and gestational carriage contracts. The goal of the gay and lesbian community was indeed to limit the definition of family to a biparental unit and to center their narratives on parentage. The community was aware surrogacy was a sensitive question and that multiparentality was too far a stretch to be included in the Bill. In that context, the lesbian and gay community limited the scope of their claims and centered their arguments around the protection of their families.

> C'est un point que je voudrais rendre très clair, c'est que, ni COSUM [Centre d'orientation sexuelle de l'Université McGill] ni même la Coalition pour les conjoints de même sexe, avec qui j'ai discuté tantôt, ne demandent la triparentalité et personne ne cautionne l'utilisation des mères porteuses. Donc, ça, c'est un point que je voulais préciser. Le projet de loi n'autorise pas l'insémination artificielle ou la procréation assistée, elle est déjà permise et les enfants existent déjà. Donc, le projet de loi est simplement là pour encadrer et protéger les enfants qui naissent. (Igartua 2002)

In addition, the reference to medically assisted conception was a problem for many lesbian activists because of the difficulty many same-sex couples had accessing fertility clinics (see chapter 4). On May 21st 2002, the Justice minister proposed amendments to clarify the first version of the Bill, which made a distinction between medically and non-medically assisted conception. The question of the necessity of medical intervention to create filiation came back rapidly after the article's introduction. The minister closed that door firmly when he stated that assisted conception, excluding sexual intercourse, medically induced or homemade were all considered "techniques".

Paradoxically, the exclusion of the medical frame became primary in the acquisition of full legal rights for lesbian mothers. Louise Vandelac, who sat on the federal Royal Commission, testified at Quebec's parliamentary commission and resurrected the issue of parentage rights in assisted conception and technology:

> En fait, on assiste là à un glissement qui s'est opéré au fil des années. L'insémination artificielle, je l'ai dit un peu plus tôt, dans sa forme élémentaire n'a rien de médical. Là où entre la médecine, c'est progressivement dans tous ces atours, je dirais, c'est-à-dire dans le travail diagnostic des problèmes de fertilité, dans un travail de stimulation ovarienne parfois qui accompagne l'insémination artificielle, etc. Mais, dans le cas qui nous préoccupe, le recours à ces technologies-là, ce n'est pas d'abord et avant tout pour des problèmes de santé. C'est d'abord et avant tout parce qu'on ne veut pas ou on n'a pas de partenaire. Il s'agit d'une pratique essentiellement sociale. Il s'agit d'autre chose. Et il s'agit de considérer qu'il y a un droit absolu de chaque individu à l'enfant. Jusqu'à présent, avoir un enfant, c'était une potentialité, une potentialité d'un homme et d'une femme et qui était relative à l'histoire de vie personnelle ou trajectoire socioprofessionnelle, à la culture d'un pays, etc. Là, on est en train d'en faire un droit absolu. Je pense que, socialement, ça risque de nous entraîner vers de drôles d'histoires. (Vandelac 2002)

The only way to recognize many, if not the majority, of homoparental units in the province was to include all types of assistance in the debate and therefore in the law. Indeed, for the lesbian and gay community, the sameness discourse that opened the issue of same-sex unions to parentage was not performative on its own. They had to get as far as possible from the debate of infertility and technology in order to fully recognize the types of family they were already building before the law. Framing infertility in medical terms was a step away from their goal.

As a result, the parental project definition became more and more discussed in experience-based terms. The discourse about panned parenthood, parents' intentions and consent to ensure the welfare of the child brought a consistency to the debate and a sense of consensus that drove the second half of the parliamentary work. In that context, space was made to introduce the paramount principle of the interest of the child.

> Et là la manière dont la partenaire ou une des deux membres est devenue enceinte, à mon sens, n'est pas pertinente pour la protection de cet enfant là [...] n'est pas pertinente. Et, maintenant, si vous dites que vous voulez commencer les distinctions entre médicalement, techniquement assistée, et vous excluez l'autre, vous avez difficulté de prévue [...] (Gautrin 2002)

The interests of the child became a common ground to discuss equality rights, exclude medical predicaments, and make sure most of the stakeholders' comments were taken into account, including those of legal experts. In other words, the lesbian and gay community discourses needed to bridge the legal frame (equality) to the experience-based fame (sameness) to become performative. Indeed, equality for families, especially families like any other, was a consensual way to define the issue at stake. When the gay and lesbian community started to argue their case by disputing that the equal recognition of their families was a substantiation of the protection of their children's interests, their discourse acquired both resonance and robustness.

> On ne peut pas avoir deux poids, deux mesures quand il s'agit des enfants. Ils doivent avoir les mêmes protections de la loi, les mêmes droits que les parents de sexe différent. La filiation doit être établie afin de faire disparaître la moindre distinction entre parents naturels, parents biologiques, adoptifs, qu'ils soient de même sexe ou de sexe différent, car, si on ne fait pas cette distinction-là, si on n'abolit pas ces différences-là au niveau des enfants, on va créer une forme de discrimination dérivée qui ne sera plus vécue par nous mais qui va être vécue par les enfants. Alors, on a cette responsabilité de mettre en place un système qui va être juste et ne jamais perdre de vue le vécu des enfants dans le quotidien: Comment est-ce que, eux autres, ils vont vivre ça? Quelles vont être les questions auxquelles ils vont avoir à répondre? Si on se met dans la peau des enfants, quelque soit la composition de leur famille, ça va être relativement facile de

> corriger ces oublis, entre guillemets. De même qu'un enfant qui est né par procréation assistée d'un couple de femmes doit bénéficier aussi des mêmes avantages. (Coalition Gay et Lesbienne du Québec 2002)

Testimonies of psychologists allayed fears regarding the welfare of children in homoparental families. In fact, they showed that the children thrived in these settings, psychologically and emotionally. In a way, what stood out from these testimonies was that it was not the parental setting in which a child was raised that created a barrier to its welfare, but the lack of recognition for the parents' relationship and thus the family itself. Equality was consequently considered as the ticket to children's full protection from discriminations and social taboos.

> Il ne fait aucun doute que pour le bien-être psychologique de nos couples et de nos enfants surtout, l'accès au mariage s'imposait. Le mariage ne donne pas seulement un statut légal mais aussi une reconnaissance sociale qui auront un impact psychologique sur nos familles. (Interview Mona Greenbaum – November 11th 2010)

The Law was adopted on June 7th 2002. The three parties congratulated themselves extensively for their work and their openness to gender diversity when commenting on the adoption of the law. Even if consensus had been reached, the new parentage rules in the Civil Code were criticized by many legal scholars and sociologists for their lack of clarity and their hurried study and resolution of the issue (among them Tahon 2004; Roy 2005). As for Mona Greenbaum and Nicole Paquette's family, the courts finally heard the adoption case they had started months before the beginning of the parliamentary work in September 2002. In line with the new legislation, they were able to establish filiation between the two of them and their sons[145].

The inevitable detour to the right to know

At the Commission, the right of donor-conceived children to know their biological origins was mentioned by different political actors. The issue was raised when the commission mentioned the interests of the child in the context of homoparental families. For some interveners, the interests of the child stemmed from their knowledge of their biological origins. The moral frame, otherwise marginal in the debate, did take the lead in broadening the debate on parentage to include questions of disclosure of information and governmental

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[145] *Re G.L. 2002 Canlii 35969 (Qc.C.Q.)* and *Re G.S. 2002 Canlii 40402 (Qc.Q.C.)*

responsibility in promoting good parentage. Interestingly, a representative of the Assemblée des évêques du Québec and a social science scholar interested in assisted reproduction and its influence on society and women were the ones bringing moral considerations into the debate.

> Parler du droit à l'enfant, c'est inverser l'ordre des choses, c'est instrumentaliser un être humain, c'est le réduire à l'état d'objet et en faire le moyen de sa propre réalisation personnelle, de son propre épanouissement, ce qui est contraire aux bases mêmes de l'éthique. Or, on semble s'engager sur cette pente dès lors qu'on accorde une importance toute particulière à la procréation assistée et qu'on en fait une option purement personnelle. A-t-on suffisamment pesé tout ce que cela soulève pour l'enfant qui a le droit de connaître ses origines, c'est-à-dire ses père et mère, de qui il détient son patrimoine génétique? A-t-on suffisamment pesé tous les problèmes que cela pose en termes de filiation? Ici aussi, il y a matière à profonde interrogation sur les valeurs que l'État veut promouvoir. (St-Gelais 2002)

For Louise Vandelac, however, the question was linked to the lack of debate on the children's right to know rather than to the morality of whether there was a duty to disclose information. She considered it irresponsible for the government to establish parentage rights without considering the context in which children were conceived.

> Je pense que, fondamentalement, en autorisant la possibilité par exemple que les enfants puissent être privés de la connaissance de leurs origines, puissent [...] fai[re] prévaloir le droit d'adultes et d'individus sur la possibilité pour des enfants d'avoir deux parents et d'avoir éventuellement un père et une mère. On fait éclater les représentations de la parentalité (Vandelac 2002)

In view of that new direction, the gay and lesbian community worked again to limit the debate to same-sex partners and homoparental family recognition. Interventions of legal scholars and lesbian partners recognized the realities from which the issue was raised, but considered the overlapping nature of that debate with medical practice, assisted reproductive technologies and adoption as suitable reason for a separate debate.

> […] je crois que la question du débat sur les origines, donc le principe d'anonymat des donneurs, lorsqu'il est question de procréation médicalement assistée ou si on parle de confidentialité des dossiers, ce qui est le cas ici, ce qui est la règle avec l'adoption plénière, c'est un débat qui est intéressant, auquel il va peut-être falloir s'attarder, mais je crois que ça dépasse largement le cadre de cette consultation et de ce projet de loi. […] ça ne concerne vraiment pas spécifiquement les parents homosexuels ou ce projet de loi en particulier. […] (Bureau 2002)

It was important for the gay and lesbian community not to close the door on issues of co-parentality and access to known donor sperm. But again, the issue was framed in such a way as to situate gay parentality in the broader debate produced by the multiplicity of family arrangements due to divorces and adoption, among other things.

> Ça, c'est tous des concepts sur lesquels il va certainement falloir se pencher dans l'avenir. Mais je pense que, là, on déborde un peu du sujet d'intérêt. Nous, ce qu'on demande, ce n'est pas de modifier les choses. […] on demande d'avoir les mêmes droits et devoirs et on demande que nos enfants aient les mêmes droits et devoirs et aient les mêmes parents et les mêmes reconnaissances parentales que tous les autres enfants au Québec. Je pense que, avant de demander de changer toute la notion de famille, on aimerait être inclus dans une famille nucléaire normale, avec deux parents, si on peut appeler ça normal. (Paquette 2002)

The gay and lesbian community did not ask for as much recognition from the state as Bill 84 granted them; the right to adopt their partner's child would have been enough for most of the mobilized actors (Interview Scholar Qc-1 – June 8th 2012). That is in part why they worked to limit the scope of the debate in order to make sure the Bill would be adopted, knowing the question could have been larger than the simple question of same-sex couples and families. However, what we can draw from this episode is the inevitable detour to the DCC's right to know their origins interveners made when discussing issues of assisted conception. The issue of donation not only question the legal relationship between children and their intended parent, but also what place the law creates for donors. In Quebec, the Civil code and the law on Civil union and filiation by assisted reproduction excludes the donor and thus, limit the possible options for donor-conceived children to access information about or meet their donors.

Testing the law

Two court decisions have addressed the legal status of known donors to lesbian women despite the fact that Quebec's legislation directly includes same-sex couples within its legal parentage parameters. First, in 2004, the decision in L.C. v. S.G.[146] is one of the first court cases that treated the issue of filiation of a child born as a result of collaboration between a sperm donor and a lesbian couple. It revealed the vagueness of Quebec's new

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[146] *L.C. v. S.G.* [2004] J.Q. 7060 (C.A.)

legislation on filiation by assisted procreation when the complete exclusion of the donor is hard to execute. The child in question registered on the birth certificate as having two mothers: the woman who gave birth and her partner to whom she was married. However, the biological father who wanted the birth registration to reveal his paternity disputed the birth certificate as it stood. The court had to untangle the arrangement before insemination: was the biological father only a "sperm donor" external to the parental project, or had he contributed to the project intending to become a "father"? While the proof regarding the parental project was questioned, the Court granted temporary access to the sperm donor, taking into account in particular the regular contacts of him and his family with the child since its birth. In these circumstances, it was impossible to totally exclude the donor from the child's life, given that he had attended almost all the preliminary medical appointments at the fertility clinic. His desire to be involved and his intention to fill the conditions of access weighed a great deal in the judgment. The court stated that the interest of the child was paramount and accordingly established access - but not parental authority - to the father in spite of granting him full parental authority.

The second case addressing paternity and sperm donation was L.O. v. S.J.[147], which led to a different outcome. Given the clarity of the factual evidence, the court had little choice but to follow the clear instruction of the filiation provisions in the Civil Code. The parties had a donor agreement that specified that the donor would renounce all rights he had to be a legal parent. The court relied on the agreement as written confirmation of the intention of the parties with regard to the parental project. Furthermore, the women already had two children conceived using the sperm of a different donor. This supported the argument that the sperm donors did not intend to be part of the family. Considering the donor did not prove he took part in the parental project, the filiation was established between the two mothers and the child.

The two court cases reinforced the predominance of the interest of the child and the idea of the parental project. In that sense, the legal frame mobilized in the parliamentary arena stayed bridged to the experience-based frame articulated through the day-to-day stories of these families. However, this time, instead of mobilizing equality and sameness, the would-be-parents mobilized intention and agreement. In the decisions of the court, the

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[147] *L.O. v. S.J.* [2006], J.Q. 450 (C.A)

interest of the child was linked to the intention of parents in fulfilling their duty after the child's birth and the foregoing agreement they approved.

<u>The need for a broader debate</u>

The same issue came back not long after the adoption of Bill 84. In 2006, when the Commission on Social Affairs studied Bill 89 (see chapter 4), different interveners asked for a broader debate on assisted reproduction and the impact of access to technology on families and children. A confrontation between legal scholar Edith Deleury and Health Minister Philippe Couillard showed the competition between the legal frame (right of donor-conceived children to access information about biological origins) mobilized by experts in the field of assisted reproduction and the medical frame mobilized by the government (access to health information when needed).

> Que dire enfin de l'instrumentalisation de l'enfant, un enfant qui en principe devrait être accueilli en tant que tel, en tant que personne à part entière et à qui pourtant on continue à nier le droit à connaître ses origines? Sur ce plan, on peut se poser la question à savoir si, dans le cadre de la foulée de l'adoption du projet de loi, on ne devrait pas s'interroger sur les dispositions du Code civil qui effectivement, contrairement d'ailleurs à ce qui existe en matière d'adoption, ne permettent pas à un enfant qui est issu de ces méthodes de procréation de pouvoir connaître ses origines. On pourrait adopter le même principe que celui que nous avons actuellement en matière d'adoption, de manière effectivement à trouver un équilibre entre la protection à la vie privée des donneurs et le droit de l'enfant à connaître ses origines, et cela permettrait également de faire en sorte que la discrimination que l'on connaît actuellement disparaisse, puisqu'on discrimine, contrairement à ce qui est affirmé dans le Code civil, en fonction de la naissance, alors qu'en principe les enfants, quelles que soient les origines de leur naissance, ont les mêmes droits et les mêmes obligations. (Deleury 2006)

> La question de la filiation, là, et de l'information, ça m'apparaît un peu glissant comme sujet, de permettre aux gens de retrouver leurs origines. Quand c'est des donneurs de gamète, là, ça m'apparaît un peu ténu comme lien. Cependant, il y a déjà un article dans le Code civil qui permet que le juge détermine, là, la cour détermine des moments ou des raisons pour lesquelles, sur la base de raisons sérieuses, on pourrait divulguer cette identité, raison pour laquelle les identités des donneurs sont préservées, comme vous le savez. Ça me semble suffisant comme... Il me semble qu'il y a un gros degré de perturbation sociale, là, le fait d'ouvrir cette connaissance de façon non encadrée. (Couillard 2006)

What Professor Deleury made clear in her statement was inequalities existed between adopted children and donor-conceived children with regard to their right to access information about their biological parents. She warned the Minister on the likelihood of the same kind of dynamics observed with the adopted children seeking information about their biological parents.

> À mon sens, c'est bien plus en les fermant totalement qu'on risque d'être confrontés à ces problèmes. On peut penser au phénomène qu'on a connu avec le Mouvement Retrouvailles il y a plusieurs années, au Québec, et qui ont amené aussi à modifier le Code civil en matière d'adoption. Et, à partir du principe où on cherche un équilibre, hein, c'est-à-dire que les informations qui permettraient de retracer le donneur ne seraient évidemment révélées que du consentement du donneur, comme on le fait en matière d'adoption ? et j'aimerais peut-être attirer votre attention sur le fait que des pays en fait qui au départ avaient adopté, eux aussi, une attitude plutôt restrictive se posent la question à savoir si effectivement ils ne vont pas devenir plus ouverts. Je pense notamment à la Grande-Bretagne, actuellement, qui s'interroge sur la question. Il y a des pays qui l'ont fait. Ça permettrait aussi peut-être de responsabiliser davantage les donneurs, bon, puisqu'il faut admettre malgré tout que ça résulte d'un geste un peu machinal et qu'il n'est pas toujours envisagé dans ses conséquences, vous l'admettrez avec moi, M. le ministre, quand on sait dans quelle couche de la société, aussi, on les recrute. (Deleury 2006)

However, it was difficult to recognize the contribution of a donor who was excluded from family building in practice as well as in law. From a medical perspective, donation was seen as something completely lacking in emotion and thus, it should be excluded from consideration in a parental project. The only reason biological information was necessary, according to the Minister, was when a child needed it for medical purposes, which was already sanctioned by the Civil Code.

> Ça me paraît une déconnexion totale sur le plan émotif, et de vouloir la réanimer ultérieurement, ça me semble très artificiel, à moins qu'il y ait des raisons de santé ou des raisons majeures, là, qu'on puisse mettre en évidence, ce qui est déjà permis dans le Code civil. Quel intérêt y a-t-il de connaître qui est allé faire un don de sperme, en pensant à autre chose, il y a 20 ans?(Couillard 2006)

In fact, what Professor Deleury was trying to make clear was that donor-conceived children were about to attain adulthood and thus experience an identity crisis that could lead to further political mobilization. Despite her expertise, the medical considerations prevailed. But this discussion’s effect was to increase the attention of the Minister on issues of donation and on the probable ethical implications of different practices. Medical self-regulation was already in the mind of the Minister and he was determined to change the practice of assisted reproduction. For that, he needed to know more about issues of donation and the social impact of medical practices.

The Commission de l'éthique de la science et de la technologie and the issue of donation

In the fall of 2007, the Minister of Health and Social Services of Quebec mandated the Commission de l'éthique de la science et de la technologie to undertake a thorough analysis of the ethical issues brought about by assisted reproduction and the underlying values of society. Édith Deleury had been president of the Commission since 2003. After consultations with the public and experts, the Commission made 19 recommendations in regard to gamete donation, surrogacy and preimplantation genetic diagnosis.

The Commission questioned the prevalence of donor anonymity and the civil code exception in cases of medical information. It concluded that anonymity gave priority to respect for the privacy of donors and to secrecy surrounding the circumstances of the child's birth, and thus deprived the child of the option of gaining access to his or her origins. The issue of the difficult construction of identity, the wellbeing of children and the importance of the sense of belonging to a family were discussed by interveners at the commission and were reflected in its report.

The Commission recognized that in some cases, because of the family and cultural context in which the child was developing, disclosure was not always in the child's best interest. It considered nonetheless that fertility clinics should routinely offer their clients a form of counselling to help them make an informed decision about the appropriateness of informing the child about the circumstances surrounding his or her birth. In this regard, counsellors were supposed to clearly highlight the potential effects of secrecy on the child and on the whole family to would-be-parents. The Commission believed in the importance, on the one hand, of ensuring that a balance was achieved between the interests involved and, on the other, of giving precedence to the wellbeing of the child, while avoiding the creation of disparities between adopted children and those resulting from assisted conception. Hence, the Commission recommended that the Government solve the legal inequality between adopted children and donor-conceived children in regard to their access to biological information

> Que le gouvernement du Québec amende le Code civil du Québec pour résoudre l'inégalité de droit entre les enfants adoptés et les enfants issus de dons quant à l'accès à leurs origines en appliquant les mêmes pratiques qu'en matière

> d’adoption ; qu’un counseling approprié s’inscrivant dans un cadre normatif qui ne relève plus de l’autorégulation soit offert de façon systématique. Un tel counseling devrait s’adresser tant aux donneurs de gamètes qu’aux personnes qui feront appel à un don de gamètes ou d’embryons afin de les sensibiliser à l’importance pour l’enfant de connaître ses origines et aux répercussions de la levée de l’anonymat.(Quebec 2009a)

A thin but thickening link between adopted and donor-conceived children

Kathleen Weil, Minister of Justice, tabled the Draft Bill for the Act to amend the Civil Code and other legislative provisions as regards adoption and parental authority in October 2009. The government’s aim was “to adapt the law to match the new social and family situations in which adoption takes place, in order to provide a better response to the current needs of children in Québec.” (explanatory notes of Quebec 2009b) The draft bill was meant to be a response to the vast movement “retrouvailles” in the province seeking to access information about biological parents of adopted children. The Commission on Institutions launched a general consultation and public meetings in January and February 2010 in order to present a public bill on the matter representing the needs of adopted people. As predicted by Édith Deleury a few years earlier, the link between the situations of adopted and donor-conceived children was established soon after the hearings begun.

> Puis, on l'a analysé aussi en fonction d'une autre réalité qui est celle de la procréation assistée […] Bien, quand on va vouloir avoir accès à nos origines, puis à notre dossier médical, puis tout ça, bien les gens vont chercher aussi à remonter à ce niveau-là. (Rhéaume 2010)

The issue was framed in terms of rights by the few interveners who talked about the particular but comparable situation of donor-conceived children. They argued that the bill should provide recognition for any type of family and offer the same privileges to children no matter how or in what context they were conceived. For this small group of people, it made sense to seize the opportunity that opening the Civil Code created to make sure all different cases were taken into consideration and included in the law.

> L'État est gardien du meilleur intérêt de l'enfant. En tant que meilleur intérêt de l'enfant, il devrait avoir cette obligation-là de conserver de l'information sur tout enfant qui vient au monde, que ce soit un enfant naturel ou un enfant en adoption, ou maintenant on va avoir le problème de la procréation assistée, les mères porteuses, etc. […] Écoutez, on sort du cadre de l'adoption, on ouvre un projet d'ouverture... accès aux origines, on ouvre le Code civil. (Claes 2010)

> Je crois qu'il y a eu un rapport remis sur les procréations assistées où... Les gens proposaient même qu'une personne née d'un don de gamètes puisse avoir accès à l'identité de son père ou de sa mère, là. Bon, le processus... le droit à l'identité, il n'est pas encore reconnu quand même, il chemine à travers beaucoup de choses, là, et c'est peut-être le temps ici, à ce comité-ci, d'appuyer sur ce concept-là, et je pense qu'il y a peut-être d'autres personnes aussi à venir, là, dans le processus de consultation qui vont venir peut-être appuyer notre point de vue. (Bégin 2010)

In Canada, the Supreme Court's decision in the judicial review of the Assisted Human Reproduction Act (AHRAct)[148] put pressure on provincial governments to introduce regulations related to assisted reproduction, particularly with respect to licensing, oversight, and research. Yet, since the Supreme Court's decision, only Quebec has passed legislation regarding assisted reproduction and its multiple sub-issues. Likewise, in spite of its sweeping regulatory power, Assisted Human Reproduction Canada, the arms-length agency created by the AHRAct, issued only one regulation during its first seven years of existence (2006-2012) and was frequently criticized for its inaction, especially with respect to patient and donor databases. The AHRAct provided for the establishment of a Personal Health Information Registry to create a national database for information pertaining to donors, patients, and donor-conceived offspring. Such registries can be important for tracking heritable diseases and preventing sperm donors from having too many biological children, but the federal registry was never created. Following the Supreme Court Reference, such registries, if they are to exist, must now be created and maintained by the provinces. Such information has been systematically gathered in Quebec only since 2009. Chapter 8 of the Act respecting

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[148] *Reference re Assisted Human Reproduction Act*, 2010 SCC 61, [2010] 3 S.C.R. 457. : Quebec's judicial review of the 2004 Act framed the issue at a broader level in terms of separation of powers to restate the Provinces' prerogative over health care. In 2004, the government of Quebec asked the Court of Appeal to review the federal law to determine whether it exceeded the provincial prerogatives over health care in the matter of assisted reproduction.[148] The Court of Appeal sided with the provincial government's arguments that the law intrudes onto provincial prerogatives and the federal government appealed the decision to the Supreme Court. Saskatchewan, New-Brunswick and Alberta supported Quebec's cause as interveners. The court allowed the appeal in part, stating that only some provisions impede provincial powers to regulate health care as ruled by the Quebec Court of Appeal, but that others alleged to do so were constitutional – these are sections 10, 11, 13, 14 to 18, 40(2), (3), (3.1), (4) and (5) and ss. 44(2) and (3) of the AHRAct. The judgment refers several times to the tension that exists between morality, health and security, and the extent to which the provincial and federal powers overlap in the case of assisted reproduction. What is of interest for the principal argument of this article is that the judgment clearly reflects the two "options" for framing assisted reproduction, as an ethical issue or rather as a question of medical practice. With only a majority of five to four judges, the decisions leaned towards the latter and, at least partly, confirmed the provincial government's and medical community's view of assisted reproduction as primarily a matter of health care.

clinical and research activities relating to assisted procreation, asked that any information on assisted procreation activities, except those determined by regulation, concerning a person who resorted to such activities, or a child born of such activities, must be kept permanently by the person that carried out those activities. Information that allows a person who resorted to assisted procreation activities, or a child born of such activities, to be identified is confidential and may not be disclosed, but the information will be available from 2009 onwards.

Conclusion

In Quebec, the debate on access to treatment had an unmistakable impact on the attention given to questions of gamete and embryo donation. Outside issues of assisted conception, the debate over same-sex unions' recognition had also a lot to do with the introduction to Parliament of the issue of parentage rights for gay and lesbian partners. But despite the importance of other policy debates, it was possible to see that the question of assisted conception and filiation was dominated in the early 1990s by a medical frame. The way to establish and to legitimize the creation of parental ties was through the assistance of a clinician and a proper consent to treatment. The medicalization of reproduction in cases of infertility rendered the concept of intention more tangible, since the parents organized their visits to the clinic.

The issue changed when same-sex partners asked to be recognized not only as spouses but also as parents. The work of Mona Greenbaum and the Association des mères lesbiennes du Québec revealed the lack of regulation granting parental authority to the biological mother in a situation of co-parentage. In that context, the gay and lesbian community had to compete with the dominant medical frame and render equal the discussion around sameness to include new considerations. The bridge between a legal frame (equality and rights) and the experience-based frame (sameness) caught the attention of the legislature who was already open to amending the law to recognize same-sex couples. That led to the exclusion of the medical frame. Thus, the debate was re-centered around the principle of the interest of the child, which combined ideas of legality and real-life experiences.

Legal scholars have noted the new tendency of the Quebec government to acknowledge the psychological dimensions of the interest of the child (Fine 2002). The recently drafted bill on adoption and parental authority demonstrate the openness of the legislature to adopted children's access to biological as well as social parents' identity. In spite of this appreciation of children's psychological needs, no formal debates were undertaken at the parliamentary level to regulate the issue. The donor-conceived children's right to know their biological origins was discussed on many occasions between 1990 and 2010, in general in relation to the comparable situation of adopted children and almost always when other issues of assisted reproduction or parentage were debated. This constant detour to DCC's right to know is interesting and leads one to think that the legal frame used by experts and organizations concerned with the wellbeing of children could lead DC children themselves to take over the debate at one point in the future. Moreover, the information will become available given the new disposition regarding the collection of information on assisted reproduction procedures.

Ontario

In Ontario, gamete donation was introduced into the political debates in a similar fashion to Quebec. The questions of same-sex marriage and equality rights were a primer for questions of parentage and assisted reproduction as well. Nevertheless, the path on which Ontario embarked is characterized predominantly by the judicialization of political processes. In that context, frames were extended and bridged to adjust to the specific circumstances and rules of the courts. The establishment of parentage of children born by assisted conception and the definition of the donor's role in that situation were outlined more often than not through court decisions. Despite dynamics of frame extension and bridging were evident, the political influence of the decisions was minimal. Furthermore, the scope of the court's decision[149] limited their legislative influence while supporting a clear legal tendency toward the prevalence of intention, consent and equality in the implementation of family law when it comes to family created through assisted conception.

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[149] As we will see, the courts decisions had an influence on the parties involved but the remedy were not extended outside of the family concerned.

Takes two to tango

Liberal representative Barbara Sullivan submitted a motion to the Ontario legislative assembly in June 1989 to urge the government to co-operate with the recently announced Royal Commission on New Reproductive Technologies. She considered that Ontario was best equipped to contribute to the many debates on issues of assisted reproduction, given that the majority of services provided then in Canada were made available in Ontario clinics.

> In February of this year, Chedoke McMaster Hospitals in Hamilton announced that they will operate Ontario's first anonymous egg donor program for infertile couples who want to become parents. It is the first female equivalent of the sperm bank, and while we have been accustomed to the anonymity of the biological father, this is the first time in Canada that the anonymity of the biological mother has been added to the legal and ethical question. To questions, which have been put about sperm donor programs, we now add those same questions about egg donor programs. What rights do children have to know about their genetic parent, their medical records, their physical and mental attributes? Should there be a register of donors accessible to the children? What right does the donor parent have to maintain anonymity? What is the legal status of the child of a gamete donation? What is the legal or ethical obligation of the donor biological parent to that child? What time limits ought we to place on the utilization of frozen eggs or sperm? Who owns the eggs or sperm? Who has the right to destroy them? (Sullivan 1989)

Many questions emerged during this period. The debates were shaken in many ways by new egg donation programs and the decrease in health risks associated with preservation of embryos. The Royal Commission was perceived in Ontario as the best "political but neutral" arena to debate these moral questions; an arena that provided, in addition, a distance that the provincial government saw as necessary. In fact, the Royal Commission needed Ontario's actors as much as the Ontario government needed the Commission to debate the issue.

> The Royal Commission was a convenient venue. The provinces were detached of any controversy and the recommendation could or could not be taken into consideration by the Ontario government. It was a battle that needed to be done, but it was suitable for provincial representatives not to participate in a direct fashion … so they could listen and act upon what was considered good and bad. […] Ontario… not only the government but the public servants, the professionals, etc… they all considered the conclusions of the Commission as needed and accurate. That is the main grounds for the moral standards that dominated for a very long period of time in the province. (Interview Legal Expert Ont-1 – October 7th 2010)

In many ways, the actors at the time saw the Royal Commission as the "Ontarian

Commission", as if the Commission was an extension of what could have happened in the province if the federal government had not taken the lead in debating the question of reproductive technologies (Interview Legal Expert Ont-1 – October 7th 2010). The imperative to "proceed with care" was shared by a majority of the actors involved in the practice of assisted reproduction in the province, maybe even more within the academic and medical communities: "Recommendations for laws and regulations that may come out of the commission may protect those who are least able to protect themselves or who are unaware of the implications of their actions. In the end, it is to be hoped this will help to protect society from its own folly." (Liberal party representative Beer 1989)

Despite the involvement of the medical community and the women's movement at the federal level, the broader issue of parentage - that was an obvious preoccupation when the motion was introduced to the legislative assembly in June 1989 - stayed relatively untouched by the Royal Commission's recommendations released in 1993. In Ontario, after the Royal Commission, the declaration of parentage was still made on a case-by-case basis for children born through assisted reproduction. Declarations of parentage drew on previous case law and legal principles could be found in section four and five of the Ontario family law statute known as the Children's Law Reform Act[150]. The courts in the different cases they heard through the years, redefined the Ontarian family. The Royal Commission did not fulfill the legislative assembly's former expectations to establish a line of conduct in regards to filiation by assisted conception. Nevertheless, the courts constructed new legal trends and established new rules of parentage when children were born through assisted conception. Three legal trends were consolidated through court decisions: consent to treatment and agreement between parents (legal frame), parental project and intention to parent (family-building frame), and equality between children (legal frame). Starting in 2006, the family-building frame and the legal frame were bridged in the decisions of the courts and provided the justification needed to establish case-by-case filiation using one central principle found in law: the best interests of the child.

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[150] Children's Law Reform Act (CLRA), R.S.O. 1990. The Statute was amended in 1990 to eliminate any distinction between children born in and out of wedlock.

Biology versus paternity

In 1994, the supreme court of Ontario declared that biological ties were not the only way to establish parentage between a child and its father in case of conception by artificial insemination. In Low v. Low[151], the court stated that the father's intention to parent and consent to treatments were proof in the establishment of parentage and were a pledge to the fulfillment of the child's best interests.

The parties concerned in *Low v. Low* married in 1989 and engaged in assisted reproduction procedures soon after. The husband was unable to conceive a child due to a low sperm count. He participated throughout the process, taking all necessary steps and executing any necessary documents leading to the insemination procedure. A successful conception with sperm supplied by an anonymous donor occurred a few weeks following the marriage, a child was born in April 1990. The husband certified the child's birth as her father under the Vital Statistics Act[152] by signing the birth registration. Throughout the pregnancy of the wife, the husband was an interested, concerned, and attentive expectant father. Nevertheless, beginning at around the fourth month of the wife's pregnancy, serious difficulties began to arise in their relationship. By the time the child was born, the relationship between the parties had deteriorated to such a degree that within hours of her return from hospital following the birth, the wife demanded that the husband leave the home. Thus, from a time when the child was only a few days old, the husband and wife had been living separately. Each party sought and was granted a divorce at the conclusion of the trial. The husband demanded joint custody of the child, but the wife requested that there should be no access, and, further, stated that the husband was not the father of the child given that he had no biological link to her.

The question of whether a father needed to be biologically related to a child to be a parent was central in the court decision. This was the first case in the province to question the relationship between intended parents and biological parents in cases of assisted conception. The court stated:

> The words "natural," "natural parent," "parent," "father," and "natural father," appearing in these sections, are not defined in the legislation. […] The omission of the word "natural" as an adjective in describing "father" in other sections suggests the intention of a meaning broader than mere "biological" father, in those sections. I note also that the declaration authorized in s. 4(1) is not that a

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[151] *Low v. Low* 1994 CanLII 7577 (ON SC)

[152] R.S.O. 1990, c. V.4

> male person is the “natural father,” rather that he is “recognized in law” to be the “father” of the child. […] The declaration is permitted when “the relationship of father and child has been established” (s. 5(3)). […] I conclude that this expression must mean something broader than a mere biological relationship. (paragraphs 17-21)

By declaring the husband as the legal father of the donor-conceived child, the court excluded the sperm donor from the parental project and established that intention and consent were proof of the relationship between the child and the father. That relationship was institutionalized through the birth registration and formalized by the court in the divorce and access declaration the judgment affirmed. This decision is the first example in which the family-building frame took a central position in the courts decisions in regards to filiation by assisted conception. The Ontario courts afterwards was prompt to consider the intention and consent principles in their declaration of parentage to exclude the sperm donor, accordingly diminishing the importance of genetic links, and creating a legal link with the intended father.

Challenging conceptions

Ten years later, another court case sustained the same kind of argument but this time the case led to the exclusion of the mother figure from the birth certificate. In 2004, Kevin Durkee won a court battle to register as the sole parent of his daughter, who was born via an anonymous egg donor and a gestational surrogate. In D. (K.G.) v. P. (C.A.)[153], the court recognized the inadequacy of the birth registration system of the Ontario Vital Statistics Act. A gay male, Durkee wished to have a biological child. He and the surrogate mother, C.A.P, were assessed to be suitable candidates for an in vitro fertilization program through a fertility clinic. The applicant provided his sperm and ova was removed from an anonymous donor. Three fertilized ova were then successfully implanted into the uterus of the surrogate. The transfer occurred in July 2002. The biological mother of the child remains unknown. Durkee had been the sole parent of the child since birth. Prior to the child's birth, he had attended all but one of the medical appointments during the in vitro fertilization process. He was the only parent responsible for the child's support and he did not wish to have any other person named as parent on the child's statement of live birth. All parties to the application (including the

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[153] *D. (K.G.) v. P. (C.A.)* [2004] O.J. No. 3508 (Ont. Sup. Ct.).

surrogate), except the Deputy Registrar General for the Province of Ontario, signed consent to judgment. By application to the Superior Court of Justice, he was able to register his child's birth in his name and obtain a declaration of parentage. The court acknowledged the legislative gap in the Act and noted that it had not kept pace with assisted reproductive technologies. Still, there was no comprehensive remedy ordered by the court, nor was any legislative action undertaken.

> Both the applicant and the Deputy Registrar General are in agreement that there is a legislative gap in the Vital Statistics Act. The Act does not contemplate the applicant's situation. The parties have acknowledged that the Superior Court has parens patriae jurisdiction to fill this legislative gap, if it finds that it is in the best interests of the child to do so. (paragraph 11)

The exclusion of the birth and biological mothers from the filiation in this court case was a first for Ontario. After excluding the biological father in Low v. Low and acknowledging the role of intended fathers in the child's life, D. (K.G.) v. P. (C.A.) newly consolidated this trend. However, this time the biological and birth mothers in turn were to be excluded from the parental project. The legal principle of the intention of the father to parent and his engagement in his own parental project were the proof needed by the court to establish that the declaration of parentage and the exclusion of a mother figure from the birth registration were in the best interests of the child. Interestingly, courts in arguing that assisted reproduction is now a channel through which families are constructed and that the law did not anticipate that kind of medical and social developments, maintained and amplified the family-building frame to include new types of families.

Same-sex unions' recognition and family law

To guarantee recognition of their parentage, gay and lesbian parents often face legal barriers, since birth registration statutes largely assume male-female, two-parent families. Low v. Low and D. (K.G.) v. P. (C.A.) were two key court decisions that continue to be influential in cases involving parentage and gamete donation. In addition, decisions with regard to same-sex couples and equality claims were also central in the subsequent bridging of the family-building frame with a legal frame, mobilized through a right-based discourse.

After the landmark decision of the Supreme Court of Canada in M v. H[154], many laws in Ontario were adapted to reflect the anti-discrimination decision of the courts. For instance, Ontario's Child and Family Services Act was revised to allow two adults of the same sex to jointly apply for adoption.

> The process was somewhat mechanical. The legislative assembly didn't make a stand by opening debate on how inclusive the law could become. They had to adapt the law to new realities and they did. It wasn't a political debate on inclusiveness or equality or on new types of families and couples and whatever; it was simply a legislative adaptation to the Charter. The legal accuracy was more important than the social message gays and lesbians would have wanted the government to spread. (Interview Rachel Epstein – December 2nd 2010)

Despite the mechanical aspect of the adaptation, it concealed in family law a new principle that would become an important feature of many court decisions in regard to parentage of donor-conceived children: equality between parents and equality between children. The legal frame mobilized through arguments of equality was positioned as central in family law and reinforced through time in parentage decisions. The courts and litigants, through charter mobilization and equality seeking, contributed to the definition of the family as an entity that should provide an equal, discrimination-free environment for the children. The best interests of the child was thus satisfied only through equality seeking procedures. Legally speaking, the discourse of equality was extended to parentage issues, first in the adoption debate and rapidly after in the assisted reproduction debate.

Equality between parents as a protection of children's welfare

In 2006, the court decision in Rutherford v. Ontario[155] found that the Vital Statistics birth registry did discriminate against same sex parents. In the litigation, four lesbian couples challenged Ontario's Vital Statistics Act (VSA) because they alleged it allowed only one mother and one father to be recorded on the birth registration. The VSA birth registration document is what most people rely on to provide evidence of parentage when dealing with daycares, schools, border crossings and with third parties in their day-to-day lives. In

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[154] *M v. H* [1999] 2 S.C.R. 3. In 1999, the Supreme Court ruled in this case originating from Ontario. The equality ruling struck down laws that treated co-habiting same-sex couples as being unworthy of the same treatment as opositte sex couples, amongst them law regarding division of property and assets in cases of separation.

[155] Rutherford v. Ontario (Deputy Registrar General) (2006), 81 O.R. (3d) 81 (S.C.J.)

addition to the inclusion of the co-mother on the document, the Rutherford applicants asked for declarations of parentage[156]. The Rutherford Applicants wanted secure parental recognition for their families and for other lesbian parents and children. All the children of the Rutherford families were included as parties to the litigation and made their own claims based on section 7[157] and 15[158] of the Charter of Rights and Freedoms. The legal and moral frames became very important in this decision considering the position of the children and their testimonies. In fact, the court expressed its opinion that the situation of children in homoparental families was increasing discrimination and the vulnerability of children, and accordingly the responsibility of the government was to prevent and thereby protect the best interests of these children.

The four Rutherford families included married spouses Melanie and Mel. Melanie gave birth to twins Emerson and Alexander, and Mel impregnated her wife using her fertilized ova. Only Melanie was registered on the children's birth certificate. Veronica and Rosemarie together decided to have a child, and are the mothers of daughter Ayoka. Only Rosemarie was recognized as Ayoka's mother on the Statement of Live Birth. Bonnie and Beatrice married and wished to expand their family, giving birth to a son, Samuel. After litigation commenced, Bonnie was diagnosed with breast cancer before Beatrice had any legal recognition of her parentage. If Bonnie had died without Beatrice having parental recognition, Samuel's relationship to Beatrice would have been uncertain. Finally, Rachel Epstein and Lois Fine were parents of Sadie Rose Epstein-Fine, then fourteen years old. While Rachel was pregnant, Lois was present and took care of Rachel, attended the midwife appointments, was present at the birth and cut Sadie's umbilical cord. Only Rachel was recognized as Sadie's mother on the birth certificate. Sadie deposed for the court:

> I just want both my moms recognized as my moms. Most of my friends have not had to think about things like this, they take for granted that their parents are

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[156] Most parents have no need for CLRA declarations, but the Rutherford applicants were concerned by the ruling of Justice Aston in *AA v. BB v. CC* (see next section) because it could change the position of the law in regards to father figures and biological ties.

[157] *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11. section 7 : "Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice."

[158] Idem, section 15 : "Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, color, religion, sex, age or mental or physical disability." Sexual orientation was read in this section in June 1996. Parliament enacted Bill C-33, *An Act to amend the Canadian Human Rights Act*, to include sexual orientation among the Act's prohibited grounds of discrimination.

> legally recognized as their parents. I would like my family recognized the same way as any other family, not treated differently because both my parents are women. Most kids understand that I have two moms. But a few kids are mean or just do not understand. They ask who my "real" mom is. I explain that both of my moms are my real moms. Some adults do not understand either. It would help if the government and the law recognized that I have two moms. It would help more people to understand. It would make my life easier. I want my family to be accepted and included, just like everybody else's family. Imagining winning the case, it would feel amazing. It would feel like we would not have to lie anymore. We would not have to worry about getting in trouble. Nobody could question who my mothers are anymore. I would feel more secure and safer.

The government hotly contested the recognition of lesbian co-mothers on their child's Statements of Live Birth. It claimed that the VSA birth registration document was meant to capture biological particulars, although the evidence was overwhelming that straight families using donor sperm or eggs registered the particulars of the intended parents without question. In fact, through cross-examination of the Deputy Registrar General of Ontario, the applicants obtained an internal government document that expressly required the rejection of applications by same-sex parents. "It seems there was a conscious effort to scrutinize the gender/sexual orientation of applicants and to reject the birth registrations of lesbian mothers" (Radbord 2010).

On June 6th 2006, Justice Rivard ruled in favor of the four families. The court said:

> Lesbian mothers lack even a language to identify themselves. Given this overall context of homophobia and heterosexism, it makes an even bigger difference to them for the government to recognize their parental relationships. Failure to recognize these relationships perpetuates views that there is something wrong or unnatural about their families. Rather than the law seeking to remedy their historic disadvantage, it is placing additional burdens upon them, and is therefore discriminatory. Likewise, for children of lesbian mothers, who are even more vulnerable than their parents to the lack of symbols of their families in popular culture, exclusion of their parents from birth registration furthers this vulnerability. (paragraph 205)

Justice Rivard suspended the declaration of invalidity for 12 months to give the government time to right the wrong. The government did not appeal the decision. Justice Rivard also granted declarations of parentage in favour of both mothers. The judge acknowledged that parenthood does not rest solely on biological or genetic connections.

> In this case, I agree with the Respondent that birth is not a social construct. At present, it takes one ovum and one sperm for a child to be created. However, that

> does not mean that parentage is not a social construct. In fact, our expanded understanding of parent for child support purposes suggests that we do see parentage as such a construct, and perhaps understand it as a concept that may change depending on context. The Respondent's error is in comparing birth to marriage, rather than parentage to marriage. (paragraph 176)

Taking the position that the Children's Law Reform Act (CLRA)[159] did not acknowledge same-sex parents and that all children were legitimate, the court justified recognizing more than one mother. The court also acknowledged that this recognition was essential to protect the constitutional rights of same-sex parents and was in the best interests of children born from these arrangements. Justice Rivard specifically found that the CLRA had a discriminatory effect on lesbians, and there was no justification under section 1[160]. The impugned provisions of the CLRA were found unconstitutional, but Justice Rivard declined to make a specific remedial order under the Charter.

> Based on these factors, I have concluded that the claimants can be characterized as lesbian co-mothers who plan a pregnancy with a spouse using assistive reproductive technology and that the appropriate comparator group is heterosexual non-biological fathers who plan a pregnancy with a spouse using assistive reproductive technology. Equally, it is appropriate to compare the claimant children with children of heterosexual non-biological fathers who planned their pregnancy using reproductive technology. While I struggled with this issue, I have made the comparison groups very specific so as to only consider the particular situation of those before the court. On the basis of these comparator groups, I concluded that there is a distinction between the claimants and the comparator group on the basis of sex and the analogous ground of sexual orientation. This distinction is as a result of both the VSA itself and of state action. This distinction is discriminatory due to pre-existing disadvantage and stereotype, the lack of correspondence between the benefit and the needs of lesbian co-mothers who use reproductive technology and their children, and the engagement of core dignity interests. […] It is my view that the Respondent's submissions on the Charter remedy are substantially correct: it is appropriate to strike down the legislation but suspend. The key problem at the remedy stage is having rejected the argument that a child's parents at birth must be her biological parents, it becomes necessary to re-define who can be a parent under the VSA. *Redefining the legal concept of parent under the VSA is a job for the legislature, not the court.*[161] (Paragraphs 113, 114, 116)

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[159] R.S.O. 1990, CHAPTER C.12

[160] *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11. section 1: "The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such ***reasonable limits*** prescribed by law as can be demonstrably justified in a free and democratic society." (emphasis added)

[161] Emphasis added

The government's answer to the Rutherford decision was introduced on August 24th 2006, less than three months after the decision was released. The government proclaimed a legislative amendment that had been on the books but had never been proclaimed. It was the easy way to amend the VSA without touching the CLRA, because the change could be made without debate in the Legislature. The VSA now permitted, as of January 2nd 2007, that two lesbian mothers couldregister their child's birth as parents, but only if the father is unknown and conception is by assisted reproduction. For many, the government has avoided a comprehensive examination of its exclusionary legislation, and thus sustains the gap between new types of families and the law. However, this decision influenced the way courts envisioned family relationship and the best interests of the child. The intention to parent and the parental project were bridged to ideas of equality that became central in the development of judicial arguments and thus, in the declaration of parentage in Ontario. In fact, the intention of parents and their involvement in the child's life were seen as partial in the fulfillment of the children's welfare after the decision in Rutherford. The equality of parents of the same-sex vis-à-vis opposite-sex couples in the eyes of the law guaranteed that the donor-conceived children raised in such a context were also seen as equals to children conceived naturally.

Multiparental family units and the interest of the child

In 2003, two lesbian partners and the sperm donor and involved father of a five years-old child sought application for a declaration of parentage for the co-mother without the exclusion of the biological father[162]. The birth mother (A.A.) and the co-mother (C.C.) became cohabiting same sex partners in 1990. From the beginning of their relationship, they shared their living expenses, debts, savings and investments. In 1992 they participated in a public ceremony, confirming their commitment to one another as life-long partners. The applicant (A.A.) stated that if it had been legally possible for her to marry C.C., then or since, she would have done so. The couple discussed the possibility of having children early in their relationship but their respective careers, though promising, were not established, nor were their finances stable and secure until late in 1999. They then decided to start a family

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[162] *A.(A.) v. B.(B.)* (2003), 225 D.L.R. (4th) (Ont. Sup. Ct.) and *A.A. v. B.B.* 2007 ONCA 2

and agreed C.C. would be the biological mother. The couple also agreed it would be in their future child's best interests to know his or her biological father and for the father to play an active role in the child's life. The respondent B.B. had been a long-time friend of both women. After a period of discussion and reflection, the three adults made a mutual commitment whereby A.A. and C.C. would be the primary custodial and decision-making parents, but B.B. would also have an active and participatory role in the child's upbringing. B.B. has three other children.

> After successful conception in April 2000, D.D. was born February 6, 2001. As far as C.C. is concerned, A.A. has equal status and responsibility when it comes to both decision-making and the day-to-day care of their child. B.B. visits the child twice a week. On Tuesdays, he has time with the child independently of A.A. and C.C. On Thursdays, he joins them for a family dinner together which sometimes also involves his other children and the woman with whom he cohabits. B.B. has not been asked to provide any ongoing or regular financial support but he does support the child informally and indirectly. The child is a bright, healthy, happy individual who is obviously thriving in a loving family that meets his every need. The applicant has been a daily and consistent presence in his life. She is fully committed to a parental role. She has the support of the two biological parents who themselves recognize her equal status with them. (paragraphs 5-8)

In Ontario, upon adoption, a birth parent ceases to be the parent of the adopted child. In *A.A. v. B.B.*, an adoption by the non-biological mother would have terminated the legal relationship between D.D. and his biological father. In spite of the facts presented to the court and the determination of the three parent's involvement in the child's life, the Superior Court of Justice did not allow the application and justified its decision by arguing:

> The legislator could have left open the possibility of more than one father but, instead, made an express opposite choice. There is no logical reason to suppose the legislator would choose to limit the number of fathers to one while allowing for more than one mother. This conclusion is also consistent with other legislation, namely the adoption provision in the Child and Family Services Act, whereby no more than two persons can apply for an adoption order and the order extinguishes other parental status. Adoption thus limits the number of parents to a maximum of two. (paragraph 35)

Judge Ashton feared that "if this application is granted [...] the door is left wide open to stepparents, extended family and others to claim parental status in less harmonious circumstances." (paragraph 41) The parties appealed the decision and in 2007, the Ontario Court of Appeals decided conversely that the CLRA did create a gap and that the court could decide parentage for the child's best interests.

The three judges in *A.A. v. B.B.* described the incoherence between the CLRA and the context of assisted reproduction and same-sex parents in this way:

> Present social conditions and attitudes have changed. Advances in our appreciation of the value of other types of relationships and in the science of reproductive technology have created gaps in the CLRA's legislative scheme. Because of these changes the parents of a child can be two women or two men. They are as much the child's parents as adopting parents or "natural" parents. The CLRA, however, does not recognize these forms of parenting and thus the children of these relationships are deprived of the equality of status that declarations of parentage provide. (paragraph 35)

A.A. repeated the same arguments as those made before the application judge. For the first time, however, she also raised constitutional arguments, claiming that the CLRA violates her rights to equality and fundamental justice under ss. 15 and 7 of the Canadian Charter of Rights and Freedoms.

The applicants obtained status as added party interveners and provided the court with the extensive evidentiary record from their hearing. Added party intervener Alliance for Marriage and the Family - a coalition including the Catholic Civil Rights League, REAL Women of Canada, the Evangelical Fellowship of Canada, Focus on the Family, and the Christian Legal Fellowship[163] - argued that there was no discrimination and that declarations of parentage were meant to be available to biological parents only, and parents in many families were excluded from parental recognition by way of the CLRA. The Ontario government did not participate in the appeal, despite the challenge to the constitutionality of the CLRA and the conflict over its interpretation.

On January 2, 2007, the Ontario Court of Appeal granted the lesbian co-mother status as the parent of her child. The Court declined to deal with the Charter issues, noting the appellant failed to meet two of the criteria required to permit a party to raise a Charter issue for the first time on appeal. First, the Court of Appeal found that the appellant failed to show that her decision not to raise constitutional arguments at trial had not been a tactical one. Second, the Court concluded that the parens patriae jurisdiction does provide the appellant with a remedy and consequently there is no miscarriage of justice if the Court does not decide the Charter issues. Justice Rosenberg J.A. relied on the submissions of the Children's

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[163] They are known to be right-wing faith-based groups.

Lawyer and the Rutherford's interveners to highlight the importance of recognizing A.A.'s motherhood under the CLRA. He recognized not only the practical and legal benefits of a declaration of parentage, but also the symbolic value. In support, Justice Rosenberg cited Sadie Rose Epstein-Fine testimony in the Rutherford case[164]. Even if the court discarded the Charter argument made by the applicant, the legal frame was still maintained and bridged to the family-building frame. Actually, the extension of the parens patriae jurisdiction, the exercise of the courts discretion and the fact that the court relied on the Rutherford case to justify its decision propose that the intention and consent between the parties are as much in the best interests of the child as the equality of his or her family as in the eyes of the law to other families.

Accordingly, the court granted the co-mother status as a parent using its parens patriae jurisdiction[165]. The Court of Appeal took the opportunity to review the scope of the inherent power of the court to "rescue a child in danger or to bridge a legislative gap […] the children of these relationships are deprived of the equality of status that declarations of parentage provide. » (paragraph 35) The Alliance for Marriage and the Family, a conservative Catholic organization, as intervener, sought standing to bring an appeal to the Supreme Court of Canada. On September 13, 2007, Justice LeBel ruled that the interveners had no specific interest in the outcome of the litigation and their request for party status was turned down[166].

The case created a minor stir in the media: "Court Rules Boy has Dad and 2 Moms." (Lai 2007) Media reports suggested that the judgment was a landmark case because it "redefine[d] the meaning of family and examine[d] the rights of parents in same-sex-unions." However, many observers and LGBT rights defenders were careful in considering the minimal echo the case could have on other similar cases and the judicial limit of its influence. Indeed, the call for a legislative debate was quite clear in the Rutherford, the A.A. v. B.B. cases and their aftermath. For instance, the court in Rutherford made the comment that "redefining the legal concept of parent [...] is a job for the legislature, not the court"(paragraph 116).

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[164] See previous quote.

[165] Given the fact-specific, highly discretionary nature of *parens patriae* there is concern about outcomes for other less traditional family formations.

[166] Alliance for Marriage and Family v. A.A., 2007 SCC 40

Sperm donor or donor sperm

In 2009, C. (M.A.) v. K. (M.) challenged the principles of family ties. In this case, M.A.C. and C.A.D., a lesbian couple, conceived B. with M.K., a homosexual male friend who acted as a known sperm donor. M.A.C., the biological mother, and C.A.D. were the child's primary caregivers. They jointly applied for an adoption order to make C.A.D. a legal parent. However, M.K. refused to consent to the application because he wished to maintain his status as a legal parent. M.A.C. and C.A.D. argued that the Court should dispense with M.K.'s consent because, absent an adoption order, C.A.D. would effectively be a legal stranger to her child. They also argued that the adoption order would protect their family from M.K.'s unwanted intrusion. Since B.'s birth, he had exercised access in increasing amounts and the couple felt that their familial status was threatened. M.K. argued that the adoption order would sever not only his legal ties to the child, but also his practical relationship. Justice Cohen accepted M.K.'s evidence that, from the beginning, he and the couple had intended that he would be involved with the child. For the first years of B.'s life, M.A.C., C.A.D., and M.K. acted in many ways as a functional family. They took trips together; sent joint Christmas cards; and drafted, but did not file, pleadings for a three-parent adoption. However, M.A.C. and C.A.D. argued that they were increasingly concerned by M.K.'s lack of structure, high number of partners, and his violations of a donor agreement executed by the parties. The court found that M.K. was indisputably a reliable presence in B.'s life and characterized him as a vulnerable access parent whose desire to see the child was being blocked by the custodial parents.

The court held that the mothers had failed to show excluding the donor was in the child's best interests pursuant to sections 136 and 138 of the Child and Family Services Act. The court specifically found the co-parenting agreement of 2002 between the parties was irrelevant in any decision regarding the child's best interests. The court refused the mothers' argument that the child, who had difficulty with transitions and a learning disability, required a stable and secure two-parent family, in favor of the father's contention that the child's reality was that she had three engaged parents. Justice Cohen wrote:

> [I]n determining B.'s best interests, the issue for the court is not the protection of a specific family structure ab initio. This court sees all kinds of family structures and, absent specific statutory provisions otherwise, the nuclear family of two

> parents and a child enjoys no special preference when the court is assessing the best interests of a child. Indeed, a child can have more, or less, than two parents for the purposes of family law […] When they decided to have a child, they fully understood that, although engaging a sperm donor was a biological necessity, engaging a known sperm donor was not. Thus, when they decided that they wanted their child to have a known and involved father, they knew that, if they chose well, their child would develop a relationship with a parent who was not part of their immediate family. They knew that a parent-and-child relationship gives rise to rights and responsibilities. They anticipated that a third parent would be involved with their family and had to have anticipated that this parent might disagree with, or challenge, their parenting choices, just as they must do with one another. (paragraph 36)

In fact, what the judgment sustains is that the child's best interests resides in the equal involvement of his parents whatever were the circumstances of his/her conception and/or the sexual orientation and conjugal relationship of his/her parents. In short, in M.A.C. v. M.K., the court prioritized B.'s interests in maintaining M.K's parental rights over the recognition of M.A.C. and C.A.D.'s intentionally formed family. The court decision indicates intention is not a principle that relates to the family form the parents expected to construct, but rather to the intention of involved adults to fulfill the child's best interests. In legal terms, the decision made clear that the principle of the best interests of the child can only be assessed a posteriori and not before the child's birth.

The expert panel, parents' intention and their protection

The principle of intention relates to a family-building frame as it is constructed around the day-to-day involvement of parents vis-à-vis the child and in relation to each other. It was first mobilized outside of the judicial arena in 2009. The Expert Panel on Infertility and Adoption addressed the issue of gamete donation and parentage in its final report and made clear that an intention-based approach to parentage would protect parties involved in a parental project.

> We believe that an intention-based approach to parentage – for everyone using third party reproduction, even surrogacy – should be used in establishing parentage in Ontario. […] Additionally, there is no law in Ontario that protects donors, surrogates and the intended parents. Donors and surrogates need protection so that it is clear that they do not have any parental responsibilities for the child that they helped to create. Parents need protection so that it is clear that a donor or surrogate cannot claim parental rights over the child. Currently, intended parents and donors face expensive legal costs to draft contracts that will

> protect the rights and responsibilities of everyone involved. (Expert Panel 2009)

The Panel called for the government to review the process for establishing parentage to accommodate assisted reproduction services wherever possible, and to ensure that no intended parents were discriminated against on the basis of sexual orientation or reproductive needs. Once they are finalized, the Panel recommended that the government review its laws in light of the Uniform Law Conference of Canada work and implement its recommendations on declaration of parentage.

In 2008, in response to the prominent place of issues of filiation related to assisted conception, the Joint Coordinating Committee of Senior Officials in Family Law of the Uniform Law Conference of Canada (ULCC) drafted recommendations on the declaration of parentage procedures. According to the ULCC the law should accommodate both natural conception and assisted human reproduction and the law should balance three potential indicators of parentage: first, the recognition of the birth mother link; second, the equality between natural and assisted conception models so that the two processes are treated the same as much as possible; and third, the intention of those who expect to parent, regardless of genetic link to the child.

While the Expert Panel's mobilization of the family-building frame took in the recommendations in regard to gamete donation and the impact it has on parentage can be accounted by the unambiguous way the Panel sustained the intention-based model, the panel did not specifically engage in the debate.

> In fact, the question arose when families came and told us about the many obstacles they face when they seek assistance in building their families. The mandate of the Panel was not to account for legal challenges per se, but rather to highlight the barriers faced by infertile parents and parents engaged in adoption procedures. We had to discuss family-planning, family-building, but I think that the Panel was aware that a real reform of Family Law was outside the scope of our workload. (Interview Legal Expert Ont-1 – October 7th 2010)

Indeed, the Minister of Health and Long-term care and the Minister of Children and Youth Services responsible for service provision of assisted reproduction and adoption had mandated the Panel. Nevertheless, the Panel reference to follow the ULCC recommendations is a way to divert the legislature's attention on this correlated issue.

Despite the limited discussion on the question highlighted in the report, it is once again a reminder of the need for reform. The path the courts blazed between 2000 and 2010 is increasingly discussed in professional communities of lawyers and academics. Hence, a rising number of fertility lawyers emerged in the last decade in the province. A contentious issue that was completely merged into family law a few years ago is now an area of its own, providing a new space to be discussed. Legal professional associations and legal communities took account of that change and discussed in an intensive manner the potential changes or interpretation from which the law could benefit.

Conclusion

In Ontario, legislative developments related to gamete donation were quite subtle if not considered null when contemplating the sole influence these events had on the law. Despite the narrow scope of the court decisions and the LGBTQ and legal communities' mobilization, clear legal trends are being modeled in the province. The family-building frame mobilized in terms of intention and consent to a parental project and the legal frame mobilized through a discourse on equality are bridging to impose a particularly flexible way of defining the family and parental rights and responsibilities.

Legal mobilization, frame extension and amplification

This chapter sought to make sense of the ideational factors that influenced the policy process, especially those explaining the distinct regulation of donor-conceived children's rights to know their origins in England, but not in Ontario or Quebec. Three elements can be drawn from the case studies that help to account for this singular development: the flexibility of the legal frame, the mechanisms of frame extension and amplification and the mobilization of the judicial arena.

The mobilization of the legal frame in each case offers some interesting insights; at one time or another parentage and access to one's origins were framed in rights-based terms in Quebec, Ontario and England. In the case of donor-conceived children and same-sex couples, the legal frame emanates from the idea that to know one's origin or to be recognized as parents is a human right or a right to equality. To frame the issue in terms of rights provides the discourse of the lesbian and gay community and the donor-conceived children's community a mix of salience in the broader political debate, of resonance with the constitutional framework and of flexibility to adapt to institutional and discursive constraints. In fact, the legal frame proved to be one of the more flexible frames mobilized in the debate over assisted reproduction.

The legal frame was amplified and extended on many occasions in Quebec, Ontario and England. These discursive mechanisms were the product of constant frame reflection by involved communities of actors. In consciously restructuring their discourses – although retaining a legal frame – communities were able to respond to the institutional constraints or the mobilization of competing frames by their opponents. Therefore, it was possible for communities to extend their argument to include new values or clarify them by enhancing the assessment of new legal principles. For instance, in Quebec, the equality discourse of same-sex couples was extended in order to enlarge the political debate on civil unions to include family recognition. Then, in amplifying the principle of the interests of the child, they were able to secure the decision to take account of the intention to parent and the consent to the parental project when creating filiation.

Many studies have shown that social actors rely on litigation not simply to win favorable precedents from the courts, but also to raise public awareness about their cause and to mobilize activists into the movement. Moreover, research showed that individual legal mobilization has political consequences. The very act of starting a lawsuit is political, calling on the power of the state to advance individual interests. In fact, a court decision has two lives: one inside the courts and the other in the broader political process. Courts can be understood as policy arenas in which different problem definitions and frames compete with one another. When the judgment is released, the decision has a second life in the arena of frame competition. This chapter has shown how the mobilization of courts contributed to the discursive construction of gamete donation as a public policy issue in Quebec, Ontario and England. The court decisions had different effects inside and outside the courts. However, the context of the frame mobilization determined the influence of a court decision on the broader public policy process. Courts contributed to maintaining the bridge between two frames in England, while it amplified the legal frame in Ontario and Quebec producing respectively new regulations and law and adjustments in the implementation of family law. In this regard, courts can be performative arenas in their capacity to trigger discursive mechanisms and thus influence policy outcomes. For instance, in England, the bridge between the legal and the moral frame consolidated through the Rose decision resonated with the already dynamic mobilization going on in the country. The political life of the decision helped to arouse the attention of elites to the situation of donor-conceived children, maintain the salience of their right-based frame, and lead to the redefinition of the welfare of the child principle.

By analyzing court cases in terms of their framing, we can assess how frames that are mobilized in the courts are part of a broader political debate; the same frames might act in a different manner inside and outside the courts depending on the context we study. One would think that the legal frame is naturally mobilized in the judicial arena because of this favorable context of mobilization. The legal frame is neither the only frame mobilized in court nor the most influential in this arena. The legal frame proved to be influential in the broader political debate when sustained or enhanced by the courts, which could have ruled in a different fashion. For instance, the medical frame was dominant in the Canadian Supreme Court's judicial review of the Assisted Human Reproduction Act in 2010 (Snow 2012).

Courts were also an important arenas in the establishment of parentage for children born of a surrogacy arrangement. However, the frames mobilized in the broader political debate were shown to be influential in the changes observed in Quebec, Ontario and England. Chapter 6 discusses how the extension of a frame can be significant in the slow development of new policy instruments or in the construction of jurisprudential responses to a social problem.

CHAPTER 6
SURROGACY

During the 1990s, the issue of surrogacy was framed in moral terms in Quebec, Ontario and England. Decision-makers, medical players and experts in the social sciences all agreed about the possible direction of surrogacy, especially when the surrogate was genetically linked to the child to be. However, this common moral frame had a very different influences on policies and their implementation. In Ontario, the recourse to the courts by would-be-parents influenced the broader debate on the issue to the extent that the legal frame became more common after 2002. Through the slow mobilization of different sub-system arenas and the mobilization of the legal frames by elites in the legal community, the shift towards a legal frame contributed both to sustaining the importance of protecting children and the creation of a coherent legal framework for families who chose surrogacy as a means to reproduce. In Quebec, through the reliance on courts by would-be-parents, the moral frame was extended through a discourse oriented around the interest of the child, which led to slow changes in the implementation of the law. As had been the case in Quebec, the moral frame was extended in England; this extension was due to the revision of the act by scholars and the Department of Health in 2008. The issue of surrogacy shows how difficult it is to legislate this policy issue in accordance with the choices made by families, and thus, how changes can occur through implementation instead of law.

Ontario

In Ontario, the issue of surrogacy was marked by a slow transformation of the moral frame through the mobilization of various legal arenas: courts, to a large extent, and professional committees. This transformation contributed to maintaining the acceptability of this reproductive alternative in the province and solidified the idea that law could secure the practice and avoid ethically contested situations. Through the years, the moral and the legal frames coexisted until the early 2000s, when the legal frame supplanted the moral frame. The dominance of the legal frame between 2000 and 2010 contributed to subsuming of the moral stance the federal law imposed in 2004 by prohibiting compensation of surrogate mothers. It also consolidated the logic according to which the best interests of the child can be fulfilled by the declaration of parentage because of the intention of intended and biologically-related parents and the consent between parties.

Law Reform Commission

Surrogacy is often seen as a possibly hazardous but inevitable reproductive alternative in Ontario. As early as 1985, the Law Reform Commission report on new reproductive technologies recommended allowing surrogacy contracts in order to avoid clandestine situations and to regulate the protection of all parties involved in such arrangements. In fact, accepting and regulating the practice was seen as the only way to avoid ethically deviant cases and to protect the children and the involved adults. This openness to debate legislative options in regard to surrogacy was still attached to a moral argument and to an evident worry surrogacy could go wrong. Without prohibiting the practice, which could lead only to worst scenarios according to the Law Reform Commission, the regulation would make sure to structure the role of each party. The report was the first step towards a slow but marked shift towards a legal framing of the issue of surrogacy in the province.

In spite of the relative openness the Law Reform Commission seemed to express, many representatives were very uncomfortable with the practice of gestational arrangements. At that period, most of these arrangements involved insemination meaning that the surrogate mother was not just a gestational carrier but that she was also genetically linked to the child. In addition to this fierce attachment to blood ties in the filiation scheme of the province and the representation of paternity and maternity in the society, the stories that were discussed in the media were all very alarming scenarios. The contribution of the media to the moralization of the issue of surrogacy was clear in Charles Beer's (Liberal) intervention on June 22nd 1989 at the Legislative Assembly of Ontario.

> A recent article in the *Atlantic* suggested that surrogate motherhood might become an option for couples who did not want to interrupt their careers. How do we decide questions like these? Surrogate mothering also raises other unresolved questions relating to artificial reproductive technology. What happens if the commissioning parents decide they do not want a child who is born with some kind of disorder? What happens to the child if both parents die, as happened in Australia where the parents were killed in an automobile accident before the child was born? There are also questions that arise after the child is born. Is a father who has donated sperm responsible for custody payments for the child?

> How much should children be able to find out about their biological parents or the mother who carried them? (Beer 1989)

An American[167] case also made the headlines all around the world and contributed to the stigmatization of the practice in Canada. In Ontario the main question was whether to prohibit the practice or not. The option to regulate the issue, as the Law Reform Commission recommended, had been discarded from the list of possible options.

> And then began a series of lawsuit that just sustained the legislative non-action. It constructed through the years a flexible framework. It made appropriate to legally establish the parentage of intended parents as soon as the parties consented to the procedure. The courts were judging the acceptability of surrogacy arrangements. […] It took many years, but in some ways, the political non-action gave time to the courts to construct the law. We were very lucky though, because we didn't witness any bad stories. That's a very big factor for the de-stigmatization […] no that's probably too much, there is still a lot of reservations […] I would say that the absence of scandal made it easier for the court to take control. (Interview Legal Expert Ont-2 – July 20th 2012)

<u>Intention and consent passing the test of a debatable agreement</u>

In 1990, a court case[168] could have changed the story, but the smooth resolution of the affair contributed to sustain the transition from a moral frame to a legal one. The applicants were married in the late summer of 1987. Mr. X. never had children. Mrs. X. had been married before and had three daughters, but was unable to bear further children because she had had a hysterectomy on the medical advice of her doctor. In 1986, Mr. and Mrs. X. entered into a surrogate agreement with Miss Y., aged 23, a daughter of Mrs. X. by her first marriage. Miss Y. took legal advice on the nature and effect of the agreement at the time it was executed in 1986. She continued to consult her solicitor after the birth of the child. The essence of the agreement was that Miss Y. agreed to conceive by artificial insemination through medical intervention, using the sperm of Mr. X. and after the birth to consent to adoption by Mr. and Mrs. X. The necessary medical procedures were carried out in the United States and, after several attempts Miss Y. became pregnant in the early summer of

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[167] *In re Baby M*, 225 N.J. Super. 267 (1988) was a custody case that became the first American court ruling on the validity of surrogacy. William Stern and his wife, Elizabeth Stern, entered into a surrogacy agreement with Mary Beth Whitehead, whom they found through a newspaper advertisement. According to the agreement, Mary Beth Whitehead would be inseminated with William Stern's sperm, bring the pregnancy to term, and relinquish her parental rights in favor of William's wife, Elizabeth. After the birth, however, Mary Beth decided to keep the child. William and Elizabeth Stern then sued to be recognized as the child's legal parents.

[168] Re Ontario Birth Registration number 88-05-045846 [1990] CanLII 3986 (ON CJ)

1987. The child was born in March 1988 and had resided with the applicants ever since. All parties had also agreed to grant a decree of adoption in which the mother and the stepfather of the natural mother would be declared the legal parents of the child and would get custody.

After ruling out the possibility of incest, coercion or payment, the court ruled that the adoption application should be granted, because the circumstances suggested that the adoption was in the best interests of the child. The intention of Mrs. and Mr X. were clear from the arrangement and the fact that the surrogate mother was not taking care of the child after the birth proved her gestational role in the parental project.

> I am of the view that this section does not apply because there was and is no "blood relationship" between Mr. X. and Miss Y. Their relationship at the time of conception was non-existent, being "stepfather-to-be" and "stepdaughter-to-be". Further, there was no sexual intercourse between Mr. X. and Miss Y. […] the mother was not deriving a profit nor any advantage from this situation that could influence the freedom of her decision to surrender the child. Moreover, the prospective adopting parents were not being coerced into making any payments; on the contrary, they found the expenses reasonable and were agreeable to the reimbursement. […] The evidence indicates that neither Mr. X. nor Mrs. X. applied any coercion on her and, in a review by an independent lawyer, the indication is that the biological mother attached no weight to the marriage and that, at all the relevant times, she acted freely and of her own will. […] Finally, it should be noted that Miss Y. no longer resides in the home of Mr. and Mrs. X. The potential for role confusion is therefore considerably diminished. I therefore conclude on the facts as set forth in the documents filed that the application by Mr. and Mrs. X. for adoption of the child should be granted, as this will be in the child's best interests. (paragraph 21)

The court considered that the altruistic and intra-familial nature of the arrangement granted the application an ethical nature that overweighed the recourse to a much disputed technique.

Inevitable impairments

In 1992, the Law Reform Commission of Canada recommended that acting as a paid intermediary in a surrogacy agreement be a criminal offence. As noted by the Commission, the objective of this recommendation was to "stigmatize traffic in human beings" (Law Reform Commission of Canada 1992). The proposal was not unanimous among the Commissioners, however. A minority took the view that the recommendation was either under-inclusive or unnecessary. It would be under-inclusive, they said, in the sense that it should not be limited only to paid intermediaries but, in keeping with its stated objective, extended to anyone who participated in a surrogacy arrangement in any material way. In what appears to be a stronger objection, the minority expressed the view that the recommendation was unnecessary because there was sufficient deterrent effect in the unenforceability of surrogacy contracts. To ensure repression of such arrangements, the minority added that the unenforceability of arrangements "could be supplemented by regulatory offences carrying substantial fines or other penalties". There was a consensus that commercial surrogacy arrangements be supressed, but there were disputes as to whether the law should prohibit all forms of participation in a surrogacy arrangement and as to which legal means were most appropriate for the stated objective. As has been indicated, Quebec decided to nullify surrogacy contracts while Ontario postponed any legislative action.

In 1993, the Royal Commission on New Reproductive Technologies came down hard on all forms of surrogacy arrangements. The commission rejected commercial practices involving the cooperation or management of third parties for profit, contractual agreements whether commercial or noncommercial, and noncommercial arrangements, including informal surrogacy arrangements undertaken by close relatives or friends. The opinion of the commission was clear: surrogacy harmed women, children and society's values. The Commission recognized that private arrangements with no intermediaries involved could not be stopped, but that the interests of children needed protection in that situation. Notwithstanding this general discomfort with the practice, the Commission concluded policy and legislation were not needed to deal with commercial preconception arrangements. Recommendation 199 was not entirely clear in its scope or its rationale in that it seeks the prohibition of conduct relating to participation as an intermediary in arranging surrogacy agreements, and conduct concerning payment for such agreements. It does not seek the prohibition of surrogacy arrangements as such and thus, in principle, the Commission would not seek to censure surrogacy arrangements. This is not quite the same as penal prohibition of any surrogacy arrangement for a financial consideration, but it is nonetheless a clear declaration of legislative policy that the commercialization of surrogacy arrangements is contrary to the public interest. In the province, the idea not to act became the easiest route away from prohibition as well as the best means of securing a future decision against an agreement in a case of an unprecedented dispute. The moral and the legal frames co-existed for many years; the absence of application for declaration of parentage in cases of surrogacy arrangements and the advent of a possible federal legislation calmed the worries down and limited the possible challenges. In this context, non-action was the best political decision to make for Ontario.

A turning point toward a legal framing

In 2002, almost 10 years after the Commission's report, the judgment in J.R. v. L.H.[169] constituted the reference point as for the establishment of filiation in cases of surrogacy arrangements in Ontario. The decision is introduced by an enthusiastic stance by Justice Kiteley:

> This is a good news case. It involves two families who shared a common goal. The applicants and respondents are not adverse. Indeed, they have collaborated in their gestational carriage agreement and this application is simply the legal outcome of a wonderful arrangement. (paragraph 1)

The judge ruled that they were entitled to legal recognition because they were the children's biological parents. JR and JK entered into gestational carriage agreement with LH because JR could not have children. The respondents in the court case were LH and her husband GH. LH gave birth to twins who were the biological children of JR and JK. After LH gave birth to twins, she and GH would normally have been recorded as the twins' parents, in accordance with the Vital Statistics Act. However, the birth of the twins was not registered, and the parties, who were amicable, came to court to resolve parentage instead. JR and JK brought an application for a declaration that they were biological parents of the twins, for a declaration that LH and GH were not the children's parents and for an order directing the Registrar General to issue a Statement of Birth reflecting these facts. Kiteley J. granted the application. Since DNA tests clearly showed that JR and JK were the genetic parents of the twins, they were entitled to be "recognized in law" as the twins' father and mother. The Children's Law Reform Act was silent on the ability of the court to make a negative declaration (i.e. GH is not the father and LH is not the mother). Hence, Kiteley J. found that section 97 of the Courts of Justice Act did permit negative declarations, since the twins' parentage was of such great importance.

The judge sustained the argument by relying on Article 4 of CLRA in order to make a declaration of maternity and paternity in this direction. After establishing legal parentage for

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[169] *J.R. v. L.H*. [2002] O.T.C. 764

the biological parents, the judge focused on determining the non-parentage of the husband of the surrogate mother. The court stated that the application of the presumption of paternity according to Article 8 was refuted. Following this conclusion, the court used section 97 of the Courts of Justice Act to make a declaration of "non-paternity". Finally, as to the parentage of the surrogate mother, the judge determined that she was the birth mother of the child under section 1 of the VSA. Because of this qualification, the judge specified that if the application was confrontational, it had to determine whether Article 4 of the CLRA could appoint two legal mothers to children. However, it concluded that, in this particular case, given that the application was not contested, such an approach was not necessary. The same way the court did with the surrogate's husband, the court used Article 97 to grant a declaration of "non-maternity".

After completing his analysis, Justice Kiteley refused to comment on the need to examine the criterion of the best interests of the child in this type of application. She specified, however, that in any case, the recognition of parentage made in this case fulfilled this criterion. She concluded by ordering the birth certificate to reflect the court's decision. The judgment marked the first decision in which a court built the legal process through which parentage could be established in a case of gestational arrangement. This procedure concealed the belief that surrogacy can be structured and regulated through the courts and the judicial arena would guard social values.

The fall of the moral frame and the construction of legal tools

In 2002, Coordinating Committee of Senior Officials (CCSO) in Family Justice of the Uniform Law Conference of Canada[170] established a working group to look at the issues of determining parent-child status and registering births of children born as a result of assisted reproductive technologies. While work initially focused on amendments to the Uniform

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[170] The Uniform Law Conference of Canada operates in two sections: the Criminal Section and the Civil Section. Delegates, sometimes called commissioners, are appointed by the member governments. The Section makes recommendations for changes to federal criminal legislation based on identified deficiencies, defects or gaps in the existing law, or based on problems created by judicial interpretation of existing law. The Civil Section assembles government policy lawyers and analysts, private lawyers and law reformers to consider areas in which provincial and territorial laws would benefit from harmonization. The main work of the Civil Section is reflected in "uniform statutes", which the Section adopts and recommends for enactment by all relevant governments in Canada. Professional drafters, known as Legislative Counsel, draft uniform statutes for the member governments. Several drafters attend the annual meetings as well.

Child Status Act, the CCSO Working Group identified that only amendments to the uniform Act would not be enough and that a more fundamental review of the policy issues involved was needed. The matter was thus considered in a more comprehensive manner, but the debate over and further adoption of the Assisted Human Reproduction Act in 2004 changed the picture in many ways.

The awaited federal legislation adopted in 2004 made it a criminal offense to pay or offer to pay a woman to act as a surrogate; to pay or offer to pay a person to arrange for the services of a surrogate; to advertise payment for surrogacy or the arrangement of surrogacy; or to assist or counsel any person under 21 years of age to become a surrogate. In addition, reimbursing a surrogate for her expenditures during gestation became a controlled act. The Act institutionalize the moral frame the Royal commission mobilized in the 1990s. However, the absence of complete prohibition demonstrated that the legislator considered surrogacy a possible alternative to create a family.

Thus, beginning in 2005, the CCSO Working Group started a broader policy review and looked at a number of reports on this topic, including the federal government's involvement in the issue. The working group considered the possibility that surrogacy could also stem in an increasing way from IVF instead of insemination - accordingly creating genetic bonds between both intended parents and the child. That could have contributed to sustain declaration of parentage between commissioning parents and the child. Nevertheless, the high cost of an IVF procedure still had a very important impact on the choice of treatment by intended parents when building their family through surrogacy. In 2005, out of the 38 children involving surrogates, 19 were created using both the egg and the sperm from the intended parents. The other 19 involved donation of either the egg or the sperm, but no surrogate births involved both donated eggs and sperm.

In 2007, Federal Provincial Territorial Ministers and Deputy Ministers Responsible for Justice approved the principles in which the report was grounded and the policy approach proposed by the CCSO Working Group. In August 2009, a joint working group with the Uniform Law Conference of Canada and CCSO Family Justice finally published a report on assisted reproduction. The working group's scheme was meant to protect the surrogate in two ways: as the birth mother, her consent would be needed to permit parentage to be transferred to the intended parents, and since surrogacy arrangements would not be enforceable, her rights would be protected and balanced with the rights of the intended parents. In addition, it permitted jurisdictions a choice in determining how to recognize parentage in surrogacy arrangements – either through registration at first instance or by requiring a court order before registration

The report dealt with surrogacy first by stating that surrogacy agreements should not be enforceable and stated how parentage could be determined in surrogacy situations. They suggested the surrogate mother could relinquish her parental status to intended parents. An intention-based structure was considered to be the most appropriate

> This approach provides stability for the child and equal treatment of natural and assisted conception. Since the child is not conceived through natural conception, proof of lack of a genetic link between the presumed parent and the child will not rebut the presumption of parentage. In order to rebut the presumption, the presumed parent will have to prove on the balance of probabilities that he or she did not consent, or prior to conception withdrew consent, to be the child's parent. Where the parent arguing to rebut the presumption provided the egg or sperm, it will be hard to establish that consent was lacking. This approach is similar to the law in Quebec… (Uniform Law Conference of Canada 2009, paragraph 47-48) [171]

Reaffirming intentions and consent

The court's decision in M.D. v. L.L.[172] was the perfect reaffirmation of the transformation of the discourse on surrogacy in Ontario. M.D. and J.D. were a married couple and M.D. was unable to bear children due to medical reasons. The applicants had family friend, L.L., who was able to bear children and was willing to act as a surrogate mother. L.L. was married to I.L. The applicants entered into a so-called "Gestational Carriage Agreement" with L.L. and I.L. in November, 2006. Under the agreement, L.L. agreed to act as a gestational carrier for M.D.'s ova, which had been fertilized with J.D.'s sperm in a fertility clinic. The applicants were thus the genetic parents of the child that was born as a result of the procedure. In the summer of 2007 L.L. gave birth to a child, E.D. After the child's birth, a "Statement of Live Birth" had to be completed and filed with the Registrar. That statement required that L.L. place her name on the form as the "mother" of E.D., notwithstanding the agreement and the fact that the applicants were E.D.'s genetic

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[171] Since the conclusion of their report was in line with Quebec's position on surrogacy with some differences in the systematization of the establishment of parentage, Ontario officials considered the report in a closer way.

[172] *M.D. v. L.L.* [2008] O.J. No. 907

parents. After making inquiries with the Registrar, the applicants' lawyer was informed that an application had to be made to the court in order to declare them to be the parents of E.D. Pursuant to the gestational carriage agreement entered into by the applicants with L.L. and I.L., it was agreed that it would be in the best interests of the child to be placed into the immediate permanent custody of the applicants after birth. The agreement stated that the applicants were not only the genetic parents of the child, but also the "social parents". L.L. and I.L. agreed to relinquish any parental rights over the child, while the applicants confirmed their intention to assume all parental responsibilities. The agreement also stated that the applicants would apply to the court to obtain an order declaring them to be the child's parents, and directing that they be named as such on the child's birth registration. The court noted that the agreement appeared to comply with the requirement under subsection 6(1) of the Assisted Human Reproduction Act, S.C. 2004, c. 2 that no payment to the surrogate mother in exchange for her assistance was made.

The judgment clearly shows how the jurisprudence and the legislative provision allowed the court, in all ways necessary, to establish filiation between the intended parents and the child. The overview of Canadian and international laws – the British HFEAct of 1990 and section 30 amongst others[173] - upheld the decision of the court to rely on intention and consent in its declaration of parentage.

> In Ontario, we rarely see traditional surrogacy; it's generally gestational surrogacy. Considering the position of the surrogate vis-à-vis the genetic origins of the child, it is easier to exclude her from parentage considering that she is not related to the child. There's no such thing as a moral ground outside of the superior interest of the child. According to the case law, as soon as intention to parent, consent and agreement are proven, the court is entitled to create filiation. It's common sense; what prevails is the law and the law tells us to consider the child's interest. (Interview Legal Expert Ont-2 – July 20th 2012)

However, the judgment distances itself from the logic of J.R. v. L.H. in the way it excluded the maternity of the surrogate mother. Indeed, after determining that she was the birth mother of the child under section 1 of the CLRA, the Court ordered a declaration of non-maternity based on its parens patriae jurisdiction. The judge noted, moreover, that it is in the best interests of the child to remove any ambiguity about his or her parentage and declare that the surrogate mother is not legal.

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[173] See next section.

In light of these judgments, the courts in Ontario appear to assume the legality of surrogacy contracts without financial compensation. It is possible to think that this position stems from reverse interpretation of the Assisted Human Reproduction Act of 2004. Since the federal law does not prohibit these contracts, they would be legal in the eyes of the provincial courts. Always being careful not to rule on the possibility of requesting the execution of such contracts, the courts are willing to assign parentage to the social parents. If the surrogate mother consents and the applicant couple provided the genetic material, the Ontario courts are inclined to establish parentage between the biological parents instead of applying the original definition of birth mother and the attached presumption of paternity.

Conclusion

Ontario did not take any direct legislative action regarding surrogacy arrangements. However we could observe a shift in the way surrogacy was perceived in the province in the early 2000s. In fact, policy inaction left the responsibility for managing the establishment of parentage to the judicial arena, which constructed legal tools to sustain the practice of surrogacy when conducted in a non-commercial manner. Even if the moral framing kept its importance through the years (and still does), a legal frame mobilized around consent and intention was adopted by the courts and applied to cases through a reinterpretation of existing statutes. This transformation contributed to institute a structure through which “parentage can be declared in morally acceptable situations” (Interview Legal Expert Ont-2 – July 20th 2012).

Quebec

In Quebec, in spite of the policy changes in regard to filiation by assisted reproduction that occurred in 2002, surrogacy continued to spark unrest and social anxiety. In fact, the moral arguments have long been debated in the province. They are founded on the fear that a preconception arrangement would lead to the commodification of the surrogate mother’s body. Following this line of thought, surrogacy, it is argued, undermines the principle of the legal unavailability of the human body since the process is akin to "renting a womb", and thus undermines the dignity of women. Surrogacy is invoked also as a probable violation of the interests of the child, which is expressly protected by the Quebec law. In this view, the child's interest is totally eliminated from the reproductive process, one that leads to the birth of a child who is the object of the desire of a couple ready to exchange money to be parents. In addition, it considers that the interests of the child cannot be assured because surrogacy has the effect of questioning the traditional structure of the family and the privileged link of motherhood. Finally, since 1992, the interest of the child is viewed as endangered by the use of a process that will create an uncertain legal status for the child and place him or her at the heart of litigation.

In the 1990s, the arguments against the commodification of women and children were tied to the general fear of assisted reproductive technologies. Even if Quebec decided to invalidate surrogacy arrangements in 1992, the practice is nonetheless legal in the province. In the event of an altruistic agreement between consenting parties, the parties would have to inevitably ask for a declaration of parentage in court. By tracing surrogacy between 1990 and 2010 in the province of Quebec, it is possible to note the general willingness of the courts to proceed to a declaration of parentage if the agreement between intended parents and the surrogate meets very strict conditions – i.e. non payment and consent of all parties to the adoption. Despite a case-by-case application of special adoption procedures by the courts, the immoral image surrogacy still carried contributed to limit the scope of any other arguments that could support policy change.

Reforming the code, limiting the practice

In 1991, the Quebec legislature studied part of the reform of the Civil Code meant to regulate each practice of medically assisted reproduction. With the recommendations of the Barreau du Québec, the mother was defined as the one who gave birth to the child and the father as the one who recognized the child or to whom the mother is married (or in common law relationship) at the time of conception. When the legislature enacted this provision, the legislators were in general agreement with this approach. This position of the doctrine and the Quebec legislature was largely consistent with the position that prevailed in French law.

> C'était une entreprise légale sans précédent au Québec. On s'est largement inspiré d'autres systèmes de droit civil plus récent que le nôtre. Le cas français était sans aucun doute l'un des plus intéressant et il faut dire qu'à l'époque la France était dans la mire du Québec. […] Mais la France était pas le seul pays à

> avoir légiférer en matière de gestation pour autrui. La Grande Bretagne aussi avait légiféré dans ce sens là. On a consulté le Barreau sur cette question et sur les autres enjeux de filiation par insémination artificielle et ils sont arrivés à la conclusion que le modèle français était le plus intéressant. Les groupes de femmes qui étaient présents dans nos consultations sur la famille et le mariage étaient d'accord. […] La nullité des contrats de gestation pour autrui semblait la seule option éthiquement responsable pour le Québec." (Interview Public Servant Qc-1 – Ministry of Finances – June 18th 2011)

Surrogacy came to the forefront of the debates on September 5th 1991. The position of all the parties taking part in the Commission des Institutions – the parliamentary group that studied the issue and heard testimonies - was clear: surrogacy was ethically disputable and should be prohibited by the legislature. Gil Rémillard the Liberal Minister of Justice was convinced that the nullification of any preconception surrogacy arrangements would discourage surrogate mothers and intended parents from entering into such endeavors:

> La question des mères porteuses, pour nous, pour le moment en tout cas, dans l'état actuel du consensus social, nous considérons qu'on ne peut pas le permettre. Donc, les conventions de procréation et de gestation pour le compte d'autrui sont nulles; 582 est clair là-dessus. […] Ce que nous disons avec l'article 582, c'est qu'il n'y a pas possibilité de mère porteuse moyennant des conditions monétaires. On ne peut pas payer quelqu'une pour qu'elle porte votre enfant. (Rémillard 1991)

Article 582, it is worth noting, did not address financial compensation or the prohibition of monetary arrangements, nor did it prohibit the practice per se. In fact, after its adoption the only actual impact of the article was to prevent the intended parents from limiting the ability of the surrogate mother to change her mind during the process. Nevertheless, Gil Remillard emphasized that the declaration of parentage would create the need to go through the adoption procedures, which would lead to extra costs and time and accordingly would keep the child and the families in legal limbo. That, in his view, would dissuade parents from pursuing this reproductive alternative.

The opposition leader at the Commission, Louise Harel (PQ), did mention the possibility for altruistic intra-familial surrogacy arrangements to be undergone without problems. However, the Minister of Justice readily dismissed the possibility citing particular situations:

> Et dans ce cas-là, ce que nous voulons faire respecter comme principe, c'est qu'on ne peut pas vendre son corps pour la gestation, pour faire un enfant. C'est ça le

> principe comme tel. L'application du principe c'est que la grand-mère - dans le cas dont vous parlez - la grand-mère, donc celle qui accepte... plutôt la mère qui accepte de porter l'enfant pour sa fille, donc qui est inséminée avec l'ovule et le sperme de son gendre et de sa fille, qui porte un enfant, elle serait finalement la mère de cet enfant qu'elle porte. (Rémillard 1991)

Once again, the intentions of the Minister were clear and the opposition expressed their claims in order to achieve a more strict policy rather than a lenient one. Louise Harel, in her concluding remarks, summarized what would be Quebec's approach in the years following the reform.

> En fait, pour empêcher tout recours à la gestation et à la procréation par autrui, c'est peut-être en visant dans la loi non seulement les personnes qui consentent, mais celles qui participent. **[...]** Le fait est que ça ne semble pas être le cas. Je sais que c'est l'intention du législateur, mais, par exemple, la Commission des droits affirme que la disposition n'est pas suffisamment rigoureuse pour mettre un terme à cette pratique, tout au plus empêche-t-elle les futurs parents d'obliger légalement la mère porteuse à exécuter l'entente intervenue entre les parties. [...] Ce qui semble assez certain, c'est que ça peut permettre, c'est sûr, une action en nullité lorsqu'il y a un contrat qui est porté à l'attention du tribunal, mais ça n'empêche pas pour autant, dans les cas consensuels, s'il n'y a pas de... puisque, dans le fond, il pourrait y avoir de la procréation médicalement assistée par le biais d'une mère porteuse, sans qu'il y ait une action en nullité qui soit introduite. (Harel 1991)

In Quebec law, the null status of surrogacy arrangements has been included in the Code in the chapter dealing with parentage of children born of assisted procreation following the adoption of the Reform of the Civil Code. As specified in the Minister's comments, the aim of this legal text seems less to reside in the prohibition of surrogate motherhood but rather in the impossibility of establishing the parentage of a child born using this practice: "Il a paru contraire à l'ordre public de permettre que la filiation de l'enfant soit déterminée par une convention. Celle-ci étant réputée n'avoir jamais existé, la filiation sera établie suivant les modes de preuve prévus précédemment" (Gouvernement du Québec 1993, p.327). Accordingly, filiation became the legislative tool available at the provincial level to limit the practice of surrogacy.

Commissioning morality

The Quebec government was not alone having concerns about surrogacy. At the federal level, the Royal Commission's review of evidence on preconception arrangements reinforced the moral stance attached to this practice in Quebec and Ontario. The Commission found that commissioning couples had much higher incomes and were more highly educated than the women undertaking the pregnancies, thus:

> […] making it unlikely that the two parties are negotiating as equals. This also undermines the gestational woman's ability to make a truly informed choice to enter such an arrangement. The arrangements have the potential to exploit women's vulnerability because of poverty, or powerlessness, and they leave women open to coercion. […] If she denies her emotional responses during the intimate and deeply human experience of pregnancy and birth, at some level she is dehumanized; if she does not deny them, and so becomes attached to the child, it results in grief and loss. (Baird 1995, p. 494)

All surrogacy scenarios were studied by the commission, and it was concluded that preconception arrangements can negatively affect all the involved parties in different ways: legal, psychological, physical, among others. The Commission was also concerned about the effect on children.

> Even if the actual number of such arrangements is relatively small, their potential detrimental effects on the way society as a whole perceives children and reproduction, are not. Preconception arrangements create social harms by undermining society's commitment to the inherent value of children and diminishing the dignity of reproduction. Canadians value having a genetically related child, but this value alone cannot be upheld in the face of the other values that would have to be sacrificed. A caring society has an obligation to ensure that individual actions--even those intended to benefit some--do not generate greater harms to other individuals or to groups. (Baird 1995, p. 494-95)

The Royal Commission made clear that the benefits of a few individuals were far outweighed by the harm to others and the infringement of the principle of non-commodification of human life. Many stakeholders at the public inquiry argued that the commercialization of motherhood was against Canadian values and the majority of women and medical communities both upheld this view. The Commission maintained and reinforced the decision of the provincial legislature, whilst contributing to the representation of surrogacy as an unethical practice leading to an unorthodox family situation and possible harm to children.

Excluding the unthinkable

This moral framing of surrogacy kept the issue out of the public eye in Quebec for almost ten years. It was only in 2002 that the National Assembly debated assisted reproduction since the reform of the Civil Code. The issue of surrogacy returned, only to be rapidly rejected. However, it was more difficult to exclude surrogacy as an assisted reproductive alternative than it seemed from the start. Louise Vandelac, former member of the Royal Commission, was the first to challenge the equality discourse of the LGBT community to argue that it could lead to moral uncertainties.

> Par ailleurs, de le reconnaître pour des personnes du même sexe dans la loi et donc de faire en sorte que ça puisse non seulement s'élargir, mais que, avec la reconnaissance au fédéral des mères porteuses... on risque fort, même si les contrats sont de nullité absolue au Québec, de se retrouver dans la situation ou, par glissements successifs, on aura recours à des mères porteuses pour pouvoir avoir son enfant, quitte à utiliser le jeu des frontières nationales ou entre... soit des frontières avec l'Ontario et d'autres provinces, soit des frontières avec les États-Unis pour pouvoir avoir son enfant. […] Et le caractère médical, c'est tout simplement que c'est le médecin qui la manipule. Je veux dire, au départ, c'est essentiellement ça. Or, cette pratique, c'est celle qui autorise avec de l'argent, et un contrat dans le cas des mères porteuses, à défaire la mère et à défaire la maternité telle qu'on l'a conçue jusqu'à présent pour instaurer un règne avec deux ou trois mères. (Vandelac 2002)

In a debate on equal access to filiation, the desire of gay fathers to build families could have been concurrent. In fact, the only way for gay male couples to have genetically-related children is through surrogacy. But since the debate on homoparentality was led mainly by lesbian couples, the question came later in the debate. As soon as the issue was raised, legal scholars who favoured the acknowledgement of homoparentality by the law were ready to exclude surrogacy from the techniques used to achieve pregnancy, legislating the outcome of assisted reproduction being more important in their view than regulating the means used to have the child. By doing so, they echoed the discomfort the legislature and many other members of society still had with surrogacy arrangements.

> Oui. C'est un point que je voudrais rendre très clair, c'est que, ni COSUM ni même la Coalition pour les conjoints de même sexe, avec qui j'ai discuté tantôt, ne demandent la triparentalité et personne ne cautionne l'utilisation des mères porteuses. Donc, ça, c'est un point que je voulais préciser. (Igartua 2002)

In short, the 2002 debate indicates how ten years after the inclusion of article 542 in the Civil Code, the issue of surrogacy and specifically, the possible commercialization of such arrangements, continued to be framed in moral terms.

A last worry tamed by the federal law

After many years of debate by the federal parliament and three different bills proposed, the Canadian Parliament finally decided to criminalize gestational arrangements involving the compensation of the surrogate mother. The AHR Act also prohibits the payment of an intermediary to obtain the services of a surrogate mother, or the fact of inducing a woman below the age of 21 to become a surrogate mother or perform a medical act in order to achieve pregnancy. A violation of these provisions is liable to a maximum fine of $500,000 or to a maximum of ten years' imprisonment or to both. Beyond the clear prohibition of commercial surrogacy contracts, the AHRAct does not rule on the validity of contracts called altruistic. The provincial courts have indirectly acknowledged the validity of these contracts through the establishment of parentage. However, in Quebec the courts were more vigilant in this regard and imposed strict conditions for special adoption procedures. While worries expressed in 1992 were tamed by the federal government's legislative action, the moral framing associated with surrogacy was reinforced. Both levels of government then strictly framed the practice of surrogacy in Quebec, first by imposing altruistic standards and then by protecting the surrogate against any harm.

> Les seuls parties prenantes d'une entente sont les parents d'intention et l'enfant. Étrangement ce seront eux qui seront au cœur des litiges entendus par les cours. C'est à travers le principe d'intérêt de l'enfant que la cour créera la filiation. La différence entre l'Ontario et le Québec, c'est qu'au Québec, le tribunal est plus prudent. Les limites de l'acceptable sont plus minces. On ne peut pas se permettre d'écart ou de situation complètement hors norme. Même les liens génétiques entre une mère d'intention et l'enfant ne sont pas assez pour convaincre un juge au Québec. (Interview Scholar Qc-1 – June 8th 2012)

Altruism happened

Quebec courts had heard no cases of surrogacy arrangement or of disputes between intended parents and surrogates. In fact, the court submitted the first judgment in 2007 in the

Adoption – 07219[174] case. Interestingly, this first case was a model of altruistic arrangement and prompt declaration of parentage.

The court studied an adoption application by the wife of the biological father of the child and sister-in-law of the biological and surrogate mother of the child in question. All parties consented to the adoption; no compensation had been given to the surrogate. The adoption was easier considering the familial bound between parties. The court acknowledged that the exercise of parental authority had been given to the applicant together with the father of the child. The period of placement for adoption had been reduced from six to three months by the judgment of February 20, 2007 rendered by Justice Dubé ordering the placement of the child with the applicant for adoption. The court briefly commented on the altruistic nature of the arrangement and the fact that the parties were all connected through enduring familial relationships.

> Vu que lors de l'audition du 29 mai 2007, la requérante a livré un témoignage transparent, crédible et émouvant, décrivant d'une manière simple, avec les mots du cœur, l'histoire de cette offre de pure gratuité, de grande générosité de la part de la conjointe de son frère (conjointe depuis plus de 10 ans) à l'effet de procéder par don de sperme de la part du père de l'enfant et de porter l'enfant à terme, en l'associant étroitement à toutes les étapes de la grossesse et de l'accouchement; Vu l'accord du conjoint de la mère porteuse; Vu que personne n'a invoqué la nullité de la convention de gestation pour le compte d'autrui (article 541 C.c.Q.) et qu'au contraire, l'entente verbale a été honorée par toutes les parties; Vu qu'il ne s'agit pas d'une situation de dérive de l'institution de l'adoption justifiant l'intervention du tribunal dans le but de protéger l'enfant1; Vu que le tribunal est invité à un acte de foi en souhaitant que l'enfant se considère également comme un beau cadeau lorsqu'il apprendra cet arrangement entre les adultes. (paragraphs 5-9)

The case was a good example of a surrogacy arrangement with a happy ending. In addition to being completed in a short period (two months), the outcome was in line with the moral standards asserted in the province since the early 1990s. However, the court's openness to surrogacy arrangements was not guaranteed through this one and only decision.

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[174] *Adoption - 07219* 2007 QCCQ 21504

The new moral turn?

In January 2009, the Court was seized by a placement order application – Adoption 091[175] - for the adoption of a child by the applicant, the spouse of the father of the child. The child had only a paternal filiation declared on her birth certificate. The applicant admitted that she initiated a plan to use the services of a surrogate mother, with the knowledge and full support of her spouse. The couple did not sign any contract with the surrogate mother, but a verbal agreement was made that included payment of 20,000$ for inconvenience and expenses. The applicant and the father of the child paid the surrogate mother the agreed amount of money and the baby was delivered to them in good health. Two days after the child was born, the surrogate mother signed a special consent for the adoption of the baby. Upon leaving the hospital, the child went to live with her father and the applicant and lived with them without interruption since. The court found that the father's consent to the adoption was vitiated because it formed part and parcel of an illegal undertaking and therefore denied the application.

> From the very start, the parental project devised by the applicant and the father of the child inevitably involved the deliberate creation of a situation in which, in order to satisfy their desire for a child, the biological mother would first abandon her baby and then the father would consent to its adoption. (paragraph 62)[176]

The child was not entitled to a maternal filiation at any cost. For the Court to authorize the father's adoption of his child would have been, under the circumstances, "to show willful blindness and confirm that the end justified the means" (paragraph 78).

Following this judgment, the public was outraged that the judge supported a decision that effectively legitimized a child having no mother. Why was he breaking such an harmonious arrangement between parties? Some have even raised the right of parents to have a child and the possible discriminatory nature of the disposition against same-sex couples that can only use this technique to have children, whereas a lesbian couple can achieve motherhood. François Bissonette of Ovo Clinic in Montreal, who uses the technique of gestational surrogacy with his patients, has even sought an amendment of the Civil Code in order to soften the application of the legal principles (Lachapelle 2009). Others have called

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[175] *Adoption 091* – 2009 QCCQ 628

[176] Translation by the court.

for a public debate on this issue, which undermines in their view the traditional concept of motherhood and the family (Collard 2009).

These reactions are reflected in the openness of the court to the principle of equality and informed consent evoked in successive decisions heard the following summer. In the decisions Adoption - 09184[177] and Adoption - 09185[178] an altruistic surrogacy arrangement between a couple and the aunt of the intended mother led to the establishment of parentage and the registration of the intended mother and father on the birth certificate of the twins. In these two decisions, the judge highlights the medical procedure and the fact that no compensation was given to the gestational carrier. The judge extensively justifies his decision and comes back to the intentions of the legislature[179]:

> Lors des débats parlementaires qui ont conduit à l'adoption des articles 538 à 542 du Code civil du Québec, dont l'article 541, une situation de mère porteuse très semblable à la situation présente a été évoquée ("une mère qui accepte de porter l'enfant pour sa fille, donc qui est inséminée avec l'ovule et le sperme de son gendre et de sa fille") et le ministre Rémillard, ayant consulté ses légistes, en venait à la conclusion que l'adoption pouvait se faire alors sous les règles du consentement spécial en faveur d'un parent en ligne collatérale. Cela a été établi précédemment, toutes les conditions objectives fixées par la loi en matière d'adoption ont été rencontrées et permettent d'accueillir la présente requête. Agir autrement en regard de la preuve faite, serait contraire à l'intérêt de l'enfant et contraire à l'ordre public. Comme l'indiquait la Cour d'appel du Québec, sous la plume de l'Honorable Jean-Louis Beaudoin, l'ordre public ne trouve pas seulement sa source dans le corpus législatif; les tribunaux doivent être créatifs et modeler l'ordre public en prenant en compte les valeurs fondamentales de la société [...] Il m'apparaît tout à fait souhaitable de permettre à cet enfant, qui représente l'avenir de notre société, de bénéficier de tous les avantages de sa véritable filiation maternelle.(paragraphs 23-24)

The decision suggests that children can benefit from a multiplicity of parental figures. In this case of an intra-familial surrogacy arrangement, the parties are seen as promoting and contributing to the welfare of the child

In addition, the courts showed that year when the parentage of a child is established, the child should be treated equally vis-à-vis other children, regardless of the circumstances of his or her birth. The opposite would negatively influence the child conceived with the help of

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[177] *Adoption – 09184* 2009 QCCQ 9058

[178] *Adoption -09185* 2009 QCCQ8703

[179] Assemblée nationale du Québec, *Journal des débats de l'Assemblée,* 1991, volume 34, no 7, 5 septembre 1991, SCI- 243 à SCI-281.

a surrogat (as was the case for illegitimate children several years ago) and subject him or her to the consequences of his or her parents' reproductive choices. The judge's decisions in Adoption – 09367[180] and Adoption – 09558[181] went in this direction:

> Le fait que le législateur ait précisé aux articles 522 et 523 que les filiations s'établissent par l'acte de naissance qui confère les mêmes droits et les mêmes obligations, quelles que soient les circonstances de leur naissance, fait en sorte que le tribunal ne voit pas pourquoi, il ferait une distinction entre cette enfant et tout autre enfant. (paragraph 15)

In these decisions, two fathers who signed a contract with a California surrogacy agency and paid for the services of a surrogate were granted a declaration of parentage notwithstanding section 541 of the Civil Code. Since the surrogacy agreement and the gestational process had not taken place in the province and given that the mother relinquished her rights in a signed and recognized document[182], the court was not faced with the same conditions as in the case of Adoption – 091. Framing the decision as one of the right of equal access to parenting rather than on the non-compliant gestational process therefore justified their interpretation of provincial values in the establishment of parentage.

However, the two cases (four decisions) that followed Adoption - 091 are much more in line with the decision in Adoption – 07219 a couple of years before. The court's decision amplified the moral ground by sustaining that the interest of the child and the principle of equality between children were fundamental values. Accordingly, the court ordered the declaration of parentage that could otherwise be denied to commissioning parents.

Moreover, in the fall of 2009, the Commission de l'éthique, de la science et de la technologie (CEST) studied surrogacy and debated it in its report on the ethic of assisted reproduction. The result was that the nullity of surrogacy agreements was still considered the most appropriate solution in Quebec. For the Commission, the legal solution existed if the surrogate mother gives the child to the commissioning parents and it could be found in adoption procedures (Quebec 2009, p. 76). The Commission was asked for more flexibility in the establishment of parentage in cases of surrogacy agreements:

> Pour la majorité des auteurs, si l'intérêt de l'enfant a priori – qui est à la source de l'encadrement de la gestation pour autrui – vise à décourager cette pratique et

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[180] *Adoption – 09367* 2009 QCCQ 16815

[181] *Adoption – 09558* 2009 QCCQ 20292

[182] The court took the document as a proof of the informed consent of the surrogate mother.

> commande de ne pas faciliter la régularisation de cette situation, il demeure qu'un enfant est né, et que son intérêt a posteriori demande peut-être que les personnes qui désirent réellement assumer le rôle de parents puissent le faire. (Quebec 2009)

Conclusion

In 2010, two other cases (3 decisions[183]) amplified the moral frame to include new possibilities under the strict legal framework imposed both by the nullity of surrogacy contracts enclosed in the Civil Code and the anti-commodification statutes sustained by federal law. The court relies on an increased number of evidence to maintain the non-commercial nature of the agreement and the informed consent in which the procedure occurred. For instance, the court asked clinicians to testify and confirm that the procedures involved all parties and was made in a informed and consensual context[184]. In addition, the equality among children takes a more important place in the decision of the courts in cases of declaration of parentage. The courts seems to align with CEST recommendation that the interest of the child a posteriori of its birth should be taken into consideration in the filiation of children born through a surrogacy arrangement. In short, the moral frame of the 1990s is still present through the legislative documents and public opinion[185] in Quebec, but the way it is implemented by the courts is shifting slowly toward an amplified version of the moral frame. Indeed, the courts used the interest of the child principle in order to declare parentage in the strict context of the non-commodification statutes. By including different legal principles, such as consent, equality and the interest of the child in discourses, the courts became a performative milieu for the frame to be mobilized and for implementation of the laws to be modeled to new families built with the help of assisted reproductive technologies.

England

England was the first country in the world to have specific legislation regarding surrogate motherhood when in 1985 the Surrogacy Arrangements Act was adopted in

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[183] *Adoption – 10330* 2010 QCCQ 17819 ; *Adoption – 10329* 2010 QCCQ 18645 ; *Adoption 10489* 2010 QCCQ 19971.

[184] See *Adoption – 10330* 2010 QCCQ 17819 and *Adoption – 10329* 2010 QCCQ 18645.

[185] In early 2011, Radio-Canada/CBC reports of surrogacy agencies in India created a lot of reaction against the commodification of women's bodies, especially in developing countries.

reaction to the Warnock report. The principal pieces of legislation governing surrogacy in England are the Surrogacy Arrangements Act of 1985 and the Human Fertilisation and Embryology Act of 1990. The legal status of a surrogate child with regard to its legal parentage was an issue unaddressed in the Surrogacy Arrangements Act, forcing all parents (including genetic parents) to go through a lengthy adoption procedure to secure filiation. The HFEAct of 1990 attempted to amend this situation through the creation of parental orders offering an administrative channel instead of a judicial venue for intended parents. Parental orders, upon successful application, enable the General Register Office (GRO) to re-register the child's birth in favour of the commissioning parents. This was further amended in 2008 by the Human Fertilisation and Embryology Act section 54, which opened the availability of parental orders from solely husband and wife to civil partners and two persons living together as partners in an enduring family relationship. While much simpler than adoption, there are still a number of conditions that must be met for a parental order to be available. For instance, informed dual consent is mandatory; one of the applicants must be genetically related to the child; conception cannot have taken place through natural intercourse; and the child must be currently living with the applicants. Finally, reflecting the aforementioned provisions prohibiting commercial surrogacy, there is a restriction in Section 8 on the making of payments to surrogates[186] and such payments preclude the availability of a parental order.

Despite the attention the issue attracted then and now, surrogacy has never provided a major technique for building families in England[187]. The moralization of the issue is quite striking when studying the policy development from the Cotton baby affair to the most recent implementation of the HFEAct of 2008. The stability in the representation of surrogacy and the somewhat common opinion that surrogacy could lead to legal and ethical problems contributed to the slow development and minimal policy changes adopted throughout the years. Nevertheless, in contrast to the situation of the late 1980s and early 1990s, there appears to have been a change in views as regards the acceptability of surrogacy from around the mid 1990s. The abovementioned first order policy changes that occurred

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[186] The courts' ability to authorise payments other than expenses reasonably incurred was used in *Re C.* Here, despite finding that the applicants had made an unlawful payment of £12 000 for 'loss of earnings', a parental order was made as it was judged that it would be in the child's best interests.

[187] Given this context, by the end of 2010, according to COTS there were more than 700 surrogate births in England.

between 1990 and 2010 were dominated by a moral paradigm that was slowly amplified in order to adjust the system to evolving values, allowing this practice to occur within the boundary of the law with increasing flexibility.

The Warnock report, the Baby Cotton affair and the moralization of surrogacy

The late 1980s saw a succession of events contributing to the moralization of surrogacy. Commentators maintain that the subsequent legislative actions were a reaction to moral panic creatyed by a series of sensationalized cases, particularly the Baby Cotton affair (Interview Eric Blyth – April 18th 2011, Interview with Legal Scholar Engl-3 – March 15th 2011, and Interview with Public Servant Eng-1, NHS Manager, Region of London, February 17th 2011). When the British government began to consider introducing legislation to regulate assisted conception in the 1980s, there was no intention to include surrogacy arrangements within the proposed regulatory framework. Mainly, surrogacy arrangements were undertaken in the privacy of homes and with simple self-made inseminations, thus excluding it from the inquiry. Indeed, members of the Warnock Committee disagreed over what to do about surrogacy. In general, the recommendations of the Warnock report were seen as overly paternalistic, in contrast to the pro-autonomy stance of other methods of assisted reproduction. The majority of the Committee's members wished to see it at least partly criminalized, although two dissenting members considered that it could provide a legitimate reproductive alternative in cases where couples tried other options. This permitting option was discarded hastily.

In the Warnock Report, surrogate motherhood is discussed only briefly; the issue is addressed in only six pages of the 89-page Report. Concerning surrogate motherhood, the Warnock Committee made two major recommendations. One was that all surrogate motherhood agreements should be illegal contracts and therefore unenforceable in the courts, just as it is in Quebec. The other was that the creation and operation of agencies whose purposes included the recruitment of women for surrogate pregnancy or making arrangements for individuals or couples who wished to utilize the services of a carrying mother should be a criminal offence. The present law in England conforms to the first but not second recommendation. The rationale given by Warnock for these recommendations highlights the moral frame the discourse on surrogacy consolidated at that period:

> That people should treat others as a means to their own ends, however desirable the consequences, must always be liable to moral objection. Such treatment of one person by another becomes positively exploitative when financial interests are involved. It is therefore with the commercial exploitation of surrogacy that we have been primarily, but by no means exclusively concerned. (Warnock 1984, paragraph 8.17)

The Warnock report neither made it clear what was meant by "exploitation", nor why surrogate motherhood, especially commercial surrogate motherhood, was exploitative. The arguments given in the Warnock Report against surrogate motherhood amount, in essence, to the claim that it was felt to be ethically unacceptable. Surrogacy was curiously the only issue studied by the committee through the lens of public opinion instead of philosophy (McHale, Fox et al. 1999, p.636-637)

> There are strongly held objections to the concept of surrogacy, and it seems from the evidence submitted to us that the weight of public opinion is against the practice. The objections turn essentially on the view that to introduce a third party into the process of procreation which should be confined to the loving partnership between two people, is an attack on the value of the marital relationship. (Warnock 1984, paragraph 8.10)

Wendy Greengross and David Davies' expression of dissent is not against the possible legal enforceability of surrogate motherhood agreements.

> If our proposals are accepted, we believe that it would be inappropriate for steps to be taken to provide that all surrogacy agreements are illegal contracts.... For the time being the Courts should be free to consider individual cases on their own merits if they so choose. (Warnock 1984, paragraph 9)

Greengross and Davies recommended that, under license and with suitable regulations, surrogate motherhood agencies of some sort, akin to traditional adoption and fostering agencies might be legally acceptable. Despite their careful openness, to a large extent, the minority agreed with the majority recommendation concerning commercial surrogate motherhood agencies but disagreed, to an extent, with the majority's rationale for it.

> We go along entirely with our colleagues in our disapproval of surrogacy for convenience. We also agree that the criminal law should be brought in to prevent the operation of profit making agencies in this field, although our reasons for this are somewhat different from those of our colleagues. In our view the question of exploitation of the surrogate mother, or the treating of her as a means to other people's ends, is not as clear cut a moral issue as our colleagues assert. On the other hand we hold firmly that the very difficult personal, legal and social issues raised by surrogacy lie close to those raised by adoption and fostering and hence

> there should be no place for commercial operations just as there is no place for commercial adoption agencies. (Warnock 1984, paragraph 3)

The report was not the only encouragement given to government anti-surrogacy legislation. In 1984, surrogacy hit the headlines with the birth of John Dodd, closely followed in 1985 by Baby Cotton. In 1985, Kim Cotton, "the first surrogate mother"[188] was paid £6 500 to have a baby for an infertile foreign couple, in an arrangement brokered through an American agency. When the deal was leaked, Kim sold her story for a further £15 000, prompting a public outcry over "rent-a-womb"[189] arrangements, which appeared to center on finances rather than the welfare of the child and the suitability of the prospective parents. In the resulting turmoil, Baby Cotton was made a responsibility of the court after she was born and looked after by nurses until the court decided[190], seven days later, that she should be adopted by the couple who had paid for her. The judge established the paramountcy of the child's welfare over any other consideration, but still mentioned the problematic nature of the arrangement.

> First and foremost, and at the heart of the prerogative jurisdiction in wardship, is what is best for the child or children concerned. That and nothing else. Plainly, the methods used to produce a child as this baby has been, and the commercial aspects of it, raise difficult and delicate problems of ethics, morality and social desirability. These problems are under active consideration elsewhere.

As a direct result of these two births, Kim Cotton and Gena Dodd came together and, in 1988, they founded Childlessness Overcome Through Surrogacy (COTS)[191].

These early influences were clearly hostile towards surrogacy and as such subsequent legislation was inevitably restrictive, discouraging surrogacy. The unenforceability of contracts coupled with strong anti-commercialization provisions provided significant obstacles to any surrogacy arrangement. The Surrogacy Arrangements Act that was adopted

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[188] She was presented by the media as the first surrogate mother despite the fact that she probably was not. Many scholars described that the practice of surrogacy was widespread well before the advent of assisted reproductive technologies.

[189] This expression is widely used in England, while very few people – apart from experts who studied the issue closely - know or use it.

[190] *Re C (A Minor) (Wardship: Surrogacy)* [1985] FLR 846

[191] COTS is a support network for surrogate mothers and intended parents. They help couples and surrogate navigate the English law and the process of having a child through surrogacy. COTS also advocates for the rights of surrogates and commissioning parents. A subsidiary group of COTS, known as *TRIANGLE*, introduces infertile couples to women prepared to become surrogate mothers. A second organisation, the *Surrogate Parenting Centre* (SPC) was set up in 1993 by Claire Austin, a former surrogate mother. A subsidiary of SPC, *HOPE*, provides the initial contact between prospective commissioning couples and surrogate mothers.

rapidly in 1985 is a direct response to the feeling of urgency the Warnock report and the media coverage of the Cotton affair instilled in the late 1980s.

Section 30

In the midst of the HFEAct formulation was an ambiguity regarding whether prohibition or strict regulation was the appropriate policy instrument. Under this Act, although it is not a crime to be a surrogate mother nor to be a commissioning parent, commercial surrogate agencies and the commercial actions of surrogacy agents were prohibited. It was restated in section 36(1) of the Human Fertilisation and Embryology Act (1990) that no surrogate motherhood arrangement was enforceable by or against any of the parties involved.

That the 1990 Human Fertilisation and Embryology Act became a vehicle for exercising any measure of regulation over surrogacy was largely unexpected, beginning with what was a rare instance of gestational surrogacy. At that time, there was little evidence that the medical profession or other health-care professionals were routinely involved in providing surrogacy services. In 1995, section 30 of the same Act came into force, the effect being that married couples who had commissioned a surrogate mother to carry a child for them could be granted a parental order and therby were regarded as the legal parents of the child. The sole condition was that one or both of them supplied the gametes of the embryo of the child. A further article was that the court had to be satisfied that the husband or wife in the arrangement, unless authorized by the court, had given no money in exchange for the surrogate 'services' other than expenses reasonably incurred.

Following its implementation, the court in Re Q (Parental Order)[192] was asked to determine a parental order under section 30 of the HFEAct for a child born as a result of a surrogacy arrangement where the child was the genetic offspring of the commissioning couple. Q was the genetic child of a sperm donor and the wife of the commissioning couple and was carried to term by an unmarried surrogate who was inseminated at a licensed clinic. The surrogate was paid £8, 280 by the commissioning couple to cover her expenses and loss of earnings. The commissioning couple applied for a parental order under section 30 of the Human Fertilisation and Embryology Act of 1990. Under section 30(5) of the Act the mother

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[192] *Re Q (Parental Order)* [1996] 1 FLR 369

and father of the child must consent to the making of the parental order. The question arose as to whether the husband was the father of the child by virtue of section 28(3) of the 1990 Act and hence his consent was necessary under section 30(5). In a decision which made no comment on the desirability of surrogacy Justice Johnson granted the order.

Over subsequent years, the BMA struggled with the ethical and professional challenges posed by surrogacy and, by 1996, it acknowledged surrogacy as a reproductive option of last resort, publishing ethical and practice guidance for health and other professionals involved in surrogacy arrangements (British Medical Association 1996). In practice, an increasing number of licensed clinics were providing treatments involving a surrogacy arrangement. In 1997, Balen and Hayden (1998), through their national survey of licensed treatment centers, identified 29 centers providing host[193] surrogacy (25% of all licensed centers) of which eight provided straight[194] surrogacy (7% of the total). Finally, in July 1998, for the first time the HFEA Code of Practice (Human Fertilisation and Embryology Authority 1998) contained guidance for centers on their responsibilities when providing treatment that might lead to a surrogacy arrangement.

Brazier and the need for reform

In June 1997, Margaret Brazier was asked by the then Labour Government to chair a review of the laws regulating surrogacy. The subsequent Brazier Review made a number of recommendations, strongly arguing the need for greater and tighter regulation. The three members of the Review Committee were Professors Margaret Brazier (Chair), Alastair Campbell, and Susan Golombok. Their report was published in October 1998.

While concerns regarding the protection of the often highly vulnerable participants in surrogacy arrangements remained, the practice of surrogacy visibly increased in the country. Infertility clinics had become gradually more involved and many were providing IVF surrogacy services, doctors had become more accepting of the procedure, and surrogacy stories were becoming more common in the media.

> The change in attitude within the medical profession has had two significant results. "Medical endorsement" of surrogacy adds to its respectability. Couples

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[193] Through IVF, meaning the surrogate is not genetically linked to the child, but the two commissioning parents are.

[194] Through insemination, meaning the surrogate is genetically linked to the child.

> who wish to utilise full surrogacy where they are the genetic parents of the child can obtain assistance in establishing a pregnancy via IVF at a licensed clinic. Couples who seek partial surrogacy but with the reassurance of medical supervision can also do so. In both cases that ability to seek professional involvement is likely to be dependent on ability to pay. There have been to our knowledge at least two instances of health authorities being asked to pay for surrogacy services, but generally such services are confined to the private sector. What medical practitioners do not involve themselves in, however, is the process by which commissioning couples find a surrogate. Doctors may often now be willing to advise generally on surrogacy arrangements and assist in establishing a pregnancy. They do not (and might well fall foul of the 1985 Act if they did) assist couples to establish a surrogacy arrangement. A couple seeking medical assistance to establish a pregnancy must either have found their own prospective surrogate independently, or have obtained assistance from one of the non profit-making organisations set up to support commissioning couples and surrogates, such as COTS and SPC. We understand that some clinics will refer patients contemplating surrogacy to such organisations. (Brazier, Campbell et al. 1998, paragraph 3.26 and 3.27)

Some of the more unusual cases, particularly those involving intra-familial surrogacy, were seen as raising novel issues regarding the welfare of potential children. Moreover, the ban on commercialization of surrogacy was hard to enforce, with the levels of payments to surrogates thought to be increasing. And, finally, one highly publicized case provided a particular impetus for reform[195].

> The incomplete implementation of the recommendations of either the majority or the minority of the Warnock Committee created a policy vacuum within which surrogacy has developed in a haphazard fashion. (Brazier, Campbell et al. 1998, paragraph 3.26 and 3.27)

The terms of references of Brazier's Review Team were quite narrow. They were to consider whether payments, including expenses, to surrogate mothers should continue to be allowed, and if so on what basis; to examine whether there was a case for the legislation of surrogacy arrangements through a recognized body or bodies; and if so to advise on the scope and operation of such arrangements; in the light of the above to advise whether changes were needed to the Surrogacy Arrangements Act 1985 and/or section 30 of the Human Fertilisation and Embryology Act 1990. It was specified that it was not the role of the team to consider surrogate motherhood overall. Tessa Jowell, the Minister for Public Health

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[195] Karen Roche publicly changed her mind after agreeing to act as a surrogate for a Dutch couple, first claiming untruthfully that she had had a termination and later stating concerns over their suitability as parents as a reason for refusing to give up the child.

at the time appointed the committee and framed the review in very strict ways, widening the legislative possibility while keeping a tight ethical direction. The most important part of the background to the setting up of the Brazier review was concern that commissioning couples were - without prior authorization by the courts - paying carrying mothers more than reasonable expenses. In other words, rather than being consequently denied parental orders, commissioning parents were having the payments authorized retrospectively after being granted the orders. The commercialization came back as the greater moral barrier to surrogacy arrangements.

The Review Team considered that its recommendations were more similar to the minority rather than the majority view of the Warnock Report concerning surrogate motherhood. Likewise, Brazier and her team wanted to regulate and control surrogate motherhood rather than to ban and/or prevent it completely. The Review Team recommended that parental orders should not be granted to couples who paid more than actual expenses directly relating to the pregnancy. In addition they recommended that a new Surrogacy Act should define the actual expenses and that parental orders should be obtainable only in the High Court as an alternative to parental orders.

Furthermore, the Brazier report recommended that surrogate motherhood agencies like COTS should legally be required to be registered by the Department of Health. And, as is presently the case, only agencies that function on a non-profit making basis should be legally permitted to operate. To operate an unregistered surrogate motherhood agency would become a crime. Moreover, it would not be a criminal offence to be a surrogate mother nor to use one, whether or not payments above that of expenses were exchanged. The Brazier report also recommended that a Code of Practice be drafted. This would, in terms of the proposed Surrogacy Act, be legally binding on surrogate motherhood agencies although it would not be binding on the surrogate mothers and commissioning couples. The Team clearly envisaged that it would be part of the Code of Practice that commissioning couples do not pay more than statutorily defined expenses. Finally, the Review Team recommended for consideration the view that the Surrogacy Arrangements Act 1985 and section 30 of the Human Fertilisation and Embryology Act 1990 should be repealed and replaced with a new act. It was also indicated by the committee members that their proposed Code of Practice: "... should confirm that the welfare of the child to be born must be the paramount concern of all those involved in any surrogacy arrangement."

Shelving Brazier

The Brazier report never made law or influenced implementation per se. In fact, between 1998 and 2004, the issue of surrogacy was discussed only with the publication of scandalous stories by the media. Within six years, the intra-familial or commercial surrogacy stories changed to become cross-borders surrogacy disputes, which complicated in many ways the debate and rendered solutions increasingly blurry in the eyes of the legislator.

> Surrogacy is a complicated issue for the parliament to deal with. In many ways the debate is founded on ethical or moral standpoints. With years, further the practice was taken care of by medical parishioners, further the law was easy to frame into policy. The appointment of the Brazier review team was a proof of the legislator's intention to put the issue on the parliament's agenda. The many changes in the government after the general election of 2001 and the fact that the review of the [HFE]Act was coming fast are factor that could have led to the overruling of the reform. But I would argue that the cross-border surrogacy arrangements that went wrong in the following years contributed to reaffirm the moralization of surrogacy." (Interview Legal Scholar Engl-3 – March 15th 2011)

In its 2004 report on human reproductive technologies, the House of Commons Science and Technology Committee had noted some of these concerns and recommended that the government should review surrogacy within the context of any overall assessment of the 1990 Act. It suggested starting with the Brazier Review's recommendations and a review of further developments since 1998. The government's subsequent consultation regarding the 1990 Act did include an entire section on surrogacy, detailing the Review's recommendations, and asking three very general questions: "what, if any, changes are needed to the law and regulation as it relates to surrogacy?'; 'if changes to the law and regulation on surrogacy are necessary, do the recommendations of the 'Brazier Report' represent the best way forward?', and, finally, 'if changes to the law and regulation are necessary, should they be taken forward as part of the review of the Human Fertilisation and Embryology Act, or in separate legislation?"(Human Fertilisation and Embryology Authority 2004). Yet, any willingness to revisit the law of surrogacy appears to have evaporated during the reform process. Other than minor amendments, the only further reforms introduced specifically with surrogacy in mind were some small changes to the criteria for a Parental Order.

In 2007, the case of In the Matter of N[196] involved a dispute over a surrogate born child between the surrogate parents and intended parents, where the court eventually awarded care of the 18 month old child to the intended parents.

> I rather think that, because the insemination was conducted with the consent of the husband of the biological mother, then her husband is to be treated under the Act as the father, and no other person is to be treated as the father, in law. That produces the situation that the biological father is to be treated as not the father, and therefore, incidentally, requires permission to apply for orders in relation to the child; it being impossible for several reasons, not least a) the passage of time, but b) more conclusively, the absence of consent, for the biological father and his wife to have applied for a parental order under Section 30 of the 1990 Act. (paragraph 19)

The case was an example of the importance of the court's use of consent to treatment and intention to parent as a basis for establishing parentage. It was one of the first judicialized affairs in England after the adoption of the HFEAct of 1990 and the subsequent parental orders. Thus, it proved the importance of facts in resolving of disputes involving surrogate motherhood for the courts considering the paramountcy of the welfare of the child born through such arrangements.

Amplify morality

When the Parliament was reforming the HFEAct in 2007 and 2008, surrogacy was introduced again into the arena. In spite of multiple occasions between 1990 and 2008 when the law was considered in need of broad reform, the debates on the new HFEAct only relied in general on the extension of parental orders to same-sex couples. The decision-makers did not consider the question of whether surrogacy arrangements should be granted legal value.

> The internationalization of the issue contributed to limit the parliament's eagerness to enter that debate. The former laws and regulations were difficult to implement in a comprehensive manner, like any other laws and regulations would have been. Surrogacy is the kind of irresolvable issue that you can try to take hold of infinitely and never do. And I would add that the HFEAct of 2008 and the previous debates were about parenthood and equality, not about ethics. That time was past." (Interview Legal Scholar Eng-2 – January 22nd 2011)

According to the 1990 law, only married couples in which one partner is also genetically related to the child are able to apply for a Parental Order; however, new legislation extends

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[196] *In the Matter of N (a Child)* [2007] EWCA Civ 1053

this right to civil partners and also to parents, opposite and same sex couples, where there is no formal union, as long as they are living as partners in an enduring family relationship.

> The HFEA Act 2008, like the HFEA Act 1990, contains powers to apply provisions of the adoption legislation to the Parental Orders. However, the adoptive legislation in England (Adoption and Children Act 2002), […] has been updated since the original 1990 Act. New regulations are required to reflect these updates, and the change in the HFEA Act 2008 to allow in addition to married couples, civil partners and other couples living as partners to apply for Parental Orders. (British Fertility Society 2009)

In 2009, the Department of Health launched a consultation on the regulation of Parental Orders, which are used to transfer legal parenthood from a surrogate to the couple who commissioned the surrogacy arrangement. Regulation was necessary to establish how the courts would grant Parental Orders in these new circumstances. The new Draft Regulations were supposed to bring the process for granting Parental Orders more closely into line with modern adoption law that had been amended in 2002. The consultation concerned the content of the Draft Regulations, including ensuring certain factors were taken into account such as the welfare of the child, as well as setting out the legal status of the child who was the subject of a Parental Order, the powers of the court and provisions about the Parental Order Register.

The Draft Regulations were specifically not intended to open up any other debate on surrogacy or its regulation, despite the fact that the new HFEAct and the consultation process leading up to it did little to re-address the issues that surrogacy raises, including those relating to parenthood.

> Importing the new adoption law without amendment fails to adequately take account of the special nature of surrogacy arrangements, and there may be a risk that this could make the process of applying for a parental order even more onerous than before. While a parental order is similar to an adoption order (in the sense that it transfers legal parenthood from one person to another), surrogacy is very different from adoption. Because a surrogate child (or at least those to which parental orders can apply) is biologically connected to at least one of the commissioning parents and is almost invariably in their care from birth, the dynamic of the family is perhaps closer to donor conception than to adoption. Adapting adoption law is therefore a difficult task, and one which we think could be handled more carefully by the regulations. (Gamble and Ghevaert 2009)

Following the Regulations, a court considering whether to grant an adoption order has to first consider the “welfare checklist”, a prescriptive list of considerations which includes ascertaining the child's wishes and feelings and considering his or her relationship with the birth family. The new parental order regulations incorporate this checklist into the parental order process.

> However, it does not seem appropriate for the court to have to address all these issues in surrogacy cases, given that the child will inevitably be less than six months old, and will be already living with the applicants. It is not because principles of intention and consent are at play that adoption and surrogacy is legally alike. The parallel went too far. It's okay to compare the children's situation vis-à-vis their need to know about their donor or parent within these parameters, but when we establish parentage the mechanism is in part easier to solve and in part way more difficult. The genetic factor creates a dynamic that modify in unintelligible ways the links between parties. (Interview Legal Expert Eng-1 – June 14th 2011)

Conclusion

In 2008, the Secretary of State for Health reminded the House of Commons how important and fundamentally ethical the issue of surrogacy was. While the issue was still framed in moral terms, the circumstances of surrogacy arrangements changed in many ways between the late 1980s and 2010. The common view that surrogacy could (and did) lead to legal and ethical problems contributed to the speed with which strict regulatory initiatives of 1985 and 1990 were introduced and the further slow implementation adaptation and minimal policy changes adopted since then. There appears to have been an evident change in view as regards the acceptability of surrogacy from around the mid 1990s that tends to disappear with the event of cross-country surrogacy contracts. It is difficult to predict if the moralization of the issue of surrogacy will be reinforced by the increasing amount of disputes heard by the courts in regard to cross-country surrogacy arrangements[197]. However, the above mentioned policy changes that occurred between 1990 and 2010 were dominated by a moral frame mobilized through a discourse of caution that was slowly extended in order to adjust the system to evolving family-building values, allowing this practice to occur within the boundary of the law with increasing flexibility.

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[197] Re L (a minor) [2010] EWHC 3146 - awarded parenthood to a British couple who had a baby through surrogacy in Illinois, USA, making the landmark principle that the court must make the child's welfare its paramount consideration (we acted for the parents in this case); Re X and Y (foreign surrogacy) [2008] EWHC 3030 – the first UK case to award parenthood to a British couple who conceived through an international commercial surrogacy arrangement (we acted for the parents in this case); Re G (surrogacy: foreign domicile) [2007] EWHC 2814 – problems experienced by a Turkish couple who conceived with a UK surrogate mother, who were not domiciled in the UK and so not eligible to apply for a parental order.

Morality, reframing and the legal experts' community

Even before the 1990s, Ontario considered surrogacy arrangements while England and Quebec legislated their unenforceability as soon as they could. The issue of surrogacy shows the common mobilization of the moral frame and the constant worries attached to this practice of assisted reproduction. But the case of Ontario reveals the ability to reframe an issue through its slow normalization by the legal expert community. In this way, the issue of surrogacy is instructive; it reveals the persistence of the moral frame, the counter-intuitive impact of reframing and the role of disciplines such as law in the construction of meaning.

The salience of the moral frame is undeniable in this issue and in the three units studied. The uncertainties and possible troubles associated with this practice conferred to a few stories of surrogacy that ended in controversy massive media coverage and increased public discomfort. One big difference was still observable: the logic of the reservations. In fact, in Ontario the involved actors were concerned with the possible harms to children most particularly, while in Quebec and England, public discourses were oriented towards both the damaging nature of the commodification of women's bodies and of potential offspring. This different articulation of the moral frame contributed to the flexibility of the Ontario discourse and its greater openness to the logic of the legal principle of the interest of the child.

The issue of surrogacy is also notable for how it presents the power of discursive mechanisms to activate changes or limit policy movement. In England, the extension of the moral frame, as small as it was, contributed by means of mobilization by would-be-parents and constant attention of elites of the HFEA, to open the legal framework and secure the relationship between parties involved in such arrangements. The 2008 changes were accompanied by discourses anchored in moral grounds: it was immoral to leave parties, mother and children, in a situation of legal and social uncertainty. Hence, the protection of roles and responsibilities of involved parties, instead of the simple prohibition of payments and contracts was linked to a moral stance that accompanied the issue when it was first regulated in 1985. In changing the law, the government and its agency (HFEA) fulfilled its role as protector of good practices of assisted reproduction and as custodian of the welfare of the child. In Quebec, the changes in the implementation of the civil code articles by the courts follow the same logic. The courts protect the child and the surrogate by examining the context of the reproductive procedures in detail and by assessing the nurturing environment in which the child will grow.

In Ontario, the largest difference resides in the shift towards a legal frame mobilized through discourses of intention, consent and parental project. Reframing thus contributed to securing the status quo by slowly implementing and sustaining a legal, 'intention-based' framework. In other words, through law and legal expertise, the debate incrementally subsumed the potential immorality of the practice; the law was therefore the guardian of children and the legal experts the emissary of legal and moral acceptability. This shows how a discursive mechanism can trigger a cascade of events as much as limit the scope of a debate. The persistence of the moral frame supported a strict regulation of surrogacy in Quebec and England. Frame transformation in Ontario, however, contributed to maintaining a case-by-case assessment of the welfare of the child in cases of surrogacy while presenting the 'implementers' – the legal experts – as the protectors of common values.

In fact, the politics and social meaning of surrogacy arrangements have slowly changed in Quebec, Ontario and England, and the alarm that surrounded this issue has diminished over time. In Ontario, an alternative frame has emerged, in which altruistic surrogates provide a valuable alternative to infertile couples and individuals. The legal response to surrogacy has also changed in recent years, not only in Ontario but in Quebec as well. The legal approach has been largely pragmatic; courts in Quebec and Ontario and British Parliament were driven by a perception that parties will continue to enter into these arrangements and thus, it is important to have procedures that establish the parental status of intended parents. In the absence of an adequate legislative framework - in accordance with the contemporary assisted reproductive alternatives preferred by would-be-parents – the courts and/or the administration have also enforced gestational-surrogacy arrangements and have held that the intended parents can be named on the birth certificate. The discursive process that led to this outcome, however, was different for Quebec, Ontario and England.

The detailed description and analysis of policy processes in regard to access to fertility treatments, gamete and embryo donation and surrogacy proved to be informative in many ways. The next comparative chapter will stress the diverse factors that came into play in the construction of meaning in the regulation of assisted reproduction and on the influence of frame mobilization on policy outcomes.

CHAPTER 7
COMPARISON AND FINDINGS

The politics of infertility is, no doubt, complex and multifaceted. The mobilization of discourses by communities of actors was shown to influence the way in which three sub-national units (Quebec, Ontario and England) regulated and implemented public policy between 1990 and 2010. The introduction laid out three goals of this dissertation: to unpack the domain of assisted reproduction in order to understand the political dynamics that surrounds these sub-issue; to study frame mobilization in Quebec, Ontario and England in order to understand how frames emerge, are articulated, by whom and where; and finally, to assess the performativity of discursive mechanisms in the policy sub-systems and thereby appraise their influence on the policy outcomes and on the practices of assisted reproduction. Examining common conditions of change and stability in very different contexts and the identification of distinct factors influencing implementation, the study of frames and discursive mechanisms within cases for the three sub-issues of assisted reproduction led me to some interesting empirical findings.

The main purpose of this chapter is to compare frame mobilization in Quebec, Ontario and England about the issue of access to fertility treatment, gamete and embryo donation and surrogacy. I will discuss three main findings that emerge from this comparison: 1) specific frames are attached to policy sub-issues, possess certain characteristics and explain in part the similarities among sub-national units; 2) frames are mobilized by diverse actors and communities in various types of arenas that can trigger a particular discursive mechanism by creating a nested context for frame reflection; 3) discursive mechanisms can influence the policy process and thus the policy outcomes by: inducing a social cascade of events, by limiting the scope of a debate or by sustaining policy status quo. Therefore, this chapter shows how the articulation of frames and the context of their mobilization increase their chance of influencing public policies and how discursive mechanisms initiate change and/or stability in the process of implementation.

Frames

A commonality exists between Quebec, Ontario and England with regard to the dominant frame mobilized by different communities of actors by sub-issues. The image of the issue of access, donation and surrogacy was the same independent of sub-national circumstances. The medical frame tends to persist over time and color all discourses on public funding and access criteria. It dominates the issue of access to fertility treatments. In the same way, a legal and a moral frame take respective priority when it comes to discussing gamete and embryo donation and surrogacy. Independently of the context, the common dominant frame stays the same, suggesting that the three sub-issues bring about set of ideas that allows (or not) the mobilization and the resonance of one policy frame over another. Issues are shaped by their own rationale regardless of the context in which they are discussed, and the resonance of the policy arguments are dependent on that predominant frame in spite of the particular institutional context or configuration of actors.

This finding supports my argument that assisted reproduction needs to be unpacked to adequately study the different policy sub-systems within this larger policy domain. The issues of access, donation, and surrogacy are three issues among others covered under the umbrella of assisted reproductive technologies. Previous comparative public policy literature on assisted reproductive technologies tended to amalgamates policy communities and frames when they are, in fact, specific to a particular sub-issue. Here, they were studied because of their common characteristic of being related to the overcoming of infertility. While they are no doubt inter-related, each sub-issue has its own policy image and thus is constructed around a specific set of ideas.

Another interesting finding comes from the distinction between how common frames are mobilized in Quebec, Ontario and England. My analysis leads me to suggest that despite the common dominant frame stemming from the issue, the way frames are articulated can account, in part, for variation in policy outcomes. Table 9 shows how the dominant frame was not articulated in the same way in all sub-national units, suggesting differences in terms of the alignment of that same frame. As I argue throughout this dissertation, the same frame can be articulated in different ways and induce a variety of political effects.

Table 9: Dominant frame by sub-issue of ART and particular supporting discourses for Quebec, Ontario and England

	Access	**Donation**	**Surrogacy**
Dominant frame	Medical	Legal	Moral
Quebec	Infertility as an illness	Consent and Intention	Exploitation of women
Ontario	Necessity	Consent and Intention	Commodification of reproduction
England	Risks	Welfare of the child	Commodification of reproduction

<u>What is different about the medical, the legal and the moral frames?</u>

How can different frames (medical, legal and moral frames) become dominant and consist in the common policy image of an issue across Quebec, Ontario and England? With the study of the policy process in three distinct spaces, we can observe that the medical, the legal and the moral frames mobilized respectively in relation to the access, donation and surrogacy issues showed four different features that differentiate them from other frames.

1) Their salience

Whatever the issue at stake, how often a related set of arguments is used tells us a great deal about the attention it attracts. In my analysis, the medical, legal and moral frames are the most frequently mobilized frames for the three issues of medically assisted reproduction and the more polysemic ones as well. Their salience is not only due to their repeated presence in policy discourses (number of times the frame was coded in documents/interviews), but also in the perception actors have of their importance in a debate. For that, interviews were instrumental in showing how actors perceived policy arguments in relation to other arguments present in the debate. Interviewees often identified spontaneously one frame as more salient.

2) Their resonance within policy communities and with the political image of the issue

How many individual arguments cluster together to constitute the frame is also important in creating resonance. The epistemic communities do not necessarily have to be big, close-knit or resourceful in order to influence the political debate. In contrast, the type of actors who make up these those communities is more important in that matter. Frame reflection within communities can lead to the emergence of a policy frame that can increase support within and outside communities involved in the policy debate. In addition, frames can resonate in a particular way with the dominant image of an issue. For instance, a frame can complement, sustain or directly challenge the image and thus produce deliberation.

3) Their persistence over time and in different arenas

How long the frame lasts matters, as well. The process of frame mobilization can also lead to the global understanding of an issue in such terms. In my analysis, the example of medicalization is most striking. Through a slow but constant mobilization of the medical frame, the issue of access to fertility treatments became dominated by medical definitions of infertility, fertility treatments, target population, and state intervention. The persistence of a frame through time is a good way to identify the representation of an issue in a given space. In addition, the mobilization of a frame in diverse arenas is also a proof of its persistence and flexibility. In other words, when a frame is mobilized in different settings it shows how it is transferable and malleable.

4) Their flexibility; their ability to be bridged, extended and amplified

The flexibility of the frames is also key; frames need to be flexible to adapt to different contexts; otherwise reframing would occur repeatedly. Yet, reframing attempts are common, but effective reframing happens rarely. That is because frames consist of many different arguments that provide them with adaptability. My analysis shows that it is possible to change the course of a policy process by combining, amplifying or extending a frame. The medical, moral and legal frames were particularly conducive to such discursive dynamics. Because they can be mobilized in different settings and can be combined, extended or amplified, frames maintain their dominance in a political debate.

The greater salience, resonance, persistence and flexibility of a frame, the more likely the frame is to affect policy outcomes. The medical, legal and moral frames were mobilized by more types of actors, in many arenas, and were thus more transferable from one context to another and persistent over time. Their redeeming quality is their ability to be bridged, amplified and extended and accordingly to maintain their dominance in frame reflection. In addition, the other frames, namely the experience-based frame, the family-building frame and the administrative frames complemented and challenged the three dominant frames. In providing new ideas that can be attached to old frames, their presence contributes to frame reflection in positive and negative ways.

Context of mobilization

The policy process with regard to access to fertility treatments, gametes, and embryo donation and surrogacy in Quebec, Ontario and England offers many insights into the factors that drive policy variation among cases. Despite the common dominant medical, legal and moral frames, the performance of the frame in context explains why the three sub-national units developed and implemented different policies in this regard. In comparing frames mobilization, and thus identifying discursive mechanisms and frame alignment, it was possible to identify the triggers of policy change.

Frame mobilization takes place at two levels. First, the policy image needs to be established or a common representation of the issue needs to be fixed and referred to by actors in the debate. This stage is time sensitive and is defined through various public actions. For instance, through media coverage, demonstrations, network creation, judicial mobilization, etc., actors develop their own representation of the issue to be adopted by a larger number of political actors. Second, entrepreneurs or communities mobilizing for policy change need to create resonance between the policy image and their policy preferences. In order to achieve resonance, the policy entrepreneurs and the communities can combine, extend, or amplify the dominant frame. The extent to which they will be able to reach policy-makers will define the nature of policy change. This finding builds on Snow et al.'s (1986) conclusions regarding frame alignment among social movements: indeed policy communities and policy arenas are spaces of deliberation in which frame reflection and alignment occurs, whereas they can also set off a discursive mechanism that will influence the policy outcomes at the outset.

The type of arena is important in the definition, mobilization and counter-mobilization of policy frames. Sub-system arenas offer a space for deliberation that already limit access to communities of actors that are recognized as having an expertise or a recognized experience. Over time, communities came to make their mark in the broader policy debate and won their place in the sub-systemic deliberations. Close-knit policy communities with support from medical, legal or academic communities are more likely to acquire this access and be recognized as interveners in the policy arena by governmental actors, namely public servants and members of parliament. Then, policy entrepreneurs become very important in bringing ideas deeper into the policy system. Prior to their mobilization in the debate, entrepreneurs usually have a favourable position in the system accordingly granting them access to sub-system arenas and decision-makers.

The structure of a nation’s political institutions affects the definition of a policy image and the variety of actors mobilized in the debate. The presence of the HFEA, NICE and the NHS in England, for instance, did offer deliberative space for actors to mobilize their claims and frame the issues in their own way. In fact, sub-system arenas are not a necessary factor for change, but they seem to be a space where frame alignment occurs. That would explain in part why there seems to be more coherence and interrelation between issues and public policies in some settings. For instance, there was more synergy between issues and communities of actors in England than in Quebec or Ontario. This is due to efforts by the Department of Health public servant to coordinate consultations and evaluation in the three sub-issue areas.

Courts also became a very important space for deliberation, especially for the issues of donation and surrogacy in Quebec and Ontario. Many studies have shown that social actors rely on litigation not simply to win favorable precedents from the courts, but also to raise public awareness about their cause and to mobilize activists into the movement. Moreover, research has shown that individuals’ legal mobilization had political consequences. The very act of starting a lawsuit is political, calling on the power of the state to advance individual interests. In fact, a court decision has two lives: one inside the courts and the other in the broader political process. Some decisions are relevant only to the parties involved, others might be of importance beyond the concrete case in question; again others can have lasting effects on future policy. While the highest courts are the most likely nationwide policy-makers, lower court decisions can affect policy implementation and policy direction in important ways. Court decisions are most likely to lead to changes in policy images and the policy status quo if they alter the current legal situation by, for example, declaring a law or parts thereof unconstitutional or overturn existing precedent in light of a new case; in other words, jurisprudence can establish new norms or declare existing norms unconstitutional. Courts can be understood as policy arenas where different problem definitions and frames compete. When the judgment is released, the decision has its second life in the arena of frame competition.

Subnational jurisdictions often are the areas in which new ideas are tried out, later to be adopted and mimicked by others if they are successful, or abandoned if they are found to be unworkable. As much as subnational jurisdictions can be influenced by decisions taken at a higher jurisdictional level, as much as they can react to non-action or to citizen's demands as well. Pressures from below are as important as any other driver for change. The study of subnational jurisdictions shows how multifaceted the discourses elites are dealing with are and how sub-national governments innovate in their ways to implement (or not) political indicators coming from the top down and from the bottom up. That is why policy entrepreneurs and policy communities are more likely to reach decision-makers, given their previous access to the system.

Second, I noted from empirical analysis that different issues are home to different configurations of actors. Some generate the interest of a great variety of competing and conflicting communities, but others witness the mobilization of only a few concerned individuals. The difference is also remarkable between spaces. For the same issue, there is a high variation in the type and number of communities and actors involved in the debate in Quebec, Ontario and England. Additionally, policy entrepreneurs seemed to have the space to act in only a few arenas and their action is sparked off by a certain ideational context. For instance, policy entrepreneurs channeled policy discourses in system arenas where extensive deliberation had already took place. In that context, they were able to introduce a new frame (or combination of frames) that resonated with the dominant image of a policy and/or the specific deliberation. These arenas were in general already limiting access to certain types of actors only or strictly structuring their discourses.

Disciplines such as medicine, social work and law, have a general importance in these debates. However, their dominant influence in the framing of the issue is more apparent in England than in the two Canadian provinces. The medical profession is involved in all sub-issues of assisted reproduction in England, but the competing frames of the social workers and the legal scholars challenged their view on public policy formulation. In Quebec and Ontario, the influence of disciplines is strictly limited to one issue or the other. For instance, the medical profession was involved in the access debate while legal experts were vocal in the donation and surrogacy issues. In England, this separation is not as clear. Professions take a major role in the discussion of policy option whatever the issue at stake. The spaces for deliberation are more numerous and the professions are more systematically consulted in England than in Quebec or Ontario. Yet, in the Canadian provinces, the legal profession seems to play an increasing role in producing policy entrepreneurs of their own. Cause lawyers seem to take a wider place in the development of family law notions as applied to assisted reproduction.

As will be suggested in the following sections, the context of frame mobilization and therefore the actors involved and arenas invested explain in part the outcome of the mobilization of a particular frame. Tables 10 (access), 11 (donation), and 12 (surrogacy) describe how, depending on the sub-issue at stake, the configuration of actors and the arenas mobilized can create a nested context (or not) for frame reflection to occur.

Access to fertility treatments

The issue of access to fertility treatments in Quebec, Ontario and England is oriented around the dominance of the medical frame. The worries related to the risks associated with the techniques tended to disappear in the three states after a few years of practice. This process of adaptation to the discipline was more intense in Quebec than anywhere else, leading me to identify a process of medicalization in the province. While dominant in Ontario and England, the medical frame did not create consensus around a definition of infertility as was the case in Quebec after 2005.

Table 10: Access to fertility treatments in Quebec, Ontario and England – the factors of frame mobilization

	Quebec	Ontario	England
Arenas	Sub-system arena	Sub-System arena	Sub-System arena
Communities	Close-knit communities and policy entrepreneurs	Large, fragmented community	Close-knit community and entrepreneurs
Discourses	Keep the medical prerogative while open for new risks, giving responsibility for care to medical players	Resistance against early policy change – failure to mobilize a counter frame to the medical dominant frame	Keep the medical prerogative while open for new risks, giving responsibility for care to medical practionners and responsibility for child's welfare to families
Outcomes	Policy change	Status Quo	Policy and Implementation changes

In Quebec, infertility came to be viewed as what Conrad (1987, p. 24-27) described as a "lived-with", "at-risk", "stigmatizing", or "invisible" illness and as a narrative response to bodily, social, and cultural failure. That is, infertile couples and women undergoing infertility treatments came to be considered at risk for medical complications and feelings of bodily and psychological failure. Although the biological factors impeding reproduction were still invisible to the majority, and sometimes even for the fertility specialist himself, the social fact of childlessness came to be seen as visible and thereby stigmatizing (Sandelowski and de Lacey 2002, p.43). In the political spheres, the medicalization of infertility offered a rationale for regulation in bringing to the surface the social needs of desperate couples and the medical risk undertaken by women in the process. It also contributed to increased awareness in the population of the social distress brought about by childlessness. In that sense, the medicalization of infertility allowed the narration of stories of infertility and childlessness in accordance with the narration of an administratively sustainable strategy to protect women and children. In Quebec, the medicalization of infertility contributed to bridge the medical frame with the experienced-based frame in political discourse. The sole dominance of a frame was not observed; instead there was a process of medicalization that was slowly constructed over time through the mobilization of the medical frame in various milieus and by various communities of actors. The common reference to infertility as a health care issue is evidence of the colonization of governmental centers, public opinion and communities of experts by the medical frame. This is quite striking in Quebec; moreover, in the interview conducted for this study it became clear that the medical definition of infertility and the solutions that can be implemented by the state revolve around the health care system and its instruments. This specific dynamic was not observable in any other case studied.

The medicalization of the issue in Quebec explains in part why there was a higher tendency toward comprehensive funding and access to fertility treatments after 2005. One interesting fact is the colonization of the medical frame in the debate over gay, lesbian and single women's access to fertility treatments in Quebec. A debate that would appear to be dominated mainly by moral and legal arguments was also dominated by a medical framing of the issue. The argument that "lesbians and their babies could be submitted to undue medical risks if they were prevented from accessing fertility clinics" was very clearly mobilized in

Quebec and led to the extension of the medical frame to enclose new values of inclusiveness and equality of access to health care. The medicalization of the issue in Quebec provided the space for the experience-based frame to emerge as a legitimate frame in the sub-system arenas. A close-knit community of would-be-parents aligned with the medical community on the basis of their common mobilization of the argument that infertility is a medical condition that requires medical assistance. This common medical frame provided a space for would-be-parents to narrate their stories of infertility in experience-based terms, which provided an illustration to a somewhat invisible "illness". One framing gave substance to the other and by that common mobilization were bridged in the discourse of a increasing number of actors in a increasing number of sub-system arenas namely parliamentary arenas, public consultations, political parties discussions over health care priorities, etc.

In Ontario, the dominance of the medical frame is also one of the major features of the issue of access to treatments, but the medical frame is one among many frames that have been mobilized over the years. The salience and the persistence of the "medical necessity" argument clarifies why all of the other frames, namely the experience-based and the family-building frames, had a difficult time emerging in the political debates but proved to be a very important part of the government's argument since 2009. In Ontario, unlike what happened in Quebec, the medical frame was mobilized largely to support the decision to de-fund IVF at first and to support the status quo afterwards. In Ontario, the argument that assisted reproductive technologies are not medically necessary and that infertility is a physical condition is still very important, even if the counter-frames are increasingly mobilized by communities outside government. However, the persistent competition between frames and the constant search for a policy arena in which to discuss the issue help to explain policy stability in Ontario since 1994. The policy communities are largely ensemble of actors that mobilize without resources on a spontaneous basis. When they do have resources, they align with the medical community, which have no direct interest in policy change. Their willingness to mobilize for policy change comes from their sense of engagement vis-à-vis their patients rather than their professional autonomy. The fact that Quebec is a first mover in Canada could also be a reason for Ontario's resistance to change. Public servants interviewed mentioned the high costs of funding and the need for an organizational restructuring as reasons to take time and decide wisely. In a context of resistance, public servants and experts reframed the issues as one of family building, simultaneously blurring policy solutions while opening to a future public engagement.

As we have seen, the constant alternating of frames in Ontario is one reason for the dominance of the ‘medical necessity’ argument and stability in policy outcomes. What analysis shows is the constant search for policy deliberation by would-be-parents and their allies. Arenas and communities were scarce in the battle over funding IVF and when active, their frames did not resonate outside of the close environment in which they are performed. Thus, the frames are not performative, because they do not resonate outside their specific site of emergence. Furthermore, lesbian and single women’s access to fertility treatments were obtained through the influence of other issues such as same-sex marriage and equality struggles. The debates, unlike in Quebec or England, were not formally included as part of the issue.

The constant risk assessment in England and the willingness to obtain high success rates limit the scope of public funding and suppose an evidence-based decision-making process on a case-by-case basis, accordingly giving to PCTs a central role in the decision-making process. Mobilized actors and national institutions such as Infertility Network UK, NICE, the HFEA and the Ministry of Health tried on many occasions to pressure PCTs to implement NICE guidelines through consultation reports, policy directives and media coverage. However, the scarcity of PCTs’ recognition of infertility as a medical condition and their attachment to financial objectives contributed to bridge the medical frame mobilized in terms of risk present at a larger scale in the country to an administrative frame mobilized in terms of cost control and sustainability. The variation among PCTs can thus be attributed to their various representations of infertility and economic responsibilities. PCTs became a milieu of deliberation where administrative considerations came to be seen as parallel to risk assessment in cases of infertility. Even if this relationship is in many cases misleading, PCTs are prone to consider cases of infertility that are “deserving” (medical condition, mostly feminine) and present a high potential for success, that is identified as cost-effective and evidence-based.

The battle over definitions that many of the interviewees mentioned helps to explain the English case. All definitions are contested: infertility, success rates, risks, etc, meaning that sympathy to infertility and its treatment becomes the only reason for funding IVF or not.

The same thing happened when it came time to consider lesbians' and single mothers' access to fertility treatments. Whereas in the two Canadian provinces the issue of lesbian couples access to treatments was seen as a moral question separated from the issue of single motherhood, England was far from being open to single motherhood or homoparentality. In that context, many clinics and PCTs opened their doors to lesbians and single would-be-mothers despite the general resistance to their access to parenthood. By granting a slow but increasing access to treatment for lesbians and single mothers, revising by a matter of fact the "need for a father" clause, the clinics became the first site for contestation of the binary heterosexual definition of the family. The extension of the medical frame came when discussion of the medical risks undertook by lesbian and single would-be-parents were discussed and considered as a pressing medical problem to be addressed. By using the medical frame, the community of actors and experts mobilizing for the exclusion of the "need for a father" clause stayed outside of the moral debate on the best family form and concentrated on the medical and psychological benefits of homoparentality and chosen monoparentality. The medical frame was a tool well-suited to surround the sensitive question of the "best" family form and reoriented the question around the security of patients and the welfare of children. On these questions, agreement came more easily.

Gametes and Embryo Donation

The issue of gametes and embryo donation created differing debates in the three cases studied. The fact that the English system of filiation was legally articulated in connection with the regulation of assisted reproduction practices influenced the debate on access for lesbian and single mothers' access to fertility treatments and legal recognition of their parentality. While in Quebec and Ontario the issue was dominated by this question of legal recognition, the debate in England centered around the rights of children conceived through gamete donation to have access to information about their biological parents. This question was also present in the Canadian provinces, but to a much less degree.

Table 11: Gametes and Embryo Donation in Quebec, Ontario and England – the factors of frame mobilization

	Quebec	**Ontario**	**England**
	Parentage	**Parentage**	**Right to know**
Arenas	Sub-system arena	System arena	Sub-system arena
Communities	Close-knit communities	Individual Actors	Close-knit community and entrepreneurs
Discourses	Bridge the equality frame mobilized to claim same-sex union's recognition to an experience-based frame in order to show how marriage and families are linked and how both needed to be recognized in the same law.	Charter cases claiming that the inability of co-mothers to register on a child's birth certificate was discrimination against same-sex couples. Slow recognition of intention to parent, consent to treatment and active participation in the child's life as fulfillment of the interest of the child principle.	The extension of the right-based frame to acknowledge a wider definition of the welfare of the child. The right to identity became a tool to secure children's welfare after their conception, while the right for supportive parenting secured their welfare a priori.
Outcomes	Policy change	Implementation change	Policy change

In Quebec, in 2002, the debate on same-sex unions led policy-makers to open up the civil code to include homoparental families. The debate on equal access to civil institutions created a window for lesbian couples to modify the filiation system in order to allow the second mother to be included on the birth registration of a donor-conceived child. By mobilizing an experienced-based discourse, the lesbian community was able to bridge their discourse on sameness to a broader legal argument of equality. A small close-knit community built around a politically active couple and a handful of legal experts helped sustain a coherent and strategic discourse at the parliamentary commission. The willingness of the government to listen and to reform created the perfect milieu to argue the intrinsic link between marriage and family and the coherence of reforming both at the time. In the 2000s, the issue of donation benefited from broad mobilization for same-sex marriage in the province. When the lesbian community began to talk about their families and their day-to-day experiences, they had an immediate positive response to their claim by the minister and the opposition representatives.

The story of Ontario showed quite different framing dynamics, however, although it benefited from positive snowball effects from same-sex marriage policy debates as well. The issue of gamete donation was marked by judicial mobilization and the amplification of a rights-based discourse that slowly structured the principle of the interest of the child born of a gamete donation. Legal principles with regard to parenting, the parental project and equality were redefined in order to secure the courts' decisions in recognizing the legal and institutional status of new family arrangements. The amplification happened through the creation of jurisprudence in the province that helped secure case-by-case analysis of the interest of the child. That led to the acceptance by the court of appeal of Ontario to register three parents on the birth certificate of a child and thus argue that in very strict circumstances, it could be in the interest of the child not to define the family in a heterosexual and bilateral way. This case shows how arenas such as courts can contribute to framing and reframing dynamics in the political process. Without entering directly into a political debate, the courts established through their judgment of filiation a self-reinforcing practice. In the case of co-parents' registration, the judicial mobilization led to an administrative change that was already about to happen. In the case of multiparentality where it is impossible to say if the courts could open up again to this form of family, the *A.A. v. B.B.* case certainly clarified the definition of the interest of the child and proposed a reflection on the role of intended parents and the rights of donor conceived children.

In England, the issue of gametes and embryo donation brought about another dimension to the debate. The regulation of parental orders in cases of assisted conception had been taken into consideration and legislated in the early 1990s. Thus, when the "need for a father" clause was reformed into the need for supportive parenting, the former parental orders regulation just adjusted to the new situation. It gave a place for the donor conceived children's voice to emerge. First through the mobilization of their parents, then through the expertise of social workers and then through their own judicial and political mobilization, their claim to access information on their biological origins emerged strongly in the years 2000s. The right to privacy that sustained donors' anonymity in the 1980-1990 period was slowly extended to new ideas on children's rights and parental responsibilities. This rights-based discourse benefited from the resolution of the welfare of the child's debate that had produced heated arguments about the definition of that welfare and how the law could protect it. The social workers and a few entrepreneurs from the discipline were involved in intense policing in order to maintain attention on the issue and raise awareness of the donor-conceived children's situation. Their right to information was linked to their right to identity formation, the pursuit of happiness and the construction of a relationship with their social parents. The legal frame was thus extended to be open to this new representation of welfare, one exempted from shame and secrecy. As was articulated in the case study, the routinization of assisted conception and the slow but sure normalization of the technologies in the mind of society increased the possible emergence of this right-based frame that argued for the right of donor-conceived children's access to biological origins. The year 2002 became a tipping point and led to a social cascade. The court's decision in the Rose affair, the nomination of a new chair at the HFEA, the increasing mobilization of social workers, the Donor Conception Network's integration in the debates, all contributed to the increased salience of the right to identity frame and its further resonance.

Surrogacy

The issue of surrogacy is the one in which the most similarities in frame reflection exist between the three cases. Worries about commodification and exploitation of women's bodies are still present in Quebec, Ontario and England. The context of the moral frame mobilization was very different, however, and can partly explain the apparent differences in outcomes. However, when looking at the implementation of laws, it can be argued that the three states implemented similar legal principles through different instruments. The variation in law seems to be erased in practice. In other words, the implementation of the law proves to be the real policy outcome here; Quebec, Ontario and England are increasingly prone to establish parentage in cases of surrogacy even if the context of such arrangements challenge the moral stances that overshadow the issue. Surrogacy is a good case for illustrating the idea that different frames can be mobilized in order to sustain the same preferences.

Table 12: Surrogacy in Quebec, Ontario and England – the factors of frame mobilization

	Quebec	Ontario	England
Arenas	System arena	System arena	Sub-system arena
Communities	Individual actors	Individual actors	Close-knit communities
Discourses	Open the moral considerations to include all families in the filiation system on a case-by-case basis.	Transform the moral arguments in a legal interpretation of individual cases in order to secure the status quo.	To regulate in order to maintain a cohesion between law and practices of surrogacy.
Outcomes	Implementation change	Reinforcing Status quo	Policy change

In Quebec, the reform of the civil code came with the nullification of surrogacy arrangements. The common worries with regard to the central role of women in surrogacy arrangements and the possible exploitation of the surrogate mother in the process contributed to moralize the issue and to limit the practice to altruistic arrangements only. The federal law of 2004 reinforced the moral frame first introduced in the province by women's movements in the late 1980s. While the moral frame always dominated and is still responsible for resistance to the practice of surrogate motherhood, an increase in number of such arrangements and the medicalization of the process created a pressure on the courts to create filiation. They indeed created filiation but under very strict circumstances only. The courts thus integrated proof-seeking procedures in order to identify which of the relationship between intended and biological parents is in the best interests of the child. The case-by-case reflection ensures that consent between parents was acquired, intention to parent was fulfilled after the birth of the child, and that the arrangement was altruistic in nature. However, a resistance to the legal interpretation of cases is still very present in Quebec. The exploitation of women is often mobilized in public arenas such the as media and Parliament.

The same process was integrated in the courts' reflection in Ontario. Still, the moral frame was transformed in Ontario and a legal frame in terms of intention and consent came to dominate in the midst of 2000. The moral frame oriented around the argument that surrogacy could lead to the commodification of reproduction and baby selling was transformed to become an argument in favor of the interest of the child a posteriori. The mobilization of this child-centered argument was facilitated by the absence of disreputable cases heard by the courts and relative silence in other policy arenas.

In England, the salience of cross-national surrogacy arrangements contributed to the complexification and the reopening of a somewhat settled issue. The 1985 Surrogacy Arrangement Act – much like Quebec's article 542 of the Civil Code - nullified arrangements and – much like the Canada Assisted Human Reproduction Act of 2004 – prohibited retribution of the surrogate mother. Through time, the continuous debate in sub-system arenas such as expert consultation, the HFEA and the family courts, contributed to the redefinition of the issue. The moral frame was extended to include a child-centered view of the establishment of filiation. The major difference in England is the policy change of 2008. The reopening of the HFEAct was the best opportunity to adapt the legislation to the new definition given to the welfare of the child's principle. The exogenous pressures coming from the multiplication of cross-borders surrogacy arrangements also sustained the argument that with the complexification of the issue, internal surrogacy regulations needed to be strictly defined and up to date.

Discursive mechanisms

Frames can be performative - and influence policy outcomes - only if they match the everyday experiences of the involved communities and actors. Frames can also bring shifting interpretations of a problem or solution into play. Frames are relatively elastic packages of ideas that can be molded or shaped in order to more or less strategically answer the context of frame competition. Theur flexible character allows them to be amplified, extended, bridged or transformed in an attempt to modify elites' attention. Table 13 shows how frame mobilization by actors in different arenas led to frame alignment and the triggering of discursive mechanisms.

Table 13: Framing and reframing mechanisms by issues for Quebec, Ontario and England

	Access	Donation	Surrogacy
Quebec	Medical frame Bridged to Experience-based frame	Legal frame Bridged to Experience-based frame	Extension of the moral frame
Ontario	Alternation Medical frame, Administrative frame, and Family-building frame	Amplification of the legal frame	Transformation of the moral frame to a legal frame
England	Medical frame Bridged to Administrative	Extension of the legal frame	Extension of the moral frame

Our analysis shows that frame bridging is often more conducive to social cascades, perhaps because it relates to the policy image while bringing new ideas into the debate. The dominant frame is enhanced by the attribution of a context-sensitive argument. At a certain moment in the policy process, the addition of a temporary but appropriate argument can raise attention and value the former dominant argument. Frame bridging most often induces social mobilization and cascades of events, but does not necessarily lead to policy change. Instead, it can also encourage changes in practices and a new way of implementing laws. This change may seem incremental in nature, but is actually very important in terms of direct effect on citizens. For instance, it could mean a significant increase in the number of people accessing funded treatments per year or in the establishment of filiation for homoparental families.

Frame amplification is more commonly observed when actors and communities attempt to sustain the status quo or justify a decision. In fact, clarifying an argument and defining the parameters of a frame can be helpful when the time comes to limit the influence or the salience of an emerging frame. Alternatively, frame extension is more sensitive to timing and other related political issues. Extension to new values and the incorporation of new parameters to a policy frame is somewhat more dependent on context than other mechanisms. While mechanisms of amplification and bridging are induced by deliberation in sub-system arenas, influencing the communities of actors and open the doors of new arenas to a policy argument, frame extension is the product of time and the slow construction of meanings in a broader sense.

Finally, reframing occurs within communities much more than within arenas. Moreover, shifts are rare, not necessarily conducive to change, and are induced by a slow process rather than spontaneous events. These dynamics and their effects are related to the frame reflection discussed in Chapter 3. In fact, actors in the sub-system are more sensitive to the context of their public actions and the limitations of the arena in which they invest. Framing and reframing dynamics are factors that cannot be analyzed on their own but only in relation to the broader context in which they are produced. The nature of frames, their performance by actors in political arenas and the context of this performance allow us to understand the variations in the implementation strategies and policy outcomes in Quebec, Ontario and England. Therefore, the performativity of frames is the ability of a discursive mechanism to be triggered and to influence the development of a policy solution through policy change or implementation.

Repacking ART

In seeking to understand policy variation across and within countries regarding assisted reproductive technology, I argued that it is necessary to unpack the policy domain and study the sub-issues of ART seperately to adequately reach and analyze sub-systems. Despite the many advantages of unpacking the domain for the purpose of analysis, we cannot eliminate the intertwined nature of these sub-issues. Indeed they are influenced by one another as much as by the resolution of related issues such as abortion and same-sex marriage, for instance. Unpacking ART, or any policy domain is a methodological tool that gives us the opportunity to trace back discourses, identify actors and communities and most importantly define frames. The only way to achieve that is to study policy sub-systems and therefore to be able todifferentiate them from other issues.

Despite the clear advantages of this strategy, the links between sub-issues, the debates around them and the actors involved in their resolution are undeniable. One of them is the presence of would-be-parents and the (specter of) children in all three sub-issues. The involvement of would-be-parents in seeking policy solution to legal, social and political issues brought about by assisted reproduction is conspicuous, as is the plurality of ways they frame their claims. In addition to their mobilization of policy arenas, would-be-parents also represent the offsprings' interest. On many occasions, the interest of one is in tension with the interest of the other, but all three issues showed how central is their position in the construction of meaning around infertility and the practices of assisted conception.

CONCLUSION

What steered this research project was a deep interest in the redefinition of reproduction as well as the multiple intersectional issues brought about by the medicalization of reproduction. It was also driven by my curiosity about the development of political rules and practices when issues at stake are multifaceted; have a deep ethical nature; and inevitably create shocks of culture and values. In these circumstances, I ask how political decision-makers get to decide, adopt, but most importantly, implement rules and regulations.

Assisted reproduction is nowadays, in western countries, a viable option for infertile individuals and couples; much as international adoption came to be in the second half of the 20th century. The normalization of the resort to technologies came to change completely the experience of infertile individuals and couples. Assisted reproduction was thus the solution to unwanted childlessness and the possible cure for the physical inability to conceive. Seeking assistance with conception transforms a private matter into a social experience. Infertility politics is characterized by the struggle among various actors to transform a private ‘problem” into an issue requiring some form of state intervention, or regulation of the relationship between the different parties involved in the process of reproduction. However, in the early 1980s, many worries were attached to possible harms to children and women when reproductive technologies - in-vitro fertilization in particular - were used to achieve pregnancy. The potential of the technology seemed unlimited and governments felt compelled to regulate and structure the practices of assisted reproduction.

This dissertation attempted to reconcile some of the social science literature in the field of ARTs in order to fully assess the complexity of the issue and the multiple policy paradoxes unleashed by the complex politics of infertility. This research project was also driven by an empirical puzzle. While doing research on Canada in a comparative perspective, I came to appreciate that the policies adopted by the federal government in 2004 were largely inspired by the British regulations. This similar starting point seemed to be a clear instance of policy transfer. Many British experts informed the policy process in Canada and the principles of the law seemed to echo common values. For instance, the rules around surrogacy stemmed from the same incentive to limit the possible commodification of reproduction.

Despite this similarity between the Canadian and British case, the Canadian law never seemed to lead to implementation, the province of Quebec rapidly contested the law before the courts and many concerns were still unregulated because they were provincial prerogatives. This observation drew my attention to implementation and the sub-national level of policy formation; a policy-making level that was until then completely absent from political science research but very much documented by scholars in the fields of sociology and social studies of science.

What if policy variation between Canada and Britain did not reside at the national level, but in the sub-national implementation of policies? Two observations came from this perspective. First, the variation within Canada was very important. Provinces like Quebec and Ontario had regulated different aspects of assisted reproduction and debated many interrelated issues. Second, the similarities and differences with England depended widely on the issue studied and on which province was compared to the British state. In some cases such as surrogacy, Ontario and England were more alike, while a Canadian connection seemed to be clear for issues of donation, for instance.

This led me to argue that assisted reproduction technologies cannot be taken as one policy domain, but an umbrella label for a variety of policy issues. As different studies examined stem cell research or prenatal genetic testing as a separate field, it seemed reasonable to extend this to issues of reproduction.

My interest in reproduction returned to the forefront and led me to think about assisted reproduction as an option to overcome infertility, as a means to conceive when social or physical circumstances prevent a couple or an individual from doing so. In that context, I needed to unpack ARTs in order to study the practices separately. Hence, I identified three sub-issues that were studied in depth in this dissertation: access to fertility treatments, including the question of public funding and access criteria; gamete and embryo donation (including the question of filiation and donor-conceived children's right to know their biological origins); and surrogacy or the enforcement of prenatal surrogacy arrangements.

When I took a closer and more systematic look at the three sub-issues and the rules and regulations that were adopted in the last few decades in Quebec, Ontario and England, I understood that by unpacking ARTs I could identify actors and describe political discourses in a more accurate manner. At the system level, it was easier to identify in a more accurate manner the distinct dynamics of mobilization as well as the factors influencing the decision-making processes for each issue.

Some of the literature on ARTs did not fully answer the question of variation and many of the authors that worked on assisted reproductive technologies had a hard time isolating the actors, networks and spaces of deliberation because of the multiplicity of policy issues at stake, but also because they were engaging in a top-down approach. In other words, they traced the policy process backwards, from the policy to the politics. I concentrated on identifying the constellation of actors and their preferences and the ways in which they framed their claims and attached them to a policy issue. From the practice to the policy, I described how ideas influenced the policy outcomes. This gave me the opportunity to map and understand the variety of discourses and arenas mobilized by communities of actors in order to change the political status quo. To be clear, the changes observed were not all wide-ranging policy changes. In fact, most of them were small implementation changes and adaptation to new information. These observations triggered a theoretical question: how does the representation of an issue affect its policy development, its nature and implementation? What if, the variation between Quebec, Ontario and England could be explained not only by the institutional context and the type of actors involved, but by the constructed image of the constitutive issues of assisted reproduction? What if the politics of infertility was a struggle over definitions and ideas?

From a framing perspective, the dominant meaning consists of the argument or discourse with the highest probability of being noticed, processed, and accepted. To identify a meaning as dominant or favored is to suggest a particular framing of the situation that is most heavily supported by the involved actors and is congruent with the society's representation of the issue. In making a piece of information more noticeable, meaningful, or memorable to elites, actors and communities of actors are able to influence the policy process. Through utterances, or the performance of frames in different spaces of deliberation, actors can alter the policy image, the meaning of a policy issue or the sense attached to a specific practice.

The frame analysis I conducted showed that frame alignment is a necessary condition for a frame to be performative and influence the policy process and ultimately the outcome.

Depending on its nature or intensity, the discursive mechanism could trigger a series of events that will lead to policy change or to a change in the implementation of a policy. My research refers to the various interactive and communicative factors that affect framing and reframing dynamics and the performativity of frames.

The major task of determining these dynamics was to identify and define the content of the frames. A first round of research in documents and the first set of interviews with key players helped me to define the relevant frames and their underlining arguments. This also gave me a broader sense of the process and the sequence of events for each cases and issues studied. Then, a formal coding of all documents and interviews helped me to locate the frames and account of the discursive structures within a situation. This led me to interpret the discursive mechanisms and their influence on events at different moments of the policy process. This methodology provides access to the locations and institutions, the actors involved in the debates, the diverse range of definitions and meanings that underpin both policy images and policy claims and the broader socio-cultural frameworks in which they are mobilized.

This dissertation brought to light three findings that can enhance our knowledge regarding: 1) discourse and its link to a policy image; 2) the intertwined nature of ideas, actors and arenas in the understanding of policy outcomes and; 3 the influence of discursive mechanism such as bridging and extension as triggers of policy change. All of these findings either sustain or challenge the previous literature on public policy analysis and frame reflection.

Issues, frames and images

The empirical analysis shows how the medical, legal and moral frames are common to Quebec, Ontario and England and define the image of the policy issues. In many ways the similarities between the three cases are induced by this common dominance in frame mobilization. While the discourses around and about the issues are articulated and performed in different manners, the core values and perceptions seems to persist in the three states.

I illustrated that the medical frame can also be enhanced through time and persistent mobilization and bring about a medicalization of an issue. It was the case with access to fertility treatments in Quebec, which explains in part the social cascade that led to policy change in the summer of 2010. The prevalence of the medical frame did not create the same process of medicalization in Ontario and England that can be explained by the presence of competing frames or the alteration of frames, which failed to change or add to the dominant policy image. This finding supports the literature on the medicalization of society and extends this sociological concept to political science. My empirical work shows how the medicalization of infertility in Quebec contributed to frame the issue of public funding for fertility treatments as an issue of access to health care for people suffering from a medical condition. This bridge between an experienced-based frame and a medical frame was a tipping point that triggered a social cascade that led to the addition of fertility treatments to the basket of universal services.

In addition, I demonstrated that the issue of donation is dominated by the mobilization of a legal frame. In Quebec and Ontario, the courts came to secure and extend that frame through time, while in England its emergence is linked to the mobilization of social workers and non-profit organizations advocating child-centered policy-making in ART-related debates. The issue of gamete donation provides insights on the pivotal role played by experts in the mobilization of frames. In Quebec and Ontario, legal experts chose to mobilize respectively the parliamentary arena and the court in order to influence the policy outcomes. Meanwhile, in Quebec legal scholars sustained the mobilization of the lesbian community at the parliamentary committee, while in Ontario legal experts constructed the legal arguments necessary for a coherent judicial mobilization. In England, experts of the child and the family and social workers assumed leadership in mobilizing for the right of donor-conceived children to know their biological origins. The court decision in 2002 contributed to sustain their right-based argument and enhance the salience of their discourse, but the persistence of their voice and the transferability of their legal frame from arena to arena contributed to slowly changing the meaning of the welfare of the child.

Moreover, the moral frame was and is, in many ways, still persistent when the issue of surrogacy is debated. It seems that even when reforming policy frameworks, the involved actors retain moral considerations. The issue of surrogacy, in the three spaces, unleashed a smaller range of discourses and arguments, and the one mobilized are mostly structured around ideas of right or wrong, good or bad. In many ways, the issue of surrogacy is related to what Mooney (2001) termed morality policy: it is characterized by clashes of first principle, is technically simple, highly salient and implies high citizen participation when it comes to public or political attention. Interestingly, surrogacy is the issue for which reframing seems the most difficult to achieve in Quebec, Ontario and England and for which adaptation, rather than changes, seems to be the norm. The case of Ontario is interesting in the way it shows how reframing can lead to policy stability in some cases.

Frame performativity: Ideas, Actors and Arenas

One of the theoretical goals of this thesis was to show how the performativity of frames is key to understanding discursive dynamics and their influence on policy outcomes. The explanation resides in the influence actors and/or arenas have on the performance of a frame. This part of the analysis challenges studies of assisted reproductive technologies that explained only part of the variation by concentrating on institutional structures and actor-networks frameworks. The missing component in this explanation relates to the study of micro-mobilization.

Following Rein and Schön's (1996) framework, I adopted a way of looking at and describing frames that treats frames as strong and generic narratives that guide both analysis and action in practical situations (p.89). Such narratives are prescriptive stories that tell us, within a given arena, the political problem at stake and how it might be regulated. Frames try to create links to norms or ideas, which resonate with the broader image of an issue in a given society. I thus consider that policy analysis seeks to name the issue, to identify the competing frames at work, and to specify the arenas in which the discourse occurs.

The empirical data shows the strength and multiplicity of discourses and how the paths they take in the political process impacts their trajectories and their resonance. By showing what process of reasoning and what repertoire of concerns are available to those participating in the debates, this study proposed a map of assumptions upon which discussion rests. In Quebec, Ontario and England, the same political issues are located in different contexts by different sets of actors and are accordingly thought to have different implications and meanings. That shed further light on how the politics of infertility might enable policy change in one context and constrain it in others.

The discursive neo-institutionalist literature often overplays the influence of institutions on public policy while other authors studying ideational factors underplay the role of actors in the performance of ideas. Bringing ideas back in the study of public policy sometimes lacks in theoretical coherence and empirical sustainability. What this dissertation shows is that institutions and actors are as important as ideas in the policy process, much like supporters of the three "i"s have long suggested. However, comparing frames and ideational mechanisms instead of nations or issues foreground the empirical study of ideas and frames. This allowed me to interpret and analyze the influence of frames in relation to actors and arenas without downplaying the effect of one factor or the other. Building the comparison on frames and mechanisms of frame bridging, amplification, extension and transformation helped me undercover how ideas influence politics and policies.

By describing and defining frames and discourses, this thesis contributes to a larger set of literature on assisted reproduction and the construction of meaning in the field of biomedicine and reproduction. This work calls for a dialogue between disciplines interested in assisted reproduction and the social impacts of biomedicine. The boundaries between them are blurred in much of the relevant work so it seems more useful to emphasize their shared interests in the conceptual, cultural, political and practical aspects of the social.

As Franklin (1997) concluded in her book Embodied Progress, the "experience[s] of IVF […] are far from simple. They are composed of feelings and perceptions that are equivocal and ambivalent, positive and negative, empowering and disempowering. These paradoxical dimensions of the experience of the IVF procedure are fundamental to many of the ways of making sense of it …" (p. 194). My study of assisted reproduction sustains in many ways this conclusion. This thesis sought to demonstrate how infertility and the recourse to assisted conception change and influence in many ways the manner all involved actors – medical practitioners, donor-conceived children, women, same-sex couples, legal experts, social workers, members of families – make sense of their experience and to what extent the way they frame issues influence their behaviors as citizens/decision-makers and indeed shape policy outcomes.

Frame bridging, frame extension, frame amplification and reframing

The mechanisms of frame bridging, extension, amplification and transformation help us understand what triggers policy changes and lead to the redefinition or the intensification of the status quo. This finding challenges the literature on frame alignment, which considered the process to happen within social movements. I argue that mechanisms of frame bridging, amplification, extension and transformation can be triggered by the mobilization of a specific arena as well as deliberation within a policy community. These political spaces for deliberation can work to connect ideas, or to modify or transform discourses. This would explain partly the indirect influence of court decisions on public policy, for instance. In providing a structured space for deliberation, the courts construct meanings and contribute to alter or sustain the policy image of an issue.

Hence, policy arenas and policy communities are spaces for deliberation and for frames to compete with one another, redefine themselves or complete one another. In the literature, frame reflection is a dynamic that needs a context where the new meets the old.

> When the policy pendulum swings from one unworkable extreme to another, what may be needed in the new situation is a mixture of an old frame that has been rejected and a new frame that does not altogether fit a new situation in which the previously unthinkable has become reality. In order to make such a reframing work, the policy makers must reflect on the old and new frames - accepting, in this process, elements of the old frame delegitimized by their recent reforms. They must import elements of the old frame that stand in direct conflict with the new one, producing emerging frames through dialectical policy discourse. (Schön and Rein 1994, p.40)

The empirical work shows how this reflection between the old and new frames lead to the redefinition, transformation or combination of frames. Frame bridging was shown to be a key process in dealing with and solving policy controversy. By bridging the dominant frames with new arguments, the policy communities extended the meaning of the former and added the salience of the latter. Frame extension was also important when it came to adapting policy issues to new considerations, new values, and new technologies. Through the same logic, the policy communities seeking changes were challenging only part of the dominant frame, which provided them with additional support and fewer counter-mobilizations. Frame extension however, seems more time-sensitive, influenced by other policy issues and limited in scope.

Paths for further research

This research sought to better understand the politics of reproduction and raise new questions about the development of public policies in situations of high conflict. My analysis identified many political dynamics worthy of further investigation. For future research, I propose a line of inquiry that unleashes two important issues for comparative public policy analysis: the process of policy diffusion and public policy transfer.

The dynamics of diffusion and policy transfer are subject to a growing body of research in political science, even more so when the issues relate to different forms of expertise. Public policies are not developed in a national vacuum. Foreign experiences can influence the development of national and sub-national regulations. Research on institutional transfer in the field of assisted reproduction concluded that in many ways policies are not transferred directly but adapted and nuanced to fit the specific context of the host. In my analysis, I identified two possible transfer mechanisms. The first mechanism is the development of links between actors of different countries and the role of professional associations in the formulation of policy solutions.

The second mechanism that I identified was targeted institutional transfer. The case of Britain is extremely interesting from this point of view. As we have seen, Canada attempted to replicate the Human Fertilisation and Embryology Authority in 2004. Very recently, Quebec has developed, based on the English model, the National Institute for Excellence in Health that has a lot to do with the National Institute for Clinical Excellence. It would be interesting to compare the circumstances of the transfer and adaptation of these structures in different contexts in order to better capture the factors influencing this policy process at the national and sub-national levels.

APPENDIX A

PRIMARY CARE TRUST SURVEY – PROVISION OF IVF IN ENGLAND 2008

Department of Health

Primary Care Trust survey – provision of IVF in England 2008

Full Survey Results by PCT

Department of Health Survey of PCTs 2008

This table is prepared on the basis of information provided by PCTs. In some cases, the information is for less than a full year. Any queries about the policies of an individual PCT should be made directly to the PCT concerned.

In defining a *full* cycle, the NICE fertility guideline includes both the replacement of fresh embryos *and* the subsequent replacement of any good quality embryos not transferred as part of the fresh cycle but frozen and stored for future use.

The term 'one fresh cycle' does not include the transfer of frozen embryos recommended by NICE.

NEC means that the couple being treated have no children from their relationship or from any previous relationship.

Where a PCT is providing more than one cycle, some of the women will have received more than one cycle in the year in question.

SHA/PCT	**Number of IVF/ICSI cycles funded for each patient In 2008/09 and 2009/10**	**Estimated number of patients provided with IVF in 2008/09 (NB in some case this information has been provided in relation to cycles)**	**Non-clinical access criteria (i.e. not in NICE guideline)**
NORTH WEST			
Warrington	2 full cycles	90 cycles	NEC Smoking criteria
Western Cheshire	2 full cycles	143 cycles	NEC Smoking criteria
Wirral	2 full cycles	131 cycles (35 second cycles)	NEC Smoking criteria
Ashton, Leigh and Wigan	1 full cycle 2 cycles in 2009/10		NEC Smoking criteria
Bolton	1 full cycle Possibly moving to 2 full cycles in 2009/10	25 women	Smoking criteria

Halton and St. Helen’s	2 fresh cycles		NEC Smoking criteria
Heywood. Middleton & Rochdale	3 full cycles		One partner has no living children Smoking criteria
Bury	3 full cycles	40 women	One partner has no living children Smoking criteria
Central & Eastern Cheshire	2 full cycles	104 cycles	NEC Smoking criteria
Central Lancashire	2-3 full cycles	56 cycles +	One partner has no living children Smoking criteria
Cumbria	2 full cycles	180 women (44 second cycle)	NEC Smoking criteria
North Lancashire Teaching	2 full cycles	25 - 47+cycles	NEC Smoking criteria
East Lancashire Teaching	3 full cycles		NEC
Knowsley	2 full cycles	48 women	NEC
Manchester	1 full cycle		One partner has no living children

			Smoking criteria
Oldham	3 full cycles	74 cycles	women under 35
Sefton	2 full cycles	96 cycles	NEC Smoking criteria
Stockport	2 fresh cycles		One partner has no living children Smoking criteria
Tameside and Glossop	3 fresh cycles	49 cycles	One partner has no living children Smoking criteria
Trafford	1 full cycle	37 cycles	One partner has no living children Smoking criteria
Blackburn with Darwen	3 full cycles	72 cycles	NEC
Blackpool	2 full cycles	27 cycles	One partner has no living children Smoking criteria
Liverpool	2 full cycles	168 women	One partner has no living children Smoking criteria
Salford	2 full cycles		One partner has no living children Smoking criteria - no smoking before referral for treatment, and

			continued non-smoking
WEST MIDLANDS SHA			
Warwickshire	1 full cycle	119 women	Male under 55 No children under 16 living with couple
Shropshire	2 fresh cycles Review 2009/10	60 women (of whom 40 received 2nd cycle)	Women age23-37.5 NEC Smoking criteria (Both partners non smoking for at least 4 weeks prior to referral)
Herefordshire	1 full cycle	28 women	Women age 25-39 Male 25-54 Smoking criteria (ref to smoking cessation service)
North Staffs.	Exceptional cases only Review 2009/10	1 patient prior to decommissioning	N/A (at present)
South Staffs.	1 full cycle Review 2009/10	160 women	Male under 55 NEC

			Smoking criteria (both partners non smoking for 3 months)
Stoke on Trent	1 full cycle Review 2009/10	24 women	
Walsall Teaching	2 full cycles	57 women	Women age 25-39 Male under 55 NEC Smoking criteria (both partners non smoking)
Worcestershire	2 fresh cycles Review 2010/11	162 women (of whom 17 also rec'd 2nd cycle)	No children living in the household. Smoking criteria
Dudley	1 fresh cycle Review 2009/10	33 women	NEC Smoking criteria (no smoking for min 1 year before treatment)
Telford & Wrekin	2 full cycles Review 2009/10	80 women (1 cycle) and 55 women (2nd cycle)	Women age 23-37.5 NEC Smoking criteria (for at least 4 weeks before referral, and continued non smoking)

Coventry	1 full cycle Review 2009/10	PCT does not hold info.	No children under 16 living with couple
Solihull	1 full cycle Review 2009/10	67 women	No children under 16 living with couple
Heart of Birmingham	1 full cycle	106 women	NEC Smoking criteria (Neither partner smoking)
South Birmingham	1 full cycle	117 women	NEC Smoking criteria (Neither partner smoking)
Birmingham East & North	1 full cycle Review 2009/10	4 women	Living children taken into account Smoking criteria
Wolverhampton	2 fresh cycles Possible review 2009/10	30 women	Male under 50 NEC Min. 2 year infertility Smoking criteria
Sandwell	1 full cycle	124 women (Includes all fertility treatments)	NEC smoking criteria (woman referred

			to smoking cessation services before referral for treatment)
EAST MIDLANDS			
Nottingham County	1 full cycle	914 women across East Midlands	Male under 55 Smoking criteria - woman non-smoking
Nottingham City	1 full cycle	See entry for Notts County	Male under 55 Smoking criteria - woman non-smoking
Derby City	1 full cycle	See entry for Notts County	Male under 55 Smoking criteria - woman non-smoking
Derbyshire County	1 full cycle	See entry for Notts County	Male under 55 Smoking criteria - woman non-smoking
Bassetlaw	1 full cycle	See entry for Notts County	Male under 55 Smoking criteria - woman non-smoking

Leicester City	1 full cycle	See entry for Notts County	Male under 55 Smoking criteria - woman non-smoking
Leics County and Rutland	1 full cycle	See entry for Notts County	Male under 55 Smoking criteria - woman non-smoking
Lincs	1 full cycle	See entry for Notts County	Male under 55 Smoking criteria - woman non-smoking
Northants	1 full cycle	See entry for Notts County	Male under 55 Smoking criteria - woman non-smoking
SOUTH EAST COAST			
East Sussex Downs and Weald	1 fresh cycle 2 full cycles 2009/10	40 women	NEC
Surrey	1 fresh cycle 2 full cycles 2009/10		NEC

Brighton and Hove	1 fresh cycle 2 full cycles 2009/10	59 women	NEC
Hastings and Rother	1 fresh cycle 2 full cycles 2009/10	21 women	NEC
West Sussex	1 fresh cycle 2 full cycles 2009/10		NEC
West Kent	1 fresh cycle 2 full cycles 2009/10		NEC
Eastern and Coastal Kent	1 fresh cycle 2 full cycles 2009/10		NEC
Medway	1 fresh cycle 2 full cycles 2009/10		NEC
SOUTH CENTRAL			
Oxfordshire	1 fresh cycle Review 2009/10	96 women	Women age 36-39 No living child Smoking criteria (non-smoking)
Buckinghamshire	1 fresh cycle Review 2009/10	70 women	Women age 36-39 No living child

			Smoking criteria (non-smoking)
Berkshire West	1 fresh cycle Review 2009/10	66 women	Women age 36-39 No living child Smoking criteria (non-smoking)
Berkshire East	1 fresh cycle Review 2009/10	42 women	Women age 36-39 No living child Smoking criteria (non-smoking)
Milton Keynes	1 fresh cycle Review 2009/10	28 women	Women age 36-39 No living child Smoking criteria (non-smoking)
Hampshire	1 fresh cycle Review 2009/10	110 women	Women age 36-39 No living child Smoking criteria (non-smoking)
Portsmouth City Teaching	1 fresh cycle Review 2009/10	8 women	Women age 36-39 No living child Smoking criteria (non-smoking)
Isle of Wight	1 fresh cycle Review 2009/10	2 women	Women age 36-39 No living child Smoking criteria (non-smoking)

Southampton City	1 fresh cycle Review 2009/10	11 women	Women age 36-39 No living child Smoking criteria (non-smoking)
YORKSHIRE AND HUMBER			
North Yorkshire and York	1 fresh cycle (limited circumstances)	19 women	Women age 39.5 - 40
North East Lincs	3 full cycles	28 women	Male under 47 NEC Smoking criteria (no smoking)
North Lincs	1 full cycle	12 women	Male under 47 NEC
Leeds	1 full cycle	189 women	No children living with couple
Kirklees/Halifax	1 full	41 women	NEC
Calderdale	1 full cycle	16 women	NEC
Doncaster	2 full cycles	91 women	Male under 55 No children living with couple
East Riding	2 fresh cycles	97 women	Male under 46

	2 full cycles 2009/10		NEC
Rotherham	2 full cycles	48 women	Male under 55 No children living with couple
Sheffield	1 full cycle	56 women	Male under 55 No children living with couple
Wakefield	1 fresh cycle 1 full cycle 2009/10	88 women	NEC
Barnsley	2 full cycles	40 women	Male under 55 No children living with couple
Bradford & Airedale	1 fresh cycle 1 full cycle 2009/10	105 women	NEC
Hull	2 full cycles	106 women	Male under 46 NEC
LONDON			
Brent	1 fresh cycle 2009/10 Proposed move to 2 cycles	95 women	No children living with the couple
Bromley	2 fresh cycles		NEC Smoking criteria (non-smoking at

			time of treatment)
Croydon	1 fresh cycle Proposed move to 1 full cycle 2009/10, 2 cycles 2010/11	Approx 55 women	
Kingston	1 fresh cycle Review 2009/10	70 women	
Kensington and Chelsea	3 fresh cycles	20 women	No children in current relationship Smoking criteria (non-smoking at time of treatment)
Enfield	1 full cycle	56 women	As per NICE guidance
Hounslow	1 fresh cycle Proposed move to 1 full cycle 2009/10	21 women	No children from current relationship and no children under 18 living with couple
Haringey	1 full cycle	Commissioned 90 cycles of IVF	NEC within current relationship Smoking cessation programme mandatory
Ealing	2 fresh cycles	211 women	NEC Smoking criteria (Referral of woman to smoking cessation and

			no funding of treatment until she stops smoking)
Westminster	2 fresh cycles Review 2009/10		NEC
Barnet	1 fresh cycle	51 cycles	
Camden	2 fresh cycles 3 full cycles 2009/10	126 cycles	No children in current relationship
City and Hackney	3 full cycles	159 cycles	No living children in current relationship; no more than 4 children from previous.
Bexley	1 full cycle	81 women	Women age 25-under 40
Richmond and Twickenham	1 fresh cycle Review 2009/10	100 women	NEC
Sutton and Merton PCT	2 full cycles	99 women	No children from current relationship. Priority to couples where neither partner has a child. Women age 25-38 Smoking criteria (couple referral to smoking cessation service)

Harrow	1 full cycle 3 cycles planned		NEC Smoking criteria (referral to smoking cessation, non-smoking at time of treatment)
Islington	2 fresh cycles Possible move to full cycles	139 women	No children in current relationship Smoking criteria (non-smoking at time of treatment)
Hammersmith and Fulham	1 full cycle Review 2009/10		No previous parenting experience
Hillingdon	1 fresh cycle	70 women	NEC Smoking criteria (clinical judgement on effectiveness)
Greenwich Teaching			
Southwark	1 full cycle	197 women	NEC Smoking criteria (non-smoking at time of treatment)
Lambeth	1 full cycle	112 women	NEC Smoking criteria (referral to

			smoking cessation, non-smoking at time of treatment)
Lewisham	1 full cycle		NEC Smoking criteria (referral to smoking cessation, non-smoking at time of treatment)
Tower Hamlets	3 full cycles	57 women	No living children from current relationship and not more than four between them from previous unions.
Newham	3 fresh cycles proposed move to 3 full cycles 2009/10		No living children from current relationship and not more than four between them from previous unions.
Barking and Dagenham	3 full cycles		No living children from current relationship and not more than four between them from previous unions.
Havering	3 full cycles		No living children in current

			relationship
Waltham Forest	3 fresh cycles Proposed move to 3 full cycles 2009/10	119 women	No living children in current relationship; no more than 4 children from previous.
Redbridge	3 full cycles		No living children from current relationship and not more than four between them from previous unions
Wandsworth	2 cycles	152 women	One partner has not been a parent
SOUTH WEST			
Cornwall and Isles of Scilly	1 fresh cycle Review 2009/10	95 women	NEC Smoking criteria (GP referral to smoking cessation programme, woman to have stopped smoking at least 6 months before treatment, unless this takes her outside age criteria)
Plymouth	1 fresh cycle Review 2009/10	33 women	NEC

Torbay	1 fresh cycle	95 women	NEC Smoking criteria (women must stop smoking before treatment)
Devon	1 fresh cycle		NEC Smoking criteria (no smoking)
Dorset	2 full cycles	77 women	NEC Smoking criteria (non smoking status a requirement)
Bournemouth and Poole	2 fresh or 1 fresh 1 frozen	62 women	Male under 55 NEC Smoking criteria (no smoking)
Bath and North East Somerset	1 fresh cycle Review 2009/10	62 women	
South Gloucestershire	1 full cycle	66 women	Male under 54 One partner no previous children Smoking criteria (both partners non-smokers or being supported by smoking cessation services)
Bristol	1 full cycle	63 women	Male under 54

			One partner no previous children Smoking criteria (both partners non-smokers or being supported by smoking cessation services)
North Somerset	1 full cycle	24 women	Male under 54 One partner no previous children Smoking criteria (both partners non-smokers or being supported by smoking cessation services)
Gloucestershire	1 full cycle	71+ women	Women age 30-39 NEC Smoking criteria (both partners non-smoking for minimum of 6 months)
Wiltshire	1 fresh cycle Proposed move to 3 cycles for women 30-39 in 2009/10 Proposed age range 23-39 2010/11	89 women	NEC from partnership and one partner has no living children Smoking criteria (non-smoking for 6 months prior to treatment, be offered smoking cessation support)

Swindon	1 fresh cycle	53 women	Women age 30- 36 NEC from partnership and one partner has no living children Smoking criteria (non-smoking for 6 months prior to treatment, be offered smoking cessation support)
Somerset	2 full cycles	116 women	One or both partners no living children Smoking criteria (neither partner should smoke, referral to smoking cessation service)
EAST OF ENGLAND			
West Essex	3 full cycles 2009/10		No children from current relationship
Mid Essex	3 full cycles 2009/10		No children from current relationship
North East Essex	3 full cycles 2009/10		No children from current relationship

South East Essex	3 full cycles 2009/10		No children from current relationship
South West Essex Teaching	3 full cycles 2009/10		No children from current relationship
Suffolk	3 full cycles 2009/10		No children from current relationship
Cambridgeshire	3 full cycles 2009/10		No children from current relationship
Bedfordshire	3 full cycles 2009/10		No children from current relationship
Luton	3 full cycles 2009/10		No children from current relationship
East and North Herts	3 full cycles 2009/10		No children from current relationship
West Herts	3 full cycles 2009/10		No children from current relationship
Peterborough	3 full cycles 2009/10		No children from current relationship
Norfolk	3 full cycles		No children from current

	2009/10		relationship
Great Yarmouth and Waveney	3 full cycles 2009/10		No children from current relationship
NORTH EAST			
Hartlepool	3 full cycles	65 women	No children from current relationship
Middlesbrough	3 full cycles	39 women	No children from current relationship
Stockton on Tees Teaching	3 full cycles	146 women	No children from current relationship
Redcar & Cleveland	3 full cycles	30 women	No children from current relationship
County Durham (and Darlington PCT see below)	3 full cycles	227 cycles (includes Darlington)	No children from current relationship Smoking criteria (both non-smokers)
Darlington	3 full cycles	As above	No children from current relationship
Newcastle	3 full cycles		Not given

North Tyneside	3 full cycles		Not given
Northumberland	3 full cycles		Not given
Sunderland	3 cycles (from Feb 2009)		NEC Smoking criteria (GP referral to smoking cessation programme)
Gateshead	3 cycles (from Feb 2009)		NEC Smoking criteria (GP referral to smoking cessation programme)
South Tyneside	3 cycles (from Feb 2009)		NEC Smoking criteria (GP referral to smoking cessation programme)

APPENDIX B
LIST OF INTERVIEWS CONDUCTED

Quebec

Public Servants
1. Public Servant Qc-1 – Ministry of Finances - June 18th 2011
2. Public Servant Qc-2 – Ministry of Health and Social Services - October 23rd 2010
3. Public Servant Qc-3 - Ministry of Health and Social Services – 25th Mai 2011

Group Leaders
1. Mona Greenbaum - November 11th 2010 and October 13th 2008
2. Caroline Amireault – July 18th 2008
3. Karine Joizil – November 1st 2010
4. Beverly Hanck – July 3rd 2012

Experts
1. Fertility Expert Qc-1, November 9th 2010
2. Fertility Expert Qc-2, December 19th 2010

Scholars
1. Scholar Qc-1 – June 8th 2012
2. Scholar Qc-2 – June 26th 2011

Ontario

Public Servants
1. Public Servant Ont-1 - Ministry of Children and Youth Services – June 10th 2011
2. Public Servant Ont-2 - Ministry of Health and Long-Term Care – June 12th 2011

Group Leaders
1. Jocelyn Smith – December 8th 2010
2. Rachel Epstein – December 2nd 2010
3. Olivia Pratten – December 14th 2010
4. Joanne Horibe – November 29th 2010

Experts
1. Fertility Expert Ont-1 – October 15th 2010
2. Fertility Expert Ont-2 – September 30th 2011

Scholars
1. Legal Expert Ont-1 – October 7th 2010
2. Legal Expert Ont-2 – July 20th 2012

England

Public Servants
1. Public Servant Eng-1, NHS Manager, Region of London – February 17th 2011
2. Public Servant Eng-2, HFEA member, March 4th 2011
3. Public Servant Eng-3, Department of Health – March 17th 2011

Group Leaders
1. Eric Blyth – April 18th 2011
2. Clare Lewis-Jones – April 6th 2011
3. Walter Merricks – February 7th 2011
4. Stonewall Representative – April 19th 2011
5. British Medical Association Representative – May 5th 2011

Experts
1. Legal Expert Eng-1 – June 14th 2011
2. BICA representative – April 9th 2011
3. Former MP Liberal-Democrat party – April 26th 2011

Scholars
1. Legal Scholar Eng-1 – February 2nd 2011
2. Legal Scholar Eng-2 – January 22nd 2011
3. Legal Scholar Eng-3 – March 15th 2011
4. Marilyn Crawshaw – April 18th 2011

APPENDIX C

QUESTIONNAIRE FOR NON-GOVERNMENTAL ACTORS

I would like to start the interview with a number of questions about your policy preferences.

1- Can you tell me a little bit about your advocacy in the field of ARTs and family-related policy?
2- What kind of policies does your organization advocate for? Who does your organization represent?
   (Probe if they do represent a constituency: How do they determine what the key issues are for that constituency?)
3- How would you characterize the current policies in place with regard to ART and Family?
4- Why is it important to you and your organization to achieve these goals?

Now, I would like to talk to you about your strategies for realizing your policy goals

5- How do you go about achieving these goals?
   (For instance: Do you lobby government officials, engage in grass-root mobilization/actions, information campaigns, online?)
6- Does your organization privilege a particular arena?
   (For instance: Parliament, the courts, the media and if so, have you been successful? If not, why not?)
7- How do you balance the different strategies you employ to influence policy?
   (Do you pursue these strategies simultaneously? If not, how do you decide which strategy to prioritize?)
8- Do you pursue these strategies alone or in collaboration with other non-governmental actors?
   (With whom are you collaborating? On what strategy/when?)
9- Are there other non-governmental actors pursuing similar policy goals that you are not collaborating with and if so, why is that?
10- Do you have contacts at the governmental level, in the bureaucracy?
   (Roughly how many? Who are they?)
11- Who are your most important allies in the political arena?
12- Who are the political parties/party or members of parliament you can count on for support?
13- Who are your most important opponents?
14- Who are the most influential players in regulating ART and/or parenting?

I have now come to the end of our interview. There are two more general questions that I would like to discuss with you.

15- Is there any aspect of policy making related to ART and family that we have not touched upon but you consider to be important to mention?

APPENDIX D

QUESTIONNAIRE FOR GOVERNMENTAL ACTORS

I would like to start the interview with a number of questions about the policies that are now implemented as regard to Assisted Reproductive Technologies (ART) and Family as well as your policy objectives for the future.

1- Can you tell me a little bit about how you came to be involved in this policy area?
2- How do you see the relationship between ARTs and parenting policy?
   (By parenting policy, I am referring to the recognition of the legal relationship between a child and an adult at its birth)
3- What kind of ART and family related policies are currently in place?
4- How would you compare them to what was in place 5 years ago, 10 years ago?
5- Could you explain the processes that preceded the adoption and implementation of these policies?
6- What kinds of policy changes are planned in the near future?
7- What the rationale for changing these policies?

Now, I would like to talk to you about your strategies for realizing government objectives as regards to ART and family

8- How do you pursue the "public interest" in a policy area as complex as ARTs?
   (Have you sought out new policy actors to engage with in the last 2 years, 3 years, 5 years?)
9- What types of strategies have been put in place to achieve these objectives?
   (For example: expert consultation, public hearings, polls, how, when, on which issues, etc.)
10- What type of contacts do you maintain outside your department?
11- What are their roles and their views on these subjects?
12- What type of contacts do you have outside government?
13- What are their roles and their views on these subjects?
14- Who are the most influential players in regulating ART and/or parenting?
15- To what extent do the policies in place reflect the views of these actors?

I have now come to the end of our interview. There are two more general questions that I would like to discuss with you.

16- Is there any aspect of policy making related to ART and family that we have not touched upon but you consider to be important to mention?

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