

**Controlling Conception:
Citizenship and the Governance of Assisted
Reproductive Technologies in Canada (1989-2004)**

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Abstract

The emergence of a neoliberal mode of governance in the 1970s occurred in tandem with the advent of new reproductive technologies. These two developments have fundamentally altered social life, and have resulted in the emergence of new governable subjects. In the case of neoliberalism the new subject is the neoliberal citizen, a responsible, self-sufficient individual free to make choices in the context of the free market. In the case of assisted reproductive technologies, donor-conceived people, egg donors, surrogates, and LGBTQ parents using reproductive technologies have emerged as new reproductive citizens to be governed in public policy and law.

This dissertation traces the confluence of these developments and the emergence of neoliberal and (assisted) reproductive citizens in the policy process leading to the 2004 *Assisted Human Reproduction Act*. Drawing on policy documents, parliamentary debates, interviews with key actors, media coverage, and the “grey literature” from interest group actors (i.e., pamphlets, websites, flyers, brochures), this dissertation argues that federal governance of assisted reproductive technologies occurred in ways that reflect the imperatives of a neoliberal citizenship. At the same time, infertile people, LGBTQ people, donor-conceived families, egg donors and surrogates emerged differently in the policy debates, media, and jurisprudence as important subjects in the governance of ARTs, and at times, there were attempts to protect the interests of the vulnerable in the legislative process. In the end, however, concerns about the interests of reproductive citizens, including women’s health and autonomy, the kinship ties of children born of these technologies, and the need to prevent infertility on a large scale were supplanted by a continuation and indeed, an escalation of practices in assisted reproduction that embrace commercialization and individual choice above all.

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List of Abbreviations and Acronyms

<i>AHRA</i>	Assisted Human Reproduction Act
AHRC	Assisted Human Reproduction Canada (also referred to as the Agency)
AHR	Assisted human reproduction
ARTs	Assisted reproductive technologies
CBS	Canadian Biotechnology Strategy
EGALE	(initially Equality for Gays and Lesbians Everywhere, now simply EGALE, or Egale Canada)
IAAC	Infertility Awareness Association of Canada
ICSI	Intracytoplasmic sperm injection
IVF	<i>In vitro</i> fertilization
LMA	Lesbian Mothers' Association (of Quebec)
NRAS	New Reproductive Alternatives Society

Chapter One: Controlling Conception

If the state has no place in the bedrooms of the nation, it maintains a stronghold in its nurseries. From the *filles du roi* who dutifully left their homeland to populate New France, to the ongoing debate on a national, publicly funded daycare program, governments have long been concerned with how parenting takes place, and who does the job. The longstanding idea that “mothers of the nation” would raise and provide civic education to their children and (re)produce potential soldiers, workers, and parents, has an exceptionally long academic history that has given rise to particular understandings of the relationship between parents and the state; a reproductive citizenship rooted in entitlements and duties, long tied to heterosexuality, whiteness, and “traditional” family structures.¹

This relationship—between parents and the state—has changed substantially over time. Historic notions of civic duty and the propagation of a viable citizenry have largely been replaced by contemporary understandings of parenthood as both a social imperative and an individual choice. The *filles du roi* and “mothers of the nation” who were charged with the duty to produce citizens in the name of Empire gave way to a model in which the obligation to bear children came with associated rights. The establishment of a social safety net in the twentieth century included family-based provisions such as baby bonuses, mothers’ allowances, and child-care subsidies that linked social entitlements to parenthood. With the weakening welfare state and the decline of social service provisions tied to parenting, today Canadians are building their families less with the expectation of state support, and more with the understanding that only those who are self-sufficient and employed can and should raise families.

The decline of the welfare state and its effects on reproductive citizenship have coincided

¹ Bryan S. Turner, “The Erosion of Citizenship,” *British Journal of Sociology* 52, no. 2 (2001): 189.

with an important change in the nature of reproduction itself. Since the 1978 birth of Louise Brown, the first “test-tube” baby, assisted reproductive technologies like in-vitro fertilization, assisted insemination, gamete donation, and surrogacy have become increasingly available to the public. The procreative model of a heterosexual couple deciding to have a baby has been joined by another model wherein doctors, nurses, embryologists, sperm donors, egg donors, surrogates, and intended parents might work together to create a pregnancy, to have a child. Although childrearing has long been a site of state intervention (as with the parental provisions of the welfare state), the advent of assisted reproductive technologies marks an even more explicit entry of conception into the public sphere. Indeed, if the welfare state established a “cradle-to-grave” social safety net, in the time that this social safety net has been coming undone, assisted reproduction and attempts to govern it have extended public interventions into parenting backwards from the cradle to the womb.

Assisted reproduction raises new questions about reproductive citizenship. If reproduction and citizenship are intrinsically linked, then what rights and entitlements should citizens engaged or seeking to engage with assisted reproductive technologies (ARTs) have? Who is entitled to use these technologies, and on what grounds? What is the role of would-be parents, surrogates, sperm and egg donors, and children born of these technologies in establishing how the state manages these new technologies? That is to say, if reproduction is an important part of citizenship, how have assisted reproductive technologies changed the citizen-state relationship? What are the implications of the simultaneous emergence of a neoliberal citizenship regime and assisted reproductive technologies? How have these two major shifts collectively altered the ways that Canadians reproduce?

This dissertation addresses these questions by examining the nature of reproductive

citizenship in the age of assisted reproductive technologies (ARTs). More specifically, this dissertation identifies how, through the development of public policy governing assisted reproduction in Canada, LGBTQ people,² egg donors, surrogates, infertile people, and donor-conceived people (and their families) have come to be understood as subjects of public policy, that is, reproductive citizens for a new age. It emphasizes the ways that certain groups have been validated as legitimate actors within the policy process, and further, how others have been left out. Although these new reproductive citizens have been engaged in forming the parameters of debate to varying degrees, the reality in the lives of Canadians has been a continuation and indeed, an escalation of practices in assisted reproduction that embrace commercialization and individual choice above all. In short, this dissertation explores how citizens engaged in the debates over ARTs in Canada have been conceived of, and have conceived of themselves as autonomous reproductive citizens or conversely, as constrained in relation to their reproductive lives.

Changing Citizenship Regimes

This dissertation begins from the premise that recognition matters. The extent to which groups and individuals are recognized—by the state, by the market, and by one another—is integral to establishing a sense of belonging and to having a robust experience of citizenship. This broad

² Throughout this dissertation, I describe the ways in which LGBTQ people and related interest groups engaged in (and contested) the policy process leading to the *Assisted Human Reproduction Act*. The dissertation, however, focuses largely on the experiences of lesbians in Canada, with some mention of implications for gay men. To limit the scope of the dissertation, bisexual people, trans people and others are largely absent from the analysis, although this is an important area for future research. See for example, Michelle Walks, “Stratified Reproduction: Making the Case for Butch Lesbians’, Transmen’s, and Genderqueer Individuals’ Experiences in BC,” in *Fertile Ground: Exploring Reproduction in Canada*, eds. Stephanie Paterson, Francesca Scala, and Marlene Sokolon (Montreal: McGill-Queen’s University Press, 2014); Stu Marvel, “‘Tony Danza is My Sperm Donor?’: Queer Kinship and the Impact of Canadian Regulations around Sperm Donation,” *Canadian Journal of Women and the Law* 25, no. 2 (2013); Lori E. Ross et. al. “Sexual and Gender Minority Peoples’ Recommendations for Assisted Human Reproduction Services,” *Journal of Obstetrics and Gynaecology Canada* 36, no. 2 (2014).

conception of citizenship draws on the work of T.H. Marshall, and is found, in the Canadian context, in the work of Brenda Cossman,³ Jane Jenson,⁴ Janine Brodie,⁵ and Wendy McKeen,⁶ amongst others,⁷ reaching far beyond notions of national boundaries and passports, marking who is included and excluded within a polity. There is something fundamental about being included in the protections, entitlements, and responsibilities within the purview of the state, validating the array of identities that make up the citizenry and the potential legitimacy of rights claims. The recognition of women, for example, has occurred through measures to establish universal suffrage, pay equity, non-discrimination laws, and court decisions articulating the importance of women's bodily autonomy. This robust conception of citizenship has not translated to perfect models of inclusion—marginalization and inequities continue—but the acknowledgement of women's interests as legitimate, and the understanding that women are citizens of the state, has occurred in part through the recognition of women as important subjects of public policy and law.

It is important to note from the outset, though, that while the starting assumption of this dissertation is that recognition matters, there are important objections to this claim. The most

³ Brenda Cossman, "Sexual Citizens: Freedom, Vibrators, and Belonging," in *Gender Equality: Dimensions of Women's Equal Citizenship*, eds. Linda C. McClain and Joanna S. Grossman (New York: Cambridge University Press, 2009).

⁴ Jane Jenson and Susan D. Phillips, "Regime Shift: New Citizenship Practices in Canada," *International Journal of Canadian Studies* 14 (1996): 110–35; Jane Jenson, "Fated to Live in Interesting Times: Canada's Changing Citizenship Regimes," *Canadian Journal of Political Science* 30, no. 4 (1997).

⁵ Janine Brodie, "Restructuring and the New Citizenship," in *Rethinking Restructuring: Gender and Social Change in Canada*, ed. Isabella Bakker (Toronto: University of Toronto Press, 1996); Janine Brodie, "Citizenship and Solidarity: Reflections on the Canadian Way," *Citizenship Studies* 6, no. 4 (2002).

⁶ Wendy McKeen, "The Politics of the National Children's Agenda: A Critical Analysis of Contemporary Neoliberal Social Policy Change," in *Public Policy for Women: The State, Income Security, and Labour Market Issues*, eds. Marjorie Griffin Cohen and Jane Pulkingham (Toronto: University of Toronto Press, 2009).

⁷ Alexandra Dobrowolsky, "Interrogating 'Invisibilization' and 'Instrumentalization': Women in Current Citizenship Trends in Canada," *Citizenship Studies* 12, no. 5 (2008); Judy Fudge, "A Question of Scale: Justice, Citizenship, and Gender," *Canadian Journal of Women and the Law* 22, no. 1 (2010); Amber Gazso, "Gendering the 'Responsible Risk Taker': Citizenship Relationships with Gender-Neutral Social Assistance Policy," *Citizenship Studies* 13, no. 1 (2009); Joyce Green, "Canaries in the Mines of Citizenship: Indian Women in Canada," *Canadian Journal of Political Science* 34, no. 04 (2001); Candace Johnson Redden, *Health Care, Entitlement, and Citizenship* (Toronto: University of Toronto Press, 2002).

significant objection is that making claims on a state that many understand to be capitalist, imperialist, heteronormative, sexist, ablest, racist (and so on), may work to legitimate the longstanding systemic inequities and marginalization on which that state was founded. Seeking recognition from an imperialist state, for example, might validate its authority. At the same time, there might be reasons to do so as engagement does not need to signify approval and support. To paraphrase scholar and activist Viviane Namaste, recognition is in part about the “banality of buying some bread, of making photocopies, of getting your shoe fixed. It is not about challenging, it is not about making a critical intervention every waking second of the day.”⁸ For those whose interests are not recognized, formal recognition in law and public policy may be necessary in order to make life within contemporary constraints, more livable. This is not to preclude more radical or liberatory projects, but simply to establish that rights claims within the framework of the state are important as well.⁹

Works that theorize citizenship as a matter of inclusion and exclusion have emphasized, in particular, the relationship between the state, the market, and civil society sometimes described as a citizenship regime.¹⁰ Following Jenson, a citizenship regime is comprised of “the institutional arrangements, rules and understandings that guide and shape state policy; problem definition employed by states and citizens; and the range of claims recognized as legitimate,”¹¹ effectively marking the boundaries of which problems count for the state, how they will be

⁸ Viviane K. Namaste, *Sex Change, Social Change: Reflections on Identity, Institutions and Imperialism* (Toronto: Women’s Press, 2005), 20.

⁹ David Rayside, *Queer Inclusions, Continental Divisions: Public Recognition of Sexual Diversity in Canada and the United States* (Toronto: University of Toronto Press, 2008), 16.

¹⁰ Jenson and Phillips, “Regime Shift: New Citizenship Practices in Canada,” 112.

¹¹ Jenson, “Fated to Live in Interesting Times,” 631. See also Jenson and Phillips, “Regime Shift: New Citizenship Practices in Canada”; Jane Jenson and Martin Papillon, “Challenging the Citizenship Regime: The James Bay Cree and Transnational Action,” *Politics & Society* 28, no. 2 (2000); Alexandra Dobrowolsky, “(In)Security and Citizenship: Security, Im/migration and Shrinking Citizenship Regimes,” *Theoretical Inquiries in Law* 8 no.2 (2007).

solved, and who will be included in the debate. The nature of a given citizenship regime is defined by four key elements.¹² First, citizenship regimes include the “responsibility mix,” that is the values and boundaries that differentiate the responsibilities of the state from those of other actors (i.e., markets, families, and communities). Second, citizenship regimes involve the recognition of rights (i.e., civil, political, social, and cultural), identifying who is formally recognized by the state and entitled to full citizenship status, and who is not. Third, to analyze a citizenship regime, one must identify the nature of democratic life for a polity, that is, the practices and institutional mechanisms that enable citizens to access the state, and the ways that participation and claims-making are made possible.¹³ Finally, citizenship regimes comprise the limits of belonging—the ways that inclusion and exclusion are made possible beyond formal mechanisms, extending to cultural and psychological sense of belonging. Here, “belonging encapsulates the idea that citizenship involves more than the narrow passport-holding sense of citizenship, and encompasses broader understandings of inclusion, acceptance, attachment and connection.”¹⁴

Thinking about citizenship regimes enables an understanding of citizenship in context, in terms of the institutions, discursive practices, socioeconomic conditions, and other factors that shape the experience of belonging, and of being recognized as such. Analyses of citizenship regimes provide insight into who belongs and is recognized within a state, which citizens represent the “‘national’ as well as the ‘model citizen,’ the second-class citizen’ and the non-citizen,” as well as the “proper and legitimate social relations among and within these

¹² Jane Jenson, “Redesigning Citizenship Regimes after Neoliberalism: Ideas about Social Investment,” (paper presentation at the International Sociological Association, Florence, IT, September 2007).

¹³ Jane Jenson, “Social Citizenship in 21st Century Canada: Challenges and Options” (Timlin Lecture, University of Saskatchewan, Saskatoon, SK, February 5, 2001).

¹⁴ Dobrowolsky, “(In)Security and Citizenship,” 657.

categories.”¹⁵ Taking citizenship regimes as a point of analysis is a particularly useful approach to the study of recognition and belonging as it allows for an analysis of the relationship between citizens, the state, the family, and the market, as well as the processes by which certain individuals and groups come to be viewed as legitimate and deserving of recognition.

In the Canadian context, citizenship regimes are most often explained through the historical evolution of a social citizenship regime to a neoliberal one.¹⁶ These works begin by describing the nature of social citizenship in the 1950s entrenched with the establishment of national state-supported social programs. Although access to social citizenship in the post-war welfare state was not wholly universal and certainly excluded some already marginalized groups,¹⁷ the social citizenship regime relied heavily on the consensus that citizens could generally access certain rights protections and social programs on the basis of their status as citizens. These rights were not equally distributed between men and women, and the collective social project espoused by the welfare state included the promotion of motherhood as an important contribution to the state. The mother-citizen was seen to play an important role in the life of the state, entitled to social supports because of their role as mothers.¹⁸ The commitment to

¹⁵ Alexandra Dobrowolsky and Jane Jenson, “Shifting Representations of Citizenship: Canadian Politics of ‘Women’ and ‘Children,’” *Social Politics* 11, no. 2 (2004): 156.

¹⁶ Jenson, “Social Citizenship in 21st Century Canada: Challenges and Options”; Dobrowolsky, “Interrogating ‘Invisibilization’ and ‘Instrumentalization’”; Gazso, “Gendering the ‘Responsible Risk Taker’”; Brodie, “Restructuring and the New Citizenship”; Brodie, “Citizenship and Solidarity”; Dean Hoxsey, “Debating the Ghost of Marshall,” *Citizenship Studies* 15, no. 6-7 (2011); Sylvia Fuller, Paul Kershaw, and Jane Pulkingham, “Constructing ‘Active Citizenship’: Single Mothers, Welfare, and the Logics of Voluntarism,” *Citizenship Studies* 12, no. 2 (2008).

¹⁷ Janine Brodie, *Politics on the Margins: Restructuring and the Canadian Women’s Movement* (Halifax: Fernwood Press, 1995); Janine Brodie, “Putting Gender Back In: Women and Social Policy Reform in Canada,” in *Gendering the Nation-State: Canadian and Comparative Perspectives*, ed. Yasmeen Abu-Laban (Vancouver: University of British Columbia Press, 2008); Fuller, Kershaw, and Pulkingham, “Constructing ‘Active Citizenship,’” Jenson, “Fated to Live in Interesting Times”; Ruth Lister, “Dialectics of Citizenship,” *Hypatia* 12, no. 4 (1997); Jane Pulkingham, “Remaking the Social Divisions of Welfare: Gender, ‘Dependency,’ and UI Reform,” *Studies in Political Economy* 56 (1998); Sylvia Walby, “Is Citizenship Gendered,” *Sociology* 28, no. 2 (1994).

¹⁸ Amber Gazso, “Moral Codes of Mothering and the Introduction of Welfare-to-Work in Ontario,” *Canadian Review of Sociology* 49, no. 1 (2012): 33.

state intervention to improve the lives of Canadians meant that the citizenship regime in the post-war period “accepted a guiding role for the state in economic development” and generated a pan-Canadian understanding of social solidarity that tied citizenship to the new relationship between the state, market, and community.¹⁹

By the early 1970s, economic crises were leading to uncertainty about the sustainability of the Keynesian economic model. Social spending was seen as problematic, “dampening economic growth, protecting inflexible labour markets, hindering labour force participation, [and] fostering welfare dependency.”²⁰ The expansive welfare state was increasingly viewed as untenable, and in need of replacement by a model that would facilitate the re-entry of citizens into the labour force, allowing them to achieve self-sufficiency rather than rely on entitlements. The privileging of the unrestricted market came to be seen as fundamental to everyday life, as the private life of the individual was increasingly understood as an important site of governance, providing “individual solutions to social problems.”²¹

The model of neoliberalism advanced in these analyses of citizenship regimes is one that extends an approach to public policy premised on the rolling back of the welfare state and the retrenchment of social policy.²² Downsizing, deregulation, and privatization are indeed integral to a neoliberal approach to policymaking, but neoliberalism is, more broadly constitutive of an extension of market-based logic to novel areas of political and social life. In her “Neo-liberalism: Policy, Ideology, Governmentality,” Wendy Larner makes this distinction, identifying the ways

¹⁹ Jenson, “Fated to Live in Interesting Times.”

²⁰ Jane Jenson and Denis Saint-Martin, “New Routes to Social Cohesion,” *Canadian Journal of Sociology* 28, no. 1 (2003): 81–2.

²¹ Alexandra Dobrowolsky, “Introduction,” in *Woman and Public Policy in Canada: Neo-Liberalism and After?*, ed. Alexandra Dobrowolsky (Don Mills, ON: Oxford University Press, 2009).

²² Wendy Larner, “Neo-Liberalism: Policy, Ideology, Governmentality,” *Studies in Political Economy* 63 (2000); Miriam Smith, *A Civil Society? Collective Actors in Canadian Political Life* (Toronto: University of Toronto Press, 2005), 15.

in which neoliberalism has been theorized as a policy framework, as well as an ideology. As a policy framework, neoliberalism may be understood through the conscious and relatively cohesive shift in policy agendas from favouring a Keynesian welfare state to “the relatively unfettered operation of markets.”²³ As an ideology, neoliberalism encompasses the policies, practices, and values that have come to emerge as “the core arguments of a society,”²⁴ including individualism, freedom of choice, commodification, the privatization of once-public services, self-sufficiency, and marketization.²⁵

This view of neoliberalism as ideology also assumes that it is not a cohesive approach to making public policy, but rather that it is an abstract ideological approach with contradictions in practice as different actors are privileged at different times. Looking to the work of a number of Canadian scholars—Brodie, Jenson, and Dominique Masson—Larner points to the ways that collective interests, including social movements and advocacy groups participate in the project of restructuring, contributing to its discursive framework in opposition, or negotiating new roles within the realities of a changing state. Larner writes here that the claims-making of interest groups makes evident the contested and “messy” nature of neoliberalism as an ideology as those who might make claims on the state inform new governing arrangements; governance under neoliberalism is a contested terrain. For Larner, understanding neoliberalism as an ideology means that neoliberal restructuring is always already a site of contestation, made up by the state as well as the interest groups, stakeholders, and others who engage. Neoliberalism as an ideology offers a view of how the values of neoliberalism that emerge in policymaking are negotiated. As

²³ Larner, “Neo-Liberalism: Policy, Ideology, Governmentality,” 6; Dobrowolsky, “Introduction,” 7.

²⁴ Wenshu Lee, “For the Love of Margins: Neoliberal Classrooms, Neoliberal Institutions and Repoliticizing Education” in *Transformative Communication Studies: Culture, Hierarchy and the Human Condition*, ed. Omar Swartz (Leicester, UK: Troubador Publishing Ltd, 2008), 129.

²⁵ Larner, “Neo-Liberalism: Policy, Ideology, Governmentality”; Smith, *A Civil Society?*.

Larner writes:

[U]nderstanding neo-liberalism as an ideology means that we are alerted to the possibility that there are different configurations of neo-liberalism, and that close inspection of particular neo-liberal political projects is more likely to reveal a complex and hybrid political imaginary, rather than the straightforward implementation of a unified and coherent philosophy. [...] [W]e are forced to explore the notion that power is productive, and that the articulations between hegemonic and oppositional claims give rise to new political subjectivities and social identities which then enter into the discourse of restructuring.²⁶

The input of interest groups, social movements, and others contesting and supporting new state forms means that the evolution of the state is informed by more than a mere policy agenda enacted by the government of the day. This dissertation takes neoliberalism, following Larner, to be an ideology that informs governing practices, that creates new subjects, and that results in a politics of contestation, understanding that “power is not constituted and exercised exclusively on the terrain of the state.”²⁷

What is important here is the way that the rise of neoliberalism from the 1970s onward has translated into a shift in citizenship regime. The move away from social service provision has meant, in one sense, a loss of pan-Canadian identity,²⁸ but also a new iteration of citizenship based around an altered “responsibility mix” increasingly distributed between citizens and the market with the state taking a lesser role. From this view, the ideal neoliberal citizen is one who takes responsibility for their actions, their body, and their self, most often through engagement with a free market economy that allows them to sustain themselves and their family through employment and consumption without putting demands on the state. Matched by a decline in social rights and new restrictions on claims-making, the sense of belonging that results is limited,

²⁶ Larner, “Neo-Liberalism: Policy, Ideology, Governmentality,” 12.

²⁷ Ibid., 10.

²⁸ Jenson, “Fated to Live in Interesting Times,” 642.

complicated by a moral imperative bound up with neoliberal citizenship insofar as it has been through market participation that citizens become deserving and undeserving of full citizenship in new ways. The inability to engage in the labour force and to enact the scripts of “active participation” in the economy are now seen as moral failings, that is, as ineptitude and inadequacy undeserving of social rights.²⁹ Social concerns are reframed as private matters to be addressed by the self-sufficient citizen and the private sphere—the market and the home—is left to fill in the gaps where the welfare state has contracted. This privatization of what was once public has meant increased care work in households, and any failure to “pick up the slack” has come to represent a moral failing on the part of those who do not or cannot meet the standards of the “good” citizen.

Importantly, this shift in citizenship regime has important implications for the governance of assisted reproduction, by offering the framework in which legitimate practices of conception, childbearing, and childrearing are possible. The privatization of public life has meant a shifting of support for both social and biological reproduction, to the home and to the private marketplace, where childcare, gametes, and “cures” for infertility are competitively priced. As reproductive technologies have made possible new and previously unimaginable means for conception and pregnancy, the market-based and moral imperatives of neoliberal citizenship have followed. In the new marketplace of assisted reproduction, a good reproductive citizen is one who either reproduces with their own genetic material, or seeks out the capacity to do so through the medical marketplace. The possibility of alternative models of thinking about family, reproduction, and childrearing are outside of this framework of reproductive citizenship, which privileges the capacity of worker-citizens to reproduce, but to do so in self-sufficient ways that

²⁹ Brodie, “Restructuring and the New Citizenship”; Smith, *A Civil Society?*, 15.

replicate existing social structures.

Interest Articulation and Participation in a Neoliberal Citizenship Regime

While neoliberal values have been at the core of attempts to govern assisted reproduction, policy in this field has not been entirely made from the top-down. Interest groups and others have emerged to engage with, contest, and at times, support privatization, marketization, and individualization related to assisted reproduction. At the outset, women's groups, religious groups and others contested the emergence of a private-for-profit infertility industry and the related lack of regulatory oversight. However, in the work of the Royal Commission on New Reproductive and subsequent attempts to develop a policy framework, a host of other actors emerged, informing and negotiating the discourse and limits of potential public policy in the field. Throughout the long policy process that would eventually lead to legislation, approaches to making policy on assisted reproduction that espoused the values of neoliberalism were addressed by the voices and experiences of citizens.

It is important to note, however, that while the view of neoliberalism as ideology understands the interactions of top-down and bottom-up approaches to governance, in a neoliberal citizenship regime there may be new constraints on what kind of democratic processes are possible. This includes profound shifts in the legitimacy of interest groups and their capacity to organize to represent the positions of Canadians, and particularly those excluded or marginalized in various ways. What interest groups and stakeholders contribute to policy debates is increasingly shaped by the pressures of a neoliberal ideology, including a contracted state,

individualism, consumerism, privatization, and ever-expanding markets.³⁰ The shift in the work of interest groups under a neoliberal citizenship regime has not only meant a change in the nature of “who counts” in policy processes, but also the changing of the “responsibility mix” that tasks interest groups with service-delivery as once-publicly provided programs are offloaded from the state to individuals, the market, and importantly, to civil society. As state obligations are displaced, political opportunities for advocacy have been disappearing.³¹

The history of interest groups in Canada is extensive and longstanding, demonstrating the changing nature of Canada’s citizenship regime.³² An important part of this history has been the expansion of these groups in the post-war welfare state, and an integration of some social movement and interest group initiatives into the apparatus of the state, particularly through granting schemes. In the post-war state, commitments to the integration of immigrants and the need to shore up Canadian citizenship gave way to new funding for a range of initiatives under the auspices of a “citizenship training program” funded through the Secretary of State.³³ Immigrant groups, women’s groups, labour unions, universities and others received funding in the 1950s under this new program, firmly embedding the federal government in the ongoing activities of a range of institutions and interest group actors. By the 1970s, the funding of interest groups was a regular activity of federal line departments, establishing in a way that the cultivation of interest group actors, including those which may present positions different from that of the government of the day, are integral to ensuring social solidarity, and to cultivating a

³⁰ Miriam Smith, “Resisting and Reinforcing Neoliberalism: Lesbian and Gay Organising at the Federal and Local Levels in Canada,” *Policy & Politics* 33, no. 1 (2002): 79; Janine Brodie, “We Are All Equal Now: Contemporary Gender Politics in Canada,” *Feminist Theory* 9, no. 2 (2008): 154.

³¹ Smith, *A Civil Society?*, 17.

³² Smith, *A Civil Society?*; Paul A. Pross, *Group Politics and Public Policy*, 2nd ed. (Don Mills, ON: Oxford University Press, 1992).

³³ Leslie A. Pal, *Interests of State: The Politics of Language, Multiculturalism, and Feminism in Canada* (Montreal: McGill-Queen’s University Press, 1993); Jenson and Phillips, “Regime Shift: New Citizenship Practices in Canada,” 115.

sense of recognition, of belonging within the state. Women's groups provide a notable example of interest groups well-supported by the state in this period as not only were there a number of local and national women's groups that received federal funding, but also state agencies were established to address the specific concerns articulated by women following the Royal Commission on the Status of Women, most prominently the Office of the Status of Women (now Status of Women Canada), and the Canadian Advisory Council on the Status of Women.

By the 1990s, however, there were significant changes to the strong relationship between the state and interest group actors that had been cultivated since the 1950s. This change came in part because "the state had begun to reconsider the wisdom of funding its critics,"³⁴ and because a shift in the federal approach to government was working to offload responsibility for social welfare to individual Canadians. One such restructuring initiative in 1993 reduced the size of the federal government considerably and saw the elimination of the Secretary of State Department, resulting in the cancellation or reassignment of longstanding programs that had funded interest group activities.³⁵ Further, throughout the 1990s, the validity of certain groups as legitimate stakeholders in public policy debates were undermined as they were alternately described as service providers rather than advocates, and as "special interests" with goals too niche to be taken seriously.³⁶ As funding was increasingly contingent on groups defining themselves as service providers, groups were left in a double-bind, unable to operate without prioritizing services, but unable to engage in policymaking because of the primacy of service provision (to the exclusion of advocacy). These groups were viewed as "special interests," including women's

³⁴ Jenson and Phillips, "Regime Shift: New Citizenship Practices in Canada," 119.

³⁵ *Ibid.*, 119–121.

³⁶ Brodie, "We Are All Equal Now Contemporary Gender Politics in Canada," 155; Alexandra Dobrowolsky, "Of 'Special Interest': Interest, Identity and Feminist Constitutional Activism in Canada," *Canadian Journal of Political Science* 31, no. 04 (1998); Jenson, "Fated to Live in Interesting Times"; Jenson and Phillips, "Regime Shift: New Citizenship Practices in Canada"; Smith, *A Civil Society?*, 11–12.

organizations, and compared against populist interests of “real Canadians” suggesting both that women’s interests are not real and that the very real work of lobbyists, businesses, and others should continue.

The erosion of the capacity of longstanding interest groups to engage in policymaking has often meant that the private sector has filled the gaps in the policy process once filled by service organizations, not-for-profits, and the voluntary sector. Market-based actors take up an increasingly important role in the legislative and policymaking process, occupying the literal and figurative spaces once held by interest groups. Canadian citizens remain engaged in the legislative process, however as individuals, on their own terms, without the engagement of embedded, well-resourced interest-group actors. Following Jenson and Phillips, under a neoliberal citizenship regime “individuals are charged with representing themselves, through referenda and petitions and during public consultation, in addition to elections.”³⁷ In policy consultations this trend is apparent, as certain groups with a long history of participation in a range of public debates have simply been shut out of the policy process, replaced by individuals each telling their own story.

The declining role of interest groups in the public policy process has occurred in tandem with greater consideration given to public consultations, the aim of which was to extend consultations with “real” Canadians participating on their own behalf, rather than those of organized interest groups. Active citizens have been enabled to participate in democratic processes of deliberation, representing their own experiences. This model positions citizens as responding to already-established policy approaches, that is, as consumers and decision-makers

³⁷ Jenson and Phillips, “Regime Shift: New Citizenship Practices in Canada”; Smith, *A Civil Society?*, 13; Dobrowolsky, “Introduction,” 6; Dobrowolsky and Jenson, “Shifting Representations of Citizenship.”

on public policy, rather than as policy actors.³⁸ A number of consultations in the 1990s were used, for example, to validate the position that citizens could independently speak to their own interests. The Spicer Commission's quest to consult with one million Canadians—individuals not groups—in three months provides an early example of the move toward individual consultations.³⁹ The Royal Commission on New Reproductive Technologies would follow soon thereafter, hearing from more than 40,000 Canadians through (as described in chapter three of this dissertation) a number of public hearings, a toll-free telephone line, and national surveys, in addition to consultations with invited experts and stakeholders.⁴⁰

The shifting nature of public consultations in the 1990s onward has worked to limit opportunities for longstanding interest groups to engage by privileging the voices of a much broader range of citizens, balancing organized interests with the views of “ordinary” citizens. Following Jenson and Phillips, this trend towards consulting individuals as well as groups works to ensure that there is no longer a “strong coordinated voice from any particular sector,” that those participants in agreement with the government's position are easily validated, and the positions of dissenters are easily dismissed as a too-small minority of views. The nature of these consultations, including things like public hearings, telephone lines, focus groups, public opinion surveys, and feedback on “workbooks” provide the opportunities for public consultation in contexts where the policy agenda is already set.⁴¹

In the examination of the governance of ARTs in Canada, the ways that the doors have

³⁸ Susan D. Phillips, “The Intersection of Governance and Citizenship in Canada: Not Quite the Third Way,” *Policy Matters* 7, no. 2 (2006): 16.

³⁹ Jenson and Phillips, “Regime Shift: New Citizenship Practices in Canada,” 126; Rachel Laforest and Susan D. Phillips, “Citizen Engagement: Rewiring the Policy Process,” in *Critical Policy Studies*, eds. Michael Orsini and Miriam Smith (Vancouver: University of British Columbia Press), 74.

⁴⁰ Jan Hatcher Roberts, “Coalition Building and Public Opinion: New Reproductive Technologies and Canadian Civil Society,” *International Journal of Technology Assessment in Health Care* 15, no. 1 (1999): 17.

⁴¹ See also Éric Montpetit, “Public Consultations in Policy Network Environments: The Case of Assisted Reproductive Technology Policy in Canada,” *Canadian Public Policy* 29, no. 1 (2003).

closed to conventional interest group actors in the legislative process are of particular import. As this dissertation will demonstrate, the consultations held with Canadians during the Royal Commission on New Reproductive Technologies were the first of many public engagement exercises that would occur throughout the policy process. As time went on, conventional interest group actors, including women's groups were shut out of the process,⁴² or as in the case of religious groups, seen to be relatively marginal. There was a "growing emphasis...on hearing from individuals rather than representatives from advocacy groups"⁴³ as conventional interest or advocacy groups were often displaced by individuals, small self-funded groups, large patient groups deeply intertwined with commercial interests, and any number of professional associations, fertility clinics, and other stakeholders with financial stakes in the policy outcomes.

Assisted Reproductive Technologies and the Neoliberal Turn

As the welfare state began to unravel and a neoliberal logic was emerging, so too was reproduction itself in flux. The rapid expansion of fertility clinics in the United Kingdom, Australia, the United States, Canada, and elsewhere in the 1980s was embedded in the market-based logic of the neoliberal citizenship regime. To borrow from Sarah Franklin, consumers "were able to take advantage of the many clinics eager to establish themselves in this rapidly expanding sector,"⁴⁴ and the physicians and clinics that were moving into the sector were able to benefit from the incentives provided to entrepreneurs. Fertility clinics, sperm banks (not to

⁴² Francesca Scala, Éric Montpetit, and Isabelle Fortier, "The NAC's Organizational Practices and the Politics of Assisted Reproductive Technologies in Canada," *Canadian Journal of Political Science* 38, no. 3 (2005); Diana Backhouse and Maneesha Deckha, "Shifting Rationales: The Waning Influence of Feminism on Canada's Embryo Research Restrictions," *Canadian Journal of Women and the Law* 21, no. 2 (2009).

⁴³ Scala, Montpetit, and Fortier, "The NAC's Organizational Practices and the Politics of Assisted Reproductive Technologies in Canada," 597.

⁴⁴ Sarah Franklin, *Embodied Progress: A Cultural Account of Assisted Conception* (London, UK: Routledge, 1997), 78.

mention the biotechnology firms and pharmaceutical companies involved) were lucrative, largely unregulated, and operated in the name of giving citizens the opportunity to make the reproductive choices that they desired. Prominent scholars argued that access to reproductive technologies was a negative right, and that so long as women freely consented to the use of ARTs, and were made aware that the technologies were largely untested, any restrictions on their use would be unfounded. Calls for “procreative liberty”⁴⁵ resonated with those eager to use reproductive technologies and to make them more accessible through the expansion of the infertility industry and mirrored Shulamith Firestone’s historic call to use reproductive technologies to emancipate women from the “tyranny of reproduction.”⁴⁶

For each promise of gendered liberation that might come with reproduction without sex, and conception outside the womb, there were many more concerns about how these technologies might limit women’s autonomy and potential for self-governance by creating a world in which women might be seen only as “egg farms”⁴⁷ and walking wombs for hire.⁴⁸ Critics identified how the rhetoric of choice⁴⁹ was undermined by “structured constraints, depending on a woman’s race, class, age, marital status, sexuality, religion, culture, and sometimes disability,” limiting to whom such choices were available.⁵⁰ From this perspective, the choice to partake in the newly available technologies was not a free one, but rather was dependent on who was

⁴⁵ John A. Robertson, “Embryos, Families, and Procreative Liberty: The Legal Structure of the New Reproduction,” *Southern California Law Review* 59 (1986).

⁴⁶ Shulamith Firestone, *The Dialectic of Sex: The Case for Feminist Revolution* (New York: Bantam, 1970), 193.

⁴⁷ Julie Murphy, “Egg Farming and Women’s Future,” in *Test-Tube Women: What Future for Motherhood*, eds. Rita Arditti, Renate Duelli Klein and Shelley Minden (London, UK: Pandora, 1984).

⁴⁸ Janice G. Raymond, *Women as Wombs: Reproductive Technologies and the Battle over Women’s Freedom* (New York: HarperCollins, 1993); Ann Oakley, “From Walking Wombs to Test-Tube Babies,” in *Reproductive Technologies: Gender, Motherhood and Medicine*, ed. Michelle Stanworth (Minneapolis: Minnesota University Press, 1987).

⁴⁹ See for example Barbara Katz Rothman, “The Meanings of Choice in Reproductive Technology,” in *Test-Tube Women: What Future for Motherhood*, eds. Rita Arditti, Renate Duelli Klein and Shelley Minden (London, UK: Pandora, 1984).

⁵⁰ Gena Corea, *The Mother Machine: Reproductive Technologies from Artificial Insemination to Artificial Wombs*, (New York: Harper and Row, 1985), 3.

considered a good reproductive citizen, that is to say, whether one was heterosexual, middle-to-upper class, and white. Caution needed to be taken in part because it was unclear that ARTs were safe for women's bodies and moreover because they were problematic to the status of women as a group.⁵¹ This scholarship identified the relationship between patriarchal control of women's reproductive capacities and the advent of new reproductive technologies, asserting that assisted reproduction was a new and insidious means to control women's bodies and to divorce women from the embodied practices of conception and childbearing, particularly through the intercession of the state, the clinic, and the laboratory.⁵² In short, the predominant view amongst feminist scholars was that "the domination of so much reproductive technology by the medical profession and by the state has enabled others to have an even greater capacity to exert control over women's lives."⁵³ No matter the potential for reproductive choice that it offered some women, the disadvantages presented by ARTs to women as a group were too great to ignore.⁵⁴

As the market in assisted reproduction expanded, and technologies like *in vitro* fertilization (IVF) and intrauterine insemination become a relatively commonplace manner of conception, a small but important subset of feminist scholarship on ARTs developed to identify how liberal discourses imbued with a market-based logic, work to privilege individual consumer-citizens seeking out assisted conception.⁵⁵ Sarah Franklin's *Embodied Progress*, for example,

⁵¹ Kathryn Pauly Morgan, "Of Woman Born? How Old-Fashioned! - New Reproductive Technologies and Women's Oppression" in *The Future of Human Reproduction* ed. Christine Overall (Toronto, Women's Press, 1989).

⁵² Corea, *The Mother Machine*; Renate Klein, *Infertility: Women Speak Out About Their Experiences of Reproductive Medicine* (London, UK: Pandora, 1989); Michelle Stanworth, "Reproductive Technologies and the Deconstruction of Motherhood," in *Reproductive Technologies: Gender, Motherhood, and Medicine*, ed. Michelle Stanworth (Minneapolis: University of Minnesota Press, 1987); Naomi Pfeffer, "Artificial Insemination, In-Vitro Fertilization, and the Stigma of Infertility," in *Reproductive Technologies: Gender, Motherhood, and Medicine*, ed. Michelle Stanworth (Minneapolis: University of Minnesota Press, 1987); Christine Overall, *Ethics and Human Reproduction: A Feminist Analysis* (Boston: Allen & Unwin, 1987); Louise Vandelac, "Sexes et technologies de procréation: 'Mères porteuses' ou la maternité déportée par la langue . . ." *Sociologie et sociétés* 19, no. 1 (1987).

⁵³ Stanworth, "Reproductive Technologies and the Deconstruction of Motherhood," 15–16.

⁵⁴ Robyn Rowland, "Technology and Motherhood: Reproductive Choice Reconsidered," *Signs* 12, no. 3 (1987), 513.

⁵⁵ Ramona Koval, "The Commercialisation of Reproductive Technology," in *The Baby Machine: Reproductive Technologies and the Commercialisation of Motherhood*, ed. Jocelynne A. Scutt (London, UK: Green Print, 1987);

includes analyses of how British couples seeking fertility services have theorized their family building projects in terms of their capacity to engage in consumer activities. In her study of women and couples undergoing IVF in the UK in the 1990s, Franklin found that her research participants articulated their experiences in terms of their capacity to partake in consumer culture, identifying that engaging in IVF was a choice that they were making rather than, for example, purchasing a house or decorating it.⁵⁶ Within the context of Margaret Thatcher's "enterprise culture," Franklin asserted that IVF in this context was one means to contribute to the new economy by consuming "on behalf of the family."⁵⁷

Deborah Spar's *The Baby Business* provides another compelling example of the relationship between the language of choice and the market in fertility treatments. Spar argues that the debate over the use of ARTs is founded in a moral conundrum; access to ARTs requires paying large sums of money to access the services provided by (most often) private clinics, while there is a fundamental aversion to thinking about "baby-making as a business."⁵⁸ This is not true for all countries, but in most parts of Canada (as elsewhere), reproductive technologies are a lucrative, private business. Even when services are offered through or in conjunction with publicly funded health care services, there is still much money to be made through additional procedures, "add-ons" to care, and increasingly, fertility preservation techniques like sperm, egg and embryo freezing. Not wanting to think about reproduction as a commercial enterprise, despite its (most often) privately funded, business-oriented mode of delivery, often pushes the

Naomi Pfeffer, *The Stork and the Syringe: A Political History of Reproductive Medicine* (Cambridge, UK: Polity Press, 1993); Laura Mamo, *Queering Reproduction: Achieving Pregnancy in the Age of Technoscience* (Durham, NC: Duke University Press, 2007); Catherine Waldby and Robert Mitchell, *Tissue Economies* (Durham, NC and London, UK: Duke University Press, 2006); Catherine Waldby and Melinda Cooper, "The Biopolitics of Reproduction: Post-Fordist Biotechnology and Women's Clinical Labour," *Australian Feminist Studies* 23, no. 55 (2008)..

⁵⁶ Franklin, *Embodied Progress*, 4; 163.

⁵⁷ *Ibid.*, 4.

⁵⁸ Debora L. Spar, *The Baby Business* (Boston: Harvard Business School Press, 2006), xi.

infertility industry outside of the public purview. Largely symbolic commitments to non-commercialization, non-commodification, and the protection of women's bodies render invisible the actual practices of an industry that remains largely unregulated today.⁵⁹

Some of this scholarship on the infertility industry has also focused on the ways in which the market for ARTs is manufactured by scientists, the popular press, and scholars obsessed with declining birth rates and the promise of now-available technologies once unimaginable.⁶⁰ The act of bringing reproduction into the space of fertility clinics and under the care of physician marks a move towards a medico-scientific solution to a cultural concern. A declining birth rate, delayed childbearing, and ongoing understandings of conceiving and bearing genetically-related children in the context of a nuclear, heteronormative family are social concerns that are increasingly conceived as sites of medical intervention. This medicalization of childbirth and the shift away from midwifery and other traditional forms of knowledge are apparent in a number of interventions that have come to be seen as unremarkable. Ultrasound, fetal monitoring, and caesarean sections were once rare interventions that are now commonplace, often expected in the birthing process. The ever-increasing number of medical interventions in childbirth are an important example of medicalization, which following Peter Conrad, refers to seeing “a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to ‘treat’ it.”⁶¹ If medicalization is indeed the process through which a lowered libido becomes sexual dysfunction, rambunctiousness becomes hyperactivity, and bad breath becomes halitosis; it follows that the

⁵⁹ Ibid., xv.

⁶⁰ Charis Thompson, *Making Parents: The Ontological Choreography of Reproductive Technologies* (Cambridge, MA: MIT Press, 2005); José Van Dyck, *Manufacturing Babies and Public Consent: Debating the New Reproductive Technologies* (New York: New York University Press, 1995); Pfeffer, *The Stork and the Syringe*.

⁶¹ Peter Conrad, “Medicalization and Social Control,” *Annual Review of Sociology* 18, no. 1 (1992): 211.

medicalization of reproduction is similarly a means to make a socio-biological experience a matter of modern medicine.⁶² As IVF, egg freezing, and sperm donation have been normalized, assisted reproduction affirms the place of reproduction within the clinic, and that women can and should use these technologies to address unwanted childlessness, precluding scrutiny of the social structures and assumptions about biological reproduction on which they are based.⁶³ In short, the medicalization of reproduction and with it, infertility, coupled with the availability of ARTs and the understanding of ARTs as an infertility “cure,” extends the possibility of using these technologies to an ever-growing number of people, constructing an inflated cycle of supply and demand that propels the market in infertility services.

The Canadian Context

There have been a number of scholarly works that take up concerns about the intersections of neoliberalism, biomedicine, and capital in the governance of ARTs in Canada. This scholarship was primarily comprised of feminist critiques of the Royal Commission on New Reproductive Technologies, which suggested that although the Commission operated under the auspices of advancing equality and the needs of vulnerable populations, its commitments to evidence-based medicine and failure to consider the political economy of infertility ensured that its recommendations would uphold the “existing class alliances”⁶⁴ of the federal government.

Although economic analysis was largely absent from the Royal Commission’s report, in part due to the lack of substantive feminist works asserting that the political economy of ARTs was an

⁶² See for example, Lorna Weir, *Pregnancy, Risk, and Biopolitics: On the Threshold of the Living Subject*. Transformations: Thinking Through Feminism. (London, UK and New York: Routledge, 2006).

⁶³ Mary Lyndon Shanley and Adrienne Asch, “Involuntary Childlessness, Reproductive Technology, and Social Justice: The Medical Mask on Social Illness,” *Signs* 34, no. 4 (2009).

⁶⁴ Lorna Weir and Jasmine Habib, “Comment: A Critical Feminist Analysis of the Final Report of the Royal Commission on New Reproductive Technologies,” *Studies in Political Economy* 52 (1997):145.

important site for interrogation,⁶⁵ the Royal Commission's failure to interrogate the links between the retrenchment of social policy,⁶⁶ "corporate incursion into medicine,"⁶⁷ and international trade agreements⁶⁸ meant that the policy field defined by the Commission report was largely devoid of these concerns. In addition to a lack of economic analysis, the Commission's advancement of liberal discourses also privileged biomedical actors, due to a commitment to scientific model of evidence-based medicine removed from the real-life experiences of clinical practice. This model served to construct the practices of reproductive medicine as matters of scientific innovation and research conducted on gender-neutral subjects, shifting away from the clinical expertise of physicians, and towards science supported by biotechnology companies, and pharmaceutical firms.⁶⁹

Recent scholarship on ARTs in Canada has moved away from these concerns. Since the Royal Commission, the literature has focused primarily on three areas of analysis related to ARTs in Canada. First, a number of articles examine the historical development of assisted reproduction in Canada as a policy field.⁷⁰ These works emphasize the factual, seeking to chronicle the nature of the evolution of such policy in Canada, often from the point of view of

⁶⁵ Ibid., 149.

⁶⁶ Deborah C. Poff, "Reproductive Technology and Social Policy in Canada," in *The Future of Human Reproduction*, ed. Christine Overall (Toronto: Women's Press, 1989).

⁶⁷ Laura Sky, "Commercial Interests and New Reproductive Technologies," *Canadian Woman Studies/Les cahiers de la femme* 14, no. 3 (1994): 106.

⁶⁸ Annette Burfoot, "In-Appropriation - A Critique of Proceed with Care: Final Report of the Royal Commission on New Reproductive Technologies," *Women's Studies International Forum* 18, no. 4 (1995); Barbara Cameron, "Brave New Worlds for Women: NAFTA and New Reproductive Technologies," in *Women and Canadian Public Policy*, ed. Janine Brodie (Toronto: Harcourt and Brace, 1996).

⁶⁹ Francesca Scala, "Experts, Non-Experts, and Policy Discourse: A Case Study of the Royal Commission on New Reproductive Technologies" (PhD dissertation, Carleton University, 2002); See also Weir and Habib, "Comment: A Critical Feminist Analysis of the Final Report of the Royal Commission on New Reproductive Technologies," 150.

⁷⁰ Patricia Baird, "The Evolution of Public Policy on Reprogenetics in Canada," *Reprogenetics: Law, Policy and Ethical Issues*, eds. Lori P. Knowles and Gregory E. Kaebnick (Baltimore, MD: Johns Hopkins University Press, 2007); Bonnie Brown, Nancy Miller Chenier, and Sonya Norris, "Committees as Agents of Public Policy: The Standing Committee on Health," *Canadian Parliamentary Review* 26 no. 3 (2003); Jean Haase, "The Long Road to Regulation" in *Third Party Assisted Conception Across Cultures: Social, Legal, and Ethical Perspectives*, eds. Eric Blyth and Ruth Landau (London, UK: Jessica Kingsley Publishers, 2004); Jan Hatcher Roberts, "Coalition Building and Public Opinion."

authors who participated directly in the policy process.⁷¹ Second, many works in this field provide analysis of how the Act came to straddle a matter of provincial and federal authority through the use of the criminal law power.⁷² These works typically take strong positions on the legitimacy of the criminal law to regulate assisted reproduction, arguing either that it is too blunt an instrument that oversteps the bounds of federal authority to govern matters of health, or alternatively that it is a critically important measure intended to protect public safety and to prevent the reproductive tourism that might emerge if a patchwork of legislation emerged in the provinces.⁷³ A subset of these works measure Canadian legislative and policy proposals against those in other jurisdictions, providing comparative analyses.⁷⁴ Third, scholarship on policy governing ARTs in Canada examines the role of various actors in policy development.⁷⁵ These

⁷¹ For example, Patricia Baird (Chairperson of the Royal Commission on New Reproductive Technologies), Bonnie Brown (Chair of the Standing Committee on Health during consideration of the draft version of the *Assisted Human Reproduction Act* in 2001), and Jan Hatcher Roberts (a director of research for the Royal Commission on New Reproductive Technologies) have all written articles on the development of public policy on reproductive technologies in Canada.

⁷² Angela Campbell, "A Place for Criminal Law in the Regulation of Reproductive Technologies," *Health Law Journal* 10 (2002); Timothy Caulfield, "Bill C-13 The Assisted Human Reproduction Act: Examining the Arguments Against a Regulatory Approach," *Health Law Review* 11, no. 1 (2002); Timothy Caulfield and Tania Bubela, "Why a Criminal Ban? Analyzing the Arguments Against Somatic Cell Nuclear Transfer in the Canadian Parliamentary Debate," *American Journal of Bioethics* 7, no. 2 (2007), Alison Harvison Young, "Let's Try Again...This Time with Feeling: Bill C-6 and New Reproductive Technologies," *UBC Law Review* 38 (2005); Alison Harvison Young, "New Reproductive Technologies in Canada and the United States: Same Problems, Different Discourses," *Temple International and Comparative Law Journal* 12 (1998); Alison Harvison Young and Nancy Wasunna, "Wrestling with the Limits of the Law: Regulating Reproductive Technologies," *Health Law Journal* 6 (1998); Patrick Healy, "Statutory Prohibitions and the Regulation of New Reproductive Technologies Under Federal Law in Canada," *McGill Law Journal* 40 (1995); Patrick Healy, "The Criminalization of New Reproductive and Genetic Technologies," in *Governing Medically Assisted Human Reproduction*, ed. Lorna Weir (Toronto: University of Toronto Centre of Criminology, 1997); Dave Snow, "The Judicialization of Assisted Reproductive Technology Policy in Canada: Decentralization, Medicalization, and Mandatory Regulation," *Canadian Journal of Law and Society* 27, no. 2 (2012); Dave Snow, "Failure to Reproduce: Assisted Reproductive Technology Policy in Canada" (PhD Dissertation, University of Calgary, 2014); Guy Tremblay, "La compétence fédérale et le projet de loi sur la procréation assistée," *Les cahiers de droit* 44, no. 3 (2003).

⁷³ Erin Nelson, "Comparative Perspectives on the Regulation of Assisted Reproductive Technologies in the United Kingdom and Canada," *Alberta Law Review* 43 (2005); Dave Snow and Rainer Knopff, "Assisted Reproduction Policy in Federal States: What Canada Should Learn From Australia," *University of Calgary School of Public Policy Research Papers* 5, no. 12 (2012): 9.

⁷⁴ Snow and Knopff, "Assisted Reproduction Policy in Federal States"; Audrey L'Espérance, "Fertilize-This: Framing Infertility in Quebec, Ontario and England Between 1990 and 2010," (PhD Dissertation, University of Ottawa, 2013).

⁷⁵ Backhouse and Deckha, "Shifting Rationales"; Françoise Baylis and Matthew Herder, "Policy Design for Human Embryo Research in Canada: An Analysis (Part 2 of 2)," *Journal of Bioethical Inquiry* 6 no.1 (2009); Mavis Jones

works chronicle the rise and fall of feminist actors in the policy debates, the influence of religious and pro-life activists, the importance of physician groups, the role of scientists, and the influence of competing party interests.⁷⁶

Within this scholarship, however, there are few works which focus explicitly on the ways that people using these technologies and born of them, partook in the policy debate. For example, although lesbians have long been important users of assisted insemination, the contributions of LGBTQ people in the policy debates are rarely identified. Francesca Scala's dissertation research on the legacy of the Royal Commission on New Reproductive Technologies and Jacqueline Luce's research on the use of ARTs by lesbian, bi, and queer women in Canada are notable exceptions,⁷⁷ but overall, there are few works that address the ways in which LGBTQ people in Canada have navigated the governance of ARTs in the Canadian context, particularly in the process of federal policymaking. Further, scholarship on the role of interest groups and other actors in the governance of ARTs has not explored the ways in which surrogates and egg donors

and Brian Salter, "Proceeding Carefully: Assisted Human Reproduction Policy in Canada," *Public Understanding of Science* 19, no. 4 (2009); Mavis Jones and Brian Salter, *Proceeding Carefully: Assisted Human Reproduction Policy in Canada* (Working Paper, Global Biopolitics Research Group, March 2007.) <http://www.kcl.ac.uk/sspp/departments/politiceconomy/research/biopolitics/publications/workingpapers/wp17.pdf>; Montpetit, "Public Consultations in Policy Network Environments"; Scala, Montpetit, and Fortier, "The NAC's Organizational Practices and the Politics of Assisted Reproductive Technologies in Canada"; Francesca Scala, "Scientists, Government, and 'Boundary Work': The Case of Reproductive Technologies and Genetic Engineering in Canada," in *Critical Policy Studies*, eds. Michael Orsini and Miriam Smith (Vancouver: University of British Columbia Press, 2007); Francesca Scala, "Feminist Ideals Versus Bureaucratic Norms: The Case of Feminist Researchers and the Royal Commission on New Reproductive Technologies," in *Gendering the Nation-State: Canadian and Comparative Perspectives*, ed. Yasmeen Abu-Laban (Vancouver: University of British Columbia Press, 2008).

⁷⁶ Backhouse and Deckha, "Shifting Rationales."

⁷⁷ Scala, "Experts, Non-Experts, and Policy Discourse"; Jacquelyne Luce, *Beyond Expectation: Lesbian/Bi/Queer Women and Assisted Conception* (Toronto: University of Toronto Press, 2010); See also Angela Cameron, "Regulating the Queer Family: The Assisted Human Reproduction Act," *Canadian Journal of Family Law* 24 (2008); Angela Cameron and Vanessa Gruben, "Quebec's Constitutional Challenge to the Assisted Human Reproduction Act: Overlooking Women's Reproductive Autonomy," in *Fertile Ground: Exploring Reproduction in Canada*, eds. Stephanie Paterson, Francesca Scala, and Marlene Sokolon (Montreal: McGill-Queen's University Press, 2014); Lisa Feldstein, "Access to Assisted Conception: A Call for Legislative Reform in Light of the Modern Family," *Canadian Journal of Family Law* 26 (2010); Fiona Kelly, "Alternative Conception: The Legality of Home Insemination Under Canada's Assisted Human Reproduction Act," *Canadian Journal of Family Law* 26 (2010); Marvel, "'Tony Danza Is My Sperm Donor?'"

were involved in the policy process.⁷⁸ This may be in part because there was limited involvement on the part of surrogates, and egg donors were completely absent in the development of the public policy (though talked about often), but this absence is both remarkable and informative. The women whose bodies have been central to the use of assisted reproductive technologies were largely not included in policy deliberations; instead, their interests were assumed—articulated on their behalf. Scholarship on the development of public policy governing ARTs in Canada does include some consideration of the positions of infertile Canadians,⁷⁹ and donor-conceived families,⁸⁰ although these works are few and far between. The emphasis on feminists, scientists, and physicians’ networks has overshadowed the role of those whose bodies were and are affected by the use of these technologies.

Ultimately, what emerges from the scholarship on ARTs in Canada is that there are two significant gaps in the literature. First, with few exceptions, scholarship on assisted reproduction in Canada has largely focused on the nature of the policy process, rather than on citizen participation. The consideration of policy actors that has occurred has largely failed to consider the importance of those who use or are born of ARTs in the development of relevant public policy. Although feminists, scientists, and pro-life advocates may have been more prominent in the policy process, the emergence of LGBTQ people, surrogates and donors, infertile people, and donor-conceived families as subjects of public policy governing reproduction, and particularly

⁷⁸ Alana Cattapan, “Risky Business: Surrogacy, Egg Donation, and the Politics of Exploitation,” *Canadian Journal of Law and Society* 29 no. 3 (2014); Alana Cattapan, “Rhetoric and Reality: ‘Protecting’ Women in Canadian Public Policy on Assisted Human Reproduction,” *Canadian Journal of Women and the Law* 25 no. 2 (2013).

⁷⁹ Éric Montpetit, “Policy Networks, Federalism and Managerial Ideas: How ART Non-Decision in Canada Safeguards the Autonomy of the Medical Profession,” in *Comparative Biomedical Policy: Governing Assisted Reproductive Technologies*, eds. Ivar Bleiklie, Malcolm C. Goggin and Christine Rothmayr (London, UK and New York: Routledge, 2004); Jones and Salter, *Proceeding Carefully: Assisted Human Reproduction Policy in Canada* (2007); Sky, “Commercial Interests and New Reproductive Technologies.”

⁸⁰ Alison Motluk, “Donor Anonymity in the Assisted Human Reproduction Act: The Back Story” in *The Right to Know One’s Origins*, ed. Juliet R. Guichon, Ian Mitchell, and Michelle Giroux (Brussels: ASP, 2012).

assisted reproduction, reveals much about who is considered a “good” reproductive citizen in contemporary Canada. The emergence of new policy subjects in the context of the governance of assisted reproduction is a notable omission. Second, scholarship on assisted reproduction in Canada has largely examined the policymaking process outside of the broader social context in which the policy field has emerged. There have been few works (other than those that critique the Royal Commission) that interrogate the relationship between the marketization of infertility and the governance of ARTs within a neoliberal paradigm. The near-simultaneous emergence of neoliberalism and assisted reproduction in Canada suggests that the making of public policy on ARTs was necessarily informed by social changes in the kinds of arguments that might be made, and the kinds of actors that might be included in the policy process.

This dissertation addresses these gaps in the literature by investigating how the experiences of particular policy actors were affirmed or contested throughout the public policy process leading to the *Assisted Human Reproduction Act (AHRA)*. Focused on the federal policymaking process between 1989 and 2004, it explores the emergence of LGBTQ people, surrogates and donors, infertile people, and donor-conceived families as policy actors and policy subjects on the long road to legislation. More specifically, it locates this policy process within the context of an evolving citizenship regime, chronicling the ways that policymakers came to understand the position of those using and born of ARTs, as well as how these actors engaged with policymakers, how they mobilized, and how they articulated their own interests. Ultimately, it demonstrates how the regulation of assisted reproduction in Canada has privileged individual patient-consumers, leaving egg donors, surrogates, and children born of reproductive technologies to navigate an effectively unregulated market, despite explicit provisions to protect collective interests. In doing so, this dissertation examines how assisted reproductive

technologies have been incorporated into Canadian public policy and law to identify the complex ways that reproductive citizenship has evolved in a neoliberal citizenship regime, grounded in notions of choice, individualism, medicalization and self-sufficiency.

Methodology

This dissertation research was conducted using a multi-faceted research strategy that relies on a number of sources, including eighteen semi-structured interviews, a review of official government and Royal Commission documents, parliamentary transcripts, secondary academic and media sources and, the grey literature of relevant interest groups. Interview participants were selected from policy actors who had participated in the development of the public policy on ARTs at more than one stage, with the understanding that they would be able to reflect on changes in state-based and interest group approaches to ARTs over time. Further, the interviews were intended to provide contextual information about the groups' activities, as well as to clarify and fill gaps in information otherwise obtained through documentary research. As this dissertation focuses on specific groups (i.e., LGBTQ people, egg donors and surrogates, infertile people, and donor-conceived families), twelve interviews were conducted with representatives and members of these groups that speak on their behalf. Many of these interview participants also engaged with the federal government through stakeholder consultations, through testimony to parliamentary committees, or by partaking in advisory groups.

The groups that the interview participants represent(ed), either consumer/patient groups (LGBTQ people and infertile Canadians), providers of reproductive services and resources (surrogates and donors), and those born of reproductive technologies (donor-conceived people) were of greatest interest as, with the exception of LGBTQ Canadians, they were not viewed as

subjects of public policy prior to the emergence of ARTs. With the arrival of these technologies, it became both important and possible to govern these new subjectivities. For LGBTQ people, who had already been engaged in parental rights claims, ARTs represented new means through which biological reproduction was possible and, as described throughout this dissertation, ARTs offered a new site to argue for equal rights and access to (reproductive) citizenship. The other groups examined in this study were formed throughout the development of federal public policy related to ARTs—some around the time of the Royal Commission and others later, just as the federal government was beginning to intervene into this policy field. It was throughout this period that they articulated their interests and identified their group identities, for themselves, for the public, and for policymakers. The groups addressed in this study then, are those whose interests were most prominent or notably absent throughout the development of federal policy on ARTs, representing people with a personal, embodied or familial interest in the policy process, including the Infertility Awareness Association of Canada, the Infertility Network, the Lesbian Mothers' Association of Quebec, the New Reproductive Alternatives Society, as well as representatives of a few other relevant organizations. These groups were selected for some combination of their prominence throughout the development of public policy on ARTs, as well as their contributions in Parliament, in consultations with the federal government, or in other measures of advocacy work. Many of the interview participants participated in different interest groups at different times or in loose coalitions of interest groups. In short, the experience of interview participants representing interest groups was widely varied, although together their experiences speak to the range and scope of much of the interest group representation in this field.⁸¹

⁸¹ For a list of interviews, see Appendix A.

As this dissertation also addresses the relationship between citizen-actors and the state, the research strategy also included interviews with three key participants from the public service (either current or retired) who were involved in the policy process, with a focus on those who had been particularly active, or had been departmental spokespeople on the ARTs file. Some had occupied more than one role throughout the long policy process, and the experience amongst them included conducting research for the Royal Commission, engaging in policy analysis for Health Canada, and working as a senior manager on the file. One of the participants (Jan Hatcher Roberts), worked both for the Royal Commission on New Reproductive Technologies, and for Health Canada. Another (Francine Manseau) worked for Health Canada on the file from the time of the Royal Commission until after the *Assisted Human Reproduction Act* was passed. The third public servant participated in this research anonymously.

The participants also included three experts in the field who have been involved in various stages of the policy process, in some combination of their work as researchers, advocates, and academics. Two of these experts (Francoise Baylis and Rona Achilles) provided research to the Royal Commission on New Reproductive Technologies, and all three (including Abby Lippman) have been engaged in advocacy work on the governance of ARTs.

In all, eighteen semi-structured interviews with these key actors were conducted, which provided critical information about the formation and work of interest groups in this field, as well as how public servants were able to interact with citizens, and to incorporate citizen perspectives into policy advice and decision-making. The semi-structured interviews varied widely based on the history of the participants and their prior work in the field, and individualized questionnaires were developed for each interview. Interviews took place by telephone, by Skype, or where possible, in person (in Ottawa, Montreal, Hamilton, and Toronto).

In-person interviews took place wherever was convenient for the participant including, for example, borrowed offices at Concordia University, McMaster University, the University of Ottawa, and the University of Toronto and in participants' homes and offices. Participants provided either oral or written consent to participate in the interview,⁸² indicating whether they wanted to have their names and organizations included in the dissertation. Anyone identified in this dissertation has given their consent to be identified, and only information provided "on the record" has been included.⁸³ Furthermore, information provided by anonymous participants (there was only one) has been verified by additional sources to ensure that the information provided can be subject to scrutiny. All interviews were recorded, and relevant information was transcribed. As the interviews were conducted in order to provide contextual information about the nature of the policy process and interest group activities, and to fill gaps in the documentary research, not all of what was discussed in the interviews was relevant to the goals of the dissertation and transcribed. For example, information about the participants' personal experiences with assisted reproduction that was not directly relevant to the research goals and information provided "off the record" were excluded from transcripts. All interview recordings were reviewed at least twice to ensure that the partial transcripts included all relevant information.

The work of the federal government and the interest groups relevant to this research are well-documented, and this study included extensive documentary research to this effect.

Documentation related to the federal government's work in this field includes the 1989 Throne Speech, press releases, memos and briefs, some internal policy documents and presentations,

⁸² For the consent form and oral consent script, please see Appendix B.

⁸³ Participants had the option of providing information that they did not want included in the dissertation. In such cases, participants indicated that information was "off the record." In such cases, the relevant information was not recorded (the recording apparatus was paused) and no notes were taken.

publicly released discussion documents, proposed legislation, and others. Collectively, these documents work to present a picture of the evolution of certain ideas about the governance of ARTs into policy documents, and occasionally, legislation. Parliamentary debates were also examined and analyzed, to give a clearer idea of the exchanges between parliamentarians and the prevalent discourses used to discuss ARTs in Parliament at any given time. As to the work of interest groups, in addition to making requests and receiving documentation from the groups themselves, their websites (including archived versions) and targeted media searches (through the Factiva and Érudit databases) were helpful in devising a clearer idea of their contributions. In the case of groups representing surrogates and donors, who did not participate in this research, the media searches provided important information about the work and perspectives of certain prominent surrogacy agencies otherwise unavailable. The transcripts of relevant parliamentary committees were also examined, providing insight as to the positions that interest group actors were presenting to Parliament on proposed legislation, as well as the reactions of parliamentarians to those positions.

The documentary research for this dissertation also included an extensive media search not only of the work of interest group actors, but also of the debates themselves. This media search focused on any discussion of “assisted reproductive technologies,” “assisted reproduction” “new reproductive technologies,” “assisted human reproduction,” “procréation assistée” and “procréation médicalement assistée” from 1989-2004 in the Factiva and Érudit databases, providing insight as to how certain perspectives were emerging in the public discourse. The documentary research was conducted prior to interviews to ensure that the interview questions would be constructed in such a way as to fill in remaining gaps in existing knowledge. Research was primarily conducted in English, although media searches were

conducted in both English and French, and some of the grey literature and websites reviewed were published only in French.

Overview of Chapters

The next chapter of this dissertation provides the theoretical and historical background for the remainder of this dissertation. It explores developments in citizenship theory that contribute to the understanding of “reproductive citizenship” in contemporary Canada. Drawing from T.H. Marshall’s conception of citizenship grounded in social rights, it examines how social citizenship has been taken up by scholars interrogating the role of gender, sexuality, and biological citizenship, as well as how these same contributions to citizenship studies inform new understandings of “reproductive citizenship.” It also provides a short history of reproductive citizenship in Canada to theorize how contemporary reproductive citizenship is grounded in the evolution of citizenship regimes, from the social to the neoliberal.

Chapters three, four, five, and six provide the substantive contribution of this dissertation. Collectively, these chapters provide a chronology of the legislative development of the *AHRA*, focusing on the ways that certain groups, namely LGBTQ people, egg donors, surrogates, infertile people, and donor-conceived families were recognized as legitimate policy actors, or otherwise engaged in activities to identify their salience as legitimate policy actors in the field of ARTs. Chapter three examines the work of the Royal Commission on New Reproductive Technologies, the Commission report, and related secondary research to identify how the Commission worked to establish a biomedical framework for legislation-to-come that would shape who came to be seen as relevant policy actors. The chapter asserts that the Royal

Commission set the stage for later public policy on assisted reproduction in Canada by both outlining the policy framework and legitimating certain actors as valid participants in the debate.

Chapter four examines the period following the Royal Commission that was marked by a three-phase approach to governing assisted reproduction comprised of a voluntary moratorium, tabled legislation, and a discussion document outlining regulations-to-come. It identifies how the assertion of biomedical authority, largely through the relationship between physician groups and infertile Canadians, undermined the capacity of the federal government to legislate. Further, it identifies how the configuration of interest groups in the period worked to highlight the interests of donor-conceived people, emphasizing their importance as relevant stakeholders. At the same time, LGBTQ people were not understood to be relevant stakeholders, although through a variety of other means, LGBTQ people were working to improve access to ARTs outside of the federal policy process. Finally, the chapter identifies the ongoing exclusion of donors and surrogates from the policy process, despite heated discussions about their potential exploitation and the need to “protect” their interests in the policy debates.

Chapter five considers the period between 1997 and 2001, and various federal initiatives undertaken during the period including a failed private member’s bill on cloning, a program of investment in the promotion of biotechnologies (i.e., the Canadian Biotechnology Strategy), regulations on the distribution and use of semen, and consultations on sexual and reproductive health. Taken together, these initiatives suggest that during this period, the federal government continued its rhetorical commitments to the interests of surrogates, gamete donors, and donor-conceived people and others vulnerable to harm through the misuse of ARTs, while promoting the expansion of the infertility industry. At the same time, surrogates and LGBTQ people were

making their interest in largely unregulated access to ARTs known, increasingly emerging as important policy actors.

Chapter six considers the consultations, policy debates, and other interventions that led to the passage of the *AHRA*, and its implications for donors, surrogates, LGBTQ people, and other groups. It argues that the *AHRA* did not merely institute the policy framework set out by the Royal Commission, but that it went much further, concretizing notions of protection, of access to ARTs as a citizenship entitlement (again, for those who could afford it), and of gamete donors, and donor-conceived people as less significant policy actors. This chapter suggests that even as many parliamentarians were committed to ensuring that there were provisions in place to prevent the exploitation of gamete donors and surrogates and to protect the interests of donor-conceived people, the *AHRA* ultimately advanced a model of reproductive citizenship that enabled the continuation of the pre-existing market in infertility services. Chapter six concludes with an overview of relevant developments since the passage of the *AHRA*, identifying the ways in which the *AHRA*'s commitments to non-commercialization and non-commodification have been tempered by a lack of regulation and enforcement. It suggests that the *AHRA* is little more than a paper tiger that does little while appearing to restrict the commercial practices of the infertility industry.

The seventh and final chapter of this dissertation revisits reproductive citizenship and the intersection of subjectivity, commercialization, and governance that it entails. This final chapter also reviews the themes that emerge through the history of the subjects of ARTs in Canada, namely the role of the state as a “protector” of the population from the unknown challenges of new technologies, and the complex language of rights that accompanies these advances. This chapter reviews the findings of the dissertation to assert that the *AHRA* and the attempts at

governance that preceded it, effectively operate to enable consumers to engage openly in a commercial market in assisted reproductive services, constraining commercial practices only to the extent that it remains rhetorically possible to claim that altruism persists. Further, it argues that the affirmation of certain subjects throughout the policy process, namely infertile Canadians and their advocates as well as LGBTQ people with the financial means to access ARTs, has worked to validate their reproductive citizenship.

Summary

The argument of this dissertation is that federal governance of assisted reproductive technologies developed in ways that reflect the influence of a neoliberal citizenship regime. Advocates of infertile people, LGBTQ people, donor-conceived families, egg donors and surrogates emerged as important subjects of the governance of ARTs in Canada throughout the policy process by asserting their own subject positions, but in the end only those interests which were aligned with the continuation of a largely unrestricted market in ARTs were propagated. At times there were (what seem to be) genuine interventions to protect the interests of the vulnerable to the detriment of the market. But neoliberalism is not a consistent project, following Brodie, it is “often contradictory, if not at times incoherent.”⁸⁴ In the case of ARTs in Canada, commitments to collective concerns and vulnerable subjects were overtaken by policy decisions that upheld commercial interests or promoted them outright.

To argue that the development of federal law and policy on ARTs in Canada has been bound up with a neoliberal citizenship regime, this dissertation focuses on discourses of liberal individualism and choice, the failure to recognize the collective interest of marginalized groups,

⁸⁴ Brodie, “We Are All Equal Now Contemporary Gender Politics in Canada,” 148.

concerns about the privileging of medico-scientific approaches to addressing infertility, and the promotion of biologically related forms of kinship. The dissertation concludes with the assertion that, while much has happened since the calling of the Royal Commission on New Reproductive Technologies, little has changed other than the expansion of whose interests are heard, so long as they replicate and reinforce the discourses of liberal individuality, medicalization, and unfettered access to ARTs.

Chapter Two: Reproducing Citizens

Citizenship theory most often begins from the premise that belonging to a political community hinges on some balance of rights and obligations, although theorists differ widely in what that balance should be, and to whom rights and obligations should be extended. Until the mid-twentieth century, citizenship theory relied on two broad traditions that conceptualized this balance between rights and obligations differently: liberalism and civic-republicanism. Theorists who have privileged rights over obligations mostly fall within the liberal tradition; a rights-based approach premised on the idea that the state protects negative rights to enable citizens the freedom to make the best choices for their individual lives. A liberal approach also assumes that, while the state exists to ensure that citizens' negative rights are protected, the power of the state must be limited to ensure that the freedoms and rights of citizens are not infringed upon through state intervention. Within the liberal model, citizens are largely free from obligations, required only to refrain from infringing on the freedoms of others, in short, to do no harm. Whereas liberals focus on the protection of negative rights, those who emphasize obligations above rights draw on the values of civic republicanism and the Aristotelian tradition. Civic-republicans value the common good over the interests of the individual, with civic duty seen as an honour and a privilege.⁸⁵ Though oversimplified here, civic-republicanism emphasizes political community and privileges that which is good and virtuous over the rights of the individual.⁸⁶

With the rise of the welfare state in the mid-twentieth century and an increasing role for governments in the provision of social goods, there was a new understanding of the citizen-state relationship. New theories emerged to accommodate the establishment of social service provisions that contested the individualism of the liberal model as well as the participatory

⁸⁵ Ruth Lister, *Citizenship: Feminist Perspectives* (New York, New York University Press, 1997), 14.

⁸⁶ Chantal Mouffe, *The Return of the Political* (London, UK and New York: Verso, 1993).

requirements of civic republicanism. The emergence of social rights, and social citizenship theory, particularly through the work of T.H. Marshall, suggested that the rights of the individual could be best protected through a measure of publicly funded social entitlements that enabled individuals to make use of their civil and political rights while establishing a basic standard of living for all. These theories of social citizenship inspired new literatures that explored the diversity of people's access to the rights of citizenship, including the diminished experiences of citizenship felt by women and LGBTQ people amongst others, as well as the ways scholarship exploring the relationships between corporeality and experiences of citizenship.

The medicalization of reproduction and the advent of new reproductive technologies have created space for a new way to theorize citizenship. "Reproductive citizenship" is emerging as a new element of citizenship studies, bridging the spaces between gendered, sexual, and biological citizenship broadly derived from the Marshallian tradition.⁸⁷ The availability of pre-natal genetic testing procedures like amniocentesis and chorionic villus sampling has changed the kinds of decisions people can make about their child-to-be well before birth is imminent. Further, with technologies like IVF, people are faced with choices about how many embryos to implant, how many times to try to conceive, how to dispose of any surplus embryos, and (when a donor is needed) what kind of relationship with the donor of their child's genetic material they want. Intended parents, donors, surrogates, and those whose families have been created using these

⁸⁷ Turner, "The Erosion of Citizenship"; Eileen H. Richardson and Bryan S. Turner, "Sexual, Intimate or Reproductive Citizenship," *Citizenship Studies* 5, no. 3 (2001); Eileen H. Richardson and Bryan S. Turner, "Bodies As Property: From Slavery to DNA Maps," in *Body Lore and Laws: Essays on Law and the Human Body*, eds. Andrew Bainham, Martin Richards, and Shelley Day Sclater (Oxford, UK: Hart Publishing, 2002); Larissa Remmenick, "Between Reproductive Citizenship and Consumerism: Attitudes Towards Assisted Reproductive Technologies Among Jewish and Arab Israeli Women," in *Kin, Gene, Community: Reproductive Technologies Among Jewish Israelis*, eds. Daphna Birenbaum-Carmeli and Yoram S. Carmeli (Oxford, UK: Birghahn Books, 2010); Deborah Lupton, "'Precious Cargo': Foetal Subjects, Risk and Reproductive Citizenship," *Critical Public Health* 22, no. 3 (2012); Didem Unal and Dilek Cindoglu, "Reproductive Citizenship in Turkey: Abortion Chronicles," *Women's Studies International Forum* 38 (2013).

technologies may understand their experiences as parents in different ways than parents of the past, challenging, reinventing, and adopting narratives about what it means to have a child. Reproductive citizenship, then, is an increasingly useful lens through which to study the ways that access to social rights and citizen-activism have changed over time in relation to how people conceive, carry, and rear their children.

This chapter provides an in-depth look at lineage of reproductive citizenship from the contributions of T.H. Marshall through to the contemporary study of assisted reproductive technologies in Canada. It begins with a brief examination of citizenship as manifest in social rights, including recent contributions on gendered, sexual, and biological citizenship. It then builds a theory of “reproductive citizenship,” extending from existing contributions to citizenship studies. The chapter then provides a brief history of “reproductive citizenship” in Canada, emphasizing how changing citizenship regimes have altered the way that reproduction has been governed. It concludes with a brief look of the nature of reproductive citizenship in contemporary Canada.

On Citizenship Theory

Marshall and Social Citizenship

Recent scholarship on citizenship most often begins with a discussion of T.H. Marshall’s “Citizenship and Social Class.” First published in 1950, this ground-breaking essay offered an examination of the development of citizenship in modern England through the lens of citizenship rights. Here, Marshall argued that modern understandings of citizenship are derived from longstanding rights of citizenship—civil, political, and social—historically “wound into a single

thread,”⁸⁸ although these rights in “early times” were contingent on one’s status in society and not uniformly applied. Contemporary citizenship, for Marshall, differs from historical conceptions in its relationship to a sense of national belonging and a sense of equality, as well as the establishment of institutions that explicitly recognize civil, political and social rights respectively. Social rights, granted through such programs as universal health insurance, social assistance, and employment insurance were newly tied to citizenship in the post-war period insofar as citizens had the right to access these social programs on their merit as citizens alone. As such, citizenship was to be theorized as more than official recognition of belonging to a particular political community and the associated civil and political rights, and became also about the right to basic levels of social welfare, extending to include citizenship-as-rights framework. In this way, Marshall argued that social rights enable an extended community of political belonging, offering the potential for a universally experienced social citizenship vested in social rights.

The contribution of Marshall’s work to contemporary citizenship theory cannot be overstated. It is rare to find an article on citizenship published since the 1990s that does not reflect on Marshall’s work. In 1994, Will Kymlicka and Wayne Norman measured the state of scholarship on citizenship in terms of how authors related to the “postwar orthodoxy” of citizenship that Marshall established⁸⁹ and today, Marshall’s legacy continues as most any discussion of citizenship includes the requisite “nod to Marshall.”⁹⁰ The wide-ranging influence of Marshall’s work can be attributed to the way that social rights work to partially reconcile the

⁸⁸ T.H. Marshall. “Citizenship and Social Class,” in *Inequality and Society*, eds. Jeff Manza and Michael Sauder (New York: W.W. Norton, 2009), 149.

⁸⁹ Will Kymlicka and Wayne Norman, “Return of the Citizen: A Survey of Recent Work on Citizenship Theory,” *Ethics* 104, no. 2 (1994).

⁹⁰ Hoxsey, “Debating the Ghost of Marshall,” 915.

positions of liberal and civic republican theorists. While liberals might contest state intervention in private lives on which Marshallian social rights rely, Marshall's argument that the creation of programs and institutions to recognize social rights work to enable civil and political rights that would not otherwise be fully realized, "giving substance" to the rights that citizens were to have already acquired.⁹¹ Without social rights, he argued, marginalized groups would not be able to exercise their political and social rights to the same effect as those in privileged positions. Social rights following Marshall, are a means to address social inequalities, enabling individuals to be full members of a community. Further, social rights also include a measure of civic republicanism, notably by asserting the importance of the welfare of the *polis* over the individual, giving citizens the resources they need to be able to contribute to society. Although the active contributions of citizens on which civic republicanism relies is largely absent from the Marshallian approach, it is clear that social rights include elements of the civic republican tradition, particularly the privileging the greater good and that which is virtuous over the interests of the individual.

Challenging Social Citizenship: Gendered, Sexual, and Biological Citizenship

The legacy of Marshallian social citizenship is also attributable to the proliferation of scholarship that has used *Citizenship and Social Class* as a starting point for critique. Theorizing about the shortcomings of Marshall's social citizenship has spawned subfields of citizenship studies that identify the exclusionary tendencies inherent to the Marshallian model. Broadly speaking, these works rely on the premise that Marshall theorized the social rights of the individual *qua* citizen, although the experience he described was that of a white, heterosexual, male citizen and did not

⁹¹ Jet Bussemaker and Rian Voet, "Citizenship and Gender: Theoretical Approaches and Historical Legacies," *Critical Social Policy* 18 no. 3 (1998): 288; Lister, *Citizenship: Feminist Perspectives*, 34.

consider the very different experiences of people of colour, women, sexual minorities, and other potentially marginalized citizens. *Citizenship and Social Class* also failed to adequately consider the differences amongst citizens and their varied access to civil and political rights. The result has been that vast literatures now exist that identifying how the lived experiences of different groups work to challenge the Marshallian ideal.

One such literature explores women's relationship to Marshallian social citizenship. Feminist scholars have argued that by writing about the experiences of citizens as a group, Marshall universalized the male experience. The "cloak of gender-neutrality"⁹² disguised the ways that the concept of citizenship on which Marshall relied was necessarily gendered. Whereas Marshall described the broad establishment of socio-political institutions to recognize civil rights in the eighteenth century, political rights in the nineteenth, and social rights in the twentieth, this trajectory of rights recognition simply did not hold true for women. In many Western states, basic political rights (such as the right to vote) were tied to women's access to basic civil rights in the twentieth century, including the rights "of access to education; to own property; to terminate a marriage to bodily integrity, such as the right not to be beaten by a husband; to professional employment; to sit on juries; to join the police."⁹³ In Canada, women did not have suffrage in federal elections until 1918, although suffrage came later in some provinces, and in 1940 for women in Quebec.⁹⁴ As for civil rights, women's capacity to maintain their bodily

⁹² Lister, *Citizenship: Feminist Perspectives*, 4.

⁹³ Walby, "Is Citizenship Gendered," 385.

⁹⁴ Indo-Canadian, Chinese Canadian, and Japanese Canadians, including women, were not able to vote in federal elections until the late 1940s, while the restrictions on voting for Aboriginal women changed gradually over time, with unimpeded voting rights were available to all Aboriginal people as of 1960. See Kiera Ladner and Michael McCrossan, *The Electoral Participation of Aboriginal People* (Working Paper Series on Electoral Participation and Outreach Practices, Ottawa: Elections Canada, 2007)

http://elections.ca/res/rec/part/paper/aboriginal/aboriginal_e.pdf, 11; Kiera Ladner, "The Alienation of Nation: Understanding Aboriginal Electoral Participation," *Electoral Insight* 5, no. 3 (2003); Alan Cairns, *Citizens Plus: Aboriginal People and the Canadian State* (Vancouver: University of British Columbia Press, 2011), 26; Royal

integrity was long undermined by, for example, the marital rape exemption which allowed husbands to legally rape their wives, embedded in the Criminal Code of Canada from 1892 to 1983.⁹⁵ In short, Marshallian social rights did not acknowledge women's longstanding exclusion from other rights of citizenship.

The exclusion of women from the Marshallian model has been used as a starting point to consider whether the very idea of citizenship is useful for women at all.⁹⁶ Liberal feminists have argued that the challenge in addressing women's unequal citizenship is to add women to existing models by identifying sites of omission and articulating rights claims that would make women "equal citizens."⁹⁷ However, this perspective has been the subject of extensive critique insofar as "citizenship" is imbued with certain notions of heroism, patriotism, and ultimately, masculinity and is tied to very specific notions of political participation in the public sphere. Rather than simply embrace existing notions of citizenship that rely on a masculine ideal, some have suggested that what is needed instead is the articulation of a feminine or maternal citizenship.⁹⁸ This differentiated feminine citizenship would recognize the nature of women's contributions to the *polis* in both the public and private spheres especially in the acts of care work, childbearing, and childrearing.⁹⁹ However, critics of this model argue that the expression of a citizenship experience unique to women would simply replicate the existing disparities between men and

Commission on Electoral Reform and Party Financing, *Reforming Electoral Democracy: Final Report* (Ottawa: Minister of Supplies and Services Canada, 2011), 28–32.

⁹⁵ Bruce A. MacFarlane, "Historical Development of the Offence of Rape," in *100 Years of the Criminal Code of Canada* (Ottawa: Canadian Bar Association, 1993).

⁹⁶ Citizenship is a concept that creates insiders and outsiders from the outset, and may not be a useful concept in analyses of social policy that seek to extend the reaches of social service provision. Emphasizing "citizenship" as a key point of analysis has been critiqued for prioritizing the distinction between "self-citizen/Other-non-citizen." See Donna Baines and Nandita Sharma, "Migrant Workers as Non-Citizens: The Case Against Citizenship as a Social Policy Concept," *Studies in Political Economy* 69 (2002).

⁹⁷ Mouffe, *The Return of the Political*, 79.

⁹⁸ Jean Bethke Elshtain, *Public Man, Private Woman*, 2nd ed. (Princeton, NJ: Princeton University Press, 1993).

⁹⁹ Mouffe, *The Return of the Political*, 79.

women, and would undermine the deep-seated nature of gender differences.¹⁰⁰ Feminist citizenship theory is thus plagued by the difficulty of reconciling equality and difference that stands at the heart of broader feminist theory. Scholarship on gendered citizenship has built on the Marshallian model to identify women's different experiences of citizenship, the desirability of citizenship as a concept for women, and how best to reconcile the history of an androcentric notion of citizenship with the need for equality and for the recognition of gender difference.

The omission of gender in conventional analyses of citizenship has opened up similar critiques about sexuality.¹⁰¹ Gendered and sexual citizenship went hand in hand as scholars in the 1990s increasingly used citizenship theory and especially critiques of Marshall to articulate women's different contributions to the public sphere through care work and reproductive labour, enabling discussions about how private lives translated into political belonging.¹⁰² Scholars of sexual citizenship have similarly explored how LGBTQ people have experienced social exclusion depriving them of the "belonging, recognition, and participation" that a full and robust experience of citizenship entails.¹⁰³ Shane Phelan, for example has identified how these exclusions exist in the case of LGBTQ people in the United States, as despite the semblance of formal equality, members of sexual minorities are not fully incorporated into social institutions such as marriage and the military and further, into the "national imaginary."¹⁰⁴ She argues that if "equal citizenship requires equal treatment by political authorities and by other citizens" LGBTQ people are not citizens, but "strangers" within their nation-state not only due to institutional

¹⁰⁰ Bussemaker and Voet, "Citizenship and Gender," 282.

¹⁰¹ Ruth Lister, "Inclusive Citizenship: Realizing the Potential," *Citizenship Studies* 11, no. 1 (2007): 50.

¹⁰² See for example Carole Pateman, *The Sexual Contract* (Stanford, CA: Stanford University Press, 1988) on women's reproductive labour, and David Bell and Jon Binnie, *The Sexual Citizen: Queer Politics and Beyond* (Cambridge, UK: Polity, 2000) on sexual orientation and citizenship.

¹⁰³ Brenda Cossman, *Sexual Citizens: The Legal and Cultural Regulation of Sex and Belonging* (Stanford, CA: Stanford University Press, 2007), 3.

¹⁰⁴ Shane Phelan, *Sexual Strangers: Gays, Lesbians, and Dilemmas of Citizenship* (Philadelphia: Temple University Press, 2001), 7.

discrimination, but also due to homophobia in various aspects of social life.¹⁰⁵ A sense of belonging to the nation-state as a political community is difficult to achieve when hate crimes and prejudice endure.

A significant part of this literature has also explored the importance of market participation in defining sexual citizenship. Early works on sexual citizenship identified the implicit and explicit ways in which experiences of full citizenship are tied to heterosexuality, excluding lesbians and gay men.¹⁰⁶ Some of this work has also identified how members of certain sexual minorities are granted a level of legal and social rights in exchange for the capital that they provide to society as workers, consumers, and taxpayers, although their access to a robust experience of citizenship remains limited because of the ongoing persistence of heteronormativity.¹⁰⁷ More recent scholarship has built on this work by differentiating between “good” socially productive, employable, non-descript citizen-consumers and “bad” citizens who seek to disrupt social convention by shirking social assimilation, failing to partake in the norms of consumer culture.¹⁰⁸

The scholarship on gendered and sexual citizenship that challenge the Marshallian approach has also created space for analyses that interrogate the role of the body in how citizenship is experienced. Following Bacchi and Beasley, the division between public and private in notions of citizenship, including the Marshallian tradition, unduly compartmentalize the public life of citizens and the private life of the body.¹⁰⁹ The social lives of citizens and the

¹⁰⁵ Phelan, *Sexual Strangers*.

¹⁰⁶ Lisa Duggan, “Queering the State,” *Social Text* no. 39 (1994); Jeffrey Weeks, “The Sexual Citizen,” *Theory, Culture and Society* 15, no 3 (1998); Davina Cooper, *Power in Struggle: Feminism, Sexuality and the State* (New York, New York University Press, 1995).

¹⁰⁷ David T. Evans, *Sexual Citizenship: The Material Construction of Sexualities* (London, UK: Routledge, 1993).

¹⁰⁸ Diane Richardson, “Locating Sexualities: From Here to Normality,” *Sexualities* 7, no. 4 (2004).

¹⁰⁹ Carol Lee Bacchi and Chris Beasley, “Citizen Bodies: Is Embodied Citizenship a Contradiction in Terms?,” *Critical Social Policy* 22, no. 2 (2002).

private lives of their bodies have long been theorized as separate concerns, including the ways that wellness, illness, and the messiness of the body complicate this divide.

Works on biological citizenship extend and contest the Marshallian tradition by understanding the way that the corporeal experiences of individuals work to shape their engagement with the state, as well as how the contested terrain of medical, legal, and socio-political discourses have made new forms of claims-making possible. These works often draw on the scholarship of Adriana Petryna, who coined the phrase “biological citizenship,” to describe how the victims of the Chernobyl disaster were able to make claims on the Ukrainian state for forms of social welfare on the basis of injuries sustained. The suffering incurred by those affected by the disaster coupled with the Ukrainian state’s provision of compensation resulted in a perceived right of victims to access certain social services including, “cash subsidies, family allowances, free medical care and education, and pensions.”¹¹⁰ Access to these state-funded resources was achieved by proving one’s physiological disability via particular medical, legal, and political criteria, and acquiring legal status as one of “the suffering.”¹¹¹ This legal designation as a sufferer became “the ground for social membership, and the basis of staking citizenship claims,” and individuals worked to negotiate their designation by using the resources and knowledge available to them. The biological citizens of post-socialist Ukraine needed to conform to the limitations of certain discourses to claim newfound rights to social services based on their experiences and identities as victims of the disaster in order to access the social rights of citizenship, broadly conceived.

¹¹⁰ Steven Epstein, *Inclusion: The Politics of Difference in Medical Research* (Chicago: University of Chicago Press, 2007); Vinh-Kim Nguyen, *The Republic of Therapy: Triage and Sovereignty in West Africa’s Time of AIDS* (Durham and London, UK: Duke University Press, 2010); Rayna Rapp, *Testing Women, Testing the Fetus: The Social Impact of Amniocentesis in America* (London, UK and New York: Routledge, 2000).

¹¹¹ Adriana Petryna, *Life Exposed: Biological Citizens After Chernobyl* (Princeton, NJ: Princeton University Press, 2002), 5.

Biological citizenship then, emphasizes the ways that illness and wellness are understood, constructed, and experienced, as well as how citizens use their biological understandings of themselves as the basis of new biosocial identities, to engage in patient activism, to fight stigma, to make claims for social services, and to help one another manage their conditions and understand their experiences.¹¹² Following Petryna, access to social rights is enabled through the iteration of particular kinds of stories, and particular kinds of experiences about one's body and its functions. In this way biological citizenship describes the ways that the body and its strengths, limitations, and malleability have become a conduit for interaction with the state, with one another, and with ourselves, especially in an age when fast-advancing technologies are enabling possibilities for new corporeal interventions.

On Reproductive Citizenship

The emergence of new technologies and ways of understanding illness have led to the study of “reproductive citizenship,” a still-nascent concept in citizenship studies that describes who can reproduce “with whom and under what social and legal conditions.”¹¹³ The term “reproductive citizenship” is most often attributed to sociologist Bryan S. Turner, who in his “The Erosion of Citizenship,” used it to identify how citizens' social contributions as parents have been

¹¹² Cossman, *Sexual Citizens*, 5.

¹¹³ Richardson and Turner, “Sexual, Intimate or Reproductive Citizenship,” 330; See also Alana Cattapan, “On Reproductive Citizenship: Thinking About Social Rights and Assisted Reproduction in Canada” in *Fertile Ground: Exploring Reproduction in Canada*, eds. Stephanie Paterson, Francesca Scala and Marlene Sokolon (Montreal: McGill-Queen's University Press, 2014); Patrick Hanafin, *Conceiving Life: Reproductive Politics and the Law in Contemporary Italy* (Aldershot, UK: Ashgate, 2007); Lupton, “‘Precious Cargo’: Foetal Subjects, Risk and Reproductive Citizenship”; Deborah Lupton, “Infant Embodiment and Interembodiment: A Review of Sociocultural Perspectives,” *Childhood* 20, no. 1 (2013); Linda C. McClain and Joanna L. Grossman (eds.), *Gender Equality: Dimensions of Women's Equal Citizenship* (London, UK and New York: Cambridge University Press, 2012); Remmenick, “Between Reproductive Citizenship and Consumerism”; Richardson and Turner, “Bodies As Property”; Amy Salmon, “Aboriginal Mothering, FASD Prevention and the Contestations of Neoliberal Citizenship,” *Critical Public Health* 21, no. 2 (2011); Turner, “The Erosion of Citizenship”; Bryan S. Turner, “Citizenship, Reproduction and the State: International Marriage and Human Rights,” *Citizenship Studies* 12, no. 1 (2008); Unal and Cindoglu, “Reproductive Citizenship in Turkey.”

historically tied to certain social rights.¹¹⁴ For Turner, the social supports provided to families (e.g., education and health care provision for children, baby bonuses, childcare subsidies) have been granted in exchange for the reproductive labour that parents provide, as “reproducers of the nation.”¹¹⁵ The result under the welfare state was a relationship of rights and obligations wherein childbearing and childrearing are rewarded with corresponding entitlements granted by the state.¹¹⁶ Based firmly in the Marshallian tradition, reproductive citizenship is, therefore, a means for certain citizens to access social rights, and for the state to achieve the reproduction of its citizenry. The granting of rights and entitlements on the basis of reproduction has allowed the state to encourage certain family forms, for example, linking entitlements to “marriage and domesticity” in ways that long kept LGBTQ families from accessing the same supports.¹¹⁷ In short, reproductive citizenship has been theorized as a confluence of biological, sexual, and gendered notions of citizenship, addressing the ways that people are thought about and come to think about their reproduction in terms of belonging, recognition and participation within a state.

Reproductive Citizenship as Gendered Citizenship

Physiologically speaking, human reproduction is disproportionately women’s lot. Conception takes both sperm and egg, but pregnancy and childbirth make the act of human reproduction largely the territory of women. This biological circumstance is particularly apparent in the use of assisted reproductive technologies. Infertility treatments, for example, generally involve medications consumed and procedures undertaken by women, even when it is the male partner

¹¹⁴ Richardson and Turner, “Sexual, Intimate or Reproductive Citizenship,” 330.

¹¹⁵ “The Erosion of Citizenship,” 193.

¹¹⁶ Remmenick, “Between Reproductive Citizenship and Consumerism,” 319; Unal and Cindoglu, “Reproductive Citizenship in Turkey,” 23.

¹¹⁷ See also Turner, “Citizenship, Reproduction and the State”; Richardson and Turner, “Sexual, Intimate or Reproductive Citizenship”; Bryan S. Turner, *The Body and Society: Explorations in Social Theory*, 3rd ed. (Los Angeles, SAGE Publications, 2008).

(in a heterosexual couple) who is biologically infertile. She is treated for her own infertility, for *his* infertility and for *their* infertility. In cases where a surrogate is involved, for male couples, or in cases where women cannot or choose not to carry their own child, it is a woman who is inseminated and carrying the pregnancy. Further, even though sperm and egg donation are generally treated the same in public policy they have different physiological implications. Unlike sperm donation, egg donation is a very complex procedure, involving weeks of time, taking hormones for an extended period, and eventual surgical extraction of the eggs. The side effects of the treatment include “breast tenderness, backaches, headaches, insomnia, bloating, and increased vaginal discharge,” amongst other risks.¹¹⁸ This is not to say that sperm donation is simple. In Canada, both sperm and egg donors have to complete extensive questionnaires and a number of blood tests to ensure that the donor is healthy, in addition to grappling with the ethical implications of donation. The physiological effects of egg donation, however, render it a relatively risky procedure. Although assisted reproductive technologies concern both men and women in different ways, women more than men are the subject of their use, and are therefore more susceptible to the consequences of their misuse.

Beyond the physiological, reproductive citizenship is necessarily a gendered concept as the governance of childbearing and childrearing has historically occurred through interventions in the lives and on the bodies of women. The history of parental entitlements, abortion, the medicalization of pregnancy and labour, access to contraceptives, and prenatal care point to the ways that the women have long been the targets of biomedical, political, scientific, social, and religious claims about who can legitimately reproduce and under what circumstances.

Furthermore, as the gendered citizenship literature has demonstrated, male-centered notions of

¹¹⁸ Lynette Reid, Natalie Ram, and R. Blake Brown, “Compensation for Gamete Donation: The Analogy with Jury Duty,” *Cambridge Quarterly of Healthcare Ethics* 16 (2007): 36.

citizenship have long relied on assumption of women as dependent on a male breadwinner within the context of a nuclear, heterosexual family.¹¹⁹ This male breadwinner model was institutionalized in social policy during the time of the welfare state, leaving women outside of the public sphere, their reproductive labour counted only as a means through which they were meeting their duties as citizens, without being independently privy to the social rights of citizenship. It was only as mothers, wives, and occasionally as incidental labourers, that women have been historically entitled to any social rights at all.¹²⁰

Scholars have also explored how women's health organizations and feminist groups have organized to take control over the ways women's reproduction and experiences as mothers are regulated.¹²¹ Contestation of the governance of reproduction has long occurred through clandestine access to abortion services, and knowledge exchange about contraception, extending to more politicized efforts at increasing access to abortion and contraception in the 1960s onward.¹²² While attempts at empowering women to make choices about childbearing in the early twentieth century replicated problematic imperatives about reproducing a certain kind of citizen, by the mid-twentieth century, empowerment vis-à-vis reproduction used the language of liberal freedom of choice, extending choice to include women's freedom to choose who to

¹¹⁹ Lister, *Citizenship: Feminist Perspectives*; Walby, *Gender Transformations*; Brodie, "Restructuring and the New Citizenship"; Susan A. McDaniel, "Women's Changing Relations to the State and Citizenship: Caring and Intergenerational Relations in Globalizing Western Democracies," *Canadian Review of Sociology* 39, no. 2 (2002).

¹²⁰ Lister, *Citizenship: Feminist Perspectives*.

¹²¹ Katherine Arnup, *Educating for Motherhood: Advice for Mothers in Twentieth-Century Canada* (Toronto: University of Toronto Press, 1994); Gwynne Basen et. al., "The Women's Health Movement in Canada Looking Back and Moving Forward," *Canadian Woman Studies/Les cahiers de la femme* 24, no. 1 (2004); Wendy Mitchinson, *Giving Birth in Canada, 1900-1950* (Toronto: University of Toronto Press, 2002); Kathryn Pauly Morgan, "Contested Bodies, Contested Knowledges: Women, Health, and the Politics of Medicalization," in *The Politics of Women's Health: Exploring Agency and Autonomy*, ed. Susan Sherwin (Philadelphia: Temple University Press, 1998); Susan Sherwin, *No Longer Patient: Feminist Ethics and Health Care* (Philadelphia: Temple University Press, 1992).

¹²² Angus McLaren and Arlene Tiger McLaren, *The Bedroom and the State: The Changing Practices and Politics of Contraception and Abortion in Canada, 1880-1980*, 2nd ed. (Don Mills, ON: Oxford University Press Canada, 1997); Melissa Haussman, *Abortion Politics in North America* (Boulder, CO: Lynne Rienner, 2005).

reproduce with, when, and how. The interaction between women demanding control over their bodies, and the religious, political, medical, and legal institutions that they were contesting, mark moments of contention in the history of reproductive citizenship in Canada, and at times, moments of change.

Reproductive Citizenship as Sexual Citizenship

The governance of sexuality has intrinsically been about reproduction, insofar as the only legitimate parents in the eyes of the state and society have historically been married, heterosexual couples with the presumed capacity to procreate.¹²³ The assertion that certain sexual acts are immoral, and should therefore be banned, governed, or otherwise regulated, is buttressed by claims that the only legitimate sexual acts are those that might result in conception within wedlock. Although the longstanding discrimination experienced by LGBTQ people reaches far beyond the challenges that LGBTQ people face in creating their families, the governance of sexuality in educational, political, legal, and religious institutions has long been, in part, a means to advance and privilege the heterosexual, reproductive family to the detriment of domestic and sexual arrangements that are (biologically) non-reproductive.¹²⁴ Understanding discrimination based on sexual orientation must include an analysis of the obstacles faced by LGBTQ people trying to create their families. As same-sex couples have only recently been included in adoption law in Canada and there are many examples of access to reproductive technologies being impeded on by homophobic clinic policies,¹²⁵ thinking about reproductive citizenship provides a theoretical framework in which to do so.

¹²³ Cossman, *Sexual Citizens*, 7.

¹²⁴ Cossman, *Sexual Citizens*; Phelan, *Sexual Strangers*.

¹²⁵ Rachel Epstein, “‘Married, Single, or Gay?’ Queering and Trans-Forming the Practices of Assisted Human Reproduction Services” (PhD Dissertation, University of Toronto, 2014).

While reproductive citizenship necessarily includes the governance of sexuality, the concept entails not only sexuality, contraception, and the regulation of homosexuality, but also fertility, adoption, childbearing, and childrearing. The study of sexual citizenship is important as it casts light on the ways that sexual minorities have been denied access to their rights as citizens. Further, it identifies how people have mobilized to contest the discrimination that they have been subject to on the basis of sexual orientation, actively engaged in taking the citizenship rights that they long felt they were owed. However, the sexual citizenship literature has largely failed to identify how the denial of those rights is tied to the state's interest in reproducing its citizenry, focusing on sex without reproduction, rather than the diverse ways that LGBTQ people engage in reproduction with or without sex.¹²⁶ Following Richardson and Turner, the governance of sexuality is “secondary and subordinate to [the state's] demographic objective of securing and sustaining the connection between reproduction and citizenship,”¹²⁷ and consequently reproductive citizenship offers a more effective theoretical framework than sexual citizenship alone to explore state interventions into family formation.

Reproductive Citizenship as Biological Citizenship

Petryna's notion of “biological citizenship” has, since its early use, been widely taken up as a theoretical grounding to identify both how citizens diagnosed or pathologized are limited in terms of things like access to services and by stigma, as well as how they work to contest such limitations through collective action.¹²⁸ Relevant works have identified how citizens have come

¹²⁶ Cossman, *Sexual Citizens*, 7.

¹²⁷ Richardson and Turner, “Bodies As Property,” 38.

¹²⁸ Adele E. Clarke, “Introduction: Gender and Reproductive Technologies in East Asia,” *East Asian Science, Technology, and Society: An International Journal* 2, no. 3 (2008); Ruth Fitzgerald, “Biological Citizenship at the Periphery: Parenting Children With Genetic Disorders,” *New Genetics and Society* 27, no. 3 (2008); Alexander I. Stigl, “The Virtualization of Health and Illness in the Age of Biological Citizenship,” *Telos* (2010); Michael Orsini,

together to take control of their lives using biomedical frameworks by negotiating the limits of law and public policy. The diverse ways that biomedical forms of citizenship are experienced have been an important subject of study, from the ways that parents of children with genetic disorders have built communities online to educate themselves and seek out new treatments,¹²⁹ to the marginalization and organization of Hepatitis C patients who are also intravenous drug users.¹³⁰ The influx of literature on biological citizenship and the ever-greater prevalence of biology in citizen activism suggest that not only are citizens increasingly understood and understanding themselves in biological terms, but further, they are using this newfound understanding to make claims on the state. The tendency to know ourselves in biomedical terms, and to understand all biological problems through the discourses of science, medicine, and the possibility of a cure, means that people are increasingly accessing and demanding health care services on the basis of biologically understood claims that may have historically been understood in social terms. Medicalization, including the medicalization of reproduction, is an important manifestation of biological citizenship.

In Canada, where the parameters of publicly-funded health insurance are decided on a province-to-province basis, each province grapples with what new services to include, and what services to eliminate from the provincial rolls. Providing services in order to address the perceived right to health care presents difficult ethical and moral questions about which

“Hepatitis C and the Dawn of Biological Citizenship: Unravelling the Policy Implications,” in *Contesting Illness: Processes and Practices*, eds. Pamela Moss and Kathy Teghtsoonian (Toronto: University of Toronto Press, 2008).

¹²⁹ Roger Cooter, “Biocitizenship,” *The Lancet* 372, no. 9651 (2008); Nikolas Rose and Carlos Novas, “Biological Citizenship,” in *Global Assemblages: Technology, Politics and Ethics as Anthropological Problems*, eds. Aihwa Ong and Stephen J. Collier (London: Blackwell, 2005); Deborah Heath, Rayna Rapp, and Karen-Sue Taussig, “Genetic Citizenship,” in *Companion to the Anthropology of Politics*, eds. David Nugent and Vincent (Oxford, UK: Basil Blackwell, 2004).

¹³⁰ Suzanne Fraser, “Hepatitis C and the Limits of Medicalisation and Biological Citizenship for People Who Inject Drugs,” *Addiction Research & Therapy* 18, no. 5 (2010); Orsini, “Hepatitis C and the Dawn of Biological Citizenship.”

conditions and illnesses are a priority to treat, that is, what counts as illness, disability, or disorder. This is not to discount the importance of citizen activism around certain diseases, one need only look to the ways that AIDS activists demanded participation in clinical trials and challenged stigma, to see the importance of biological citizenship activism to promote access to much needed services.¹³¹ However, it is important to identify that as more issues are pathologized and seen to be issues of health care, and as more medical technologies enable treatments of newly identified health care problems, the scope of the right to health care expands outward.

Reproductive citizenship takes these lessons from biological citizenship, including the ways that citizens have come together to fight for access to childcare, health care, and the capacity to raise their children in the ways that they think are best. And in many ways, reproductive citizenship takes from biological citizenship the basic tenet that citizens are increasingly understood in biological terms, configuring their understandings of what is possible in terms of claims-making along the lines of their biological limitations, experiences of illness and infirmity, and activism. However, as reproductive citizenship focuses explicitly on how citizens are governed in terms of procreation, biology and biomedical understandings are a significant part, but not all of what reproductive citizenship comprises. One need not bear children or be genetically related to a child to be their parent, and, as the experiences of adoptive families have long shown, biology is only a small part of what the extensive process of creating a family entails.

¹³¹ Steven Epstein, *Impure Science: AIDS, Activism, and the Politics of Knowledge* (Berkeley, CA: University of California Press, 1998).

On Reproductive Citizenship

Even when taken together, the biological, sexual, and gendered elements of reproductive citizenship do not, then, fully address how reproduction is governed. Social inequalities shape the ways that people reproduce, governed as marginalized people may be by different interventions on their bodies, their access to resources, and in short, their lives. For example, disability theory has provided insight into the social construction of infertility, and the ways in which people with disabilities are enabled and constrained in the ways that they reproduce.¹³² From the history of forced sterility for “mentally deficient” Canadians in Alberta and British Columbia,¹³³ to the ways that adoption and access to infertility treatments are restricted for people with severe disabilities and terminal illnesses, the governance of reproduction occurs in tandem with the governance of disabled bodies. Furthermore, reproductive citizenship is racialized. Dorothy Roberts, for example, has explored the ways that the contraceptive implant Norplant—which lasts up to five years, and is expensive to remove—has been imposed on low-income women in the United States as a means to prevent them from having children while on social assistance.¹³⁴ As Roberts chronicles, this has altered the capacity of women who took Norplant to choose when and how to have their children, particularly as implantation would be subsidized or free, while removal would come at a cost. In the Canadian context, Amy Salmon’s work has pointed to the ways that Aboriginal women’s bodies have been subject to scrutiny in conception and throughout pregnancy, unduly surveilled as a result of assumptions made about

¹³² Virginia Kallianes and Phyllis Rubinfeld, “Disabled Women and Reproductive Rights,” *Disability and Society* 12, no. 2 (1997); Roxanne Mykitiuk and Ena Chadha, “Sites of Exclusion: Disabled Women’s Sexual, Reproductive and Parenting Rights,” in *Critical Perspectives on Human Rights and Disability Law*, eds. Marcia H. Rioux, Lee Ann Basser, and Medlina Jones (Leiden, Netherlands: Martinus Nijhoff, 2011).

¹³³ Jana Grekul, “Sterilizing the ‘Feeble-Minded’: Eugenics in Alberta, Canada, 1929-1972,” *Journal of Historical Sociology* 17, no. 4 (2004); Angus McLaren, *Our Own Master Race: Eugenics in Canada, 1885-1945* (Toronto: McLelland and Stewart, 1990).

¹³⁴ Dorothy Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty* (New York: Pantheon Books, 1997), 104–149.

the consumption of alcohol and the ability of Aboriginal women to care for their children.¹³⁵

Reproductive citizenship is thus bound up with the diverse experiences of social life and the marginalities that mark peoples' lives.

For purposes of this dissertation then, reproductive citizenship is at once gendered, biological, racialized, and concerned with sexual orientation and disability, as well as other markers of identity. It is also about the fundamental biological processes of conception and bearing children, and the often (but not always) related social processes of childrearing. Reproductive citizenship marks "a route to active social participation through reproduction,"¹³⁶ that is an avenue to the exchange of rights, obligations, and entitlements between citizens and the state, as well as a means through which to promote belonging and recognition. Public policies targeting pregnant women, parents, and families, for example, point to the ways that reproduction and family building operate to establish the boundaries of reproductive citizenship. Given the state's ongoing interest in the growth of its population, the relationship between citizenship and reproduction is significant. It is important to note, however, that reproductive citizenship is about rights and entitlements that are not neutral, but rather, are experienced in the context of a citizenship regime shaped by the context of institutions, "rules and guidelines," "problem definition" and "claims recognized as legitimate."¹³⁷ The citizenship regime in which one's experience of reproduction occurs has important implications for the rights and entitlements exchanged, and the recognition, participation, and belonging that subsequently occurs.

¹³⁵ Salmon, "Aboriginal Mothering, FASD Prevention and the Contestations of Neoliberal Citizenship."

¹³⁶ Remmenick, "Between Reproductive Citizenship and Consumerism," 319.

¹³⁷ Jenson, "Fated to Live in Interesting Times," 631.

Reproductive Citizenship and Social Policy in an Evolving Citizenship Regime

The explicit governance of reproduction in Canada, as elsewhere, can be most clearly traced to the turn of the twentieth century. The period between 1880 and 1920 was an important transitory time in Canada, insofar as it was marked by the expansion of the Canadian economy and bureaucracy, significant urbanization, industrialization and a burgeoning new nationalism. The nation-building project of the newly confederated Canada was based on the assumption that a thriving nation required strong population growth, requiring women to bear and raise children as a public good and a duty of citizenship, an obligation “at least as important as that of men-as-soldiers.”¹³⁸

While the obligations of women as mothers (i.e., mothers-as-citizens) were clear at the turn of the twentieth century, related entitlements were slow to come. There were a few state funded programs to assist mothers at that time,¹³⁹ but for the most part supports offered to mothers in need of assistance were provided by churches and other charitable organizations. This would change with the establishment of Mothers’ Allowance programs during and after the First World War that created a clear role for the state in not only funding, but also regulating the “virtuous” mother.¹⁴⁰ These programs, available only to poor widowed or deserted mothers, were bound to assumptions about the centrality of a male wage earner, without whom mothers would need support.¹⁴¹ These early interventions into family life extended the logic of the moral and

¹³⁸ Ida Blom, “Gender and Nation in International Comparison,” in *Gendered Nations: Nationalisms and Gender Order in the Long Nineteenth Century*, eds. Ida Blom, Karen Hagemann, and Catherine Hall (New York: Berg, 2000), 16–17.

¹³⁹ Programs included a pre-school at British Columbia’s Infant’s Hospital, early crèches in a few cities, and some measures of social assistance to deserted wives in a few provinces. Alan Finkel, *Social Policy and Practice in Canada: A History* (Waterloo, ON: Wilfrid Laurier University Press, 2006), 70–75 ; Prentice et al., *Canadian Women: A History* (Toronto: Harcourt Brace Jovanovich, 1988), 208.

¹⁴⁰ Veronica Strong-Boag, “‘Wages for Housework’: Mothers’ Allowances and the Beginnings of Social Security in Canada,” *Journal of Canadian Studies* 14, no. 1 (1979): 25–26; Finkel, *Social Policy and Practice in Canada*, 100.

¹⁴¹ The regulation of the “virtuous” single mother is of great importance here. The level of scrutiny that recipients were subject to varied widely from town to town and province to province, but in general, women were constantly

social reform movements that sought to keep the children of the destitute in their homes and out of more costly public orphanages.¹⁴²

These early Mothers' Allowance programs worked to legitimate a form of reproductive citizenship in which some mothers *qua* mothers were seen to make a valuable contribution to the nation through their reproductive labour. Concern about a declining birthrate at the turn of the century was supplanted by increasing concern about the quality of childrearing and the assumption that it was in the best interests of "virtuous" but destitute mothers to keep their children at home. The establishment of Mothers' Allowance programs made the interests of poor mothers an issue of public concern, and although moral regulation and eligibility requirements limited the scope of the programs considerably, there was, for the first time in Canada, substantive and financially supported recognition of certain forms of mothering as deserving of social support.

By the 1940s, there were new state-funded interventions into the governance of motherhood in Canada that broadened the range of assistance available to women. The challenges of the Depression era led to social organizing around protecting Canadians from future spikes in unemployment which, after many years, resulted in the passage of the Unemployment Insurance Act in 1940. This national, federally administered program was the first contributory benefit program in Canada—where recipients would pay into future benefits—and it served as a centerpiece of Canada's emerging welfare state. In 1941, maternity leave was

monitored by "an array of snoops," including "Children's Aid Society volunteers, churchgoers, the men of Kiwanis, and others" to ensure that the recipients of aid were adhering to strict standards of "morality" (i.e., keeping a clean house, celibacy) (Finkel, *Social Policy and Practice in Canada*, 102). In part, this was to address aver-prevalent concerns about abuse, but it was also a way to ensure the moral regulation of poor mothers within and beyond the state, Margaret Little, "*No Car, No Radio, No Liquor Permit*": *The Moral Regulation of Single Mothers in Ontario, 1920-1997* (Don Mills, ON: Oxford University Press, 1998). See also Margaret Little, "The Blurring of Boundaries: Private and Public Welfare for Single Mothers in Ontario," *Studies in Political Economy* 47 (1995).

¹⁴² Finkel, *Social Policy and Practice in Canada*, 100; Nancy Christie, *Engendering the State: Family, Work, and Welfare in Canada* (Toronto: University of Toronto Press, 2000), 99.

granted for a short time to women through the new unemployment insurance program, and although unpaid, it provided a way for women to leave and return to the workforce following childbirth.¹⁴³ In addition to the small, largely symbolic inclusion of maternity leave under Unemployment Insurance, the onset of WWII led to women's mass engagement in manufacturing work and the establishment of Canada's first and only, national childcare program.¹⁴⁴ Women's work during wartime meant that there was a pressing need for available childcare, and in 1942, the federal government announced a federal-provincial cost sharing program in which Ottawa would provide fifty percent of childcare costs for women engaged in "industries essential to the war effort."¹⁴⁵ The reach of the program was limited, however, as the concentration of manufacturing jobs in Ontario and Quebec meant that women outside of these provinces did not benefit.¹⁴⁶ Further, in the early 1940s, the MacKenzie King government introduced a program of family allowances providing parents with funds to subsidize child rearing. Paid directly to mothers, family allowances were a means through which the Government of Canada could mitigate demands for higher wages; reducing the need for employers to pay salaries that could independently support entire families, while giving many women the funds they needed to offset the income they would lose by leaving their wartime jobs.¹⁴⁷ Throughout the war, the citizen duty to reproduce was met by related entitlements that framed women both as mothers and as workers, at once engaging in both the public and the private sphere.

¹⁴³ Rianne Mahon, "Child Care in Canada and Sweden: Policy and Politics," *Social Politics* (Fall 1997): 397; Leslie Pal, "Maternity Benefits and Unemployment Insurance: A Question of Policy Design," *Canadian Public Policy* 11, no. 3 (1985).

¹⁴⁴ Friendly and Prentice, *Childcare*.

¹⁴⁵ Mahon, "Child Care in Canada and Sweden," 397.

¹⁴⁶ Friendly and Prentice, *Childcare*, 73.

¹⁴⁷ Brodie, "Restructuring and the New Citizenship," 129–130; Finkel, *Social Policy and Practice in Canada: A History*, 130–3.

In whatever ways women's contributions as workers were recognized during the war, entitlements in the post-war period continued as in the early twentieth century, to recognize women as contributing members of society, first and foremost through their reproductive labour. The small, symbolic steps made to recognize women's capacity to be both workers and parents through the establishment of national childcare funding and promises of maternity leave were quickly retrenched after the war, and the relevant programs eliminated. By the 1950s, social policy related to parenthood was working once again to reinforce the contributions of women as mothers and men as breadwinners. The assumption of the post-war social contract was that women involved in a two-parent, heterosexual, nuclear family would necessarily have children, with a male breadwinner in the workforce and a mother in the home. The imperative to provide care for children within the context of the household with some measure of state support remained strong, only now more expansive and bound up with new understandings of entitlement to a family wage within the context of a two-parent home. Throughout the 1960s, the commitments of the welfare state would be further expanded, including new provisions for family benefits, and some subsidies for childcare¹⁴⁸ that would reaffirm the social citizenship of the welfare state by giving parents financial support in exchange for the necessary work of childbearing and childrearing in which they were engaged.

The ascendancy of a neoliberal ideology from the 1970s onward brought important changes to social policy provision, and with it, provisions to parents. Widespread cuts were slow to come, and while some retrenchment occurred earlier,¹⁴⁹ the 1995 federal budget has been most

¹⁴⁸ Martha Friendly and Susan Prentice, *Childcare*, About Canada (Halifax, NS: Fernwood, 2009), 208.

¹⁴⁹ One important cut that occurred prior to the 1995 budget was the replacement of the Family Allowance program with the income-dependent Child-Tax Benefit in 1993, which worked to alter the nature of the entitlement. The provision shifted from being universal wherein eligibility required simply having a child, to being income-tested ensuring that only the poorest parents would be provided with income supplements.

widely cited as a turning point and the marker of significant decline in the social citizenship regime in Canada. This budget included an important “downloading” of services through the elimination of the Canada Assistance Plan and the establishment of the Canada Health and Social Transfer which, together with changes to Unemployment Insurance and childcare benefits, brought about a new understanding that the once-strong social safety net was weakening. The elimination of programs like Mothers’ and Family Allowances and their replacement with models that left families to their own devices within the broader framework of the free market, removed the explicit family-orientation of some forms of social service provision, and focused increasingly on the citizen-worker as the deserving recipient of social assistance.

For example, without the Canada Assistance Plan, the condition that work could not be a requirement to receive social assistance was removed, and the Ontario government replaced welfare with *Ontario Works*, a workfare program that required that all recipients to “take advantage of welfare-to-work programmes that will prepare them for paid employment and end their ‘dependency’ on the state.”¹⁵⁰ Welfare recipients were framed, under this new program, as people who did not contribute to society or the state, and who were simply paid to “do nothing.”¹⁵¹ Although Mothers’ Allowance had originally been conceived as a way to enable mothers who could not afford to stay home to make a valuable contribution to society by raising their children, the workfare legislation reframed single mothers on social assistance as part of the *Ontario Works* program, undeserving and therefore not entitled to support.¹⁵² As such, it required them to engage in some combination of employment, community work, and training activities for thirty-five hours a week, despite their obligations as sole-support parents. The contribution to

¹⁵⁰ Shelley A.M. Gavigan and Dorothy E. Chunn, “From Mothers’ Allowance to Mothers Need Not Apply: Canadian Welfare Law as Liberal and Neoliberal Reforms,” *Osgoode Hall Law Journal* 45, no. 4 (2007): 771.

¹⁵¹ *Ibid.*, 759.

¹⁵² *Ibid.*

the labour force that single parents might be making was clearly valued over their potential role in childrearing. In British Columbia, similar reforms to social assistance also included the introduction of workfare, and a significant reduction to the assets that someone was able to hold and still qualify for assistance. While (some) single mothers were once eligible for social assistance to ensure that they could stay home with their children until they reached school-age, the shift in social policy reframed “the social identities of single mothers...and their capacity to make claims on the state by redefining them as the welfare problem—as undeserving, employable, and dependent.”¹⁵³

The replacement of the social citizen of the post-war period by a responsabilized citizen-subject under neoliberalism is a critical shift. Whereas the social citizen is entitled to a wide array of social rights to ensure that they can enjoy a robust experience of citizenship, the neoliberal citizen is the subject of a shrinking state, a state in which an interest in privatization allows for the “rolling back” of government functions and a shifting of social service provisions from the public to private sector. As described in chapter one, the citizen-subject of this state is one who is self-sufficient and only requires state assistance in the most dire of circumstances.¹⁵⁴ Ever ready to bounce back from troubled times, the neoliberal citizen is responsible for their own well-being, and when unemployed or otherwise troubled, can look to the state for short-term stop-gaps. Coupled with their own work ethic and skills-building, this “hand up” will help them re-enter the workforce. For reproductive citizenship, this shift from a social to neoliberal citizenship regime is particularly important, as certain policy interventions in the post-war welfare state, and certainly by the late 1960s, addressed the needs of certain kinds of parents *as*

¹⁵³ Brodie, *Politics on the Margins*, 58.

¹⁵⁴ Richardson, “Desiring Sameness? The Rise of a Neoliberal Politics of Normalisation,” *Antipode* 37, no. 3 (2005). 516.

parents (though they might be workers too), considering the particular needs and lives of those engaged in social reproduction. Programs like family allowances, for example, considered the material circumstances of families, and committed the state to providing benefits that would allow those families to survive. And though the examples presented here identify only a few of the ways that reproduction has changed in the decline of the welfare state, they represent how the parental (and largely maternal) obligation to engage in childrearing once met with relevant entitlements has been displaced by a model in which entitlements are bound to self-sufficiency and individualism. A different history, for example, might trace the liberalization of abortion law and access to contraception, focusing on the emergence of abortion as embedded in a language of choice, with access provided historically (and to a certain extent, contemporaneously) through private clinics.¹⁵⁵ Or still another might explore the medicalization of reproduction and its increased regulation and governance through the administration of professional medical associations. However, the crude history of social policy related to parenting provided here demonstrates similarly that it is increasingly as individuals, as workers, as consumers, and as taxpayers—rather than as parents—that people are seen as legitimate reproductive citizens. In short, the shift away from welfarism in has marked a new chapter in the history of reproductive citizenship in Canada, an individualizing model wherein reproduction is a private matter and the responsibility of the self-sufficient citizen within the context of the market.

Summary: Reproductive Citizenship in 21st Century Canada

The pressures of an increasingly neoliberal citizenship regime are met with lingering pressures

¹⁵⁵ Scala, “Experts, Non-Experts, and Policy Discourse”; Rachael Johnstone, “The Politics of Abortion in Canada After Morgentaler Women’s Rights as Citizenship Rights” (PhD Dissertation, Queen’s University, 2012); Angus McLaren, “Birth Control and Abortion in Canada, 1870–1920,” *Canadian Historical Review* 59, no. 3 (1978); McLaren and McLaren, *The Bedroom and the State*.

on women to bear biologically related children, and to do so within the context of a white, middle-class, able-bodied, two-parent (often heterosexual) family, and in ways that do not commercialize reproduction. The paradox of reproductive citizenship in a neoliberal age is that certain things have not changed—there is an ongoing reticence not to commercialize or commodify conception, childbearing, and reproduction, as well as concern about the public interest where the exploitation of vulnerable women or children are involved. However, at the same time, these commitments are increasingly mitigated by new obligations to participate in, and not to impede, the workings of the free market. While reproduction is not typically viewed as a commercial enterprise, there are many industries built to benefit from procreation—from pregnancy tests to baby yoga classes—and having children often means partaking in the commercial exchanges of those industries. One straightforward example is the employment of low-wage childcare workers, which at once disproportionately exploits the labour of racialized women, in the name of enabling privileged women to engage in the paid labour force while ensuring that their children are well cared for. The individual benefits to privileged women’s families occur as a result of their capacity to marginalize the labour of another, more vulnerable person, although this is seemingly an acceptable practice given the disparate nature of wages in the market economy and the valuation of some forms of labour above others. Exploitation of labour is a reality in the context of the free market, and seemingly acceptable within its parameters so long as engagement is freely chosen, or at least, the “fiction of consent” is present.¹⁵⁶ Reproduction has long been an economic and exploitative enterprise, but the exchange of goods and services is often viewed as acceptable so long as it is understood as a

¹⁵⁶ Vickers, “Gendering the Hyphen: Gender Dimensions of Modern Nation-State Formation in Euro-American and Anti- and Post-Colonial Contexts,” in *Gendering the Nation State: Canadian and Comparative Perspectives*, ed. Yasmeen Abu-Laban (Vancouver: University of British Columbia Press, 2008), 41.

means to improve one's life or that of one's child; enjoyed within the context of a neoliberal citizenship regime. There are shifting boundaries about what are considered legitimate practices in reproduction, with payment for childcare, reimbursement for surrogacy services, the purchasing of embryos amongst the practices involved in reproduction that are deemed acceptable or unacceptable depending on the limits of choice, exploitation, and commercialization of the governing regime. Here, inequalities are recaptured in the language of individual decision-making, where workers are seen to choose to partake in gendered, low wage jobs, rather than being relegated to them by virtue of structural inequities. For those without economic stability, or whose days squeeze in part-time jobs and caretaking responsibilities, there may be little access to the parameters of "good" market-based parenting, and the capacity to choose how to engage in reproduction.

The possibility of purchasing a better life, or at least, better opportunities for one's child is not unique to neoliberalism, it was certainly present during the heyday of the welfare state. Elites are always already able to access better opportunities for their children than others, and to engage in a seemingly privileged form of childrearing. What has changed is that longstanding commitments to a basic standard of living, and to publicly provided social services have become less accessible to marginalized people, thereby making it increasingly difficult to meet the standards of what constitutes an adequate parent, let alone a good one. The recognized reproductive citizen, is one always already engaged in paid employment, who partakes in the market, and indeed, relies on privately funded childcare to ensure that their labour is not too-interrupted by the demands of social and biological reproduction. Alternatively, the good reproductive citizen exists in a two-parent family with a single income in which one parent stays home. Those with low incomes, in single-parent households, or otherwise marginalized are

necessarily excluded from a robust experience of reproductive citizenship. The recognition of certain citizens as legitimately reproductive thus involves both the market and the state, knowing that it is only with a certain kind of engagement with the labour force and consequently the purchase of goods and services (including childcare) that “good” parenting practices can occur.

While good parenting in a neoliberal context operates—at least to a certain degree—as a function of purchasing power legitimated by the state, having a child is not seen as an engagement with the market, but rather (most often) as a choice that people make to fill their home and hearts and to engage in the proliferation of their families. Purchasing goods and services can help parents improve the lives of themselves and their families, fulfilling their ethical obligation to do right by their children. Although historically, people had children in part to participate in labour—agricultural, industrial, domestic or otherwise—in Canada today, this is practically unthinkable. Ethical practices of reproduction seemingly occur for their own sake, that is to say for the altruistic desire to either have or raise a child. One is *supposed* to build a family because they want to and because it is simply the right thing to do.

Thinking about the acquisition of childcare, or the purchase of diapers solely as acts of care invisibilizes the ways that reproduction is embedded within a neoliberal citizenship regime. This theoretical compartmentalization is easy in the case of buying clothes for one’s child, for example, made possible by the understanding that such clothing is necessary to take good care of one’s child. From this view, the market provides what for many is the only viable means of exercising one’s capacity to care; constructing the parameters of what practices of parenting are possible and desirable. However, in the case of the use of ARTs, the intersection of market forces and care makes these practices visible and perhaps even more problematic. The commercial acquisition of highly prized gametes, or the services of a surrogate who has a history

of healthy pregnancies means that commercial exchanges that have been an increasingly foundational part of parenting in a neoliberal age are coming to mark conception in new and profound ways. When the purchase of goods and services is not for a child, but rather for the creation of that child, the lines between care and commercialization are unclear. Conception itself becomes a commercial endeavour, not only the care work that follows. The desire to reproduce is theorized here, not as a collectively felt social pressure, but rather as an individually felt, biological-but-personal desire, and one that individuals can act upon by making the best possible choices (with their physician) about what technologies they undergo and how.

The movement of conception into the site of the (mostly) private space of fertility clinics has also meant that the desire to have a child, and to do so using reproductive technologies is increasingly understood in medical terms. Although the inability to reproduce biologically is not necessarily a dysfunction—not all bodies are necessarily reproductive—unwanted childlessness has been articulated in the language of clinic, as “infertility,” as an illness to be cured. Where “social infertility” exists (when someone cannot reproduce biologically with their sexual partner) that too is seen as a condition to be “cured” with the intervention of ARTs. The framing of infertility as a site of medical intervention, and of high-priced infertility treatments as the cure, has created a new means in which choices about how to reproduce, with whom, and how can occur, so long as one has the means to pay.

The medicalization of infertility, however, has also brought with it a new discursive framework with which to think about reproduction and infertility. Just as biological citizenship enables individuals to think about themselves in biological terms (and contest biomedical paradigms), reproductive citizenship enables people to think about themselves as reproductive or non-reproductive, and to understand reproductive capacity and family building in terms of

medical notions of fertility and infertility. If the medical model of infertility and ARTs as treatments of choice are a new reality in Canada, it is through these newfound reproductive identities that citizens involved with these technologies have made their voices heard.

Examining reproductive citizenship in the transition from a social to a neoliberal citizenship regime provides an important lens to interrogate how the most fundamental aspects of human life, life itself, have been incorporated into new modes of governance. Focusing particularly on the inclusion and exclusion of individuals and groups in the process leading to the *AHRA*, the remainder of this dissertation interrogates how individuals and groups seeking to use ARTs (or born of them) emerged as policy subjects, that is, as reproductive citizens included or excluded in the relevant policy debates. The policy process leading to the *AHRA* provides a particularly useful case for interrogating the intersections of reproduction and a neoliberal citizenship regime, as it addresses not only who was seen as a legitimate reproductive citizen but also, who could engage in claims-making, and whose interests were addressed in the legislation eventually passed.

Chapter Three: The Emergence of ARTs

The historical evolution of reproductive citizenship—particularly from the collective entitlements and protections of the welfare state to the individualizing self-reliant experiences following the neoliberal turn—has been replicated in the ways that assisted reproduction in Canada has been debated and governed. The history of public policy on assisted reproduction in Canada demonstrates how the governance of motherhood and parenthood remain subject to state intervention, increasingly through neoliberal practices presented under the auspices of the public good and the protection of women’s interests. The ascendancy of a neoliberal politics emphasizing personal choice and individualism in reproduction has always already been reflected in the development of public policy on ARTs, beginning in the late 1980s with the Royal Commission on New Reproductive Technologies.

Drawing on early scholarship on ARTs (focusing on feminist analyses and the social policy literature), as well as primary documents and interview research, this chapter examines the work of the Royal Commission on New Reproductive Technologies and the context in which it emerged. It argues that the work of the Royal Commission had three significant consequences for the governance of (assisted) reproduction and the reproductive citizenship of Canadians. First, the Royal Commission’s work advanced the adoption of a biomedical framework that privileged the understanding that infertility is a disease for which ARTs are the best “cure” or at the very least, treatment. Reproductive technologies were thus framed primarily as a privately experienced matter of medicine rather than a matter of public health policy. Second, and relatedly, the Royal Commission’s emphasis on biomedicine worked to favour financially privileged, heterosexual couples as parents deserving of care, that is, as the ideal parent-citizens in a neoliberal citizenship regime. Third, the Royal Commission and particularly its public

consultations influenced the emergence of an “infertility community” to be included in subsequent processes of policy development. These actors, whose interests would be differently included and excluded in future attempts to make policy in this field, were first recognized as groups with a stake in the regulation of assisted reproduction at the time of the Royal Commission.

Overall, the chapter demonstrates that the Royal Commission on New Reproductive Technologies set the framework for future policy interventions, identifying not only the privileged position of biomedical interventions, but also whose interests amongst those using reproductive technologies would be recognized as important in future legislation. In so doing, the Royal Commission came to recognize certain groups as legitimate and illegitimate users of ARTs—(assisted) reproductive citizens—tied closely to each groups’ position vis-à-vis biomedicine, individual choice, and the continued non-regulation of the market in infertility. The Royal Commission thus identified who counts as a reproductive citizen in terms of the ongoing authority of biomedical actors, couched in the language of individual choice, with small concessions made to address concerns about collective interests and commercialization.

The Royal Commission on New Reproductive Technologies

Although the first live birth of a child conceived *in vitro* occurred in 1978, it was not until the mid-1980s that high-profile legal cases that involved surrogacy and semen donation were heard,¹⁵⁷ or that many new reproductive technologies were available in Canada. As more and more families were using reproductive technologies, they struggled with how to address the use

¹⁵⁷ See *Matter of Baby M.*, 537 A.2d 1227 (1988); *McIntyre v Crouch*, 780 P. 2d 239 (Or. App. 1989).

of the technologies for their families and in their lives, and the socio-legal implications of using ARTs became increasingly apparent.

The rallying cries for government study and intervention into the use of ARTs in Canada were voiced by a national coalition of feminists led by Dr. Margrit Eichler, a professor at the Ontario Institute for Studies in Education, and Maureen McTeer, a prominent feminist lawyer (and wife of former Prime Minister Joe Clark). Eichler and McTeer, as well as activists, students and others, worked to form the Canadian Coalition for a Royal Commission on New Reproductive Technologies to call for an inquiry into the implications of ARTs, for women, for the resulting children, and for society. Informed by the successes of the Royal Commission on the Status of Women, a Royal Commission was seen as a means to raise “awareness and consciousness nationally about women’s issues.”¹⁵⁸ Led by Eichler, the Coalition engaged in extensive lobbying, letter writing, and collaboration with various women’s groups throughout the late 1980s, to significant effect. In a news article about a 1987 symposium held by the Canadian Advisory Council on the Status of Women, Eichler was quoted as saying that, “if we fail to act we may find ourselves in a nightmare society in which women of color become breeders and money determines who can and cannot give up their children,” making clear her position that the implications of reproductive technologies for Canadians could be dire.¹⁵⁹

The work of the Canadian Coalition for a Royal Commission on New Reproductive Technologies was important for two key reasons. First, the Coalition’s advocacy for a Royal Commission was an intervention intended to assert women’s control over their bodies and to do so in public policy. Policy on ARTs was seen as a means to address women’s health and contest the medicalization of reproduction, as part of a broader legislative and regulatory vacuum on

¹⁵⁸ Scala, “Feminist Ideals Versus Bureaucratic Norms,” 101.

¹⁵⁹ Catherine Dunphy, “Surrogate Mothers ‘Threat to Equality,’” *The Toronto Star*, March 3, 1987, Final edition, F1.

reproduction and reproductive autonomy coming out of *R. v Morgentaler*.¹⁶⁰ Second, the Coalition worked to identify reproductive technologies as a matter of collective moral concern not only for women, but also for society writ large. Informed by the Coalition's fact sheets¹⁶¹ and media releases, the Royal Commission once called, would be framed by the federal government and the press as an important social issue that required government intervention to protect the public from little-understood but potentially dangerous technologies. Although the debate would later shift, the idea that families should have access to reproductive technologies in order to build their families, and that there was an implicit right to access ARTs in order to have one's children were largely absent from the initial debate. The implications of these technologies for individuals were seen to be of minimal importance relative to the broader moral, ethical, social, and legal implications. Describing ARTs as a matter of women's health and reproduction embedded in broader moral concerns about the future of Canadian society allowed for the Coalition to call for the study of assisted human reproduction as a widely-felt ethical issue of particular concern for women.

On April 3, 1989, the Mulroney government announced in its Speech from the Throne that it would be calling a Royal Commission on New Reproductive Technologies (herein, "the Commission") as a means to address concerns that "medical and biological science" would "outpace our ability to deal with their moral, ethical, legal, and social implications."¹⁶² In the midst of questions about how the federal government would deal with the *Morgentaler* decision, it was clear that the calling of the Commission was a means to both diffuse the pressure of

¹⁶⁰ *R. v. Morgentaler*, [1988] 1 S.C.R. 30.

¹⁶¹ Canadian Coalition for a Royal Commission on New Reproductive Technologies, "New Reproductive Technologies in Canada: Some Facts and Issues," Box 10: Canadian Coalition for a Royal Commission on New Reproductive Technologies (Toronto, ON): correspondence, fact sheets, bibliography and other material, 1987-1989, Canadian Women's Movement Archives, Ottawa, ON.

¹⁶² Canada, "Speech from the Throne to Open the Second Session of the Thirty-Fourth Parliament of Canada," 1989.

activist groups, and to delay addressing reproductive rights until some sort of “appropriate course of action” could be found.¹⁶³ The Order-in-Council establishing the Commission’s mandate came in October 1989,¹⁶⁴ and the Commission was, at that time, officially charged with inquiring “into and report[ing] on current and potential medical and scientific developments related to new reproductive technologies, considering in particular their social, ethical, health, research, legal, and economic implications and the public interest, recommending what policies and safeguards should be applied.”¹⁶⁵ The wide range of its mandate meant that the Commission would not just focus on reproductive technologies themselves but rather, on a broader range of related issues including the causes of infertility and the general reproductive health of Canadians. Further, while not exactly reproductive technologies, the use of reproductive tissues for research also fell to the Commission’s purview, and the Commission was effectively charged with identifying acceptable research standards for embryonic and fetal tissues. In addition to Patricia Baird (Chair of the Commission and a medical geneticist), six commissioners were appointed representing a variety of backgrounds including medicine, theology, feminist sociology, and law, bringing a wide range of perspectives to the work that the Commission was set to undertake.

After the appointment of the commissioners, public hearings were set up for the following year, and slowly, the Commission began its work.¹⁶⁶ It divided its efforts into two

¹⁶³ Ibid.

¹⁶⁴ Prior to the announcement of the Commission, there had been a number of consultations and discussions about what to do about ARTs within the federal government. In correspondence between then-Minister Responsible for the Status of Women, Barbara McDougall, and feminist philanthropist (and now Senator) Nancy (Ruth) Jackman, McDougall noted that reproductive technologies were discussed at the 1988 “annual conference of Ministers Responsible for the Status of Women,” and that as a result, “a federal/provincial/territorial working group has been established to further address this issue.” See Barbara McDougall, “Letter, August 2, 1988.” Box 10: Canadian Coalition for Royal Commission on New Reproductive Technologies (Toronto, ON): correspondence, fact sheets, bibliography and other material, 1987-1989, Canadian Women’s Movement Archives, Ottawa, ON.

¹⁶⁵ Royal Commission on New Reproductive Technologies, *Proceed with Care: Final Report of the Royal Commission on New Reproductive Technologies* (Ottawa: Minister of Government Services Canada, 1993), 3.

¹⁶⁶ Scala, “Feminist Ideals Versus Bureaucratic Norms,” 104.

streams, public consultations and a research programme, culminating in the publication of a final report. Over the course of its mandate, commissioners would hear from over 40,000 Canadians (a number repeated in nearly all accounts of the Commission's work) by means of public hearings across the country, polls, written submissions, calls to a dedicated hotline, and informal consultations with key stakeholders.¹⁶⁷ The Royal Commission paid special attention to those who had experiences with reproductive technologies, conducting private "armchair" sessions with five hundred "individuals or couples who had personal experiences with one or more of the new reproductive technologies."¹⁶⁸ Although it is unclear to what extent the consultations informed the Commission report, the Commission is notable for the extensive and far-reaching nature of its public deliberation process. Further, the Commission would eventually produce fifteen volumes of research on an array of topics related to reproductive technologies, including novel research on the use of ARTs in Canada at the time.

The Commission is perhaps best known for the controversy that marred its tenure. The Commission had problems from the beginning: from the appointment of the Chair, to the discontent of commissioners with her perceived unilateral and non-transparent decision-making. In "Frankenstein Meets Kafka: The Royal Commission on New Reproductive Technologies,"¹⁶⁹

¹⁶⁷ Forty-thousand Canadians is the number of Canadians consulted by the Royal Commission according to *Proceed with Care*. However, scholars have contested this number for its inclusion of those who participated in polling that produced questionable data. See Christine Massey, "The Public Participation Program of the Royal Commission on New Reproductive Technologies" (MA Thesis, University of Ottawa, 1994). See also Christine Massey, "The Public Hearings of the Royal Commission on New Reproductive Technologies: An Evaluation," in *Misconceptions: The Social Construction of Choice and the New Reproductive and Genetic Technologies* (vol. 1), eds. Gwynne Basen, Margrit Eichler, and Abby Lippman (Hull, QC: Voyageur, 1993).

¹⁶⁸ Royal Commission on New Reproductive Technologies, *Personal Experiences with New Reproductive Technologies: Report From Private Sessions* (Ottawa: Royal Commission on New Reproductive Technologies, 1992), 1.

¹⁶⁹ As noted above, Eichler was also a leader of the Coalition for a Royal Commission on New Reproductive Technologies. She was also seen to be a likely choice for Chair of the Commission, or to at least be appointed as a commissioner. Although this history is suggestive of a conflict of interest in her critique of the Commission's work, Eichler does not claim objectivity (indeed, the work appears in an edited collection published in part to challenge the work of the Royal Commission). Rather, she uses insight as editor of the volume and an activist in the field to

Margrit Eichler paints a disturbing picture of a Commission hampered by an atmosphere of mistrust. She describes the inner workings of the Commission as secretive, and the work of the Commissioners paralyzed by a Chair who hindered their participation.¹⁷⁰ In an unprecedented move, four commissioners were fired, including Maureen McTeer, who had been an important part of the lobbying for the Commission in the first place. The dismissal of those commissioners seen to espouse a feminist perspective, as well as problems with the transparency of its research programme, led to widespread critique of the Commission by feminist groups, by the Social Science Federation of Canada,¹⁷¹ and by the press.¹⁷² The Commission's authority was challenged and the scandal "made it necessary for Dr. Baird to appease, or to be seen to appease feminist public opinion" in order to retain any legitimacy.¹⁷³

The much-anticipated report of the Commission was released to the public on November 30, 1993. The report, entitled *Proceed with Care*, is a substantial document that identifies an "urgent need for boundaries to regulate unethical uses" of assisted reproductive technologies to protect the public interest.¹⁷⁴ The report is divided into three main parts. The first part is an examination of the relationship between new reproductive technologies and Canadian society,

collect grey literature that presents a well-researched, nuanced, insider perspective of the Commission's internal challenges.

¹⁷⁰ Perhaps the most disturbing discussion of the inner workings of the Commission comes from those who worked there themselves. See relevant commentary in Gwynne Basen, Margrit Eichler, and Abby Lippman, eds., *Misconceptions: The Social Construction of Choice and the New Reproductive and Genetic Technologies*, vols. 1 & 2 (Hull, QC: Voyageur, 1993); Lorna Weir and Jasmine Habib, "Comment: A Critical Feminist Analysis of the Final Report of the Royal Commission on New Reproductive Technologies," *Studies in Political Economy* 52 (1997).

¹⁷¹ Social Science Federation of Canada updates, cited by Eichler in Margrit Eichler, "Frankenstein Meets Kafka: The Royal Commission on New Reproductive Technologies," in *Misconceptions The Social Construction of Choice and the New Reproductive and Genetic Technologies*, vol. 1 (Hull, QC: Voyageur, 1993).

¹⁷² See, for example Rod Mickleburgh and Ross Howard, "Women Denounce Commission: Group Say Firings Strip Reproductive Technology Inquiry of Legitimacy," *The Globe and Mail*, December 23, 1991, A1; Rod Mickleburgh, "Riddled Panel Keeps Marching On," *The Globe and Mail*, December 23, 1991, A1; Michele Landsberg, "Commission Is Crumbling Under Familiar Tory Chaos," *The Toronto Star*, January 11, 1992, SA2.

¹⁷³ Mariana Valverde and Lorna Weir, "Regulating New Reproductive and Genetic Technologies: A Feminist View of Recent Canadian Government Initiatives," *Feminist Studies* 23, no. 2 (1997): 420.

¹⁷⁴ Royal Commission on New Reproductive Technologies, *Proceed with Care*, 1049.

which effectively outlines the Commission's guiding principles (including a balance of individual and collective interests), its use of evidence-based medicine as a research approach, and the validity of federal interventions in the field. The second section represents the most significant part of the report and defines how infertility is experienced, prevented and treated, with additional chapters on sex selection, gene therapy and genetic alteration, judicial intervention in pregnancy and birth, and uses of fetal tissue. The third section provides an overview of the Commission's two hundred and ninety-three recommendations, directed to a wide variety of actors, amongst them provincial governments, health care professionals, employers, and school boards. The most substantive recommendations are those made to the federal government, which propose a framework for sweeping federal legislation that would use criminal law to prohibit certain practices and establish a regulatory agency to develop guidelines and implement regulations to govern ARTs on an ongoing basis. The focus of the Commission's recommendations in *Proceed with Care* are the legislative and regulatory recommendations made to the federal government that seek to criminalize the most reprehensible technologies and regulate others through a National Commission in the vein of the CRTC (Canadian Radio-television and Telecommunications Commission). These recommendations would form the basis of proposed legislation and, as will be explored over the course of this dissertation, what would eventually become the *AHRA*.

Biomedicine as the Commission's Dominant Frame

What emerges from a review of the Royal Commission's recommendations is an overemphasis on medical and scientific understandings of ARTs. The Royal Commission was mandated to study the broadly conceived implications of reproductive technologies, but there was a clear

prioritization of perspectives that viewed ARTs predominantly as a matter of medicine and science, as opposed to a legal, social, or moral issue. The appointment of epidemiologist Patricia Baird as the Chair of the Commission was a harbinger of this approach, confirmed in the Commission's research programme, the hiring of staff, public consultations, and most clearly in its final report. There is a substantial literature documenting the various ways that the biomedical focus of the Commission was manifest, tracing its public consultation process, research programme, and report.¹⁷⁵ The biomedical bias was not sweeping, and there were important ways that the Commission addressed feminist concerns, including the commercialization of reproduction. However, the biomedical perspective would render sociological, ethical, and legal analyses of reproductive technologies peripheral to the Commission's analysis, and would identify ARTs as, above all, a potential treatment for infertility rather than as a matter of ethics, and of public health. In so doing, the Royal Commission emphasized medicine and science as the most important elements of ARTs and the use of ARTs as an individually experienced medical matter.

It was in the early stages of the Commission that an emphasis on biomedical approaches to studying ARTs began to emerge. In addition to Baird's appointment, at the so-called search conference in Wolfville, Nova Scotia (intended to provide a forum for commissioners to sort out how to fulfill the Commission's wide-ranging mandate), attendees with medical and scientific backgrounds or with an economic interest in the use of infertility treatments were

¹⁷⁵ Baylis and Herder, "Policy Design for Human Embryo Research in Canada: An Analysis (Part 2 of 2)"; Eichler, "Frankenstein Meets Kafka"; Massey, "The Public Hearings of the Royal Commission on New Reproductive Technologies"; Montpetit, "Public Consultations in Policy Network Environments"; Montpetit, "Policy Networks, Federalism and Managerial Ideas"; Roberts, "Coalition Building and Public Opinion"; Scala, "Feminist Ideals Versus Bureaucratic Norms"; Scala, "Experts, Non-Experts, and Policy Discourse"; Scala, Montpetit, and Fortier, "The NAC's Organizational Practices and the Politics of Assisted Reproductive Technologies in Canada"; Weir and Habib, "Comment: A Critical Feminist Analysis of the Final Report of the Royal Commission on New Reproductive Technologies"; Valverde and Weir, "Regulating New Reproductive and Genetic Technologies."

overrepresented¹⁷⁶ and the workshops within the conference focused on medical and scientific approaches to the exclusion of other relevant perspectives. As noted by Scala, the failure to adequately consider perspectives outside of medical and scientific discourse was seen by some commissioners, conference participants, and researchers to be, at this early stage, edging out the possibility for women's health, disability, and religious perspectives to be substantively represented in the Commission's work.¹⁷⁷

The indication of biomedical bias evident at the search conference would become apparent in at least four aspects of the Commission. First, its research program was divided into four working groups, each reflecting a specific area of medical or scientific interest: infertility, assisted human reproduction, prenatal diagnosis and genetics, and fetal tissue and embryo research.¹⁷⁸ Changing notions of kinship, and the social role of donors and surrogates in new reproductive technologies were not, for example, seen as critical components of the Commission's research. Instead, relevant concerns "were dispersed among the four research areas."¹⁷⁹ The Commission did conduct research on such matters (for example, there was research on the social construction of infertility in the "infertility" group), however this research was organized around biomedical concepts rather than sociological ones, minimizing the attention paid to what had been conceptualized by feminist actors as the key concerns of a potential Commission. The framing of the research programme along biomedical lines also led to a predominance of certain kinds of researchers among those commissioned to do studies or hired

¹⁷⁶Royal Commission on New Reproductive Technologies, *Proceed with Care*, 1198. Scala, "Experts, Non-Experts, and Policy Discourse," 122.

¹⁷⁷ Scala, "Experts, Non-experts, and Policy Discourse: A Case Study of the Royal Commission on New Reproductive Technologies," 120-124. See also, Scala, "Feminist Ideals Versus Bureaucratic Norms," 103.

¹⁷⁸ Royal Commission on New Reproductive Technologies, *Proceed with Care*, 5; Roberts, "Coalition Building and Public Opinion," 17; Scala, "Feminist Ideals Versus Bureaucratic Norms," 106.

¹⁷⁹ Scala, "Feminist Ideals Versus Bureaucratic Norms," 106.

to research work.¹⁸⁰ While there might have been an interdisciplinary approach to the research amongst the scholars, the commitment to a medical-scientific approach to the Commission's work hindered potential for more nuanced and socio-ethically interested analysis.

Secondly, the research process (and the Commission report) was deeply embedded in principles of evidence-based medicine, which limited the attention given to qualitative, sociological, political, feminist, legal, philosophical, and historical approaches to the study of new reproductive technologies.¹⁸¹ Evidence-based medicine was defined in the Commission report as “medical practice and management of the health care system based on knowledge gained from appropriate evaluation of treatments and their results” and was used to try to provide a seemingly objective approach to reproductive technologies “based on data and assessment.”¹⁸² While evidence-based medicine can be important in the application of clinical evidence in decision-making related to the course of treatment for individual patients, the appeal to evidence-based medicine in the case of the Royal Commission worked to displace the legitimacy of those who were using non-scientific evidence and approaches.¹⁸³ As noted by Scala, at the time of the Commission, evidence-based medicine was increasingly being used as a tool for policymaking in health care, particularly as it could be used to evaluate the cost-effectiveness of treatments. Operating at a time when health care costs were increasingly falling to provincial governments,

¹⁸⁰ Ibid.

¹⁸¹ These are just a few of the more overt examples of the ways in which the Royal Commission took a distinctly biomedical direction, shifting away from the feminist, socio-ethical perspectives that had been integral to the lobbying for its creation. More surreptitiously, the Commission hired a lobbying firm (Burson-Marsteller) to conduct some of its research on commercial interests in reproductive technologies while simultaneously in the hire of many of the world's largest pharmaceutical and biotechnology companies and advocacy groups, although this conflict of interest was never disclosed. See Sky, “Commercial Interests and New Reproductive Technologies.”

¹⁸² Weir and Habib, “Comment: A Critical Feminist Analysis of the Final Report of the Royal Commission on New Reproductive Technologies,” 144.

¹⁸³ Regarding the ubiquity of evidence-based medicine and relevant critiques, see Eric Mykhalovskiy and Lorna Weir, “The Problem of Evidence-Based Medicine: Directions for Social Science,” *Social Science & Medicine* 59, no. 5 (2004).

the Royal Commission took evidence-based medicine as a frame of analysis that could identify “the most effective use of finite resources” for reproductive technologies.¹⁸⁴

Third, the privileging of a biomedical frame of analysis would become apparent in the Commission’s consultation process. Unlike other Royal Commissions (e.g., the Berger Commission and the Royal Commission on Aboriginal Peoples) that provided funding to interveners, the Commission did not provide such funding, which might have “levelled the playing field” among potential participants to a certain extent.¹⁸⁵ While certain large professional organizations had the capacity to conduct research on ARTs anticipating the call for the Commission, smaller, non-professional groups had no such capacity. Consequently small, non-professional, non-expert organizations that might have been interested in participating in the Commission’s public hearings or in submitting briefs did not necessarily have the resources, expertise, or time to dedicate to participating.¹⁸⁶ In contrast, well-funded organizations within the “medical and research communities, the pharmaceutical industry, and the legal profession”¹⁸⁷ were at a significant advantage. Organizations like the Society of Obstetricians and Gynaecologists of Canada, the Canadian Medical Association, the Canadian Fertility and Andrology Society, and the Canadian College of Medical Geneticists as well as pharmaceutical companies, worked to make their voices heard in the public participation process, providing briefs, giving testimony in public hearings, and engaging in private sessions with commissioners.¹⁸⁸

Finally, the biomedical approach of the Royal Commission was evident in the framing of

¹⁸⁴ Scala, “Experts, Non-Experts, and Policy Discourse,” 130.

¹⁸⁵ *Ibid.*, 244.

¹⁸⁶ Massey, “The Public Hearings of the Royal Commission on New Reproductive Technologies,” 242.

¹⁸⁷ *Ibid.*

¹⁸⁸ Jones and Salter, *Proceeding Carefully*, 13.

its report, *Proceed with Care*. Despite its use of a framework that drew on “secular mainstream ethics, feminist theory, and religious thinking,”¹⁸⁹ *Proceed with Care* was largely about infertility and its potential remedies. Seventeen of the report’s thirty-one chapters were dedicated to either the discussion of the causes of infertility and subfertility or otherwise to addressing circumvention of infertility through reproductive technologies and adoption.¹⁹⁰

Recommendations about the use of reproductive technologies to address infertility combined the idea of reproductive technologies as a necessary medico-scientific approach to reproduction with evidence-based medicine. Here, the Commission implicitly suggested that the use of ARTs to treat infertility was a desirable course of action for individuals, particularly when justified by the balance between scientific data about the efficacy of certain technologies and a cost-benefit analysis. This was evident, for example, in the Commission’s near-outright dismissal of adoption as a “feasible alternative” to infertile Canadians.¹⁹¹

The biomedical frame of the Commission report is perhaps most apparent in its recommendation to provincial health care programs to limit public funding for IVF except in cases of bilateral fallopian tube blockage. This recommendation asserted that the limited state of evidence made it an “experimental” procedure, moving it out of the publicly funded health care system and into the private sector. The Commission made this recommendation on the basis that IVF had been proven effective only in cases of complete fallopian tube blockage, suggesting that future research be conducted for other indications. The reason given by the Commission was that using IVF for indications that were not proven to be effective “amount[ed] to experimentation on

¹⁸⁹ Royal Commission on New Reproductive Technologies, *Proceed with Care*, 51.

¹⁹⁰ Five chapters outline the Commission’s framework and perceived role, and there are also chapters on embryo research, commercial interests in ARTs, prenatal genetic diagnosis, sex selection, gene therapy, judicial intervention in pregnancy and birth, and uses of fetal tissue.

¹⁹¹ Royal Commission on New Reproductive Technologies, *Proceed with Care*, 372.

women's bodies without their informed consent."¹⁹² The Royal Commission thus recommended that provincial health insurance plans terminate funding for all uses of IVF other than for cases where the patient presented with bilateral fallopian tube blockage (although Ontario was the only province funding IVF at the time). All other uses of IVF would have to be made available outside of the provincially funded health care system, largely within private clinics where patients would be responsible for paying for their own care.

This recommendation was particularly important given that the Commission recognized the widespread use of IVF for indications other than blocked fallopian tubes. *Proceed with Care* explicitly noted that between 1987 and 1991, "just under 45 percent of the IVF services provided were for indications other than tubal blockages,"¹⁹³ providing evidence that women were seeking out and receiving IVF for a variety of reasons other than tubal blockage. By the time *Proceed with Care* was published, IVF had been available as a publicly funded service in Ontario since 1985. Women in Ontario had come to expect funded IVF for treatment of endometriosis, single-blocked fallopian tubes, male-factor infertility, amongst other reasons, and the Commission's suggested restrictions on IVF were seen as an impediment to what had, for nearly a decade, been seen as a matter of medical necessity under the Ontario Health Insurance Plan.¹⁹⁴ This stratification of diagnoses meant that patients with one diagnosis became the legitimate, state-funded recipients of IVF while others would have to pay for treatments themselves or do without.¹⁹⁵ For those patients who sought out IVF without state funding, the prohibitive costs of the procedure, and related medications, were identified as leading patients to make riskier

¹⁹² Ibid., 502.

¹⁹³ Ibid., 500.

¹⁹⁴ Cattapan, "Rhetoric and Reality."

¹⁹⁵ Francesca Scala, "IVF Policy and the Stratification of Reproduction in Canada," in *Fertile Ground, Exploring Reproduction in Canada*, eds. Stephanie Paterson, Francesca Scala, and Marlene Sokolon (Montreal: McGill-Queen's University Press, 2014), 56–57.

choices such as what procedures and drugs to use, and how many embryos to implant to ensure cost-effective success.¹⁹⁶ Given the percentage of IVF patients who did not have tubal blockages, people were not likely to stop using IVF as a means of conception, but rather, they were more likely to mitigate the costs through cheaper, more experimental uses of ARTs.¹⁹⁷ While the Commission's recommendation to limit IVF funding was justified as, first and foremost, a matter of public health grounded in evidence-based medicine, and second, as a cost-saving measure, it is unclear that the public health outcomes were more significant than the cost-savings. This is not to say that public funding of IVF should occur, but rather that the reasoning of the Commission—that funding for IVF should be restricted to protect women from experimental uses of the procedure—was an application of evidence-based medicine in the name of public health that may, in fact, have put women at greater risk of engaging in experimental uses of ARTs. The claim that restricting funding would result in safer, more effective uses of IVF is a vacuous one when seemingly less effective, unsafe practices continued to be available outside of the public system.

In short, in centering the study of assisted reproduction around the treatment and prevention of infertility, reproductive technologies were implicitly reduced to seemingly ethically neutral medical treatments. Again, it is important to note that the Commission was not exclusively biomedical in its analysis as *Proceed with Care* did pay attention to issues of family and gender and legalities surrounding ARTs, but in its focus on medical understandings of infertility, the biomedical frame and the individual experience of infertility were reified. Consequently, the overall effect of the Commission's biomedical approach is the subtle

¹⁹⁶ Cattapan, "Rhetoric and Reality"

¹⁹⁷ Regarding the eventual delisting of IVF services for indications other than bilateral fallopian tube blockage, see L'Espérance, "Fertilize-This," 124-130.

individualization of reproductive technologies initially described in the work of Margrit Eichler and Maureen McTeer's feminist coalition as a broader social issue. Whereas those originally calling for a Royal Commission attempted to challenge the ongoing and increasing medicalization of reproduction and to approach ARTs as a broadly conceived moral and social issue, the Commission's work did little to unseat the biomedical orthodoxy in the field. In-vitro fertilization, artificial insemination, gamete donation and other reproductive technologies were constructed as, above all, medical concerns, in the Commission's work. The consequence was a validation of the biomedical expertise of doctors, of clinics, and of biotechnology and pharmaceutical firms to the detriment of other kinds of knowing, and the affirmation of biomedical authorities, in conjunction with government, as the legitimate gatekeepers of reproductive technologies.

Furthermore, the biomedical framework worked to individualize ARTs through its advancement of liberal, individual rights discourse and the expansion of reproductive choice. Francesca Scala has suggested that the failure of the Royal Commission to understand ARTs as a broader social concern is attributable not only to the advancement of a biomedical frame, but also, the application of the biomedical model in conjunction with individual rights discourse that had been a rallying cry of the abortion rights movement. She finds that while the Commission was poised to identify ARTs as an important socio-ethical issue, the Commission's "formative decisions" and its emphasis on individual autonomy resulted in recommendations that put ARTs squarely within the domain of biomedicine.¹⁹⁸ This model of individual interests within a biomedical framework is particularly clear in the Commission's overview of recommendations which begins with the statement that: "as a society we need to create a situation such that

¹⁹⁸ Scala, "Experts, Non-Experts, and Policy Discourse."

individual Canadians can make decisions about their involvement with new reproductive technologies in the knowledge that their ethical, legal, and social aspects and their safety and effectiveness have been given due consideration.”¹⁹⁹ Here, socio-ethical concerns serve as the bounds of assisted reproduction, that is, a means to facilitate individual choice. To this end, the Commission asserted that if reproductive technologies are evidence-based, ethically neutral elements of medicine and science, then there is no reason to restrict women’s access to choice, and instead, ARTs should only be restricted within the limits of cost-effectiveness and the relative-safety of procedures determined through evidence-based medicine.²⁰⁰

The biomedical and evidence-based approach to governing ARTs not only propagated a model of liberal choice, but with it, a neoliberal model of reproductive citizenship. The individual choices made possible by access to ARTs were made broader by recommendations for shrinking state support. Although IVF was deemed experimental, untested, and unproven for most medical indications, rather than promote further investigation or cautious use of the technology, IVF was moved outside of the publicly funded health care system in the name of “evidence” where regulation would remain largely outside of governmental purview. The risks of engaging in IVF, financial, medical, or otherwise, were shifted to the patient-consumer, self-reliant and responsible for their own health and that of their offspring.

The biomedical approach would come to shape official discourse on ARTs when (as described in the next chapter of this dissertation) the federal government would make an official response to the Commission, and the broad, social understanding of ARTs that it hoped to espouse would be eroded more and more as a valid approach to studying and governing ARTs. From a biomedical perspective, ARTs are a matter of infertility and its treatments, and primarily

¹⁹⁹ Royal Commission on New Reproductive Technologies, *Proceed with Care*, 1020.

²⁰⁰ Scala, “Experts, Non-Experts, and Policy Discourse,” 199.

a matter of individual health and well-being. Although Royal Commissions are not institutions tasked with policy design and do not necessarily represent the interests of the federal government, they may provide government with direction in a policy area, and this was certainly the case for the Royal Commission on New Reproductive Technologies. The Commission would have a substantive legacy, as its recommendations would provide the framework for future legislation, and the privileging of a biomedical model and liberal individual rights discourse would be an important part of legislation-to-come.

Biomedicine, Exclusion, and the Ideal (Assisted) Reproductive Citizen

The Royal Commission's focus on infertility, its prevention, medical indications, and treatments worked to advance the position that the subjects or primary users of ARTs are infertile or likely to be infertile heterosexual couples, looking either for a means to build their family or to prevent reduced fertility. The treatment of infertility, which had slowly and steadily become the domain of obstetricians, gynaecologists and reproductive endocrinologists, expanded more rapidly than ever before, and the shift of infertility from the bedroom to the doctors' office meant that infertile people became *patients with infertility*, an understanding of infertility that was explicitly embraced by the Commission, and many of those who testified before it.

As noted above, the Commission's early consultations were focused not only on strategizing how best to achieve the Commission's mandate, but also identifying key actors and interested parties. Due to the work of the Canadian Coalition for a Royal Commission on New Reproductive Technologies, feminists were amongst those most clearly in need of consultation, as were physician groups, legal experts, and scientists, all of whom were well-represented in the early consultations and discussions. However, LGBTQ Canadians, gamete donors, and

surrogates—groups with explicit and direct interests in the governance of ARTs—were not particularly evident in the work of the Commission. Its consultations, research, and recommendations demonstrate a significant lack of attention paid to the needs of these groups, particularly for gamete donors and surrogates whose interests had until that point (and since) rarely been mobilized. Despite its efforts, the Commission’s framing of reproductive technologies as a matter of infertility that emerged from its biomedical approach, failed to adequately consider changing norms of kinship, including the concerns of lesbians, single women, and those families that differ from the two-parent, heterosexual, nuclear family.

LGBTQ People

The Royal Commission at once recognized and marginalized the interests of LGBTQ people. In the early chapters of *Proceed with Care*, the use of reproductive technologies was portrayed as a heterosexual pursuit that is extended to lesbians and single women. By focusing on infertility as the primary reason to use reproductive technologies, lesbians and gay men were imagined out of the Royal Commission’s conceptual frame, only to be added on as an equality concern. From this view, infertility was defined in terms of failure to conceive through heterosexual intercourse after a period of two years, and the potential medical conditions associated with “the man” and “the woman” were discussed in turn. However, the Commission then acknowledged the exclusionary nature of this definition, and articulated that ARTs were also a concern of lesbians and single women. Indeed, *Proceed with Care* included descriptions of the practice of donor insemination, including some discussion of self-insemination (donor insemination outside of a medical setting, without medical intervention),²⁰¹ recommending that “self-insemination [be] available as a safe

²⁰¹ The term “self-insemination” is used here to emphasize the actors involved in the insemination, drawing attention to the idea that in “self-insemination” it is not a clinician who conducts the insemination, but rather the woman

effective, and low-cost alternative to DI [donor insemination] carried out in a medical setting.”²⁰² For lesbian intended mothers, for whom there was already a long history of self-insemination, it was important that the Commission enable the continuation of at-home self-insemination and not medicalize the experience of conception. Furthermore, the Commission recommended changes to family law to protect families (specifically those including lesbian couples) from future claims of parentage by donors.²⁰³ The Commission report also included a discussion of sexual orientation and different family forms,²⁰⁴ insofar as the Commission recognized the discriminatory nature of certain fertility clinics’ refusal to provide services to lesbians and single women. As such, the Commission was fairly progressive for its time in recognizing the needs of lesbians vis-à-vis assisted reproduction, despite its privileging of ARTs as a heterosexual concern.

For the most part, however, LGBTQ citizens were not well-represented in the consultations of the Royal Commission, or its research programme. EGALÉ (a national LGBTQ equality-seeking organization) did participate in one public hearing, and noted the importance of access to ARTs to enable LGBTQ people to build their families. However, the testimony also noted that EGALÉ had neither the time nor the inclination to participate actively in the debate on ARTs given its more pressing concerns about relationship recognition.²⁰⁵ Another organization,

herself, or someone close to her. See Fiona Nelson, *Lesbian Motherhood: An Exploration of Canadian Lesbian Families* (Toronto: University of Toronto Press, 1996); Mamo, *Queering Reproduction*; Luce, *Beyond Expectation*, 160; Cameron, “Regulating the Queer Family.” This terminology is frequently used, however some scholars prefer to make similar distinctions by distinguishing between “clinic inseminations” and “home inseminations,” particularly as the insemination is not always conducted by the “self” in question (See for example, Epstein, ““Married, Single, or Gay?””).

²⁰² Royal Commission on New Reproductive Technologies, *Proceed with Care*, 474.

²⁰³ *Ibid.*, 467.

²⁰⁴ *Ibid.*, 42–43.

²⁰⁵ Equality for Gays and Lesbians Everywhere (EGALÉ), “Public Hearing Transcripts for the Royal Commission on New Reproductive Technologies,” September 19, 1990. Box: RCNRT RG33-154 1993/94/531, file PH-15-OT. Library and Archives Canada, Ottawa, ON. For more information about EGALÉ’s operations during this period, see Miriam Smith, *Lesbian and Gay Rights in Canada: Social Movements and Equality-Seeking, 1971-1995* (Toronto: University of Toronto Press, 1999).

the Halifax Lesbian Committee on New Reproductive Technologies, participated in the Commission's public hearings in Halifax in October 1990; however they were not invited back to a private Commission session with "Community Leaders and Organizations" in June 1991, unlike the Women's Health Education network, the Nova Scotia Advisory Council on the Status of Women, the Atlantic Research Centre for Mental Retardation, and the Metro Area Family Planning Association, groups that has also testified at the public hearings in Halifax.²⁰⁶

No matter the cause, the relative absence of varied LGBTQ advocacy in the Commission hearings may have had the consequence of limiting the ways that LGBTQ people were included in the Commission's work and future legislation that took *Proceed with Care's* recommendations as a starting point. Self-insemination and the protection of woman-led families was a notable concern of the Commission, more as a matter of non-discrimination than as a means to enable access. At the time of the Commission, the equality struggles of LGBTQ people in Canada using the equality provisions of the Canadian Charter of Rights and Freedoms were just beginning, and while attention was being paid to the elimination of discriminatory practices, less attention was given to expanding notions of the family and parenthood to challenge longstanding heteronormativity. To this end, addressing access to donor conception meant that the Commission recognized that lesbian intended parents should not be discriminated against, but again, through the advancement of the biomedical model of infertility, the Commission quietly affirmed and reaffirmed that the deserving, legitimate (and potentially state-funded) users of ARTs are heterosexual married couples with a medical history of infertility. Furthermore, the Commission did not consider the potential of surrogacy and gamete donation to enable gay men

²⁰⁶ Royal Commission on New Reproductive Technologies, *Proceed with Care*, 1206–7. For more about the participation of the Halifax Lesbian Committee on New Reproductive Technologies, see Scala, "IVF Policy and the Stratification of Reproduction in Canada."

to conceive biologically related children, nor did it discuss the importance of relationship recognition to recognize LGBTQ families within the context of Canadian law. While this is, in part, attributable to the articulation of the interests of lesbian mothers (and the non-articulation of other relevant LGBTQ issues), it remains that the medicalized framing of ARTs precluded broader social understandings of involuntary childlessness that would have better included LGBTQ Canadians.

Egg Donors and Surrogates

Following Thelma McCormack, the emphasis on the heterosexual couple or the nuclear family renders the third-party often involved in the use of reproductive technologies to the status of a non-person.²⁰⁷ In the case of the Royal Commission on New Reproductive Technologies, this was certainly true. While gamete donors were explicitly identified in the Commission's mandate and *Proceed with Care* examined the contributions of donors and surrogates, their interests were not taken seriously in the public consultations. Only one anonymous donor was included in any of the public or private hearings of the Commission. The Commission thus assumed knowledge of donors concerns based on perceived social, ethical, and legal challenges, but with the exception of some research conducted on donor insemination and the one donor who testified before the Commission, donors' voices simply were not heard. This absence is in part attributable to the "clandestine" and commercial nature of gamete donation at the time of the Commission,²⁰⁸ but nevertheless, donors were largely described in the Commission report as disembodied providers of reproductive material, and as objects, rather than subjects actively

²⁰⁷ Thelma McCormack, "Public Policies and Reproductive Technology: A Feminist Critique," *Canadian Public Policy*, 14, no. 4 (1988).

²⁰⁸ Interview with Rona Achilles, February 9, 2012.

involved in the use of reproductive technologies.

As to sperm donation, the only consideration given in *Proceed with Care* is about the need to limit compensation, and to protect the privacy of donors in the procurement and use of their donation. There was one recommendation suggesting that law be made to “ensure that the donor’s rights and responsibilities of parenthood are severed by the act of sperm donation” although this was seemingly included in order to protect the families of donor-conceived people, rather than the donors themselves. Again, only one donor was ever consulted in the Commission’s work, and his engagement was largely with a group representing donor-conceived people and their families. Heard with testimony on the challenge of knowing one’s origins, and the need for legal protection for donor-conceived families, concerns about how donation might change the donor’s own family life come across in the report as relatively minor.²⁰⁹ *Proceed with Care* paid slightly more attention to egg donation likely due to the invasive nature and significant physiological consequences of egg donation relative to sperm donation. As noted in chapter two, the differences between sperm and egg donation are extensive, and the risks and potential side effects of egg donation are exceptional particularly in comparison to sperm donation. The Commission also included a short section on “donors” in its chapter on the use of eggs and embryos, suggesting that counselling for donors might be useful.

Overall, the Commission took a very strong position on egg donation, expressing concern about the health risks that donors face, as well as the potential commodification of human life that might come with any commercial trade in gametes. *Proceed with Care* discussed the potential health risks associated with egg donation, and suggested that ovarian stimulation and egg retrieval should not be performed on otherwise healthy women, unless the woman in

²⁰⁹ Royal Commission on New Reproductive Technologies, *Personal Experiences with New Reproductive Technologies*.

question is already undergoing medical treatment that might harm her fertility (i.e., chemotherapy). The report also examined the potential commercialization of egg donation, asserting that while egg donation is problematic due to the potential risks to women's health, the practice is even more problematic when payment is involved, recommending that commercial gamete donation be prohibited by law.²¹⁰

Although *Proceed with Care* included an examination of the health effects of egg donation and the potential economic exploitation of different circumstances for donation, the Commission's examination of egg donors focused largely on egg sharing. Egg sharing occurs when a woman undergoing IVF treatment including egg retrieval donates her "surplus" eggs to another infertility patient. In this case, where the donor is herself a patient, the experiences of the theoretical donor are seen as nuanced and complex, involving a number of relevant concerns (i.e., potential for coercion, psychological distress, the nature of informed consent) supported by relevant research. The agency of the donor-patient was recognized, and their informed consent was prioritized. This stands in stark contrast to the Commission's limited discussion of other egg donors, not otherwise undergoing a medical procedure, who were assumed to be at significant physiological risk and without the capacity for informed consent because the risks they might face in donation were too great for anyone to be able to consent. Due to egg donation's "attendant risks, on an otherwise healthy woman for the benefit of someone else, particularly in the absence of information about the long-term effects of these procedure" the Commission proposed a ban on altruistic as well as commercial egg donation. This is particularly notable given that there is no research on egg donation cited or conducted by the Commission, and no consultations with egg donors themselves. This is not to say that egg donation is a safe

²¹⁰ Royal Commission on New Reproductive Technologies, *Proceed with Care*, 587–94.

procedure, but rather that the needs and interests of donors *qua* donors were not given the same consideration as infertility patients engaging in egg sharing.

The interests of surrogates, like those of egg donors, were largely presumed by the Royal Commission, and recommendations were made that aligned with the positions of certain feminist actors and religious groups opposed to reproductive technologies with limited consideration of the position of surrogates themselves. Surrogacy was of particular interest to the feminists who had called for the Commission. The case of *Baby M.* in the United States had caught the public imagination and interest had grown around the socio-legal implications of “contract motherhood.” The Commission funded two studies on surrogacy including one bibliography and another “legal and ethical analysis,” dedicating a chapter of its final report to the issue. In this chapter, the Commission recommended that surrogacy arrangements should be unenforceable, that commercial surrogacy be illegal, and that non-commercial surrogacy be prevented through sanctions against medical practitioners, brokers, and others. In short, the Commission condemned surrogacy (and especially commercial surrogacy) for a number of reasons including the potential for exploitation in such arrangements, the possibility for the commodification of children and reproduction, and assumed psychosocial consequences for surrogates.

The Commission’s arguments about exploitation in surrogacy arrangements—its reasoning—were presented as a matter of fact, despite the existence of “little empirical research on preconception arrangements in Canada and elsewhere.”²¹¹ Where evidence did exist, the Commission report noted that what research did exist at the time was of “limited reliability.”²¹² Rather than funding its own empirical study, the Commission largely relied on a 1985 study of approximately 118 cases of preconception arrangements that in some way involved Canadians.

²¹¹ *Ibid.*, 664.

²¹² *Ibid.*, 672.

Perhaps the most significant finding of this research (which was conducted for the Law Reform Commission of Canada by Margrit Eichler and graduate student Phebe Poole) was that there were significant disparities in the socio-economic circumstances of surrogates and intended parents.²¹³ Taken together with anecdotal evidence heard by the Royal Commission, this study was taken to be an indication of commercialization and exploitation in surrogacy arrangements,²¹⁴ even though no reports of exploitation or coercion were made in Eichler and Poole's work, and the one surrogate who participated in the Commission's "armchair" sessions spoke positively of her experience. In fact, she chose to participate in the session in order to "encourage that pre-conception arrangements be legalized in Canada and to dispel the myths about women who choose this arrangement."²¹⁵ In a Commission seemingly dedicated to evidence-based research, *Proceed with Care*'s unsupported claims about surrogacy appear particularly problematic, and suggest that the evidence-based framework of the Commission was very selectively applied.

In addition to a lack of research, the Royal Commission did not adequately consult with surrogates themselves. Rather than use the narratives of surrogates to describe potential exploitation and negative psychosocial consequences of surrogacy arrangements, *Proceed with Care*'s chapter on surrogacy contained a number of quotations from feminist organizations opposed to surrogacy, including the Canadian Research Institute for the Advancement of Women (twice), the National Organization of Immigrant and Visible Minority Women of Canada, and

²¹³ The data regarding the socioeconomic disparities and other demographic data was based on a subset of the 118 cases identified in the research that focused on the case files of one American surrogacy broker. Margrit Eichler and Phebe Poole, *The Incidence of Preconception Contracts for the Production of Children Among Canadians: A Report Prepared for the Law Reform Commission of Canada* (Toronto: Ontario Institute for Studies in Education, 1988), 35.

²¹⁴ Royal Commission on New Reproductive Technologies, *Proceed with Care*, 572.

²¹⁵ Royal Commission on New Reproductive Technologies, *Personal Experiences with New Reproductive Technologies*, 9–10.

the Canadian Federation of Business and Professional Women's Clubs, the *Fédération des femmes du Québec*, and the Canadian Federation of University Women (as well as the decidedly non-feminist Archdiocese of Vancouver). There was no representation of quotations from the surrogate who did participate in the hearings, or any substantiated claim about the experiences of surrogates. Like gamete donors, there was no mobilization of surrogates at this time, but regardless surrogates were taken by the Commission to be inherently exploited, non-consenting subjects of assisted reproductive technologies, rather than potential agents involved in making choices about their reproduction. The potential legitimacy of surrogacy arrangements was never really considered, and the Commission's recommendations on this issue come across more as a concession to feminist stakeholders than a measured consideration of the interests of women, surrogates and people conceived using ARTs.

Additionally, when taken together with the Commission's dismissal of adoption as a viable option for infertile Canadians, the recommendations against egg donation and surrogacy suggest a maternal bioessentialism in *Proceed with Care*. Whether or not the Commission was justified in its suggested restrictions on surrogacy and egg donation, if implemented, these recommendations would mean that women would (except in rare cases where donor eggs from infertility patients were available) have to reproduce using their own bodies, using their own eggs. Women would have to be the biological, gestational mothers to their own children, whenever possible, and given that adoption was seen as a highly unavailable option, maternity could only come to those able to carry or conceive using their own biological material (perhaps with donor sperm). The Commission did raise the possibility of embryo donation, but the Commission found that Canadian "IVF programs are not set up to deal with implications of

embryo donation.”²¹⁶ IVF then, was presented as a treatment for infertility to the exclusion of other practices, propagating the understanding that involuntary childlessness was best “cured” through medical techniques that use one’s genetic material to create a child. In this way, the Commission advocated for people trying to have genetically-related children, validating genetic relationships as an important form of kinship, and the most desirable way to have a child.

The Commission’s recommendations about LGBTQ Canadians, surrogates, and donors demonstrate underlying concerns about reproductive technologies and the future of Canadian families. For LGBTQ people, donor insemination for lesbians was the only potential means of using ARTs theorized by the Commission (i.e., gay fatherhood was not imagined, nor did the Commission address the potential to open up adoption legislation to LGBTQ parents). The inclusion of lesbian mothers in the work of the Royal Commission is important, and marked burgeoning recognition of LGBTQ families, but in a way limited to reasons of non-discrimination rather a need to reimagine the bounds of what constitutes family life. The Commission’s discouraging of surrogacy and egg donation can be thought of along the same lines, insofar as recognizing surrogates and donors as important subjects and actors in the use of reproductive technologies would challenge conventional understandings of what reproduction entails, and who is, and should be included in conceptions of the family. The failure to adequately engage with surrogates and donors in the Commission’s consultative work is indicative of a view that only those who are actively working to build their families are legitimate reproductive citizens worthy of consideration.

²¹⁶ Royal Commission on New Reproductive Technologies, *Proceed with Care*, 599.

Inclusion and the Ideal (Assisted) Reproductive Citizen

By the time the Royal Commission was announced, a small number of Canadians were already mobilizing around issues related to assisted reproduction, notably families who had conceived one or more children using donor sperm and those experiencing infertility. By the mid-1980s, these groups had already started to mobilize, and were consequently ready to make their cases to the Commission. These groups were well-reflected in the Commission's work, including its consultations, research, and report. Unlike LGBTQ Canadians, surrogates, and gamete donors, infertile people and donor-conceived families benefited from the biomedical frame of the Commission and its understanding of reproductive technologies as neutral and necessary treatment for infertility. The biomedical understanding of ARTs meant that these groups were understood as the appropriate, deserving benefactors of assisted reproductive services.

Infertile Canadians

As noted above, infertile Canadians and infertility were well-represented in the work of the Commission. The focus on infertility and infertile families advanced by the Commission's biomedical frame was also buttressed by the significant representation and organization of infertile Canadians themselves. When the Royal Commission was called, there were a few small groups doing advocacy work for infertile people, but they were rather limited in scope and number. One organization, the Infertility Awareness Association of Canada (IAAC), would come to represent the interests of infertile people for the Commission and, due to their articulation of their interests and their alignment with a number of medical associations, to validate the Commission's biomedical frame.

The organization that would come to be known as IAAC was founded as the Infertility

Self Help Support Group in Ottawa in 1983. Co-founded by three infertility patients, the Infertility Self Help Support Group held support group meetings in Planned Parenthood's offices with the assistance of director Norman Barwin (a fertility specialist and then-President of Planned Parenthood Ottawa).²¹⁷ In 1990, just as the Commission was beginning its work, the Infertility Self Help Support Group changed its name to the Infertility Awareness Association of Canada. The organization received a three-year \$450,000 grant from Health Canada's Health Promotion Directorate,²¹⁸ and by the summer of 1990, it was expanding to include a number of other emerging support groups, to create a national newsletter, to create a help and information hotline, and to establish new branches. Until that point, the group had been focused almost exclusively on creating a network of support for infertile people, but it was poised to speak on behalf of infertile Canadians from coast-to-coast-to-coast when the well-timed injection of funding from the federal government increased its capacity to do so.

IAAC was active in the public consultations and research of the Commission, with IAAC representative Nancy Jackson participating in both the public hearings of the Commission (as an individual) and in the Search Conference in Wolfville (as a representative of IAAC).²¹⁹ Furthermore, two representatives of IAAC, National Coordinators Trish Maynard and Paula Timmons were invited to participate in the one of the Commission's research panels, and Dr. Barwin (although he testified in relation to his work with Planned Parenthood Canada) also spoke to the interests of infertile Canadians and engaged extensively with the Commission. Other representatives of infertile Canadians also participated in the Commission's work, for example,

²¹⁷ Infertility Awareness Association of Canada, *Response to Bill C-47 and "New Reproductive and Genetic Technologies: Setting Boundaries, Enhancing Health"* (Ottawa: Infertility Awareness Association of Canada, September 1996).

²¹⁸ "A Healthy Canada," *The Globe and Mail*, October 11, 1990, A16.

²¹⁹ Royal Commission on New Reproductive Technologies, *Proceed with Care*, 1198–201.

Jan Silverman (an infertility counsellor and founder of “Infertility – Facts and Feelings”) participated in the Commission’s Search Conference, and Diane Allen (who had just co-founded IAAC’s Toronto branch) testified at the Commission’s public hearings in Toronto. The Kingston Infertility Network also participated in the public hearings, and there were numerous written and oral submissions from people who had personally experienced infertility in some way.²²⁰

The infertility lobby was strong, because of its established support groups, its newfound organizational capacity, and its clear articulation of interest in expanding access to ARTs. IAAC board members and representatives not only spoke to the Commission, but also wrote letters to the editor in newspapers across the country,²²¹ and released statements to ensure that the voices of IAAC’s membership were heard.²²² Additionally, its links to Dr. Barwin (and through him, to a broader network of physicians) enabled IAAC to position itself alongside the Society of Gynaecologists and Obstetricians of Canada, the Canadian College of Medical Geneticists, and the Canadian Fertility and Andrology Society, as experts ready to speak to the interests of infertile people. Indeed, IAAC’s response to *Proceed with Care* was made as a joint statement together with these medical professional associations, as if their interests were one and the same.²²³

It is clear that IAAC quickly positioned itself as an authoritative national interest group speaking to the interests of infertile people, with the support of the doctors who could help them. This meant that while IAAC was (and continues to be) actively engaged in the day-to-day

²²⁰ Ibid., 1177–251.

²²¹ Trish Maynard and Paula Timmons, “Does Not Speak for Them,” *The Globe and Mail*, January 21, 1992, A14; Jamie Cameron, “Reproductive Choice,” *The Globe and Mail*, February 22, 1992, D7.

²²² Infertility Awareness Association of Canada, “IAAC Asks Who Determines What’s ‘Necessary,’” *Canada Newswire* July 19, 1993; Infertility Awareness Association of Canada, “IAAC Supports Royal Commission Announcement on Infertility Clinic Practices: Cites Need For National Infertility Standards,” *Canada Newswire*, 28 April 1993.

²²³ “A Joint Statement by Four National Associations,” *Canada Newswire*, November 30, 1993.

management of infertility and its devastating consequences, at the same time, it did so with the understanding that infertility is a medical condition, that is, a disability best addressed through Canada's health care system. The biomedical focus of the Commission was not, by any measure, IAAC's doing, as the die for the biomedical approach of the Commission may have already been cast. At the same time, however, the prevalence of IAAC representatives at public hearings, and in the press meant a visibility of the very sympathetic position of Canadians suffering with infertility.

It is important to note, however, that the Royal Commission did not simply take up IAAC's interests. In its initial response to the Royal Commission, IAAC, together with the Society of Gynaecologists and Obstetricians of Canada, the Canadian College of Medical Geneticists, and the Canadian Fertility and Andrology Society outlined support for the Commission's work, but also concern about recommendations that might inhibit access to ARTs, including the elimination of public funding for IVF in all cases but bilateral fallopian tube blockage, and restrictions on access to donor gametes. The Commission's attempts to balance individual autonomy with collective concerns meant that there were recommendations about tempering what was then unregulated access to reproductive technologies, and while IAAC supported some measure of regulation, the emphasis was on concerns about limiting the capacity of infertile Canadians to use ARTs to build their families.²²⁴ IAAC was interested in extending the language of reproductive choice used by the Commission even further than the Commission had taken it.

²²⁴ Ibid.

Donor-conceived Families

The Royal Commission on New Reproductive Technologies took a special interest in donor conception, focusing a volume of research studies as well as a chapter on the issue. Donor-conceived families, and more specifically, donor-conceived children were seen to need protection from the misuse of ARTs, and a number of recommendations were made to this end, including the recommendation for an entire subcommittee of the proposed National Commission on New Reproductive Technologies to address issues of donor conception. Things did not start out this way, as according to Rona Achilles (who completed the first Canadian study on donor-conceived families before the Commission began its work), “the Royal Commission did not get how important donor insemination was [...]. IVF was nothing; really, really, small numbers and a really, really small success rate, whereas donor insemination was incredibly prevalent comparatively, and no one seemed to get that.”²²⁵ However, Achilles was hired by the Commission to conduct research for the Royal Commission and to facilitate a hearing, and subsequently the interest of the Commission in donor conception grew.

Throughout the Royal Commission’s work, Achilles would be a key figure articulating the needs of donor-conceived people, and coordinating dialogue between commissioners, Commission research staff, and donor-conceived people, the latter largely represented by the (now defunct) New Reproductive Alternatives Society. The New Reproductive Alternatives Society (NRAS) was established in 1987 after a frequent sperm donor and his wife attempted to get information about the children conceived via his sperm. With no real responses from the clinic, the donor contacted a lawyer in Vancouver. The lawyer put out a “Donor Insemination Alert”²²⁶ about potential legal action that eventually reached Shirley Pratten, a mother who had

²²⁵ Interview with Rona Achilles, February 9, 2012.

²²⁶ Elizabeth Noble, *Having Your Baby by Donor Insemination* (Boston: Houghton Mifflin, 1987), 309.

conceived via donor insemination. Pratten and other parents, as well some sperm donors, contacted the Vancouver-based lawyer, who wrote to the clinic about their particular concerns, most notably a lack of communication on the part of the clinic. The parents of donor-conceived children were concerned that they would not be able to procure information about their donors for their children. Donors and their families were interested in keeping open lines of communication with the clinic to know how many children were conceived with their sperm, and in some cases, to update any changes to their health information.²²⁷ When the clinic failed to respond again, the lawyer held a press conference in Vancouver in 1987 calling “on the government and the medical profession to regulate” the practice of sperm donation.²²⁸ After the press conference, the lawyer proposed forming an organization in order to keep the momentum of the group going, and the NRAS was born. In addition to the immediate goals of pressing the clinic in question to communicate with donors and lobbying for regulation of donor insemination, the NRAS was imagined, according to Pratten, as a “vehicle to put forward the needs of the offspring, and what we as parents felt their needs were, and should be, and what should be protected around the records.”²²⁹ The newly founded NRAS held a small self-funded conference in Vancouver later in the year, and then quickly got to work on another.

The first conference had attracted the attention of the Human Rights Law Section of the federal Department of Justice. The Department of Justice allocated \$5000 to fund the second conference, expressing interest in the rights of donor-conceived people, particularly under the newly implemented equality rights section of the Canadian Charter of Rights and Freedoms. The second conference was much bigger than the first, in part due to the funding from Justice, and

²²⁷ Interview with Shirley Pratten, March 13, 2012

²²⁸ Ibid.

²²⁹ Ibid.

put the NRAS on the media and federal government radar as an important stakeholder in the emerging field of reproductive technologies. At the same time the NRAS was working as a support group for donor-conceived families, holding annual barbeques, and helping donor-conceived children to meet one another. The experience of knowing other families who had been involved in donor conception and especially donor insemination was an important part of the group, especially to let the children know that there were other children born like they were.” As noted by Shirley Pratten, the group “was unique, and there wasn’t another one like it in Canada of its kind at that time.”²³⁰

By the time that the Royal Commission was called, the NRAS had been around for two years, articulating its interests to the press, to the public, and to the Department of Justice. When the Royal Commission was called, and the search conference in Wolfville was held to identify areas of research, donor insemination was not immediately identified as a key element of its work. No representatives of the NRAS were invited to the search conference, nor was there significant representation from people who had used or had been conceived with donor gametes in the public hearings. Shirley Pratten testified to the Commission in Victoria on the last day of its public hearings, November 29, 1990. However, when the Royal Commission started its research work and hired Rona Achilles, there was new interest in donor conception, in part because of the findings of Achilles’ doctoral research. Achilles invited the New Reproductive Alternatives Society to participate in a “Commission Roundtable Discussion” with the commissioners. Shirley Pratten has stated about this roundtable discussion: “we got their attention.”²³¹ Pratten and the NRAS were primarily concerned about the climate of secrecy around donor conception, a lack of record keeping on the part of clinics, and the inability of

²³⁰ Interview with Shirley Pratten, March 13, 2012.

²³¹ Ibid.

children conceived this way to access any information about their genetic origins, including relevant medical information. Informed also by Achilles' research, the Commission took up a number of these concerns, noting that secrecy should be discouraged, that detailed records should be kept, and that donor information should be available to donor-conceived people for medical reasons only. Quickly, the NRAS became a key stakeholder group, and Pratten their national spokesperson.

The Commission then, was integral to the emergence of interest groups in this field. People who had long thought that they were alone in their experiences of infertility, or in the challenges that their donor-conceived family was facing, started to form support groups and interest groups to not only share their experiences, but also to express clear positions to the Royal Commission. Although some of these groups had formed before the Commission, the public hearings and other consultative endeavours gave impetus to infertile people and parents of donor-conceived children to clarify and make known their opinions on various aspects of reproductive technologies in Canada. The Commission offered opportunities for consultation that enabled the concretization of emergent interest group actors, and marked certain groups, such as the NRAS and IAAC as integral to policy formation. What this meant was recognition, almost an endorsement, of the positions that they had presented. The Royal Commission effectively recommended that the federal government take action, and their subject-position as important actors in the governance of ARTs was vindicated.

Summary

What emerges from the work of the Royal Commission, then, is the affirmation of ARTs as a matter of medicine and science, largely for the purposes of addressing the needs of infertile

people. Infertility in this framework, is a medical condition, experienced by heterosexual couples, to be treated through the use of reproductive technologies. This position, this biomedical model, allowed for the emergence of a then-new sort of biological-reproductive citizens, empowered to make claims about the regulation of reproductive technologies on the basis of a medicalized experience of infertility. In adopting a biomedical frame, the Commission was able to make relatively small commitments to addressing public health, while establishing that assisted reproductive technologies are primarily a remedy for infertile couples (and research activities a means to aid the same group). Using liberal rights discourse, and particularly a language of “choice” in reproduction, understandings of the collective interests of Canadians in the social, ethical, and legal implications of ARTs were made peripheral to medical and scientific perspectives that privileged the individual-as-patient over the social-collective. In doing so, the Commission shifted away from discursive understandings of reproductive technologies as an urgent social issue and worked to individualize ARTs. More clearly, the Commission’s biomedical framework made what might have been an issue of social policy, a privately experienced medical one. As explored in subsequent chapters of this dissertation, the validation of a biomedical and individualized approach to reproductive technologies enabled by the Royal Commission would lead to a policy framework in which individual citizens who are involuntarily childless are seen to be responsible for obtaining infertility treatment, either by acquiring a particular medical diagnosis or by financing their own treatment. The emphasis on individual access to infertility treatments in order for heterosexual couples to have genetically related children pointed to the ongoing social importance of biological ties, and relatedly, a minimization of alternative means of family building, like adoption.

The use of the biomedical model using evidence-based medicine, and its application to an

“ethics of care,” is another key element of the Commission’s legacy. Although the individualization and medicalization of assisted human reproduction evident in the Commission’s work is clear, it is important to note the Commission’s continual engagement with ethical arguments, and its attempts to protect the interests of Canadians, for example, through its recommendations about surrogacy and egg donation. The repeated articulation of the Commission’s intention to act in the public interest, while ultimately promoting an individualistic approach to citizens’ use of reproductive technologies, suggests that the Commission struggled with addressing vestiges of social welfare while upholding the role of private-for-profit clinics as the providers of health care services that the state was unwilling to provide. Cutbacks to the health care system, the use of experimental procedures on women’s bodies, and the expansion of commercial interests in the use of ARTs were simultaneously addressed through the application of evidence-based medicine in the name of the public interest.

The legacy of the Commission is also found in its identification of relevant stakeholders *qua* reproductive citizens. Prior to the calling of the Royal Commission, potential parents, donor offspring and their families were not conceptualized in Canadian law and policy as subjects necessitating governance. However, with the validation of their subject-positions through their engagement with the Royal Commission and the Commission’s re-articulation of their concerns, these groups emerged as new political subjects whose activities and experiences required regulation. This did not preclude addressing some of the needs of lesbian and single women, although the interests of LGBTQ Canadians were narrowly conceived, including only the need for access to donor insemination (including self-insemination) and some legal protections for women-led families. Without advocacy groups to articulate their interests, the interests of donors and surrogates were also narrowly conceived, and consequently, donors and surrogates were

largely imagined as marginal contributors to infertility patients' use of ARTs. Recognizing donors, surrogates, and LGBTQ people as important and engaged actors in the use of ARTs would have challenged conventional models of the family, and the use of these technologies, through the advancement of the medical model of infertility, worked to reaffirm the two-parent, nuclear, heterosexual norm.

The legitimation of groups representing infertile people and donor-conceived families may have occurred, in part, because they were not contesting who was a reproductive citizen in Canada at the time, rather, they were largely challenging how middle-to-upper class, heterosexual Canadians could conceive. The interests of infertile Canadians did not fundamentally challenge family norms, or the importance of biological ties; rather they reiterated the importance of having one's own children within the context of a nuclear, heterosexual family. Infertile Canadians were seeking out the fulfillment of conventional Canadian family life, only they needed to use ARTs to do so. As for donor-conceived people and their families, their experiences challenged bio-essentialism and kinship to a degree, although their interest in acquiring information about their donors worked to validate the importance of knowing one's biological origins. These groups did contain some LGBTQ families, however neither the NRAS nor IAAC worked to challenge the two-parent, biologically based model of kinship, and instead tried to expand longstanding constructions of the ideal reproductive citizen to include their experiences.

The Royal Commission on New Reproductive Technologies thus set the stage for legislation-to-come. As a publicly funded, high profile investigation of ARTs, and through its work and engagement with interested parties, the Royal Commission provided a particular frame of analysis—a biomedical lens focused on infertile couples and the children they conceived—

that would later be repeated and re-inscribed. The Royal Commission's work contributed, at least in part, to the neoliberal turn in reproductive citizenship described in chapter two, and a model for governing reproductive technologies based on legitimacy of the individually diagnosed would-be parent largely responsible for funding their own care. Further, the exclusions of marginalized populations (including single women, LGBTQ people, those with low socio-economic status, and others) from accessing ARTs replicates longstanding exclusions of marginalized populations from parental entitlements. Overall, the Royal Commission identified models of deserving and undeserving users of reproductive technologies, and consequently, reproductive citizens, that would inform future policy development.

Chapter Four: Setting Boundaries?

The legacy of the Royal Commission was deeply felt throughout the 1990s and later, as the *Assisted Human Reproduction Act* came into being. The absence of certain voices, and the privileging of others that emerged in the Commission would occur in different ways over time, and variations on the theme of the individual, medically-infertile citizen-subject would be repeated again and again throughout the legislative process. This was the case in the mid-1990s, when officials at Health Canada started to take steps towards legislation, first with a voluntary moratorium, and then with proposed legislation (Bill C-47) and a discussion document (*Setting Boundaries, Enhancing Health*) outlining the scope of future regulation. Although C-47 did not pass, this period (between 1995 and 1997) was marked by important interventions in the regulation of ARTs that would continue the trends of variously recognizing and disregarding the reproductive citizenship of diverse actors that had occurred in the work of the Royal Commission.

As the federal government was formulating this three-phase approach, growing markets for sperm, eggs, and surrogates were taking root. Infertile people with the financial means to do so (or through a measure of public insurance in Ontario) were engaging in commercial egg donation and surrogacy arrangements, as the relevant technologies became increasingly available in Canada. There were more and more LGBTQ Canadians accessing reproductive technologies than ever before, and despite discrimination faced in the clinics, there were new inroads made to access. At the same time, infertile Canadians were reorganizing, aligning themselves more closely with the specialists of reproductive medicine, pharmaceutical companies, and biotechnology firms that would ultimately help them try to conceive, while donor-conceived

families were working to make the voices of their children and their families' needs heard without stepping on the toes of those seeking to build their families using ARTs.

This chapter examines reproductive citizenship and the governance of ARTs in the period between 1995 and 1997. It proceeds in two parts. In its first section it examines the three-phase approach to governing ARTs taken by the federal government in the mid-1990s. It explores each phase in turn, identifying not only how the phase proceeded, but also how it intersected with broader trends in reproductive citizenship, namely neoliberalism, individualism, and the advancement of biomedicine. It argues that all three phases worked to uphold the status quo in the governance of ARTs, namely an open market in reproductive services that privileged biomedical actors and failed to take decisive action to legislate or regulate. Following the examination of the three-phase approach, the chapter turns to a discussion of how citizen groups, namely those representing LGBTQ people, egg donors and surrogates, infertile people, and donor-conceived families were included and excluded in this policy process as well as how these groups otherwise articulated their interest in the use and governance of ARTs during this period. Effectively, advocates of infertile people and donor-conceived families were negotiating access to reproductive technologies, inclusion in policy development, and the need for regulated access to donor information, that is to say, negotiating the terms of use of reproductive technologies as legitimate reproductive citizens. At the same time, surrogates, donors, and LGBTQ people continued their engagement with reproductive technologies without being recognized as relevant actors. Overall, the chapter demonstrates that the individual, biomedical focus of the Royal Commission emerged clearly in federal attempts to govern ARTs in the mid-1990s, although the experiences of stakeholders varied.

A Three-Phase Approach to Governing ARTs

The federal government responded to the Royal Commission with a “three-phase” approach comprised of a voluntary moratorium, proposed legislation, and promises of regulation-to-come. The three-phase approach was developed as a means to govern ARTs in the public interest to protect vulnerable citizens, although at the same time, in its failure, it reinforced the understanding that infertile Canadians and clinicians should continue to freely use and develop assisted reproductive services in the context of a largely unregulated market.

The Royal Commission’s report was issued in late 1993, in the immediate aftermath of the 1993 federal election, and it took two years for the new Liberal government to issue a response. It was in 1995, then, that Minister of Health Diane Marleau announced a voluntary moratorium (sometimes referred to as the “interim moratorium”) banning nine of the practices seen to be most abhorrent, including: sex selection for non-medical reasons; commercial surrogacy arrangements; buying and selling of gametes and embryos; egg donation in exchange for discounted or free in-vitro fertilization services (egg sharing); germ-line genetic alteration; the creation of a fetus in an artificial womb (ectogenesis); cloning human embryos; the formation of animal-human hybrids (chimera); and the retrieval of gametes from cadavers and fetuses for purposes of donation, fertilization and research.²³² In order to promote compliance, Marleau also announced related restrictions on federal funding to organizations and individual researchers engaged in the practices covered by the moratorium.²³³ The announcement also suggested that a

²³² See Canada, Health Canada, “Health Minister Calls for Moratorium on Applying Nine Reproductive Technologies and Practices in Humans. News Release,” July 17, 1995; Montpetit, “Policy Networks, Federalism and Managerial Ideas,” 66; Baylis and Herder, “Policy Design for Human Embryo Research in Canada: An Analysis (Part 2 of 2),” 109; Cattapan, “Rhetoric and Reality.”

²³³ Derek Ferguson, “Ottawa May Ban Human Eggs Sale Minister Vows to End ‘exploitation’ of Women in ’95,” *The Toronto Star*, December 13, 1994, A1.

more “comprehensive approach”²³⁴ to governing reproductive technologies was in development, including legislation and regulation that would take up the recommendations of the Royal Commission to criminalize some technologies and create a regulatory framework for others.

As a voluntary measure, the moratorium was not enforceable, and incentives for compliance were practically nonexistent. The moratorium was defied by clinicians and researchers who were open about their continuation of commercial practices in gamete donation and surrogacy,²³⁵ suggesting in one case that without legislation there was “no legal reason”²³⁶ to adhere.²³⁷ Without compliance, critics (including Patricia Baird) suggested that the moratorium simply could not go far enough, and that the absence of legislation was permitting the exploitation of women’s bodies, the commercialization of human life, and otherwise reprehensible aspects of reproductive technologies to continue.²³⁸ The one incentive for compliance—that federal funding would be withheld from those acting in breach of the moratorium—had little real value, as it did not apply to private fertility clinics, most of the banned technologies were not occurring (six out of nine “had never been done in Canada”), and there was not one research grant at the time being funded by the federal government which might be subjected to restriction under the moratorium.²³⁹

The voluntary approach was a surprise to those expecting the federal government to respond rapidly to the Royal Commission with a broad legislative and regulatory framework.

²³⁴ Canada. Health Canada, “Health Minister Calls for Moratorium on Applying Nine Reproductive Technologies and Practices in Humans. News Release.”

²³⁵ Françoise Baylis and Matthew Herder, “Policy Design for Human Embryo Research in Canada: A History (Part 1 of 2),” *Journal of Bioethical Inquiry* 6, no. 2 (2009): 114.

²³⁶ Linda Hurst, “Techno-Life: Make Babies in a Test Tube? That’s Easy Compared to Making Laws about Making Babies in a Test Tube,” *The Toronto Star*, August 20, 1995, F1.

²³⁷ “Fertility Industry Defiant: Won’t Observe Ban on High-Tech Baby-Making Techniques,” *The Hamilton Spectator*, July 28, 1995, A1.

²³⁸ Hurst, “Techno-Life.”

²³⁹ Edward Greenspon, “Ottawa Backs Off Test-Tube Issues: Marleau Prefers Voluntary Curb,” *The Globe and Mail*, July 28, 1995, A1.

The cautious approach taken by the federal government was met with much critique, as it was broadly seen as a policymaking placeholder on a controversial issue, intended to give the new Liberal government time to make policy on ARTs in the wake of the Royal Commission report and the 1993 election.²⁴⁰ However, the need to “buy time” to develop legislation may also have been influenced by the state of federal-provincial relations in health at the time. In February 1995, just a few months before the announcement of the voluntary moratorium, the federal budget was tabled in Parliament including significant reductions to provincial health transfers. The announcement of the moratorium in this context may be viewed as temporary compromise to both allay provincial concerns about federal interventions into health and to address pressures to respond to *Proceed with Care*. The federal government could start to take action by trying to restrict some activities without requiring provincial assent or incurring the costs of more comprehensive legislation.

The voluntary moratorium, however, may also be explained by an ongoing commitment to the self-regulation of biomedical actors on the part of the federal government. At the time that the moratorium was announced, a little-known bill, Bill C-62 was making its way through Parliament. Bill C-62, the Regulatory Efficiency Act, “would have allowed companies to cut individual deals with government departments to completely bypass environmental, health, and safety legislation.”²⁴¹ Although the Bill was developed with the goal of reducing the costs of making and enforcing regulation and “to enable innovation,”²⁴² clinics, research facilities, biopharmaceutical companies, and biotechnology firms involved with reproductive technologies

²⁴⁰ This would be the explanation given for the moratorium when legislation was tabled the following year. Canada, Health Canada, *New Reproductive and Genetic Technologies: Setting Boundaries, Enhancing Health* (Ottawa: Minister of Supplies and Services, 1996).

²⁴¹ Joel Lexchin, “Hear No Secrets, See No Secrets, Speak No Secrets: Secrecy in the Canadian Drug Approval System,” *International Journal of Health Services* 29, no. 1 (1999): 168.

²⁴² Hurst, “Techno-Life.”

would have been able to engage in self-regulation by developing agreements with the federal government under the terms of C-62.²⁴³ This may have allowed for the deregulation of industries that might otherwise have significant “legislative hurdles.”²⁴⁴ Proposing a voluntary moratorium, rather than criminal legislation or a regulatory regime, or both, would have left room for the development of alternative regulatory arrangements under C-62, although C-62 was never passed. Nonetheless, the moratorium presented a temporary middle ground between criminalization and complete inaction that allowed for the continuation of self-regulation on the part of the biomedical community without restricting the rapidly expanding market in infertility services, all while enabling the federal government to take a position against certain reproductive technologies.

Following the announcement of the voluntary moratorium, Health Canada appointed an Advisory Committee to monitor compliance, but violations continued²⁴⁵ and by June 1996, the federal government took more decisive action by introducing Bill C-47 (*An Act respecting human reproductive technologies and commercial transactions relating to human reproduction*). The second phase of the three-phase approach, Bill C-47 proposed the criminalization of the nine technologies included in the moratorium,²⁴⁶ as well as five others.²⁴⁷ The penalties attached to

²⁴³ Cohen et al., “Globalization: Some Implications and Strategies for Women,” *Canadian Woman Studies/Les cahiers de la femme* (Spring/Summer 2002), 8.

²⁴⁴ Hurst, “Techno-Life.” See also *An Act to Provide for the Achievement of Regulatory Goals through Alternatives to Designated Regulations and through Administrative Agreements*, 1994.

²⁴⁵ Canada, Health Canada, *New Reproductive and Genetic Technologies: Setting Boundaries, Enhancing Health*, 25; Baylis and Herder, “Policy Design for Human Embryo Research in Canada: A History (Part 1 of 2),” 114.

²⁴⁶ The voluntary moratorium listed nine banned technologies wherein payment for gametes and embryos was identified as a different practice than egg sharing. Bill C-47 grouped these practices together.

²⁴⁷ The new prohibited practices included the “transfer of human embryos between human and other species,” “the use of human sperm, eggs or embryos for assisted human reproduction procedures or for medical research without the informed consent of the donor(s),” conducting “research on human embryos later than 14 days after conception,” the “creation of embryos for research purposes only,” and making an “offer to provide or offer to pay for prohibited services.” See Canada, Health Canada, “Comprehensive National Policy on Management of New Reproductive and Genetic Technologies Proposed,” 1996.

the banned practices were substantial; up to \$500,000 in fines, or ten years in jail, or both.²⁴⁸ The legislation was clear in its intent, with the preamble stating that Parliament was “gravely concerned with human dignity, the risks to human health and safety...serious social and ethical issues, exploitation of women and children for commercial ends...and the need for measures to protect and promote the best interests of children affected.”²⁴⁹

This intent of the legislation then, as noted in the preamble, was to protect the broadly conceived public interest, as well as to make certain reproductive technologies a matter of criminality, suggesting both a sense of urgency and an important underlying assumption that ARTs were a matter of national importance necessitating federal intervention. A federal role in the governance of reproductive technologies was not obvious, but the first section of *Proceed with Care* had previously identified the bases on which interventions could be made. To this end, the Commission recognized the complexity of jurisdictional issues pertaining to ARTs and suggested intervention through a number of parliamentary powers, including the “peace, order, and good government” (POGG) power, as well as under the criminal law, trade and commerce, spending and other relevant federal constitutional powers.²⁵⁰ The federal government’s use of the criminal law power was its best method of intervention in ARTs given that any use of the peace, order, and good government clause would be strained at best. Historically, POGG was used to allow the federal government to intervene in issues of provincial jurisdiction for pressing matters of national concern, and it was unclear that ARTs would fit this criterion.²⁵¹ Further,

²⁴⁸ Under section 8, “any person who contravenes” the prohibited activities of the act “(a) is liable, on summary conviction to a fine not exceeding \$250,000 or imprisonment for a term not exceeding four years or to both; or (b) is liable on conviction on indictment, to a fine not exceeding \$500,000 or imprisonment for a term not exceeding ten years or to both.” Canada, *Bill C-47, An Act Respecting Human Reproductive Technologies and Commercial Transactions Relating to Human Reproduction*, 1997.

²⁴⁹ *Ibid.*

²⁵⁰ Royal Commission on New Reproductive Technologies, *Proceed with Care*, 18.

²⁵¹ Healy, “Statutory Prohibitions and the Regulation of New Reproductive Technologies Under Federal Law in Canada,” 918.

although the commissioners could not have predicted this at the time, the use of POGG as support for controversial legislation would fall out of favour with the courts after 1993, and the criminal law was increasingly seen as a means to engage in federal legislation in areas of provincial jurisdiction.²⁵² Taken together with the ongoing hostile climate of federal-provincial relations in health following cutbacks to provincial transfers, the criminal law power was the most effective means to make law at the federal level on assisted human reproduction, leaving regulation to occur (in consultation with the provinces) once a federal foot-in-the-door had been established.²⁵³

In addition to establishing ARTs as a site of federal policymaking under the criminal law power, Bill C-47 attempted to identify how the bodies of vulnerable women and children might have been commercialized, appropriated, or exploited by the misuse of ARTs if certain practices were not banned. *Setting Boundaries, Enhancing Health*, the discussion document released at the time that C-47 was tabled, identified this intent of the legislation clearly:

The major objectives of the new legislation are the following: first, to protect the health and safety of Canadians in the use of human reproductive materials for assisted reproduction, other medical procedures and medical research; second, to ensure the appropriate treatment of human reproductive materials outside the body; and third, to protect the dignity and security of all persons, especially women and children.²⁵⁴

C-47 then, presented the view that the governance of reproduction would require the state to act in the public good by putting collective interests before those of individuals. From this view, the interests of intended parents would be secondary to the protection of women using ARTs and

²⁵² Gerald Baier, *Courts and Federalism: Judicial Doctrine in the United States, Australia, and Canada* (Vancouver: University of British Columbia Press, 2011), 135–143; Snow and Knopff, “Assisted Reproduction Policy in Federal States,” 9; Snow, “Failure to Reproduce.”

²⁵³ Montpetit, “Policy Networks, Federalism and Managerial Ideas,” 77.

²⁵⁴ Canada, Health Canada, *New Reproductive and Genetic Technologies: Setting Boundaries, Enhancing Health*, 25.

children born of them, as well as the “collective values” of Canadians as a group.

However, while the stated objectives of C-47 included public health and safety, the legislative process related to C-47 suggests a privileging of biomedical understandings of infertility that would maximize the interests of clinicians, lawyers, and infertile Canadians. Over the course of the legislative process, those with a vested interest in the continuation of an open market in gametes, surrogacy, and infertility services, would cast a shadow over the legitimacy of the legislation and would condemn it for its failure to address the importance of biomedical interests. Ultimately the federal government was unwilling to make legislation on ARTs without the endorsement of these groups, suggesting that C-47 was not necessarily intended to protect public health and safety, but rather to provide the veneer of doing so while ensuring the ongoing authority of biomedical actors and the non-regulation of medical practices.²⁵⁵

The legislative process leading to and following the introduction of C-47 involved a series of consultations and engagements with stakeholders—a cross-country tour by Health Canada, a federal-provincial-territorial working group, a discussion group on embryo research,²⁵⁶ and witness testimony to the Standing Committee on Health—which sought input into the approach the federal government was taking. The ongoing consultations with a range of policy actors, might suggest that the three-phase approach took seriously the changing interests and opinions of Canadians vis-à-vis ARTs. Following Montpetit, however, despite the inclusion of a range of actors, the consultations were largely a means for Health Canada to confer legitimacy on an approach it was already set on putting forth rather than a site for meaningful input from

²⁵⁵ Montpetit, “Policy Networks, Federalism and Managerial Ideas,” 75–76; Scala, “Scientists, Government, and ‘Boundary Work,’” 223.

²⁵⁶ For more information about the functioning of Discussion Group on Embryo Research, see Laura Shanner, “Teaching Women’s Health Issues in a Government Committee: The Story of a Successful Policy Group,” *Women’s Health Issues* 7, no. 6 (1997).

stakeholders. A number of officials in the Health Policy Division of Health Canada who were working directly on the three-phase approach had contributed significantly to the work of the Royal Commission, and were committed to the broad framework that it had recommended in *Proceed with Care*.²⁵⁷

Biomedical and legal professionals were amongst the most ardent critics of C-47 and the process that led to its tabling, concerned that banning payment for gametes and surrogacy services went too far and would inhibit the capacity of Canadians to access assisted reproductive services. These critics suggested that such a ban would be unlikely to prevent commercial transactions in assisted reproduction, and would also create barriers to safe access that could result in both a significant decline in available gametes and surrogacy services²⁵⁸ as well as the proliferation of “underground economies” resulting in exploitation and “damage to women.”²⁵⁹ Further, critics of C-47 generally argued that criminal law would be too blunt an instrument to regulate assisted reproduction despite criminal prohibitions limiting similar activities existing in a number of other Western countries, including Denmark, Germany, Sweden, and the United Kingdom.²⁶⁰ Instead, the preferred option was regulation that might achieve a similar effect with fewer implications on commercial practices and would not limit possibilities for medical self-regulation.²⁶¹

²⁵⁷ Montpetit, “Public Consultations in Policy Network Environments,” 105.

²⁵⁸ Cathy Ruberto and Alfonso P. Del Valle, “Press Release - Response to the Health Minister David Dingwall’s Moratorium to Ban the Sale of Human Sperm,” Repromed Limited, June 6, 1996.

²⁵⁹ Canada, House of Commons Standing Committee on Health (Subcommittee on C-47: An Act Respecting Human Reproductive Technologies and Commercial Transactions Relating to Human Reproduction), *Evidence*, Meeting No. 5, March 20 1997. See also Bernard Dickens, “Do Not Criminalize New Reproductive Technologies,” *Policy Options* 17 (1996); Harvison Young and Wasunna, “Wrestling with the Limits of the Law,” ; Harvison Young, “New Reproductive Technologies in Canada and the United States.”

²⁶⁰ Nancy Miller Chenier, *Regulating Reproductive and Genetic Technologies Internationally* (Ottawa: Library of Parliament, 2002); Matthew Herder, “Banning Bans on New Reproductive and Novel Genetic Technologies,” *Canadian Journal of Law and Technology* 2, no. 3 (2003): 156.

²⁶¹ Montpetit, “Policy Networks, Federalism and Managerial Ideas,” 75-77.

Critics of C-47 also took issue with the nature of the consultations that had taken place prior to its tabling. Both the Canadian Medical Association and the Canadian Fertility and Andrology Society took the position in testimony before the parliamentary subcommittee on C-47 that as experts of reproductive medicine, they had not been consulted about the particulars of the Bill. The result of this failure, they argued, was not only a bill that infringed upon the capacity of doctors to engage in reproductive medicine (through restrictions on gamete donation and embryo research), but also one that was simply incorrect due to technical errors including misuse of the term “zygote.”²⁶² There were also complaints by other groups, including the National Action Committee on the Status of Women about the limited nature of the pre-tabling consultations.²⁶³ However, it was biomedical and legal groups that emphasized the failure of the proposed legislation and regulatory regime to recognize the reproductive autonomy of Canadians, and further, to take seriously the importance of including biomedical stakeholders to ensure that any legislation is not only sensitive to the needs of doctors and patients, but also that it is technically correct.

C-47’s death on the Order Paper has widely been attributed to the failure of Health Canada to Canada to adequately consult medical and scientific stakeholders in the development of the legislation, and thereby prevent their reaction to “what they perceived as the generally

²⁶² The term “zygote” is typically used to describe the initial cell that results following the fertilization of an oocyte (egg). Upon cellular division (although the amount of cellular division necessary is a point of contention amongst embryologists), the zygote becomes an embryo. In C-47, the term “zygote” is used to describe “a human organism during the first fourteen days of its development following fertilization, excluding any time spent in a frozen state,” extending the use of the term to include much of what would conventionally be identified as an embryo. See Canada, House of Commons Standing Committee on Health (Subcommittee on C-47: An Act Respecting Human Reproductive Technologies and Commercial Transactions Relating to Human Reproduction), *Evidence*, Meeting No. 4, March 17, 1997; See also Scala, “Scientists, Government, and ‘Boundary Work,’” 223.

²⁶³ National Action Committee on the Status of Women, *For Reproductive Rights and Social Justice: Regulating the New Reproductive and Genetic Technologies (Brief Submitted to the Sub-Committee on Bill C-47 of the Standing Committee on Health)* (Toronto: National Action Committee on the Status of Women, 1997).

hostile tenor of the legislation.”²⁶⁴ In short, without the support of the biomedical community, C-47 could not proceed, particularly given the Liberal government’s interest in having stakeholder support and the particular pressure of an impending election.²⁶⁵ In both the clinic and in the legislature, doctors were seen as the authorities on assisted reproduction, and without their support, the proposed legislation was too controversial to proceed.

The importance of medical expertise and authority in the debates over C-47 cannot be overstated. As with the consultations that took place on abortion prior to the 1969 amendments to the Criminal Code,²⁶⁶ there was a concerted effort on the part of physicians to articulate that the matter of assisted reproduction was first and foremost, a matter of medical practice, rather than a matter of criminality. Many physicians were not interested in the criminalization of practices in which they were already engaged (namely commercial gamete donation and surrogacy), and emphasized the medical nature of ARTs as matters of health care services. For physicians, regulation was fine, but only so long as regulation would validate the choices of patients, and ensure the ongoing provision of services. This framing aimed to protect the interests of physicians and people seeking out assisted reproductive services as intended parents (i.e., who might be in need of donor gametes or surrogacy services), but left out the need to protect surrogates and donors and donor-conceived people through more comprehensive legislation. The medical model of infertility, in which individual patients engage with doctors to seek out treatment for infertility (diagnosed on the basis certain physiological criteria), was thus legitimated through the legislative process resulting in C-47’s failure. The passage of any

²⁶⁴ Scala, “Scientists, Government, and ‘Boundary Work,’” 223.

²⁶⁵ Montpetit, “Policy Networks, Federalism and Managerial Ideas”; Montpetit, “Public Consultations in Policy Network Environments.”

²⁶⁶ Jane Jenson, “Getting to Morgantaler: From One Representation to Another,” in *The Politics of Abortion*, eds. Janine Brodie, Shelley A.M. Gavigan, and Jane Jenson (Don Mills, ON: Oxford University Press, 1992).

legislation would necessitate the support of doctors and a more explicit dedication to the importance of reproductive technologies as a necessary and useful treatment for medically diagnosed infertility.

As noted above, when C-47 was tabled so too was an accompanying discussion document, *Setting Boundaries, Enhancing Health*. *Setting Boundaries* explicitly laid out plans to regulate ARTs following the passage of C-47, beginning with consultations with the provinces and territories on “a proposed regulatory structure”²⁶⁷ and then to amend C-47 to accommodate the new regulatory framework, resulting in a single piece of legislation that would address the range of reproductive technologies, criminalizing some, and regulating others. Much of the document was dedicated to identifying the guiding principles of the federal approach to governing ARTs and the issues (i.e., addressing vulnerability in infertility treatment, the interests of children born of ARTs, and disability and prenatal genetic diagnosis) deemed of greatest concern. The most significant contribution of *Setting Boundaries*—the description of the impending regulatory regime—occupied only eight of the document’s forty pages, and described only the framework for how licensure of clinicians and researchers would be implemented and parameters for relevant information registries. The range of other areas for regulation identified by the Royal Commission as key to the comprehensive governance of ARTs (e.g., provisions regarding informed consent, compensation for research tissue provision, record keeping) were only briefly mentioned in *Setting Boundaries*, in ways peripheral to the areas designated for regulatory intervention. Further, infertility prevention and other complex matters of addressing reproductive health beyond regulation were included in *Setting Boundaries* (i.e., acknowledging the importance of “infertility prevention” and “social solutions”) although only as matters for

²⁶⁷ Canada, Health Canada, *New Reproductive and Genetic Technologies: Setting Boundaries, Enhancing Health*, 5.

future, collaborative interventions without concrete, actionable ways forward. Overall, recommendations were reserved for unclear future regulation that would one day occur in collaboration with the provinces and other stakeholders.

As with the voluntary moratorium, uncertainty about when and how regulation would occur in *Setting Boundaries* is attributable to a need to tiptoe around the complex intergovernmental relations in health that were occurring at the time. *Setting Boundaries* included careful nods to C-47's use of the criminal law power as a legitimate intervention. It was written as a hybrid discussion document and white paper, setting out federal priorities in regulation, and suggesting that these priorities would likely change in consultation with other stakeholders, that is to say, the provinces. The federal government's intended policy direction in *Setting Boundaries* was clear; however the role for the federal government in making regulation was not to be assumed given that ARTs were not clearly a matter of federal jurisdiction. The use of the criminal law power could be a toehold for federal intervention in the governance of ARTs, and there was little to do but wait for C-47 to pass before moving forward with regulation.

After C-47 died on the Order Paper, there was little movement on assisted reproduction at the federal level for a number of years; however, the attempt to govern ARTs represented by the three-phase approach would have important ramifications in terms of how the federal government would include and address certain stakeholders in the future. The way that these documents took up certain recommendations of the Royal Commission, and left others to tentative future collaboration, reveal the federal priority in addressing reproductive technologies. As with the Royal Commission, the importance of social understandings of infertility, preventative care, and reproductive autonomy were acknowledged in the three-phase approach, but the use of the criminal law power to restrict certain reproductive technologies with the

promise of future regulation demonstrates an overarching commitment to the use of reproductive technologies as an at-once dangerous and useful site for governing reproduction. At first, this may have been understood as a matter for government alone, particularly as the consultations that informed C-47 and *Setting Boundaries* worked to “verify the validity”²⁶⁸ of the Royal Commission’s recommendations, rather than to consider new perspectives or determine a policy direction. Nevertheless, with the failure of C-47, particularly when the Liberal majority at the time could have pushed it through, there was an affirmation of the role of biomedical actors in determining the ways in which ARTs in Canada could be governed.

Reproductive Citizenship During the Three-Phase Approach

As biomedical and legal actors (as well as, to a certain extent, religious actors) came to the fore as key stakeholders in the governance of ARTs during the three-phase approach, groups less prevalent in this stage of the long policy process found other means to make their interests known. LGBTQ Canadians, egg donors and surrogates, infertile Canadians, and donor-conceived families were much less apparent in the three-phase approach, although as with the Royal Commission, the interests of each group were very differently recognized. The strategies used by these groups to gain recognition differed as well, and included the formation of new organizations, expansion, engagement in public education, and looking to the courts to make claims that the use of reproductive technologies are a part of fundamental rights of citizenship.

LGBTQ People

The period following the publication of the Royal Commission report saw little

²⁶⁸ Montpetit, “Policy Networks, Federalism and Managerial Ideas” 75.

acknowledgement or intervention on the part of LGBTQ people regarding assisted reproduction. The recognition of lesbian mothers as users of reproductive technologies included in the Royal Commission, however marginal, was simply not present in the three-phase approach, and it seemed that the constituency of users of ARTs imagined at the time of the Royal Commission was narrowed. No groups explicitly advocating for LGBTQ Canadians were consulted in the deliberative work leading up to C-47 or during its consideration before the parliamentary subcommittee, nor were LGBTQ Canadians identified as key stakeholders in the proposed legislation or regulatory regime. The National Association of Women and the Law spoke out about how limiting payment to gamete donors might have a negative impact on lesbian access to sperm for insemination, but it was the only such intervention.²⁶⁹ While the Royal Commission made a point of discussing donor insemination, self-insemination, discrimination in access to services, and the need for family law reform to protect lesbian-led families, the three-phase approach to governing ARTs did not include any mention of the particular concerns of LGBTQ people at all. Given the explicit articulation of the interests of lesbian mothers in the Royal Commission report, and *Setting Boundaries*' discussions of equality as a guiding principle, the particular concerns of queer families are remarkable in their absence.²⁷⁰

This is not to say, however, that LGBTQ people were not engaging in assisted human reproduction, or engaging with the state to ensure that their families would benefit from rights protections; rather, LGBTQ people were organizing outside of the three-phase approach. Lesbian

²⁶⁹ National Association of Women and the Law, *The National Association of Women and the Law Response to Bill C-47 and Working Document on New Reproductive and Genetic Technologies* (Ottawa: National Association of Women and the Law, 1997).

²⁷⁰ As discussed below, LGBTQ interest groups and advocates were often using the courts rather than legislative processes to make rights claims during this period. The efforts of relevant advocates were taking place outside of Parliament, although the non-inclusion of LGBTQ people as stakeholders in assisted reproduction is not only evident in the consultations, but in the policy documents themselves. This is a marked shift from the work of the Royal Commission.

mothers in particular were continuing to use the courts and provincial legislatures and to do community-based organizing in order to ensure that they could build the families that they wanted.²⁷¹ The negotiation of reproductive citizenship on the part of LGBTQ people, and particularly lesbian mothers, was occurring outside of the development of federal legislation. Lesbian mothers were working to create their families in ways that both ignored and contested the federal government's emphasis on the individual, medically infertile, heterosexual subject.

At the same time that the three-phase approach was being developed, a case about lesbian access to fertility clinics was being addressed at the British Columbia Council of Human Rights that challenged the right of physicians to refuse artificial insemination services on the basis of sexual orientation. In this case, a Vancouver physician, Dr. Korn, refused to provide artificial insemination services to a couple because they were lesbians, referring them instead to another doctor.²⁷² After the couple had a successful pregnancy, they brought a case regarding their denial of services by Dr. Korn to the British Columbia Council of Human Rights. The Council ruled that Dr. Korn had denied the applicants, “a service customarily available to the public because of their sexual orientation” in breach of the Human Rights Act of British Columbia. The couple was awarded a total of \$3396.44, including funds for “emotional injury” and expenses.²⁷³ Dr. Korn appealed the decision, but it was dismissed by the British Columbia

²⁷¹ Rayside, *Queer Inclusions, Continental Divisions*, 173–178; Brenda Cossman, “Family Inside/Out,” *University of Toronto Law Journal* 44, no. 1 (1994).

²⁷² *Potter v Korn* (1995), 23 C.H.R.R. D/319 (B.C.C.H.R.) at para 5. Dr. Korn did provide some artificial insemination services to lesbians in the 1980s, even though he changed this practice after being publicly criticized for doing so. Also noteworthy that Dr. Korn has been involved in a number of problematic cases regarding donor insemination. He is the doctor who destroyed the records related to the conception of Olivia Pratten, leading to a Charter challenge regarding the rights of donor-conceived children. Further, Dr. Korn was also involved in a case that was heard at the Supreme Court (*ter Neuzen v Korn* 1995), in which he was accused of causing the infection of a woman with HIV by using untested donor sperm (see discussion below).

²⁷³ Katherine Arnup, “Out in This World,” *Journal of Gay & Lesbian Social Services* 10, no. 1 (2000): 14.

Supreme Court.²⁷⁴

Potter v Korn came at an important juncture in the history of LGBTQ parenting in Canada. The case recalled the history of custody challenges in the 1970s and 1980s, wherein claims that lesbians were unfit parents on the basis of their sexual orientation had resulted in the custody of children being given entirely to women's ex-husbands or former male partners with whom they had conceived.²⁷⁵ The legal framework of these custody battles was often that lesbians were deemed unsuitable parents because their children would not be exposed to traditional gender role modelling, that they would somehow be made to be gay themselves, and that they would be otherwise damaged. These custody cases were hard-fought and often lost, and it became increasingly clear that in order to win custody, women had to establish that they had stable lives, fit into the two-parent family model, and were otherwise “‘just the same as’ and ‘just as good as’ an ideologically based notion of the heterosexual nuclear family.”²⁷⁶ This often necessitated moving away from longstanding notions of queer families challenging the conventional heterosexual two-parent model, or even challenging the heteronormative frame of the family, and instead iterating that one was a good or deserving lesbian mother that was not sexual, an activist, a lesbian feminist, or in any way disputing the legitimacy of the conventional family form. Groups like the Lesbian Mothers' Defence Fund worked throughout the 1980s to keep custody issues out of court where the likelihood of their keeping their children was slim,

²⁷⁴ *Potter v Korn* (1995), 23 C.H.R.R. D/319 (B.C.C.H.R.); (1996), 134 D.L.R. (4TH) 437; Arnup, “Out in This World”; Karen Capen, “Lesbians, Artificial Insemination and Human-Rights Laws: Can Doctors Place Limits on Their Medical Practices,” *Canadian Medical Association Journal* 156 (1997); EGALÉ, *EGALÉ Submissions to House of Commons Standing Committee on Health: Re: Bill C-13: An Act Respecting Assisted Human Reproduction* (Ottawa: EGALÉ, November 2002); Luce, *Beyond Expectation*, 169; Joanna Harris, “Lesbian Motherhood and Access to Reproductive Technology,” *Canadian Woman Studies/Les cahiers de la femme* 24, no. 2/3 (2005): 44.

²⁷⁵ Arnup, “Out in This World.”

²⁷⁶ Rachel Epstein, “Introduction,” in *Who's Your Daddy And Other Writings on Queer Parenting*, ed. Rachel Epstein (Toronto: Sumach Press, 2009), 14; Luce, *Beyond Expectation*, 83.

and to provide support to those engaged in legal battles to keep their children.²⁷⁷

It is in this context that *Potter v Korn* is an important case in terms of the recognition of the reproductive citizenship of lesbian mothers. The custody battles of the 1970s and 1980s were part of an on-going denial of parental rights to LGBTQ people, and it was only by the 1990s that institutional change, largely through the courts, was beginning to occur. As Miriam Smith has argued, the courts have been used as a site for LGBTQ rights claims in the post-Charter era in which litigation has taken up the “rights talk” generated by social movement organizing. She argues that increasingly litigation has been used as a strategy for equality-seeking groups to make rights claims and to address discrimination against LGBTQ people in Canada.²⁷⁸

Following the *Egan* decision in 1995, the Supreme Court affirmed that sexual orientation was a grounds of discrimination under s. 15 of the Charter,²⁷⁹ making clear that sexuality alone could no longer be used as a justification for denying women custody of their children.

By the mid-1990s, it could no longer be taken for granted that the courts would side with a biological fathers’ custody claims, and new laws, including the Ontario Children’s Law Reform Act (1990) allowed non-biological parents, including non-biological lesbian mothers, to make custody claims. The idea of family at this point, and particularly in the courts, was broadening to make room for LGBTQ families.²⁸⁰ Further, in 1995, just months before the

²⁷⁷ Epstein, “Introduction”; Smith, *Lesbian and Gay Rights in Canada*, 30.

²⁷⁸ See Smith, *Lesbian and Gay Rights in Canada*; Miriam Smith, “Social Movements and Judicial Empowerment: Courts, Public Policy, and Lesbian and Gay Organizing in Canada,” *Politics and Society* 33, no. 2 (2005).

²⁷⁹ *Egan v Canada* [1995] 2 S.C.R. 513. In *Egan*, the Supreme Court found that a man who was denied spousal pension benefits under the *Old Age Security Act* because his partner was male and they were therefore not “spouses” had experienced discrimination insofar as sexual orientation was/is grounds for discrimination analogous to those listed. See also Brenda Cossman, “Lesbians, Gay Men, and the Canadian Charter of Rights and Freedoms,” *Osgoode Hall Law Journal* 40 (2002): 228–229; Miriam Smith, *Political Institutions and Lesbian and Gay Rights in the United States and Canada* (New York: Routledge, 2008), 96.

²⁸⁰ This is not to say that this strategy was unproblematic. Indeed, as Brenda Cossman has often argued, the use of litigation as a rights-seeking strategy has often relied on the framing of the queer family as “the same” as heterosexual families, wherein queer families must aspire to replicate the heteronormative family. See Cossman, “Family Inside/Out”; Cossman, “Lesbians, Gay Men, and the Canadian Charter of Rights and Freedoms.”

judgement in *Potter v Korn* was rendered, an Ontario court decided in favour of a group of lesbians who sought to adopt their partners' children. In this case (*Re K*),²⁸¹ an Ontario court judge found that the Child and Family Services Act of Ontario discriminated against same-sex couples in violation of s.15 of the Canadian Charter of Rights and Freedoms.²⁸² Although the changes to the law would still require non-biological parents to make an application for adoption and required the two parents to be "spouses" (thereby replicating many elements of the conventional family form), this case recognized not only that lesbians were parenting already-existing children together but also that LGBTQ people might intend to have children together. Taken together with *Potter v Korn*, it is clear that there was not only a shift in the recognition of the parental rights of lesbians who were already mothers, but also those who were intended parents.

Potter v Korn only applied to British Columbia, and the law regarding adoption would not change in that province for another year, but the implicit outcome of the case was that lesbian mothers should be able to build their families together in the ways that they want, be it through services available in fertility clinics, or through the adoption of one another's children. Furthermore, the acknowledgement of access to assisted reproduction as a right (so long as one could pay for services), or at least as a service that could not be unduly restricted, went far to extend the frame of potential stakeholders of ARTs to implicitly include LGBTQ Canadians, even if they were not included in the legislative process.

The effect of *Potter v Korn* was not merely the statement that clinics could not

²⁸¹ *Re. K. and B. and six other applicants* (1995) 23 O.R. (3d) 679.

²⁸² Laws were rapidly changing during this period with British Columbia changing adoption legislation in 1995 to enable LGBTQ couples to partake in step-parent and joint adoptions. Saskatchewan would similarly allow joint adoption in 1998, followed by relevant legislative changes in Alberta (1999), Nova Scotia (2001), Newfoundland (2002), Manitoba (2002), Quebec (2002), the Northwest Territories (2002), and New Brunswick (2004). Rayside, *Queer Inclusions, Continental Divisions*, 174–182.

discriminate against lesbians, or a marker of the use of the courts as a continued site for parental rights claims, but the case also affirmed that the clinic was (and is) a recognized site of lesbian reproduction. The Royal Commission did recognize lesbian self-insemination as an important site for LGBTQ family building, noting problems around denial of services and discrimination against lesbians, but even still, use of the clinics by lesbians had been complicated, with physicians openly refusing to provide services, demanding psychiatric assessments, or requiring women to write explanations of why they should provide access to donor sperm or to “insemination services.”²⁸³ In the absence of legislation, with discrimination in clinics continuing,²⁸⁴ and with so little acknowledgement of LGBTQ people in the three-phase approach, *Potter v Korn* served the important role of recognizing the legitimacy of lesbians as stakeholders in assisted human reproduction, even if it was outside of the formal policymaking process.

Additionally, *Potter v Korn* was part of the increased recognition of donor insemination as necessarily occurring within the context of conventional medicine. This challenged the longstanding idea that self-insemination was the best option for lesbian motherhood, insofar as it allowed women to conceive on their own terms, and to control their reproductive experiences outside of a medical context. Women inseminated themselves in all kinds of spaces outside of clinics, including their homes, “campgrounds, parked cars, and the apartments of friends,” and there were many formal and informal networks of information sharing that allowed lesbians to pass information about techniques for insemination, acquiring sperm, and navigating clinics

²⁸³ Epstein, “Introduction,” 17; Epstein, ““Married, Single, or Gay?,”” 4.

²⁸⁴ Barratt et al., “Access to Fertility Services for Lesbians: A Question of Health (Submission to the Standing Committee on Health on Draft Legislation Governing Assisted Human Reproduction)” (Montreal: Lesbian Mothers Association of Quebec, 2001).

when necessary.²⁸⁵

By the mid-1990s, however, there was an increased focus on clinics and medical practices as the site where donor insemination should occur. This is attributable to changing priorities in relation to donor insemination. Whereas self-insemination by donor was seen as a means to contest the medical model of reproduction in the 1970s and 1980s, with the rise of HIV/AIDS, and new anxieties about the risks of using fresh semen, engaging with clinics and doctors in order to obtain “safe” semen was a new priority for lesbians seeking semen to use. The Royal Commission had funded and published research that found that three clinics were not freezing semen before use, instead using fresh sperm, which cannot be adequately tested for HIV. The same study found that one sperm donation program (out of a total of 33) was not doing initial testing for donors, two were not doing follow-up testing and a significant number of others were not testing for a range of other sexually transmitted infections.²⁸⁶ Fresh semen was increasingly identified as a cause for concern, and although many people who used known donors and fresh sperm were asking their donors for HIV tests, the advantage of frozen semen was that the semen itself was tested twice, six months apart, rather than the donor. As the typical incubation period for HIV testing is six months, receiving negative HIV tests for a donor six months apart only identifies that the donor did not have HIV at the time of the first test. Testing the semen itself six months apart identifies that the semen is HIV negative, and therefore tested frozen semen is viewed as a safer choice for insemination.

The reaction to the research contracted by the Royal Commission, the subsequent media coverage, and a Supreme Court case in which a woman had contracted HIV from donor semen without knowledge of the risk of exposure (*ter Neuzen v Korn*) raised public awareness of the

²⁸⁵ Luce, *Beyond Expectation*, 161.

²⁸⁶ Royal Commission on New Reproductive Technologies, *Proceed with Care*, 448–450.

risks of using fresh sperm. With concern about HIV and AIDS running high, lesbians who might have otherwise used friends as donors were turning to frozen sperm as a safer option. This did not mean that women had to actually be inseminated in the clinic, indeed, they could simply order the semen to a fertility clinic, or to their family physician (so long as there was a liquid nitrogen tank available for storage). Once a physician was already involved in the process of insemination, and women were already in the doors of the clinic, women were more likely to be inseminated in the clinic or doctors' office.²⁸⁷

Furthermore, in 1996, Health Canada introduced the first iteration of its *Semen Regulations (The Processing and Distribution of Semen for Assisted Conception Regulations)* that curbed potential use. The semen regulations required semen used for “artificial reproduction” to undergo a six-month quarantine and rigorous testing, and for donors to undergo testing as well. Imported semen was also subject to the same standards,²⁸⁸ and consequently obtaining semen from the two California-based sperm banks which had long served lesbian populations in Canada became more difficult than ever, and forced many women who would have otherwise ordered sperm directly to involve their doctors in the process.²⁸⁹ Semen had to be ordered to a doctor's office, and any semen used had to conform to Canadian standards, labeled and quarantined following the regulations. Although the intention of the semen regulations was simply to “decrease the risk of infectious disease transmission”²⁹⁰ the consequence for lesbians and single women who may have ordered sperm directly from a queer-friendly sperm bank in the United States, or those who may have wanted to involve a known donor in their insemination, was a new set of obstacles to donor conception.

²⁸⁷ Mamo, *Queering Reproduction*, 157–182.

²⁸⁸ Montpetit, “Policy Networks, Federalism and Managerial Ideas,” 66.

²⁸⁹ Luce, *Beyond Expectation*, 169.

²⁹⁰ Canada, Health Canada, “New Regulations for Safer Semen Donations,” May 30, 1996.

The outcome of the concerns about HIV/AIDS in relation to donor sperm that really emerged in the late 1980s and early 1990s was a shift in the language used around lesbian-led families and access to donor sperm. Following Jacqueline Luce, “clinic-based insemination is often conflated with safety” even though, as was the case in *ter Neuzen v Korn*, clinic-based insemination did not preclude exposure to sexually transmitted infections. While at-home self-inseminations and insemination support networks had been a way to circumvent medical intervention in one’s reproduction, the need to mitigate the risks associated with donor semen was seen as too great to ignore. This is not to say that self-inseminations were halted or that people did not continue to contest the medicalization of conception, but it is clear that the practice of self-insemination described by the Royal Commission was slowly being displaced by a more medicalized practice in which women were moving into clinics to protect themselves and their future children.

The exclusion of LGBTQ people in the policy process then, was not offset in any way by the shift into the clinic or relevant litigation, but increased access to reproductive technologies, where and when it occurred, legitimized lesbians as part of the constituency of people using assisted reproduction, assuming their place among other intended parents. At the same time, the more costly clinically-managed care that this entailed also meant a mediation of reproductive citizenship that had long worked in contestation of the norm. The “social infertility” of lesbian intended parents became, in many ways, subsumed into a broader understanding of infertility care within a medical context.

As clinic doors were slowly opening, many obstacles for lesbians remained, particularly difficulty acquiring “safe” sperm in the late 1990s after the semen regulations were enforced.²⁹¹

²⁹¹ Dr. Norman B. Barwin, “Therapeutic Donor Insemination (TDI) For Women without Partners and Lesbian Couples: Considerations for Physicians,” *Canadian Journal of Human Sexuality* 2, no. 3 (1993); Katherine Arnup,

With increased engagement in clinic-based insemination, access to semen outside of clinics for lesbians was limited (unless women were using known donors). It was in this context that Rachel Epstein was asked by her former mid-wife Kathie Duncan to “plan and co-facilitate a course for lesbian/bi/queer women considering parenthood”²⁹² This course, entitled Dykes Planning Tykes, would grow and evolve over the years to come, but it was developed in 1997 to fill an important gap in education and service provision, namely knowledge about parenting options for queer families. Although Dykes Planning Tykes never focused solely on artificial insemination, it has long served as an important site, at least in Toronto, for lesbians seeking to build their families, providing them with the information they need to make informed choices about how to have their children, and on what terms. As will be discussed in chapter five, groups like Dykes Planning Tykes in Toronto, and the then-yet-to-be-established Lesbian Mothers’ Association of Quebec would become increasingly important service providers in the late 1990s, offering information to lesbian intended parents and others. These groups would provide sites for LGBTQ people to acquire information about possibilities for family building, to ask questions, and share experiences. As time went on, both Dykes Planning Tykes and the Lesbian Mothers’ Association of Quebec would extend their work from primarily service providers and became strong advocates for the LGBTQ community with the federal government (although the Lesbian Mothers’ Association would focus more strongly on issues within Quebec), becoming important stakeholders in the policy process.

The reproductive citizenship of LGBTQ people, and particularly lesbians seeking to use reproductive technologies in the mid-1990s came not then, through the outright inclusion of their

“Finding Fathers: Artificial Insemination, Lesbians, and the Law,” *Canadian Journal of Women and the Law* 7 (1994); Luce, *Beyond Expectation*.

²⁹² Epstein, “Introduction,” 18.

interests in the legislative process. The emergence of lesbians as subjects of public policy on assisted human reproduction came through new demands for access to clinical care, in part as access to “safe” sperm became an issue of concern. Through the recognition of LGBTQ people as would-be parents with particular rights and responsibilities, *Potter v Korn* and the semen regulations mark the recognition of the reproductive citizenship of LGBTQ people using reproductive technologies in a new way. Further, while self-insemination has been and continues to be a practice for women to become pregnant outside of the clinic, the shift to seeking clinical care would create a greater space for the interests of many intended lesbian mothers to undergo insemination within the context of biomedicine. Affirmed in *Potter v Korn*, the movement of lesbian insemination into the clinic created a new and expanded market for the infertility industry as women who may have used a known donor (or simply have purchased sperm outright from a sperm bank) began to engage in the litany of costly tests and interventions that come with biomedical care. This early recognition of lesbians as potential patient/clients of fertility services was a sign of the eventual recognition of LGBTQ people and single women in the *Assisted Human Reproduction Act* to come, as access to ARTs was identified as a matter of equality (i.e., non-discrimination on the basis of sexual orientation and marital status) so long as one had the financial resources needed for access to occur.

Egg Donors and Surrogates

As in the consultative processes of the Royal Commission, consultations leading to and following C-47 failed to include gamete donors and surrogates. Nevertheless, the three-phase approach did mark an important change in the discursive practices used by parliamentarians and in the policy documents around egg donation. Whereas the Royal Commission recommended

that egg donation should be heavily restricted due to relevant health risks and payment should also be prohibited, in the three-phase approach health protection and limiting exploitation were seen as one and the same. In other words, throughout the three-phase approach, the debate over how to address egg donation shifted to emphasize the prevention of exploitative practices as the only public health measure that was needed.

The discussion of egg donation included in the work of the Royal Commission both problematized the commercial aspects of donation when compensation or payment were involved, and further, suggested that all egg donation is problematic because of the undue harms faced by donors. The ovarian stimulation and egg retrieval required for egg donation were seen as risky and the Commission recommended that women should not be able to undergo these procedures unless they were doing so for themselves, or were undergoing medical treatment likely to harm their own fertility. Egg donation for pay was also deemed unacceptable, but in the Royal Commission's report, egg donation was broadly seen as impermissible, primarily due to the risks to women's health, and only secondarily as a matter of non-commercialization.²⁹³

The three-phase approach, however, took a very different stance vis-à-vis egg donation. Like the voluntary moratorium, Bill C-47 proposed an outright ban on egg donation but only when pay was involved. The banning of commercial (but not altruistic) donation suggested that egg donation itself was a relatively safe procedure—at least benign enough for Canadian women to engage—and that commercialization was reason enough to ban the procedure. However, this prohibition on payment relied on a logic that conflated the protection of women's health with the prevention of commercialization. Women could consent to undergo egg donation, but only when pay was not involved, and only when fully informed of the risks of donation. In other words, egg

²⁹³ Royal Commission on New Reproductive Technologies, *Proceed with Care*, 585–95.

donation was identified as only risky when occurring for pay, minimizing the substantive health risks outlined by the Royal Commission.

When C-47 was debated in the House of Commons, exploitation, payment, health risks, surrogacy, and egg donation would become conceptually entangled to a greater extent. Members of Parliament took up the language of the Royal Commission, repeating some of the leaps in data interpretation made by *Proceed with Care* in regards to the exploitation of surrogates discussed in Eichler and Poole's 1985 study. When C-47 was tabled, Liberal MP Andy Scott, and then-Secretary of State for the Status of Women Hedy Fry used the same phrases and same ideas that had appeared in *Proceed with Care* to describe egg donation. They both stated that the socioeconomic disparities between surrogates and intended parents were so great, and the risks of egg donation so dire, that women could simply not participate in surrogacy or gamete donation "on equal footing" if pay was involved.²⁹⁴ Egg donation and surrogacy were thus constructed as exploitative practices on the basis of very limited data, and the potential for economic exploitation became the *crie-de-coeur* for regulating surrogacy and egg donation.

The understanding of egg donation and surrogacy as exploitative, and therefore necessitating a ban on commercial practices emerged even more strongly in other contributions to the debates in the House of Commons. When introducing Bill C-47 at second reading, Parliamentary Secretary to the Minister of Health, Joe Volpe explained the rationale for the ban on payment for egg donation, stating that if paid, an egg donor "will undergo invasive and painful medical interventions...[and] in exchange for the risk and burdens she will bear, she will go home probably about \$2,000 richer but she will have taken unknown risks with her own health and her own future fertility."²⁹⁵ The reason for the ban, following Volpe, was that egg

²⁹⁴ Canada. *House of Commons Debates*, October 31, 1996 (Andy Scott, Lib.) and (Hedy Fry, Lib.).

²⁹⁵ Canada. *House of Commons Debates*, October 23, 1996 (Joe Volpe, Lib.). See also Cattapan, "Risky Business."

donors would undertake undue physiological risks for the sake of someone else, and would do so for pay. Following this logic, these risks were illegitimate when undertaken for compensation or payment of any kind. However, altruistic egg donation remained permissible. Given C-47's explicit dedication to protecting women from "the risks to human health and safety" as outlined in its preamble,²⁹⁶ and the admission that egg donation is a risky procedure that women need not undergo, the permissibility of altruistic egg donation is relatively problematic despite the existence of the same risks. Either egg donation is a risky procedure that women should not undergo for someone else, or it is a legitimate procedure that women can undergo (although commercial donation could still be banned on the principle of non-commercialization). The equation of payment with risk and non-payment with safety inherent in Volpe's argumentation came to characterize subsequent debate over commercial practices in egg donation and surrogacy.

The conflation of the health risks of donation with commercialization (and exploitation) is an important shift in the language around egg donation and surrogacy used in public policy on assisted reproduction in Canada with important implications for reproductive citizenship. Whereas the Royal Commission report identified egg donation as inherently problematic because of the unnecessary health risks that women face for the sake of others,' as well as because of potential commercialization, the voluntary moratorium and C-47's banning of commercial egg donation enabled the continuation of egg donation, no matter the physiological consequences. Although egg donation was to be restricted in some ways through prohibitions on payment, egg donation was implicitly identified by C-47 as an appropriate, ethically sound procedure when payment did not occur, putting the onus on women to balance the risks of donation, and to make

²⁹⁶ Canada, *Bill-C-47*.

the choice to proceed or not. The concerns about the risks to donors' health in non-commercial or altruistic donation simply faded away in the debates around C-47, and access to egg donation (albeit altruistic/non-commercial/unpaid egg donation) could persist allowing, infertile people in need of eggs, and their doctors to continue to engage.

The decision-making about whether egg donation should be occurring was thus downloaded from the state to potential egg donors, privatizing what the Royal Commission had clearly articulated as a matter of public health. What had been theorized as a public health risk to be managed by blanket restrictions on egg donation was replaced by an understanding of egg donation as an individual risk to be managed by the responsible, informed, self-sufficient would-be egg donor. In this way, the recognition of the health of egg donors became less important to the discussion of egg donation than balancing non-commercialization and continued access to eggs. This worked to erase egg donors as important actors in the policy process whether or not they were consulted, as consulting donors may have meant addressing the physiological risks that egg donors face, and possibly impeding access to the eggs produced. The reproductive citizens deserving of care, here, were those needing access to eggs, rather than those providing them. In the context of a neoliberal citizenship regime, where limited governance gives way to market imperatives, and individuals are responsible for themselves, egg donors were required to weigh the little-known risks of donation against the benefits of participation, just as surrogates were left to make decisions about whether or not to engage in reproductive labour (with or without pay).

Furthermore, the failure to consult with egg donors or surrogates or to provide any evidence of their exploitation (despite attempts to protect women from exploitative practices) represents a paternalistic norm about the nature of surrogacy arrangements and egg donation

long perpetuated by unsubstantiated fears about exploitation and the use of women's bodies. Outright commercialization was widely held as immoral from the time of the Royal Commission, but the failure to engage with egg donors and surrogates meant that there was no opportunity to explore how ethical compensation might occur. The assumed exploitative nature of commercial surrogacy and gamete donation were taken up indiscriminately from the Royal Commission to the voluntary moratorium and C-47 without questioning the possibility of approaches other than the outright prohibition of commercial practices. Assuming exploitation in commercial practices worked from the outset to validate non-commercial surrogacy and egg donation thereby allowing the continuation of the practice in Canadian fertility clinics.

This non-inclusion of egg donors and surrogates in the three-phase approach, and the prevalence of discourse on exploitation in the debates of the House of Commons on C-47 are particularly notable given the expansion of the infertility industry during the mid-1990s. In the absence of regulation (other than the *voluntary* moratorium) fertility clinics were appearing across the country and both egg donation and surrogacy were more prevalent than ever. Advertisements for egg donors and surrogates were appearing in university newspapers across the country, and physicians were openly admitting that they were continuing to arrange commercial surrogacy and egg donation arrangements. The concerns of potential exploitation were not unfounded, but they were unsubstantiated.

Overall, the non-inclusion of egg donors and surrogates in the three-phase approach resulted in a policy framework and proposed legislation that assumed exploitative experiences with little-to-no supporting data. Donors and surrogates were not seen in clinical settings to be the primary agents of infertility treatments, rather infertile patient-consumers were seen to be the subjects of infertility treatment. This understanding of the surrogate and donor as secondary in

the process of assisted reproduction minimized their legitimacy as potential policy actors, and consequently, interest in hearing their voices. Indeed, surrogacy and egg donation are often referred to as “third-party” reproduction insofar as it is assumed that a couple who represent the first and second party interests are assisted in their reproductive efforts by a third-party, that is a gamete donor or surrogate.

Although donors and surrogates themselves did not organize or demand to participate in the consultative processes associated with the three-phase approach, this may be attributable to the ephemeral nature of both egg donation and (to a lesser extent) surrogacy, and to the patina of immorality and illegality acquired through public debate over these practices, in Parliament, and the popular press. Donors and surrogates themselves did not actively engage in the policy process; however, no research was conducted, no consultations were attempted, and consequently, the already secondary or tertiary status of donors and surrogates as reproductive citizens, that is to say, as non-actors, was maintained. The conflation of health concerns with assumed exploitation of donors worked to legitimate the continuation of egg donation, despite potential harms to women’s health, and to expand the discourse of exploitation opened up around surrogacy at the time of the Royal Commission, giving a nod to those concerned about commercialization while simultaneously allowing the fertility industry to continue its work. Although the status-quo of legal, commercial surrogacy and egg donation would continue when C-47 died on the Order Paper, the three-phase approach thus promoted the view that surrogates are not reproductive citizens in and of themselves, but rather are volunteers or labourers peripheral to the family building taking place in fertility clinics. The reproductive citizen entitled to care from this perspective is the citizen consumer, the neoliberal citizen subject, who has the financial capacity to seek out the family that they want without the help of the state, within the

parameters of the (assisted) reproductive marketplace. The reproductive citizen able to make well-informed, autonomous choices about their reproductive life is the paying intended parent(s) to the exclusion of others.

Infertile Canadians

Although *Proceed with Care* validated infertile Canadians as important, legitimate stakeholders in the governance of assisted human reproduction, Bill C-47's criminalization of payment to gamete donors and surrogates was seen to be problematic by the most vocal advocates of infertile Canadians, namely IAAC. By the time of the three-phase approach, IAAC had expanded considerably, holding support groups across the country, and doing so with increased financial support from pharmaceutical companies, fertility clinics, and other beneficiaries of the commercial practices in assisted reproduction.²⁹⁷

Although representatives of IAAC had participated in the Royal Commission and the organization had responded to its work, the organization only received its seed money in 1990, when it sought to establish a network of support groups for infertile people across Canada. By 1994, however, IAAC was a relatively significant advocacy group speaking for infertile Canadians and its network of support groups was well-established. The Royal Commission had given the organization a chance to strongly articulate its position, and taken together with its federal funding, its organization of seminars (including seminars on adoption in 1993), the expansion of support groups, and media coverage of their activities, IAAC gained credibility as the national interest group representing infertile people in Canada.

As discussed in chapter three, IAAC's affiliation and cooperation with fertility specialists

²⁹⁷ Interview with Beverley Hanck, December 7, 2011.

(including the Canadian Fertility and Andrology Society and the Society of Obstetricians and Gynaecologists of Canada) was longstanding. Dr. Barwin (who was involved in and supported IAAC from the beginning) remained deeply involved with the organization, serving as the Chair of its Board of Directors, ensuring a continued relationship between IAAC and fertility specialists. But by the mid-1990s, there were new sponsorships and partnerships, both with the fertility clinics themselves, and with pharmaceutical companies manufacturing infertility drugs.

Perhaps the most visible of these relationships has been between IAAC and Serono Canada, the leading manufacturer of fertility drugs for the Canadian market. Serono Canada (one division of a larger Swiss firm) was incorporated in 1990 at the time of the Royal Commission and has, from the outset, been an integral part of the development of public policy governing ARTs in Canada, largely through affiliations with physicians and patient groups. By the time of *Proceed with Care*'s publication in 1993, Serono was responsible for three-quarters of the market share in fertility drugs in Canada. In fact, Serono was so important a presence in the infertility industry that rather than partake in the Royal Commission consultations with the Pharmaceutical Manufacturers Association of Canada in October 1991, there was a separate session for Ares-Serono and Serono Canada Inc. held in Ottawa in February 1992.²⁹⁸ At this time, Serono had already established relationships with the Canadian Fertility and Andrology Society, providing \$36,300 (U.S.) to establish a new, U.S. based registry to track IVF procedures

²⁹⁸ Another pharmaceutical company, Roussel-Uclaf also had its own private session with the Commission, in October 1991. Roussel-Uclaf (which has since merged with Bayer) is notable for its development of RU-486 (also known as mifepristone), the so-called abortion pill. Legal in France since 1988, pro-choice groups in Canada were advocating for the approval of the drug for use in Canada at the time of the Royal Commission. Lorna Weir, "Left Popular Politics in Canadian Feminist Abortion Organizing, 1982-1991," *Feminist Studies* 20, no. 2 (1994): 255; Royal Commission on New Reproductive Technologies, *Proceed with Care*, 1218; Melissa Haussman, "Health Canada and RU-486: No More Foot-Dragging!," *Impact Ethics* (blog), March 10, 2014, <http://imipactethics.ca/2014/03/10/health-canada-and-ru-486-no-more-foot>. The drug finally received approval from Health Canada in 2015.

and the use of relevant drugs.²⁹⁹ By the time that the Royal Commission's report was issued in 1993, Serono was deeply embedded in the Canadian community of physicians and advocates of ARTs.

It is unclear when the relationship between Serono and IAAC began, but in 1994, Canada Newswire included an announcement of Serono's "Miracle Program," a project designed to increase access to fertility drugs for patient-consumers-intended parents through public education and proposals to provide public funding for relevant drugs. Together IAAC and the Demeter Quebec Fertility Association³⁰⁰ were engaged in Serono's Miracle Program, which was at once a "public information service," a means to "address the cost of fertility drugs and the limited access to these drugs through government reimbursement policies," and a way to expand "the potential for including cost-effective reimbursements for fertility drugs in health benefit designs with employers, insurers and financial institutions."³⁰¹ In short, Serono, together with the partner organizations, was providing information about infertility, relevant surgical and pharmacological treatments, to both physicians and patients. In the case of direct-to-patient delivery, intended parents would be able to access information published by Serono and endorsed by IAAC. For information kits sent to physicians with information to be distributed to patients, the documentation would take on another level of legitimacy, seemingly endorsed by the clinics and

²⁹⁹ Rod Mickelburgh, "Fertility Clinics Reprimanded by Head of Royal Commission: Registry's Link to Drug Company May Leave Public Skeptical," *The Globe and Mail*, September 19, 1991, A8. For more information about commercial interests in the Royal Commission, see Weir and Habib, "Comment: A Critical Feminist Analysis of the Final Report of the Royal Commission on New Reproductive Technologies"; Sky, "Commercial Interests and New Reproductive Technologies."

³⁰⁰ Although Demeter Quebec Fertility Association (Association Québécoise pour la Fertilité Déméter) would not play a significant advocacy role in the development of public policy on assisted reproduction at the federal level, the organization would have a significant role in the eventual funding of ART services in Quebec. See L'Espérance, "Fertilize-This."

³⁰¹ Serono Canada Inc., "Finding the Road to Success in Reproductive Healthcare," *Canada Newswire*, June 1, 1994. See also "Program Provides Answers to Patients' Questions About Infertility," *Canadian Medical Association Journal* 151, no. 6 (1994).

physicians doing the distribution. Essentially, the Miracle Program was an effective means of getting much-needed information to potential patients facing the challenging and very personal experience of undergoing infertility treatments. However, the implicit support of Serono by IAAC, Demeter, and relevant physicians built into the structure of the program might have left patients to feel like the interests of Serono, the physicians, and intended parents were one and the same. The partnership between IAAC and Serono continued, and soon, the funding structure of IAAC changed to reflect a model in which pharmaceutical companies, clinics and others benefiting from the use of reproductive technologies were, in conjunction with a number of smaller federal grants, underwriting the costs of running the organization.

This is not to say that there is anything inherently problematic with patient groups accepting funding from private sources. Indeed, it is increasingly common for patient groups to be in some way sponsored by pharmaceutical, biotechnology firms, or other private sources, and it has been suggested that this funding need not be problematic if patient groups are upfront and transparent about where funding is coming from, how it is used, and ensure that it is given with “no strings attached.”³⁰² When costs of research and advocacy work are high and subsidies low, patient groups have few places to look other than private funds. With a rise in “disease and consumer advocacy” since the 1990s and a rolling back of public funding to such groups, it is no surprise that advocates of infertile Canadians have looked to private funding.

However, funding from any private source might influence the actions of patient groups, leading to support and advocacy for access to the drugs, biotechnologies, and services that pharmaceutical companies, biotechnology firms, and clinics respectively and collectively provide. IAAC has engaged with pharmaceutical companies in ways that suggest that there are

³⁰² Sharon Batt, “Marching to Different Drummers: Health Advocacy Groups in Canada and Funding from the Pharmaceutical Industry,” *Women and Health Protection* (2005), <http://www.whp-apsf.ca/pdf/corpFunding.pdf>.

“strings attached,” with mail-outs from Serono going to their members, and advertisements for Serono and other sponsoring pharmaceutical firms appearing on the IAAC website. This cooperation of the private-for-profit actors and charitable organizations advocating for patients enables slippage between what is best for those financially benefiting from the use of ARTs, and infertile people themselves. It may not only result in conflicts of interest and the public representation of the interests of commercial actors and infertile people as the same, but it may also lead infertile people to understand their infertility as a medical issue to be treated through medical interventions, connected to the work of pharmaceutical and biotechnology firms, and to the work of fertility clinics.³⁰³ In this way, IAACs emphasis on infertility as illness supported by their engagements with Serono and other commercial actors obscured the possibility for social understandings and for discussions about preventative care, instead presenting drugs and surgical interventions as the most important part of their advocacy, and as the correct and necessary way to address infertility. By 1995, and the establishment of the voluntary moratorium, IAAC was jointly funded by private sponsorships, donations, as well as its the initial starting grant from Health Canada. While it continued to facilitate infertility support groups, and to publish a bimonthly (and at times, monthly) newsletter, it was increasingly involved in advocacy work, fighting against the delisting of IVF in Ontario in 1994 and engaging in the consultations that preceded the three-phase approach.

Bill C-47 was tabled and *Setting Boundaries* released in June of 1996 and by August, IAAC had formed a committee to respond to the proposed legislation and regulatory regime, reaching out to fertility clinics, the Society of Obstetricians and Gynaecologists of Canada, and the Canadian Fertility and Andrology Society to “speak as a united force” to the Federal Minister

³⁰³ Ibid.; Sharon Batt, “Who Pays the Piper? Industry Funding of Patients’ Groups,” in *The Push to Prescribe*, eds. Anne Rochon Ford and Diane Saibil (Toronto: Women’s Press, 2010).

of Health. In a letter to the CFAS, Debra McNevin (Chair of the IAAC NRGT Response Committee) and Norman Barwin (Chair of the IAAC Board of Directors), proposed further collaboration between the CFAS and IAAC. The letter suggested both a “joint Press Conference”³⁰⁴ to address concerns about C-47, as well as sending designated members to one another’s committee meetings where responses on C-47 or *Setting Boundaries* was being drafted, ensuring alignment between the organizations’ written responses.³⁰⁵

While IAAC had largely supported the work of the Royal Commission, its opposition to the three-phase approach was strong, and it released a report articulating “disappointment” with the “condescending, demeaning, and patronizing attitude reflected in the language and tone” of C-47 and *Setting Boundaries*.³⁰⁶ Its opposition was based on two key points. First, IAAC opposed *Setting Boundaries*’ prioritization of preventative infertility care, and its proposed hierarchy of care wherein invasive treatments were to be the last resort. Citing the ineffectiveness of non-invasive care for certain medical indications, IAAC suggested that leaving invasive care as a “last resort” was not a beneficial approach for all users of reproductive technologies and that it should be left to doctors, not to the state, to determine what is “appropriate treatment for individuals.” Second, IAAC opposed the prohibitions on payment for donors and surrogates, citing a potential decline in access to reproductive services, the potential use of “dangerous self-help methods” that might expose women to undue risks (i.e., self-insemination), and the disproportionate nature of the proposed penalties in relation to the potential harms.³⁰⁷

³⁰⁴ Dr. Norman B. Barwin and Debra McNevin, Letter to Dr. Claude Gagnon (President, CFAS), “Re: New Reproductive and Genetic Technologies Legislation,” August 6, 1996.

³⁰⁵ Ibid.

³⁰⁶ Infertility Awareness Association of Canada, Inc., *Response to Bill C-47 and “New Reproductive And Genetic Technologies: Setting Boundaries, Enhancing Health.”*

³⁰⁷ Ibid.

IAAC's response to C-47 is particularly notable given its discussion of infertility as a medical issue. IAAC was originally established to coordinate and facilitate a network of support groups to help families experiencing infertility, with the additional intention to provide public education and engage in advocacy work. It had largely advertised itself as a support and educational organization working on behalf of infertile Canadians, but at the time of the announcement of the Miracle Program, it noted that this support and education was to be achieved...through the "provision of information and advocacy efforts, in partnership with health professionals, government, industry, and like organizations," an evolution from the language of infertility support groups and peer education that had been its initial focus. Even while IAAC had never been divorced from industry, the early 1990s marked a shift from a focus on self-support and peer education that included adoption, to a medical-only model that relied on advocacy to access infertility treatments in conjunction with industry partnerships and funding from for-profit firms.

The work of IAAC in the mid-1990s was bound up with rise of deference to medical authority and an understanding of pharmaceuticals and new biotechnologies as the desirable "cure" for infertility. Unlike patient advocacy groups and health social movements that had emerged in the 1980s to contest the nature of expertise and the closed networks of biomedicine,³⁰⁸ the work of infertility advocates in the mid-1990s sought to support the status quo. Whereas patient advocacy groups had long opposed the institutions of the medical establishment including "national biomedical research agendas and the organizational principles of clinical trials vis-à-vis access and inclusion,"³⁰⁹ IAAC's conflation of an open market in

³⁰⁸ Epstein, *Impure Science*.

³⁰⁹ Adele E. Clarke et al., "Introduction," in *Biomedicalization: Technoscience, Health, and Illness in the U.S.*, eds. Adele E. Clarke et. al. (Durham and London, UK: Duke University Press, 2010), 12.

reproductive services and patients' best interests worked to solidify the role of fertility clinics, pharmaceutical companies, and biotechnology firms in identifying the ways forward in fertility care. This dedication to a medical understanding of infertility and to reproductive technologies as a cure is exceptionally clear in IAAC's discussion of "social infertility" and social solutions to infertility, where it is noted that:

...encouraging adoption, counselling, fostering and other types of loving contact with children are good things, but they are not solutions for infertility. An approach which gives social 'solutions' priority to medical solutions is wrong-headed. We cannot support it. Medical interventions will enable many people to have children and we feel they should be given the opportunity to do so.³¹⁰

In addition to the embedding of biomedical interests in the advocacy of infertility work, there was another important development in infertility advocacy in Canada that occurred at the time of the three-phase approach. Diane Allen (who had co-founded IAAC's Toronto chapter in 1990 with Sherry Dale and the help of a number of other volunteers) created a new national advocacy group to help infertile people. The Toronto chapter of IAAC had always been particularly active, and in 1995 it branched out on its own, receiving charitable status in 1996. According to Allen, the move away from IAAC occurred in part due to the limited funds available to the Toronto chapter in relation to its rather substantive membership.³¹¹ The new organization, the Infertility Network, did not receive government grants and relied on personal and corporate donations to fund its increasingly ambitious work. Like IAAC, the Infertility Network received corporate grants from pharmaceutical companies, including Serono, especially

³¹⁰ Infertility Awareness Association of Canada, Inc., *Response to Bill C-47 and "New Reproductive And Genetic Technologies: Setting Boundaries, Enhancing Health,"* 5.

³¹¹ Interview with Diane Allen, January 20, 2012. See also Diane Allen, "How We Began," Infertility Network, n.d., https://infertilitynetwork.or/how_we_began; Diane Allen, "Independence Day," in *Infertility Network Newsletter* (Toronto: Infertility Network, 1997).

during its early years.³¹²

The founding of the Infertility Network is not itself of great note, but the organization would come, over the course of the next few years, to distinguish itself from its origins in IAAC. Allen herself is the central organizer of the Infertility Network, and while she was initially opposed to any restrictions on access to gametes or infertility treatments, her position and with it, the work of the Infertility Network would change over time. As will be discussed in chapter five, the Infertility Network came to present an alternative model of understanding infertility, focusing on sociality by forming a network of those interested in the interrelationships between infertile people, LGBTQ people, and donor-conceived families, emphasizing the best interests of children born of ARTs. The three-phase approach marked early days for the Infertility Network, but the medically-based approach advanced by IAAC, would in some ways be contested by the Infertility Network's socio-ethical approach that emerged in the years-to-come.

Overall, the years between the Royal Commission and the death of *C-47* on the Order Paper were, for those advocating on behalf of infertile Canadians and namely IAAC, marked by a shift in funding sources with more and more involvement with the private beneficiaries of assisted reproduction. The resulting tangle of clinics, physicians, infertile Canadians, biotechnology and pharmaceutical companies suggests both a great possibility for conflicts of interest, and for the conflation of the needs of infertile Canadians with those of commercial actors. What would emerge in the subsequent years is that by reinforcing of the interests of infertile Canadians as necessarily biomedical, other possible approaches are obscured including preventative care, or addressing the self-articulated interests of children conceived through

³¹² Approximately 13 per cent of the organization's income came from these sources between 1996 and 1999 (not including any newsletter ad sales). Also, note that the Infertility Network has not received financing from any corporate entities, including pharmaceutical companies since 2006. See Infertility Network, "Financial History," n.d., <https://www.infertilitynetwork.org/files/FinancialHistory.pdf>.

reproductive technologies. The reproductive citizenship of infertile Canadians was necessarily intertwined with a biological citizenship in which infertility *qua* infertile people came to mean a need for potential treatment through ARTs.

Donor-conceived Families

The expansion of advocacy on behalf of infertile Canadians occurred in tandem with the growth of the New Reproductive Alternatives Society. Following the Royal Commission, Shirley Pratten and the NRAS emerged even more significantly as important actors in the policy debates. The work of the organization continued to be part support, part advocacy, and Pratten continued to organize meetings of donor-conceived people and their families (including the yearly picnic), in addition to acting as spokesperson for the NRAS in consultations with the federal government leading to and during the three-phase approach.

At this time, the policy preferences of the NRAS were broad and varied. The organization continued to work on behalf of donor-conceived families, again providing a balance between support and advocacy, and working to ensure that people could continue to use donor conception to build their families. The organization spoke on behalf of at least one sperm donor concerned about the implications of benefiting from the avails of paid donation, several families of donor-conceived people wanting to discourage the widely held practice of keeping donor-conception a family secret, and others interested in legal reforms to ensure that the non-biological parent(s) of donor-conceived children had substantive parental rights.³¹³ The organization would slowly come to focus more and more on the issue of donor anonymity, but at the time of the three-phase

³¹³ Interview with Shirley Pratten, March 21, 2012. See also Canada. House of Commons Standing Committee on Health (Subcommittee on Bill C-47: An Act Respecting Human Reproductive Technologies and Commercial Transactions Relating to Human Reproduction) *Evidence*. Meeting No. 6, April 9, 1997.

approach, the NRAS was broadly engaged in providing support and protection to “other people who are wanting children this way,” as well as privileging the best interests of children conceived using donor gametes.³¹⁴

The interest of the NRAS in addressing the needs of both children conceived of donor gametes and those who had used to use donor gametes to conceive, is particularly notable given that the interests of intended parents and donor-conceived children (and their families) are sometimes seen as divergent. Although donor anonymity was not necessarily the primary issue of interest for the NRAS at the time of the three-phase approach, it was an important part of its work, and Shirley Pratten spoke about donor anonymity widely, asserting that children should have the option of knowing who their donor is, and proposing limits on anonymous gamete donation. She advocated for a system of open-donor identification in which children could choose to know their donor if desired. This stood in contrast to the position of IAAC and the professional organizations representing specialists of reproductive medicine, who advocated for a continuation of anonymous donation as it was believed that there would be a dearth of donors if they were forced to forego the protection from future parental claims and privacy that anonymous donation offered. Infertile Canadians likely to use donor gametes to build their families, as represented by IAAC, were concerned that their access to donor conception would be impeded by challenges to the existing system of anonymous, paid donation, and further, that eliminating anonymity would mean a breach of donors’ privacy. This would emerge more clearly in the hearings on *AHRA*, but the tension between the needs of intended parents, and donor-conceived people was present both in the consultations that occurred throughout the three-phase approach, as well as in the various interests represented by the NRAS.

³¹⁴ Ibid.

The NRAS was not afforded more opportunities to speak with government representatives than IAAC for example, however the policy documents and particularly *Setting Boundaries, Enhancing Health* suggest that the positions of the NRAS on addressing the interests of donor-conceived people had a significant influence on the government's work on donor conception and specifically on the issue of donor anonymity. The Royal Commission had recommended that the practice of allowing gamete donors to remain anonymous should continue, although monitored by a registry so that medical information could be disclosed in cases of "serious medical need as determined by a court of law."³¹⁵ The Royal Commission noted concern about the access of donor-conceived people to medical information about their donors, and the need to protect anonymity to ensure that the supply of donor semen could continue.³¹⁶ As noted above, *Setting Boundaries* took a different approach, noting that "the desire of infertile Canadians to have a biological child of their own was being given more attention than the health of children born from these technologies,"³¹⁷ a problem to be remedied through regulations that put children first. This included enabling children to know their genetic origins, allegedly ensuring that they do not experience "negative psychological consequences" by being deprived of knowing "half of who they are."³¹⁸

Setting Boundaries also proposed a donor registry system to ensure the centralization, protection, and availability of donor information in an ongoing way. The commitment of the NRAS to enabling donor-conceived people to have access to identifying information about their donors was therefore more prevalent in *Setting Boundaries* than it had been at the time of the

³¹⁵ Royal Commission on New Reproductive Technologies, *Proceed with Care*, 483. Note that commissioner Suzanne Scorsone wrote a dissenting opinion on a number of the Commission's recommendations, and on donor anonymity, she suggested that donor-conceived children should have a right to know their genetic origins. Scorsone in *Proceed with Care*, 1062–63.

³¹⁶ Royal Commission on New Reproductive Technologies, *Proceed with Care*, 441–50.

³¹⁷ Health Canada, *New Reproductive and Genetic Technologies: Setting Boundaries, Enhancing Health*, 19.

³¹⁸ *Ibid.*, 19–22.

Royal Commission. This shift followed the changing attitudes of the NRAS itself, which moved from asking for non-identifying information about donors with a registry to a system of open donation in which donor-conceived people should be entitled to know who their donors are, including but beyond their medical histories. According to Pratten, “when the New Reproductive Alternatives Society was formed...we had a belief that somehow we didn’t have a right to expect more than non-identifying [information] because that the way this was, and this had been done this way for so long. Somehow it was so deeply entrenched, and this had been done this way for so long.”³¹⁹ By the mid-1990s, the NRAS was clearer about the interests of children born of ARTs, and asserted that there should be access to donor identities in a broader, more substantive way than had been previously articulated. Following Health Canada’s consultations with Pratten and her daughter Olivia in the kitchen of their Nanaimo home,³²⁰ as well as discussions with a number of other donor-conceived families, this position was included in *Setting Boundaries, Enhancing Health*.

The explicit articulation of the interests of donor-conceived people in *Setting Boundaries* did not result in any substantive policy change. When Bill C-47 died on the Order Paper, the potential regulatory framework set out by *Setting Boundaries* died too. Even if C-47 had passed, IAAC and the Canadian Fertility and Andrology Society, amongst other organizations, were adamant that eliminating anonymous donation would result in a dearth of eggs and sperm, and it is likely that had the regulatory proposals been pushed forward, they would not have passed.³²¹

What did occur, however, was recognition of the importance of donor-conceived people and

³¹⁹ Interview with Shirley Pratten, March 21, 2012

³²⁰ Interview with Shirley Pratten, March 21, 2012; Interview with Francine Manseau, December 8, 2011.

³²¹ This would ultimately occur when proposals for the elimination of donor anonymity occurred during the consideration of the Assisted Human Reproduction Act. See discussion in chapter six of this dissertation. See also Motluk, “Donor Anonymity in the Assisted Human Reproduction Act.”

their families as important actors in the governance of assisted human reproduction far beyond what had occurred at the time of the Royal Commission. In no small part due to the considerable efforts of the NRAS, donor-conceived people were understood to be central to the analysis of reproductive technologies.

Summary: Boundaries Indeed

On the one hand, the three-phase approach effectively identified Canadians as in need of “protection” from the adverse effects of ARTs, and without regulation or at least, regulations-to-come, asserted a sweeping understanding of the public interest in this field. Legal scholars, medical professionals, scientists, and advocates of infertile Canadians argued that the outright banning of commercial surrogacy and gamete donation infringed on the capacity of infertile Canadians to use reproductive technologies, limited their perceived right to build their families or, limited the capacity of gamete donors and surrogates to consent to helping others do so.

On the other hand, by making criminal law about reproductive technologies and relegating all other aspects of ARTs to future regulations and interventions-to-come, the attempts to govern in this period worked to reassert the biomedical understanding of infertility and assisted reproduction. Fertility preservation, judicial intervention in pregnancy, adoption, and other elements of the Royal Commission’s work that did not directly concern the use of reproductive technologies in the context of the laboratory or the clinic were not included in the federal government’s proposed interventions. The voluntary moratorium and C-47 explicitly focused on the need to criminalize the most ethically challenging of ARTs, addressing the most important and concerning practices in terms of their potential misuses. Ensuring access to contraception and providing social supports to enable women to have their children earlier in

life, for example, were not really taken up by the federal government at this time, and the broadly conceived area of study imagined for the Royal Commission and subsequent federal intervention was demonstrably narrowed to the use and practice of ARTs in a biomedical context.

Furthermore, by using the criminal law power (under s.91 (27) of the *Constitution Act 1867*) and addressing ARTs as a matter of public health and safety, the federal government tried to establish a foothold in the governance of assisted reproduction as a means to circumvent the complicated jurisdictional politics of health care. Using the criminal law, however, meant that the federal government had to identify its engagement with ARTs as an issue of public health and safety, attaching sanctions to prohibitions. The advancement of individual reproductive autonomy and the capacity to choose reproductive technologies as a method of medical treatment were challenged by the proposed law, which took up some of the harshest elements of the Commission's recommendations, and applied the criminal law. The proposed legislation, justified in the name of public health, safety, and human dignity, necessarily clashed with the desire to self-regulate articulated by physicians and scientists, and conflicted with infertility patients' interests in medical self-regulation. While a biomedical imperative was apparent in the Royal Commission, the federal efforts to govern ARTs attempted to curb biomedical freedom in the name of "protection." This tension between individually understood biomedical interests supported by infertile Canadians and medical professionals, and the broad criminal approach taken by the federal government was an important reason that Bill C-47 did not become law.

At the same time, stakeholders were working to establish their own place and advance their own interests in the use of ARTs. For LGBTQ Canadians, and particularly lesbian mothers, concern about safe uses of donor sperm meant an increased desire to engage in insemination in clinical contexts, or at least to order semen from safe, typically anonymous sources through

physicians or sperm banks. The consequence was a medicalization of assisted insemination and new inroads to using ARTs in the context of fertility clinics. Through litigation, and namely *Potter v Korn*, fertility clinics opened more and more to LGBTQ patients, normalizing queer experiences of reproduction as occurring within clinical settings. For surrogates and donors, little changed in this period beyond a shift away from broad concerns about women's health and towards unsubstantiated claims about exploitation. The reframing of third-party reproduction from a matter of health to a matter of exploitation refocused the debate to an issue of altruism versus commercialization, and made possible the continuation of unpaid egg donation—a relatively risky, and not-entirely-necessary procedure that is always done for the benefit of someone other than the donor. This period also saw an emphasis on the part of the federal government on the interests of donor-conceived people, including an explicit affirmation that at times, the needs of children born of ARTs should be put before those wanting to build their families. The inclusion of recommendations to eliminate donor anonymity in the three-phase approach, attributable to the efforts of the NRAS, amounted to little more than a discursive shift, but for the first time, donor-conceived people and their families were identified outright as important actors in the governance of assisted human reproduction in Canada.

Infertile Canadians, particularly through the work of IAAC, were more and more wrapped up in the work of commercial and biomedical actors including professional medical associations, fertility clinics, and pharmaceutical firms. The diverse interests of infertile people and the potential for a wide variety of supports, treatments, and alternatives to reproductive technologies that might be of use to infertile people were largely discounted in favour of the expensive, and invasive use of ARTs. This is not to say that IAAC did not legitimately advocate for infertile people needing access to ARTs, or that clinicians, clinics, or others were not

providing good care to patients, but rather, that throughout the three-phase approach, the interests of infertile people were intertwined with the interests of a number of for-profit actors.

In short, throughout the mid-1990s, the Government of Canada largely reasserted the understandings of reproductive citizenship put forth by the Royal Commission. The advancement of an individual biomedical model of infertility care was held up as the primary site for legislative intervention at the federal level, exclusive of LGBTQ people as well as donors and surrogates who might be engaged in the use of reproductive technologies. The already-peripheral commitments of the Royal Commission to addressing preventative care, exposures to environmental chemicals, and sexual and reproductive health moved further and further down the government agenda as the criminalization and regulation of reproductive technologies themselves were prioritized. At the same time, several stakeholder groups were effective in identifying their opposition to the federal approach and working to ensure access on their own terms. Employing a variety of strategies including litigation, grassroots advocacy and lobbying work, educational campaigns, and partnerships with fertility clinics, pharmaceutical companies, and biotechnology firms, LGBTQ people, infertile Canadians, and donor-conceived people came to be understood as increasingly important to the governance of reproductive technologies in Canada.

Chapter Five: Stakeholders in the Breach

The failure of the three-phase approach that occurred with the death of C-47 is often seen as the beginning of a four-year lull of federal action to govern ARTs in Canada.³²² Existing texts on the development of the *AHRA* explore the period between 1997 and 2001 briefly, if at all. However, following the death of C-47, there were a number of important developments from a policy standpoint, including the establishment of a Canadian Biotechnology Strategy, the passage of new regulations governing the importation and use of donor semen, the creation of a framework for sexual and reproductive health, and a private member's bill to address reproductive cloning. And although none of these developments alone signifies a major shift in the direction of the public policy following C-47, taken together, they demonstrate that assisted human reproduction was increasingly identified both as a private matter (wherein individuals are responsible for making choices about their health care) and a means of regulating family formation. The focus on ARTs as a matter of private choice and the expansion of infertility services throughout the late 1990s worked to undermine the understanding of ARTs as a matter of health, and particularly a matter of health with important implications for women as well as resulting children. Also, more than ever before, concerns about federal-provincial relations filtered into the federal government's approach to governing ARTs given a new emphasis on consultation in social policy and attempts to diffuse tensions around federal interventions in health care.

While these federal interventions were incrementally moving the policy field forward, donor-conceived people, infertile people and LGBTQ Canadians were articulating their own

³²² See for example Campbell, "A Place for Criminal Law in the Regulation of Reproductive Technologies"; Cattapan, "Rhetoric and Reality"; Cameron and Gruben, "Quebec's Constitutional Challenge to the Assisted Human Reproduction Act"; Juliet Guichon, Ian Mitchell, and Christopher Doig, "Assisted Human Reproduction in Common Law Canada after the Supreme Court of Canada Reference: Moving Beyond Regulation by Colleges of Physicians and Surgeons," *Canadian Journal of Women and the Law* 25, no. 2 (2013); L'Espérance, "Fertilize-This." Two important exceptions are Scala, "Scientists, Government, and 'Boundary Work'" and Neil Gerlach et al., *Becoming Biosubjects: Bodies, Systems Technologies* (Toronto: University of Toronto Press, 2011).

interests in diverse ways. These stakeholders participated in consultations and in some cases, refocused their efforts in the period following C-47. In the case of donor-conceived people, the New Reproductive Alternatives Society forged new alliances with infertile Canadians, establishing that donor anonymity is an important issue both for families who have donor-conceived children and for those looking to build their families with donor gametes. This period was also marked by other important developments for infertile Canadians, most notably, the case of *Cameron v Nova Scotia*, which attempted (but failed) to increase access to IVF in Nova Scotia based on the argument that IVF is a medically necessary procedure. This case is of particular importance, given that in the absence of legislation governing ARTs, and a lack of access to the relevant technologies, Canadians began to look to the courts to have their perceived right to reproduce using IVF and other technologies recognized. The *Cameron* case provides an important example of the discourse surrounding access to and payment for IVF. Infertile Canadians have contested not the lack of regulation in a high-cost, privately provided field, but rather, that they had to pay for it themselves. For LGBTQ Canadians, the courts also provided a viable means for reproductive citizenship claims in the period after C-47, particularly when the regulations governing the use of donor semen impinged on the capacity of LGBTQ Canadians to access sperm. Further, in this period, Dykes Planning Tykes expanded considerably, offering much-needed information about conception options to LGBTQ people in Toronto, and the Lesbian Mothers' Association of Quebec (LMA) emerged to do similar work in Quebec.

For egg donors and surrogates, things were quite different. While egg donors and surrogates remained far from visible as stakeholders after C-47 died on the Order Paper, throughout the late 1990s, there was a significant increase in surrogacy, as well as egg donation that accompanied the proliferation of ARTs in Canada. What emerged were a number of

brokerage agencies, led by former surrogates that at once organized the largely ad-hoc business of surrogacy and egg donation, and also, came to represent the voices of surrogates and, to a lesser extent, egg donors.

This chapter traces both federal government and stakeholder interventions that occurred in the period from 1997-2001. It identifies actions at the federal level that were not direct or immediate predecessors to the *AHRA*, but served to reinforce the idea that ARTs were a matter of individual, private, reproductive choice and, in the case of the semen regulations, choice accessible only to certain kinds of families. This chapter also addresses the ways in which community stakeholders, namely donor-conceived people, infertile people, LGBTQ Canadians, and egg donors and surrogates engaged with these interventions (where and when they did) and how they sought to articulate their interests outside of federal action. With or without legislation, there was still work to be done.

Federal Initiatives in the Wake of C-47

The failure of C-47 left the federal government reeling. As noted in chapter four, there had been much criticism of the three-phase approach for being hastily introduced, too-tentative, unenforceable, and a matter of provincial jurisdiction. It was clear that Ottawa would have to reconsider before trying again. A more comprehensive program was out of the question, largely due to the tenuous relationship between the federal and provincial governments,³²³ and there would need to be considerable intergovernmental consultations before any legislation could

³²³ Alana Cattapan, "Of Steering, Rowing, and Pipers Unpaid: Assisted Human Reproduction as an Issue of Federal-Provincial Relations in Health Care" (paper presentation at the Canadian Political Science Association Annual Conference, University of Alberta, Edmonton, AB, June 16, 2012).

proceed.³²⁴ Beyond comprehensive legislation, however, there were a number of other ways that progress was to be made in the governance of ARTs.

Bill C-247

In February 1997, just a month prior to C-47 being reviewed by the Standing Committee on Health, scientists from the United Kingdom announced they had successfully cloned the first mammal, Dolly the sheep. Parliament and media alike were swept up in renewed discussions about the need to regulate genetic technologies.³²⁵ This fervour was apparent in the committee debates regarding C-47, but with the legislation already under significant scrutiny and doomed to die on the Order Paper, there was little to be done.

When the next parliamentary session began, Pauline Picard (a Member of Parliament for the Bloc Québécois who had been a member of the Standing Committee on Health's subcommittee on C-47), introduced new legislation. Bill C-247 was a private member's bill designed to criminalize genetic manipulation and cloning, effectively reintroducing the relevant clauses of C-47 as new amendments to the Criminal Code. Picard's bill not only responded to the urgency to legislate raised by Dolly, but also to some of the critiques raised against C-47. Rather than address reproductive *and* genetic technologies in one bill, C-247 suggested simply taking action to criminalize certain genetic technologies, treating the commercialization of reproduction and advances in genetic research differently. Bill C-247 also took up one of the least contentious elements of C-47, as all parties had previously supported a ban on human cloning. Further, the Bloc Québécois had critiqued C-47 for developing new statutory legislation that would require

³²⁴ Nancy Miller Chenier, *Intergovernmental Consultations on Health: Toward a National Framework on Reproductive Technologies* (Ottawa: Library of Parliament, 2002), 5.

³²⁵ Gerlach et al., *Becoming Biosubjects*, 92.

federal coordination to implement and that would centralize responsibility for addressing breaches of the law. As C-247 would criminalize cloning and genetic manipulation by amending the Criminal Code, it would circumvent jurisdictional concerns by focusing not on matters of health, but rather on genetic technologies, putting “science fiction procedures” into the criminal law.³²⁶

Although private members bills are rarely passed, and particularly when introduced by backbenchers belonging to parties that are not the government of the day, they also serve an important parliamentary function by keeping important issues on the Order Paper, providing a site for parliamentary debate on areas of public interest on which the government is not yet ready to take action.³²⁷ It was clear from the outset that the Liberal government would not support C-247. At first reading, Joe Volpe, Secretary to the Minister of Health, stated frankly that the discussion should continue, but that omnibus legislation was soon to come.³²⁸ Nevertheless, C-247, was passed through to second reading and committee stage—remaining on the Order Paper throughout the parliamentary session—and was considered a number of times during meetings of the Standing Committee on Health, when a number of amendments to the proposed bill were made. In a majority Liberal government, the Bill could have easily been made to fail at second reading, so it is notable that the debate over C-247 went on for an extended period, and was even considered in committee; the federal government allowed this debate to continue and for perspectives on the need to ban cloning to be heard. Although C-247 was destined to die on the Order Paper, it allowed the debate over cloning to continue as the federal government struggled

³²⁶ Canada. *House of Commons Debates*, October 31, 1996 (Grant Hill, Reform).

³²⁷ Kelly Blidook, “Exploring the Role of ‘Legislators’ in Canada: Do Members of Parliament Influence Policy?” *The Journal of Legislative Studies* 16, no. 1 (2010).

³²⁸ Canada. *House of Commons Debates*, October 17, 1998 (Joe Volpe, Lib.)

to develop more comprehensive legislation that would fulfill both the criminal and regulatory functions imagined by the Royal Commission and re-articulated in the three-phase approach.

C-247, and its emphasis on genetic rather than reproductive technologies, was particularly important for the then-impending introduction of the *AHRA*. The Bill not only allowed for ongoing debate about assisted reproduction to take place in the House of Commons, but it also worked to reframe the legislation-to-come as a matter of rapidly developing genetic technologies as much as (or more than) assisted reproduction. For women's health advocates and those engaged in the real-life use of reproductive technologies, this reframing of the impending legislation as a matter of genetics rather than reproduction was problematic insofar as it shifted concern away from the risks of reproductive technologies to women and the children thus conceived. The hype about Dolly was harnessed through the debate over C-247, and in the government's responses in the House of Commons and in committee, it was clear that action on cloning was imminent.

The Canadian Biotechnology Strategy

When the new parliamentary session began in August 1997, the Speech from the Throne included the recognition of "biotechnology as one of the important knowledge-intensive sectors targeted for future jobs and growth."³²⁹ The Canadian Biotechnology Strategy (CBS) was officially announced in August 1998, detailed in a policy document entitled *The 1998 Canadian Biotechnology Strategy: An Ongoing Renewal Process*. As noted in this document, the CBS was

³²⁹ Canada, "Speech from the Throne to Open the First Session Thirty-Sixth Parliament of Canada," 1997. The establishment of the CBS is attributable in part, to the work of the Coalition of Biomedical and Health research, which had long been advocating for investment in biotechnology, arguing that "basic research in genetics yielded a high social rate of return by building human capital, creating employment and new technologies, and alleviating the economic burden of illness through the development of treatments and cures;" Scala, "Scientists, Government, and 'Boundary Work,'" 224.

a policy framework coordinated within and across a number of federal line departments of the federal government to promote the advancement of biotechnology. This new strategy was, in fact, an attempt to redouble the efforts of the National Biotechnology Strategy which had, since 1983, been a means to coordinate biotechnological projects across the federal government.³³⁰ A secretariat for the CBS was established within Industry Canada, and the department also chaired the CBS Biotechnology Ministerial Coordinating Committee. In total, eleven departments and agencies were represented.³³¹ Although the CBS would eventually involve diverse projects and different attempts to garner investment in the Canadian biotechnology sector, it is particularly notable that the federal government provided significant funding to these projects, which from 1998 to June 2007 involved total spending of approximately \$450 million.³³²

Critics of the CBS were concerned that the strategy would privilege the voices of industry, marginalize social, ethical, and health-related interests, and would require citizens to engage in self-protection from the harms of new biotechnologies (i.e., by educating themselves, by making the “right” choices in terms of the appropriate uses of technologies) in the name of expanded consumer choice.³³³ These critiques were not unfounded, as although the funding,

³³⁰ Canada, *The 1998 Canadian Biotechnology Strategy: An Ongoing Renewal Process* (Ottawa: Government of Canada, 1998), 3.

³³¹ The departments and agencies that were primary actors in the CBS were as follows: Agriculture and Agri-Food Canada, Environment Canada, Fisheries and Oceans, Health Canada, Industry Canada, the Medical Research Council, the National Research Council, Natural Resources Canada, the Natural Sciences and Engineering Research Council, and the Social Sciences and Humanities Research Council. Other departments, including Foreign Affairs and International Trade, were also involved, to some extent in the CBS’ activities. Working Group on Women, Health, and the New Genetics, *If Women Mattered: A Critical View of the Canadian Biotechnology Strategy and Alternative Visions for Community Action* (Working Group on Women, Health, and the New Genetics, 2001), <http://www.cwhn.ca/sites/default/files/groups/biotech/altcbs/altcbs.pdf>, 8; Chuck McNiven, *Canadian Biotechnology Statistics: In Support of the Implementation of the Canadian Biotechnology Strategy* (Ottawa: Industry Canada, 1999).

³³² Canada, *2006-2007 Estimates — Report on Plans and Priorities*. Report, 2006, <http://www.ic.gc.ca/eic/site/017.nsf/eng/00665.html>

³³³ Abby Lippman, “Geneticization and the Canadian Biotechnology Strategy: The Marketing of Women’s Health,” in *The Gender of Genetic Futures: The Canadian Biotechnology Strategy, Women and Health*, eds. The Working Group on Women, Health, and the New Genetics 1999-2000 (Toronto: National Network on Environments and Women’s Health, 2000); Roxanne Mykitiuk, “The New Genetics in the Post-Keynesian State,” in *The Gender of Genetic Futures: The Canadian Biotechnology Strategy, Women and Health*, ed. The Working Group on Women,

focus, and organizational structure of the CBS would evolve throughout its existence, it was primarily presented as a means to enable economic growth through the expansion of the biotechnology sector, and only secondarily in terms of the benefits and challenges to the lives of Canadians that might result. This is clear, for example, in the language of “producers” and “consumers” used to describe Canadians engaged with biotechnologies throughout the 1998 CBS document, even though most of the Canadian biotechnology industry at that time (approximately 60%) focused on health care,³³⁴ with consumers and patients theorized together.³³⁵ Despite the inclusion of social, ethical, and health-related concerns as part of the CBS and the organizations which grew out of it, overall, the policy documents and reports published in relation to the CBS “leave the reader with the unmistakable conclusion that the commercialization of this science and its resulting technological applications is the driving motivation.”³³⁶ For critics of the CBS, the problem was not the expansion of the biotechnology sector *per se*, but rather the privileging of economic expansion at the expense of social, ethical and health-related interests.

The CBS did not explicitly focus on women’s health, or assisted human reproduction, but reproductive technologies and genetic research were largely assumed to fall within its

Health, and the New Genetics 1999-2000 (Toronto: National Network on Environments and Women’s Health, 2000); Roxanne Mykitiuk, “Public Bodies, Private Parts: Genetics in a Post-Keynesian Era,” in *Privatization, Law, and the Challenge to Feminism*, eds. Brenda Cossman and Judy Fudge (Toronto: University of Toronto Press, 2002).

³³⁴ The recognition of the integrated nature of health care and biotechnology within the CBS is also clear in the design of a specific pre-CBS consultation document designed explicitly for the health care sector. See Canada, Industry Canada, *Health Sector Consultation Document: Renewal of the Canadian Biotechnology Strategy* (Ottawa: Her Majesty the Queen in Right of Canada, 1998).

³³⁵ The industry-focus of the CBS is also noted by Catherine Frazee, in her short work on disability in the CBS. She writes that the CBS’ now-defunct internet site was clearly aimed at producers and investors rather than patients and stakeholders, as indicated by the site’s home page, which included “the Canadian flag, the Industry Canada banner, and the greeting ‘The Information Site that Means Business!’” Frazee, “Obscuring Disability: The Pursuit of ‘Quality’ in the Canadian Biotechnology Strategy,” in *The Gender of Genetic Futures: The Canadian Biotechnology Strategy, Women and Health*, ed. The Working Group on Women, Health, and the New Genetics 1999-2000 (Toronto: National Network on Environments and Women’s Health, 2000), 191.

³³⁶ Wilhelm Peekhaus, *Resistance Is Fertile: Canadian Struggles on the BioCommons* (Vancouver: University of British Columbia Press, 2013), 25.

purview.³³⁷ The CBS' emphasis on the commercial uses of biotechnologies was particularly problematic for feminist scholars, given the absence of any discussion about the disproportionate use of reproductive biotechnologies on women's bodies, as well as women's engagement in managing decision-making about "health care, food, household products, medical devices, drugs, and other pharmaceuticals."³³⁸

Others critiqued the CBS for its emphasis on expanding the biotechnology sector, and with it women's reproductive choices, insofar as the language of "choice" brings with it an understanding of individual risk management, and personal responsibility for mitigating harm.³³⁹ In the context of a neoliberal citizenship regime, the commitment to choice above all may translate to a failure to recognize the ongoing importance of collective concerns. Rather than preventative care and a focus on ensuring no harm is done, the expansion of biotechnology couched in the language of choice often works to provide new solutions to newfound harms, rather than preventing problems in the first place. For example:

[I]n response to demands for healthy pregnancies and healthy babies, women are offered a gamut of prenatal tests. In response to demands for safer, cleaner environments from which carcinogenic materials are removed to protect our health, we are offered costly procedures that will screen us for DNA patterns thought to be associated with an increased risk of developing breast cancer, as well as with 'prophylactic' mastectomies, or expensive drugs (of unproven safety) alleged to prevent breast cancer.³⁴⁰

It follows that in response to demands to address rising rates of infertility, more reproductive choices, such as the use of IVF, donor eggs, or surrogacy, were made available and, through the

³³⁷ While reproductive and genetic technologies are not addressed directly in the CBS, the Royal Commission on New Reproductive Technologies is discussed in supporting policy documents, including the CBS Roundtable Discussion Document and the Resource Document. Canadian Biotechnology Strategy Task Force, *Renewal of the Canadian Biotechnology Strategy*, (Ottawa: Government of Canada, 1998), 3-11.

³³⁸ Anne Rochon Ford and Working Group on Women, Health, and the New Genetics, *Biotechnology and the New Genetics: What It Means for Women's Health* (Winnipeg: Canadian Women's Health Network, 2001).

³³⁹ Lippman, "Geneticization and the Canadian Biotechnology Strategy."

³⁴⁰ *Ibid.*, 34.

promotion of new investment in the biotechnology sector promoted by the CBS, could be made even more widely available. However, for many women, fewer biotechnological solutions might do more to enhance reproductive choice. Improved sexual health education, increased availability of obstetrical and gynaecological care, unpolluted environments, and increased supports for young mothers might have been more effective in heralding an expansion of reproductive choices in a way biotechnologies could not provide.

In response to the CBS (and the simultaneous reorientation of Health Canada's Health Protection Branch to emphasize industry self-regulation), Roxanne Mykitiuk has noted the discrepancy between the urgency given to industry-oriented initiatives and the relatively tentative, hesitant approach on the part of the federal government to introducing "legislation to regulate the health effects of the new reproductive and genetic technologies."³⁴¹ Bill C-47 died on the Order Paper in early 1997, and reports suggested that the Bill would soon be reintroduced.³⁴² It was not until 2001, however, that any bill was brought to Parliament, and even then, it was presented as draft legislation. In contrast, the CBS was identified as a government priority in the 1997 Speech from the Throne, and within months, consultations, a secretariat, and funding were established.³⁴³ Although feminist actors and other critics had long advocated a cautious approach to developing biotechnology and a need to understand ethical, legal, and social implications, the CBS moved forward quickly, touted as a means to advance the Canadian economy and to bring Canada into the new millennium.³⁴⁴

³⁴¹ Mykitiuk, "The New Genetics in the Post-Keynesian State"; See also Mary Wiktorowicz, "Shifting Priorities at the Health Protection Branch: Challenges to the Regulatory Process," *Canadian Public Administration* 43, no. 1 (2000).

³⁴² In February 1998, for example, the *Hamilton Spectator* reported that a spokesperson from Health Canada stated that federal legislation would be released within the year. "Cloning Expert Deplores 'Designer Babies,'" *The Hamilton Spectator*, October 20, 1997, Final edition, C1.

³⁴³ Canada, "The 1998 Canadian Biotechnology Strategy."

³⁴⁴ See also Scala, "Scientists, Government, and 'Boundary Work.'"

The Semen Regulations

As noted in chapter four, concerns about the use of fresh semen in donor insemination led to the introduction of the *Semen Regulations (The Processing and Distribution of Semen for Assisted Conception Regulations)* in 1996, requiring not only stringent testing of semen, but also going through a physician to acquire semen for insemination. This at once worked to medicalize and legitimize lesbian insemination through direct engagement with physicians (and oftentimes with fertility clinics), although it also somewhat limited the capacity of women seeking to order semen from the United States or to use a known donor to do so.

In 1999, the restrictions were revised, presenting new, significant obstacles for LGBTQ Canadians using or donating semen. Following a reported case of chlamydia contracted from donor semen, Health Canada inspected a number of sperm banks in Canada, and found that there were “deficiencies in testing” and non-compliance with the 1996 regulations.³⁴⁵ Donor semen both domestic and imported was quarantined until compliance could be proven. During the quarantine, Health Canada collaborated with the Canadian Fertility and Andrology Society (and the Canadian Standards Association) to review the 1996 regulations to develop revisions.³⁴⁶ The revisions were issued in December 1999 as a Health Canada Directive called the *Technical Requirements for Therapeutic Donor Insemination*, adding another element of regulation to the use and donation of donor semen. In addition to new testing requirements, the Directive stipulated who could donate. The exclusion criteria included (amongst others), donors employed by sperm banks, donors older than forty years of age, donors with a history of certain diseases,

³⁴⁵ “Canadian Government Enforces Stricter Safety Controls at Sperm Banks,” *Agence France-Presse*, July 8, 1999; Dennis Bueckert, “Alarms Sound over Canadian Reliance on U.S. Sperm Bank for Donor Insemination,” *The Canadian Press*, April 18, 2001.

³⁴⁶ Sonya Norris, *Reproductive Technologies Surrogacy, and Egg and Sperm Donation* (Ottawa: Library of Parliament, 1996).

and donors excluded from blood donation in Canada.³⁴⁷ This latter criterion—donors excluded from donating blood—notably included “men who have had sex with another man, even once, since 1977.”³⁴⁸ Additions to the Directive would allow exceptions “in exceptional circumstances, to donor semen that would otherwise be prohibited from distribution under the Semen Regulations,” that did allow men who have had sex with men to provide semen as donors if they received special dispensation from the federal Minister of Health.

The 1999 revisions of the semen regulations had important implications for LGBTQ use of donor sperm. First, the ever-more stringent testing (which rightly sought to protect the health of women and those conceived) limited the number of sperm banks in Canada, as many were unable to uphold the new, high standards. Fewer choices were available to all women, although this was particularly important for lesbians whose access to queer-friendly sperm banks was already a significant challenge.³⁴⁹ Secondly, the 1999 updates to the semen regulations required that the semen of anyone who was not the sexual partner of the recipient be quarantined. This meant that only heterosexual sexual partners could avoid the six-month waiting period and the quarantine because of the presumption that if a woman was having intercourse with someone, she was already subject to the sexual health risks associated with insemination. Single women and lesbians would nearly always be subject to the regulations. However, as Epstein has suggested, a woman’s choice to be inseminated by a known donor and to undertake the risks of donation are her choice, and the risks of “being inseminated with the sperm of someone one is having sex with”³⁵⁰ are no different from being inseminated by a known donor that one chooses.

³⁴⁷ Canada, “Processing and Distribution of Semen for Assisted Conception Regulations SOR/96-254 Enacted under the Food and Drugs Act, RSC 1985,” 1996.

³⁴⁸ Ibid.

³⁴⁹ Stu Marvel, “‘Tony Danza Is My Sperm Donor?,” 228

³⁵⁰ Rachel Epstein, *The Assisted Human Reproduction Act and LGBTQ Communities* (Toronto: AHRA/LGBTQ Working Group, Sherbourne Health Centre, 2008), 6–7.

The concern is not that choice is unduly limited, but rather that the risks of a known donor are seen to be greater than those of sexual intercourse. From this view, one can autonomously choose the risks of intercourse, but not of using a known donor. Subjecting women who are not having sex with their donors to a waiting period (and to more stringent testing) places an undue burden on lesbians and single women and impedes their ability to reproduce. Finally, the restriction preventing men who have had sex with men from donating sperm, even in cases where they are known donors, without special dispensation, reflects a homophobic equation of gay identity with a risky body, and particularly with the HIV/AIDS virus. This not only discriminates against gay men, but also inhibits their ability to be donors or to engage in genetically related co-parenting relationships without undertaking a “different and costly process in order to get special permission from Health Canada.”³⁵¹

LGBTQ Canadians would fight back against the new semen regulations, using the courts to assert that the capacity to use or donate sperm should not unnecessarily burden people on the basis of their sexual orientation. The provisions prohibiting men who have had sex with men from being sperm donors was the subject of an Ontario court case challenging the 1999 *Directive*. This case was brought forward in 2003 by a woman who attempted to conceive using the semen of a known donor who was both gay and over the age of forty, and therefore not eligible to provide sperm without approval from the Minister of Health.³⁵² The woman wanted to use artificial insemination in a clinic to improve the likelihood that the insemination would be

³⁵¹ Ibid., 7.

³⁵² The semen regulations were amended in 2000 to allow for “patients, through their physicians, to access donor semen under exceptional circumstances” when the semen in question did not qualify for distribution. This allowed people to apply for access to semen that would otherwise be ineligible for use, although only through special requests to the Minister of Health, an obstacle that weighs more heavily on the LGBTQ community than other Canadians. Cameron, “Regulating the Queer Family;” Health Canada, “Health Canada Sets Up Special Access Program for Donor Semen [News Release],” December 8, 2000.

successful,³⁵³ but her donor did not want to apply for approval or even to have his semen quarantined and stored.³⁵⁴ He wanted fresh semen to be used to avoid the possibility that it would be held in storage facility and potentially misused. “Susan Doe” claimed that in preventing her from choosing her semen donor, the *Directive* infringed upon her equality rights and right to security of the person under s.15 and s.7 of the *Charter* and further, that in unjustly differentiating between her donor and other donors, it also infringed upon her donor’s equality rights. Egale Canada (formerly EGALE) served as an intervener in the case although it had not prioritized ARTs and queer parenting relative to other issues in its mandate,³⁵⁵ and had not engaged in the policy debate during the three-phase approach. Nevertheless, the *Susan Doe* case was aligned with Egale Canada’s interest in Charter cases addressing discrimination on the basis of sexual orientation, and the organization sought and won intervener status in the case.

The Court, however, found that there was no discrimination against lesbians seeking out known donors on the basis of sexual orientation, because the *Directive* did not establish a scheme in which only the donor, single women, and lesbians are subject to scrutiny. Rather, Dambrot J argued that all donor semen is scrutinized, with the exception of women using the semen of her spouse or sexual partner as “there is little point in imposing the Regulations on a woman seeking assisted conception with the semen of her spouse or sexual partner, because she has already been exposed to any risk that exists.”³⁵⁶ Furthermore, the Court did not consider the claims that the *Directive* discriminated against Susan Doe’s donor on the basis of his sexual orientation because

³⁵³ *Doe v Canada (Attorney General)* (2006) Can LII 1185 (ON SC).

³⁵⁴ This case was originally known as *Jane Doe v Canada* as it involved a plaintiff who had become pregnant using the donor semen in question. Although the case was dismissed for being moot, when another case with similar facts arose (*Susan Doe v Canada*), it was expedited given the findings in the original case, and the importance of the *Charter* issues in question.

³⁵⁵ Rayside, *Queer Inclusions, Continental Divisions*, 189.

³⁵⁶ *Doe v Canada (Attorney General)* (2006).

he was not the plaintiff. The decision was upheld on appeal.³⁵⁷

The *Directive*, especially in consideration of the *Susan Doe* case, is indicative of how semen collection and distribution are regulated in ways that understand nuclear families and heterosexual couples as the “normal” users of assisted reproductive technologies, and all others as exceptions to the rule. The restrictions on both known donors and on gay donors fail to consider how single women and lesbians may rely on donors to build their families, and further perpetuates gay stereotypes about being “diseased with HIV unless a physician and the government state otherwise”³⁵⁸ As with the restrictions on blood donation from which the semen regulations were derived, there is a double standard of risk that is based on outmoded and problematic assumptions about the precarity and safety of gay men’s bodily fluids.³⁵⁹ It is clear that testing and quarantine are necessary and important when derived from an anonymous donor, or in cases where women do not know about or trust the safety of their donor’s semen. However, requiring women to delay insemination for at least six months to have the semen of a trusted, known donor tested and quarantined is an infringement on her capacity to reproduce, and creates a restriction on choice of donor that does not exist for heterosexual women using the semen of a sexual partner.³⁶⁰

The limits on the use of known donors established by the semen regulations are

³⁵⁷ *Doe v Canada* (Attorney General), 11 (ONCA 2007).

³⁵⁸ Andrew Pinto, “Factum of the Interveners (*Doe v Canada*): The Foundation for Equal Families, EGALE Canada Inc., B and D,” (2005): 28.

³⁵⁹ There may have been a too-tentative approach to the establishment and maintenance of the semen regulations given the concerns about contracting HIV through insemination raised in the research of the Royal Commission, and the findings of the Krever Inquiry (the Royal Commission of Inquiry on the Blood System of Canada). Nevertheless, such restrictions on both blood and semen remain. In 2013, Canadian blood services did lift the lifetime ban on donations from men who have sex with men (MSM), but only if they are celibate for five years prior to donation. No changes have yet been made to the semen regulations. See Andre Picard, “Ban on Gay, Male Donors Is Lifted: This Change in Policy is Unreasonable,” *The Globe and Mail*, May 23, 2013, A11; Helen Branswell, “Canada Lifts Ban on Blood From Gay Men,” *Edmonton Journal*, May 23, 2013, A12.

³⁶⁰ For further discussion of semen regulations and the *Susan Doe* case, see Harris, “Lesbian Motherhood and Access to Reproductive Technology,” Feldstein, “Access to Assisted Conception”; Kelly, “Alternative Conception.”

compounded when women choose a known gay donor, given the requirement of ministerial approval in such cases. This “permit to procreate scheme”³⁶¹ suggests that semen of gay men is inherently problematic whereas the semen of men in a sexual relationship with the intended recipient of their donation is not. The specific restrictions on the use of semen provided by gay men unjustly limits the capacity of all women to use the semen of the donor they want to use, and moreover, establishes boundaries for gay men engaged in donation for others, or providing semen to conceive their own children. The semen regulations send a clear message about Health Canada’s understanding of legitimate participants in the use of assisted reproductive technologies that excludes gay men and perpetuates a heteronormative, singular (nuclear) model of the family that precludes the provision of semen from men who have sex with men.

The Consultations on a Framework for Sexual and Reproductive Health

In 1998, following the failure of C-47, Health Canada took steps to implement a different set of recommendations from the Royal Commission, namely preventative approaches to sexual and reproductive health. The causes of infertility were an important aspect of the Royal Commission’s report, and while its recommendations focused largely on establishing a legislative and regulatory framework, some attention was given to the need to also engage in infertility prevention especially in relation to the transmission of sexually transmitted infections. Following the publication of the Commission’s report, there had been efforts to address sexual and reproductive health including the development of guidelines for sexual health education through the work of a federal-provincial-territorial working group,³⁶² but a comprehensive national strategy as proposed by the Royal Commission was yet to occur.

³⁶¹ Pinto, “Factum of the Interveners (Doe v Canada),” 28.

³⁶² Miller Chenier, “Intergovernmental Consultations on Health” 7.

Working to establish a “coordinated national approach for promoting sexual and reproductive health,”³⁶³ Health Canada officials led a consultation process that included other stakeholders, namely, “federal departments, provincial and territorial governments, and key national non-governmental organizations.”³⁶⁴ The purpose of the consultations was, broadly, to develop a strategic framework on improving the sexual and reproductive health of Canadians, directly addressing the Royal Commission’s recommendations.³⁶⁵ The resulting report titled (very literally) *A Report from Consultations on a Framework for Sexual and Reproductive Health*, provided a broad overview of some of the most significant concerns about the sexual and reproductive health of Canadians, providing “quite general” strategies that establish “a comprehensive yet flexible foundation for development of more specific actions by various partners.”³⁶⁶

The *Report’s* broad approach to sexual and reproductive health recognized the fundamental nature of sexuality to human experience, and explicitly explored issues of gender, socioeconomic status, ability, race and ethnicity, sexual orientation, age, and health status. The *Report* also articulated some of the concerns of women’s health advocates about the rising use of reproductive technologies, suggesting that infertility prevention be prioritized rather than reproductive technologies. Ultimately, the *Report* provided eight ethical principles, six “strategic directions,” and a number of suggested “next steps,” to guide future actions discussed in the consultations. These next steps proved to be problematic as there was little uptake of the *Report*, and no real plans to develop specific future actions or a strategy for implementation. The vague

³⁶³ Canada, Health Canada, *A Report from Consultations on a Framework for Sexual and Reproductive Health* (Ottawa: Health Canada, 1999), 1; See also Royal Commission on New Reproductive Technologies, *Proceed with Care*, 230.

³⁶⁴ Canada, Health Canada, *A Report from Consultations on a Framework for Sexual and Reproductive Health*, ii.

³⁶⁵ *Ibid.*

³⁶⁶ *Ibid.*, iii.

guiding principles, directions, and next steps were never more than words on a page.³⁶⁷ The consultation process and report stood alone as initiatives to address women's reproductive and sexual health, but the national strategy envisioned by the Royal Commission and in the *Report* was never established.³⁶⁸ The commitment to protecting sexual and reproductive health, and particularly women's reproductive health, that the *Report* was intended to address resulted in yet another exercise where the recommendations of the Royal Commission were considered and not implemented. The consultative approach was important to ensuring that stakeholders were listened to, but the vacuous promises of the *Report* pushed the possibility of decisive action on sexual and reproductive health too far down the federal agenda, and too far into the future for anything to tangibly occur.

Taken together, C-247, the Canadian Biotechnology Strategy, the semen regulations, and the proposed framework for sexual and reproductive health, are indicative of the range of federal engagement with policymaking on reproductive technologies following the failure of Bill C-47. These attempts to govern assisted human reproduction set by advancing discussions of cloning, investing in biotechnologies, regulating queer families, and holding consultations on future sexual health initiatives, suggest that in the immediate wake of failed legislation, the federal government was engaging in the governance of assisted human reproduction outside of attempts to broadly legislate. These attempts prioritized the marketplace of biotechnology and biomedicine, while advancing understandings of the appropriate use of reproductive technologies as occurring in nuclear, heterosexual families, despite the advances made through cases like *Potter v Korn* in the mid-1990s. Although the consultations for a framework on sexual and

³⁶⁷ Olena Hankivsky, "Beijing and Beyond: Women's Health and Gender-Based Analysis in Canada," *International Journal of Health Services* 36, no. 2 (2006).

³⁶⁸ "Hot Issues: Call to Action!" *Planned Parenthood Federation of Canada*, n.d. <https://web.archive.org/web/20010214043436/http://www.ppfca.ca/issues/action.htm>.

reproductive health did point to some potential movement towards the advancement of broader understandings of how infertility might be addressed, the investment in biotechnology and the decisive and discriminatory actions to restrict access to semen for LGBTQ people marked the overall continuation of the individual, biomedical, consumer-based model of reproductive citizenship advanced in earlier attempts at policymaking.

Stakeholders in the (Unregulated) Marketplace

As these developments occurred in Ottawa, Canadians continued to seek out and use of assisted reproductive technologies and, as in the *Doe* case, to try to overcome obstacles to building their families. Participation in the failed legislative process gave way to capacity-building projects and new strategies to advance the interests and positions of infertile Canadians, donor-conceived people, LGBTQ Canadians, and surrogates and egg donors.

LGBTQ People

The semen regulations had significant implications for LGBTQ people, but in addition to the restrictive regulations, there were additional obstacles posed by adoption and parentage law that largely failed to recognize queer families, and service providers that were not always welcoming. Reports suggested that, following *Potter v Korn*, access to fertility clinics in certain provinces was improved, but access was not widespread until well into the 2000s.³⁶⁹ In fact, a 2013 study of Canadian fertility clinics indicated that one clinic was still not providing access for lesbians, and three clinics (of thirty-four surveyed) had policies that restricted access to care in some

³⁶⁹ Interview with Mona Greenbaum, December 7, 2011.

way.³⁷⁰ How to continue to create families inside and outside of fertility clinics, in spite of barriers to access and the heteronormative framework of federal interventions remained (and remains) an important area of concern.³⁷¹

As described in chapter four of this dissertation, Dykes Planning Tykes was developed in 1997 in Toronto to inform and provide support for lesbians thinking about their family building options. Rachel Epstein and Kathie Duncan first held the course with sponsorship from the Centre for Lesbian and Gay Studies as a “community-education program” at the University of Toronto’s International Student Centre.³⁷² After convening the group a few times, Epstein and Duncan began responding to inquiries about holding the course again; at a housing co-op, at the Toronto Women’s Bookstore, and later at the 519 Church Street Community Centre. Over time, Epstein took more responsibility for the course, and the course expanded to a twelve-week long program.³⁷³

Dykes Planning Tykes was not focused solely on using self-insemination or going to fertility clinics to get pregnant; it was not really about ARTs. Rather it was about sharing information and offering a site for people to meet others in the same circumstances, to ask questions, and to sort out what kinds of options they had to build their families. The course, which continues to run at the time of writing,³⁷⁴ includes ARTs and biomedical understandings of conception as a small component of its curriculum, and as one of the many options available to LGBTQ people looking to build a family. The course aims to help prospective parents work

³⁷⁰ Shannon L. Corbett et al., “Access to Fertility Services for Lesbian Women in Canada,” *Fertility and Sterility* 100, no. 4 (2013).

³⁷¹ Epstein, ““Married, Single, or Gay?”; Interview with Rachel Epstein, December 14, 2011.

³⁷² Epstein, “Introduction,” 18.

³⁷³ Interview with Rachel Epstein, December 14, 2011.

³⁷⁴ The course has since expanded to multiple courses, including courses for gay, bisexual, and queer men (Daddies & Papas 2B), lesbian, gay, bi, and queer women who are considering parenthood (Dykes Planning Tykes), and another course for others with diverse family forms and identities (Queer & Trans Family Planning). See LGBTQ Parenting Network, “Courses,” *LGBTQ Parenting Network*, n.d., <http://lgbtqpn.ca/courses/>.

through diverse “practical, emotional, social, and legal issues” associated with conception, pregnancy, and parenting.³⁷⁵

Nevertheless, Dykes Planning Tykes has been, from its inception, an important venue for lesbians to share information about family building and insemination in ways that harken back to self-insemination networks of the 1970s.³⁷⁶ It has been integral not only in providing support and resources to people thinking about starting their families, but also, it has been a site through which lesbian mothers and those interested in parenthood can learn more about the possibilities for building their families inside and outside of fertility clinics.

A year after Dykes Planning Tykes began, the Lesbian Mothers’ Association was founded in Montreal. In 1997, Mona Greenbaum and Nicole Paquette called a fertility clinic to ask about an appointment and were told that they did not provide services to unmarried women, which effectively excluded many lesbians. Although the Canadian Medical Association (in response to the ruling in *Potter v Korn*) had revised their Code of Ethics in 1996 to address discrimination on the basis of sexual orientation,³⁷⁷ after Greenbaum and Paquette contacted the clinics it was clear that there was no access to fertility clinics for lesbians in Montreal. Furthermore, as the 1996 semen regulations required that imported semen be sent to physicians’ offices, those wanting to use anonymous donors were required to involve a physician receptive to receiving imported donor semen to their office or clinic. With the concerns about the safety of known donor semen that led up to the establishment of the semen regulations, there was a gap between demand and access for women wanting procure “safe” sperm.³⁷⁸

Greenbaum and Paquette found a way to navigate this gap; importing semen to

³⁷⁵ LGBTQ Parenting Network, “Courses.”

³⁷⁶ Luce, *Beyond Expectation*, 245.

³⁷⁷ Capen, “Lesbians, Artificial Insemination and Human-Rights Laws”; Luce, *Beyond Expectation*, 169.

³⁷⁸ Luce, *Beyond Expectation*, 175–190.

Paquette's dermatology office and then banking it in their home. At first, they simply imported semen samples as needed when they were trying to conceive, but there were sometimes delays at the US-Canada border, and with the delays came concern that the samples would thaw prior to arrival or would fail to make it to their destination in time—insemination is a relatively time sensitive matter. They soon realized that the panic that ensued when semen samples were “stuck at the border” could be avoided by “order[ing] a bunch of samples at the same time” and storing them themselves; replacing the nitrogen, rather than the samples. They procured a liquid nitrogen tank to do so, and after Greenbaum got pregnant, they continued to store the remaining (extra) samples with the intention of using the same donor if and when they wanted to conceive again.³⁷⁹

After their first son was born, Greenbaum and Paquette, together with another couple, decided to try to organize something with other lesbian mothers, mothers-to-be, and others thinking about conceiving.³⁸⁰ The first meeting of what would become the Lesbian Mothers' Association³⁸¹ (LMA) was held in October 1998 in Paquette and Greenbaum's living room, with approximately forty women in attendance. It started off as a support group, “building community, doing educational work and sharing information about supportive doctors,”³⁸² but pretty quickly Greenbaum and Paquette took on the role of facilitators of what was effectively a small, “lesbian mothers' sperm bank.”³⁸³ The group knew of a few doctors who would order sperm, and some people asked Paquette to order it as well. They kept samples in the tank that Greenbaum and Paquette already had and came to get it as needed.

³⁷⁹ Interview with Mona Greenbaum, December 7, 2011.

³⁸⁰ Ibid. Nancy Nicol, “Politics of the Heart: Recognition of Homoparental Families in Quebec,” 189.

³⁸¹ The organization has been known widely by its French name, the *Association des mères lesbiennes*. With the broadening of its mandate to include a “Papa-Daddy” group, it changed its name first to the *Coalition des familles homoparentales* (the LGBT Family Coalition) and again in 2014 to the *Coalition des familles LGBT* (LGBT Family Coalition).

³⁸² Nancy Nicol, “Politics of the Heart: Recognition of Homoparental Families in Quebec,” in *Who's Your Daddy? And Other Writings on Queer Parenting*, ed. Rachel Epstein (Toronto: Sumach Press, 2009), 189.

³⁸³ Greenbaum in *ibid.*, 188.

It was only a small number of people that used Paquette and Greenbaum's liquid nitrogen tank,³⁸⁴ but the innovation in ordering the semen themselves and storing it at home (and for other people) is an important instance of community organizing and navigating obstacles to using reproductive technologies faced by LGBTQ Canadians. The 1996 semen regulations requirement that imported semen be ordered to a physician's office compelled many women to seek out artificial insemination at a fertility clinic, including Greenbaum and Paquette. The regulations combined with the discriminatory policies of the clinics excluded lesbians in Montreal from access to the ART services available to others, based on an assumption about who could legitimately reproduce and raise children that was exclusive of lesbians and other unmarried women. Faced with these challenges, Greenbaum and Paquette found a way to circumvent fertility clinics, using Paquette's capacity to order semen samples, and her knowledge about acquiring a liquid nitrogen tank to create the family that they wanted.

The liquid nitrogen is just one example of how Greenbaum, Paquette, and the LMA challenged limits put on the reproductive citizenship of lesbian mothers in the late 1990s and thereafter. Following the birth of their first son, and in the early days of the organization they sought recognition of Paquette's parental rights, but no provisions for same-sex adoption had been put in place in Quebec. As with access to fertility clinics, Quebec lagged behind other provinces, including Ontario, British Columbia, Saskatchewan, and Alberta in recognizing the rights of same-sex families,³⁸⁵ despite legislation passed in 1999 that broadly extended rights recognition to same-sex couples.³⁸⁶ When Paquette and Greenbaum launched the first case to

³⁸⁴ About the extent to which the liquid nitrogen/sperm bank "set-up" was used, Greenbaum has said "it isn't like we did it for a hundred people, maybe like seven or eight." Interview with Mona Greenbaum, December 7, 2011.

³⁸⁵ The differences between Quebec and the rest of Canada regarding advancements of rights claims made on the basis of sexual orientation is discussed at length in Miriam Smith's work on LGBTQ rights after the Charter. See for example, Smith, *Lesbian and Gay Rights in Canada*, 126–132.

³⁸⁶ Rayside, *Queer Inclusions, Continental Divisions*, 179; Barratt et al., "Access to Fertility Services for Lesbians: A Question of Health (Submission to the Standing Committee on Health on Draft Legislation Governing Assisted

recognize co-parenting rights of same-sex couples in Quebec,³⁸⁷ the LMA also launched a campaign for the recognition of same-sex parents in law, which meant an expansion of the then-proposed civil union legislation to include parentage rights for same-sex couples.³⁸⁸ The legislation proceeded more quickly than the court case, and ultimately, progressive same-sex adoption and relationship recognition provisions were included in Quebec's civil-union legislation, which passed unanimously and without abstention in 2002.³⁸⁹ Between education programs, support groups, at-home sperm banking, and legal demands for parental rights, lesbian mothers (and would-be mothers) were negotiating the challenges of building their families in the late 1990s, at least as much as they did in the decades prior. Epstein, Greenbaum and Paquette are particularly visible examples, but LGBTQ people across Canada were finding ways to circumvent discriminatory clinic policies and to address legal ambiguities.³⁹⁰

In many ways, this self-sufficient, do-it-yourself approach to overcoming the numerous barriers to a robust reproductive citizenship for LGBTQ people speaks to the kinds of innovations needed to advance LGBTQ family building within the heteronormative framework of Canadian society. The absence of formal recognition of the needs of LGBTQ people to parent using ARTs has meant establishing new ways, new networks to make lives livable, to fulfill dreams of family building. At the same time, however, there is an underlying thread of neoliberal logic that permeates the focus on access to ARTs advanced by LGBTQ activism in the field.

Human Reproduction)"; Smith, "Recognizing Same-Sex Relationships: The Evolution of Recent Federal and Provincial Policies," *Canadian Public Administration* 45, no. 1 (2002): 10; Marie-Blanche Tahon, "Nouvelles formes de régulation de la famille au Canada et au Québec : Avant-gardisme et marginalization," *Enfances, familles, générations* 5 (2006).

³⁸⁷ Rayside, *Queer Inclusions, Continental Divisions*, 179.

³⁸⁸ Nicol, "Politics of the Heart," 190.

³⁸⁹ *Ibid.*

³⁹⁰ For example, Michelle Walks has described the experiences of women trying different clinics after following the denial of services in British Columbia. Walks, "Stratified Reproduction: Making the Case for Butch Lesbians', Transmen's, and Genderqueer Individuals' Experiences in BC," 83–84; See also Luce, *Beyond Expectation*. Interview with Rachel Epstein, December 14, 2011.

Through engagement with the clinic and the broader spectrum of biomedicine there has been an understanding of the best way to contest family forms as occurring through consumer practices, that is, by undertaking a family building project that requires the consumption of pharmaceuticals, biotechnological interventions, and the larger framework of for-profit clinical engagement in order to create a genetically related child, or to engage in a pregnancy.

At an individual level, it is challenging to fault those who simply seek entry into a fertility clinic as a means to build their families. However, following Laura Mamo, “[f]ertility biomedicine produces new subjectivities: lesbian mothers, gay fathers, and new family arrangements brought into being through consumption.”³⁹¹ Mamo writes elsewhere that, “for many lesbians—buying sperm and all that sperm embodies—becomes a route not only to achieving parenthood, but also to realizing their imagined senses of self”³⁹² that is, becoming a self-sufficient parent able to make individual choices about how to partake equally in the infertility industry. Longstanding concerns about the advancement of “good” sexual citizenship are relevant here as the demands of LGBTQ people seeking to build their families through fertility clinics have hinged largely on the demands of LGBTQ people to access private-for-profit fertility clinics to create genetically related children. This model stands in contrast to broader historical critiques of the normalization of certain kinds of families and the socioeconomic advantages needed, at least in the context of clinic-based fertility treatments to create those family forms. The move to the clinic has created equal access to fertility treatments within a model of reproductive citizenship that is always already grounded in individual choice and economic privilege.

³⁹¹ Laura Mamo, “Fertility Inc.,” in *Biomedicalization: Technoscience, Health, and Illness in the U.S.*, ed. Adele Clarke et. al. (Durham and London, UK: Duke University Press, 2010), 176–177.

³⁹² Mamo, *Queering Reproduction*, 4; See also Mamo, “Fertility Inc.,” 177.

Egg Donors and Surrogates

Although the three-phase approach had set out to ban commercial surrogacy and gamete donation, all that was left after the failure of C-47 was the voluntary moratorium, unenforced, and largely unenforceable. Both altruistic and commercial practices continued in the absence of legislation, even though the link between payment and exploitation made throughout the debate on C-47 seemed to lend a sense of greater legitimacy to “altruistic” arrangements, at least at first. As demand for egg donation and surrogacy expanded, so too did commercialization of these practices.

The proliferation of surrogacy was of particular concern in this period. The Ethics Committee of the Society of Obstetricians and Gynaecologists issued clinical practice guidelines on “preconception arrangements” in April 1997 that identified the probability that surrogacy in Canada was on the rise. The committee identified that when fertility programs were surveyed in 1991 for the research programme of the Royal Commission on New Reproductive Technologies, “only one hospital had participated in preconception arrangements, and...this hospital had only one child born to a gestational mother.”³⁹³ By 1997, six fertility clinics were listed by the Canadian Fertility and Andrology Society as offering surrogacy services.³⁹⁴ Additionally, one clinic, (IVF Canada), was reported to have performed six surrogacy arrangements in 1995 alone,

³⁹³ Ethics Committee of the Society of Obstetricians and Gynaecologists of Canada, *SOGC Clinical Practice Guidelines: Preconception Arrangements* (Ottawa: Society of Obstetricians and Gynaecologists of Canada, 1997). The research conducted by Eichler and Poole for the Law Reform Commission of Canada in 1988 identified approximately 118 known instances of surrogacy that included at least one Canadian participant. It was unclear, however, to what extent physicians were involved in the process of conception (i.e., traditional rather than gestational surrogacy may have been used). Eichler and Poole, *The Incidence of Preconception Contracts for the Production of Children Among Canadians*. Regarding gestational and traditional surrogacy see, for example, Karen Busby and Delaney Vun, “Revisiting the Handmaid’s Tale: Feminist Theory Meets Empirical Research on Surrogate Mothers,” *Canadian Journal of Women and the Law* 25, no. 2 (2013): 96–97; Glenn Rivard and Judy Hunter, *The Law of Assisted Human Reproduction* (Markham, ON: LexisNexis Butterworths, 2005), 8.

³⁹⁴ Alanna Mitchell and Jane Coutts, “Making a Baby in a Petri Dish: There Are Things Going on in Fertility Clinics That Federal Authorities Know Nothing of,” *The Globe and Mail*, September 27, 1997, A1.

with two surrogates actively recruited.³⁹⁵

The Society of Obstetricians and Gynaecologists of Canada's guidelines are particularly notable because they articulate the position that both paid and unpaid surrogacy were "morally unacceptable" as "the potential for coercion of the gestational women in these arrangements is extremely high."³⁹⁶ Despite the emphasis on exploitation only in paid surrogacy evident in committee testimony, parliamentary debates, and in *Setting Boundaries, Enhancing Health*, the Society took a strong position against any and all surrogacy. If followed, these clinical practice guidelines should have eliminated the provision of surrogacy services by Canadian obstetricians and gynaecologists, and consequently, the provision of such services in Canadian fertility clinics.

This was not the case, however, and as an advocate for surrogates emerged, it became clearer that surrogacy was a booming business in Canada. This advocate, Joanne Wright, had been a surrogate twice, and eventually went "into the business of surrogacy full force."³⁹⁷ After several years of brokering arrangements, Wright founded Canada's first surrogacy agency, Canadian Surrogacy Options, matching intended parents and surrogates for a fee.³⁹⁸ As of 1999, she claimed to have helped in fifty surrogacy arrangements (one media report suggests that she was "liaising with 250 surrogates each year").³⁹⁹ This was possible, perhaps because, as she asserted by 1999 "all the fertility clinics in Toronto are 'surrogate friendly'" and "some clinics in

³⁹⁵ Andrew Duffy, "Couple Risks Prison to Hire Surrogate Mom; Coming Law Would Make \$10,000 Deal a Crime," *Edmonton Journal*, November 2, 1996, A3; Laura Pratt, "Womb Service: An Inside Look at Surrogate Motherhood," *Today's Parent*, June 2000.

³⁹⁶ Ethics Committee of the Society of Obstetricians and Gynaecologists of Canada, *SOGC Clinical Practice Guidelines: Preconception Arrangements*.

³⁹⁷ Pratt, "Womb Service."

³⁹⁸ Wright's fee was reported to be "nominal" in 2000 at \$400 to create a match between a couple and a surrogate. *Ibid.* In 2001, however, reports suggest that Wright was charging a "referral fee" of \$2,500 (See Hamida Ghafour, "Netting a Newborn--Infertile Couples Are Shopping the Internet for Surrogate Mothers to Carry Their Child," *The Toronto Star*, February 16, 2001, 1). By 2007, the fees were reportedly \$5,500 (Richmond, "Womb Mates"). Today, the fee to "guide you [intended parents] through your surrogacy journey" is \$6,250 (Alison Motluk, "The Baby - Making Business," *Toronto Life*, February 14, 2014).

³⁹⁹ James Pasternak, "Selling Yourself for Love and Money: Big Pharma Will Pay You More than a Fast Food Joint Will," *National Post*, September 23, 2000, C07.

Vancouver and Calgary are starting to do surrogacy work.”⁴⁰⁰ Articles about Wright appeared in newspapers across the country, presenting to Canadians the notion of a happy, healthy surrogate who enjoyed the experience of being a surrogate so much that she was willing to help others do the same. A few women had previously spoken to media about their positive experiences with surrogacy,⁴⁰¹ but as both a two-time surrogate and a broker, Wright was a more palatable expert, and from 1999 onward she was often quoted and cited in media reports addressing ARTs. She quickly became the *de facto* spokesperson for surrogacy in Canada.

The emergence of a strong advocate of surrogacy, coupled with the increased availability of surrogacy services left the Society of Obstetricians and Gynaecologists actively opposing a practice in which its constituent physicians were increasingly involved. While the Society had been unequivocal in its 1997 guidelines that Canadian obstetricians and gynaecologists should not enable surrogacy arrangements in any form, in 1999 it issued a joint statement with the Canadian Fertility and Andrology Society on ethical issues in the use of assisted human reproduction. The joint statement affirmed, like the 1997 clinical guidelines, that commercial surrogacy is “morally unacceptable” but left some room for unpaid surrogacy, asserting that “the committee was not unanimous in ruling out the potential that true altruism could exist in some cases of gestational arrangements.”⁴⁰²

Joanne Wright’s advocacy, and the shifting position of the Society of Obstetricians and Gynaecologists of Canada marked a change in the public conversation about surrogacy heralded

⁴⁰⁰ Bueckert, “Plenty of Wombs for Rent: Surrogate Motherhood Phenomenon Growing in Canada, Advocates Say,” *Winnipeg Free Press*, May 31, 1999, B1.

⁴⁰¹ See, for example Robert Matas, “Surrogate Mother Tells Her Opponents to Respect Decision,” *The Globe and Mail*, May 19, 1987, E12; Paula Adamick, “Surrogate Mother Defends Her Role,” *The Toronto Star*, May 27, 1988, A3.

⁴⁰² Renée Martin et al., “Ethical Issues in Assisted Reproduction (Joint Canadian Fertility and Andrology Society/Society of Obstetricians and Gynaecologists of Canada Report),” *Journal of Obstetrics and Gynaecology Canada* 21, no. 3 (1999).

by the debate over paid and altruistic surrogacy in the federal government's three-phase approach. Debate over surrogacy had long been framed as a two-part question, asking first if surrogacy is permissible, and then, if so, what forms of surrogacy could ethically occur. By the mid-1990s, the question was different, taking for granted that altruistic surrogacy is permissible⁴⁰³ and that it could ethically occur, asking only how to prohibit or govern the tenuous reality of commercial surrogacy arrangements.

The founding of Canadian Surrogacy Options, and other agencies soon thereafter,⁴⁰⁴ also represented an important moment for surrogacy in Canada in regards to how paid surrogacy would be understood. No matter their trajectories, other organizations that came to represent people engaged in or born of ARTs (i.e., IAAC, the Infertility Network, Dykes Planning Tykes, the Lesbians Mothers' Association, and the New Reproductive Alternatives Society) emerged out of support groups. In the case of surrogacy, Joanne Wright had (and would continue to be) a surrogate, and had been involved in many surrogacy arrangements, but it was also her business. Her media commentary was at once a way to advocate for her position on surrogacy, and to increase the visibility and legitimacy of her business. The possibility emerged that regulated, paid (or compensated) surrogacy could be a viable option for Canadian families.

As to egg donation, little occurred in the period following the three-phase approach. At the time that the Royal Commission on New Reproductive Technologies conducted research on the provision of egg donation services in Canada, eight of fifteen IVF programs in Canada offered "either egg or embryo donation" with egg sharing being the most prevalent source of donor eggs. While the clinics did not provide data on the number of donations that were

⁴⁰³ Haase, "The Long Road to Regulation," 68–69.

⁴⁰⁴ A second agency, Surrogacy in Canada Online, was founded in 2001 (following the experience of owner Sally Rhoads-Heinrich as a surrogate to an American couple). In 2007, a third agency (Canadian Fertility Consultants) was established by Leia Picard, who has been both a surrogate and an egg donor.

occurring, the researchers concluded that “few such transfers are believed to occur” and that there was “no evidence that women are being recruited as donors.”⁴⁰⁵ After the failure of Bill C-47, solicitation in campus newspapers for egg donors continued, as did the practice of egg sharing, and a number of media reports of egg donations occurring with American donors were published, suggesting that more than a few transfers were happening each year.⁴⁰⁶ By 2001, the Canadian Assisted Reproductive Technologies Register reported that 301 cycles of IVF with donor eggs occurred in Canadian IVF clinics.⁴⁰⁷ At the very least, the significant change between the data reported in the research of the Royal Commission and the data provided by the Canadian Assisted Reproductive Technologies Register for 2001 suggests that there was an increase in the number of clinics offering egg donation in Canada, as well as a significant increase in the number of Canadians engaged in egg donation over the course of the 1990s.

Nevertheless, no advocates emerged, and there was limited consideration of egg donation in media reports between 1997 and 2000. The few articles that were published lamented the lack of legislation, or the possibility that banning egg sharing and compensation for egg donors might result in a “shortage” in eggs in Canada and subsequently importation of eggs and egg donors from the United States.⁴⁰⁸ No egg donors were cited, but both Justine Espenant from IAAC, and Dr. Art Leader (past-president of the Canadian Fertility and Andrology Society) were quoted as

⁴⁰⁵ Thomas Stephens et al., “Survey of Canadian Fertility Programs,” in *Treatment of Infertility: Current Practices and Psychosocial Implications*, Research Studies of the Royal Commission on New Reproductive Technologies, vol 10 (Ottawa: Royal Commission on New Reproductive Technologies, 1993), 37.

⁴⁰⁶ Peter Cheney, “Human Egg Trade Lures Elite Students,” *The Globe and Mail*, July 9, 1998, A1; Mitchell and Coutts, “Making a Baby in a Petri Dish”; Anne McIlroy and Sean Fine, “Blind Choice: What Fertility Clinics Don’t Say,” *The Globe and Mail*, May 26, 1999, A3.

⁴⁰⁷ The Canadian Reproductive Technologies Register was established in 1999 as a voluntary data collection program for Canadian IVF programs. Data was first reported by the registry for 2001 and reported data from nineteen of twenty-two IVF centres operating in Canada at the time. Joanne Gunby, Salim Daya, and IVF Directors Group of the Canadian Fertility and Andrology Society, “Assisted Reproductive Technologies (ART) in Canada: 2001 Results from the Canadian ART Register,” *Fertility and Sterility* 84, no. 3 (2005).

⁴⁰⁸ Harper, “Law of the Seed,” *The Toronto Star*, January 15, 2000, 1; Cheney, “Human Egg Trade Lures Elite Students.”

supporting broadly conceived “reimbursement” for egg donors.⁴⁰⁹ The desire for intended parents to access gametes was carefully weighed in these articles, against the perceived immorality of paying for eggs. The 1999 joint statement on ethical issues in ARTs published by the Society of Gynaecologists and Obstetricians of Canada and the Canadian Fertility and Andrology Society articulated the same position presented by Leader and Espenant, that compensation for egg donors was both ethical and necessary to prevent a shortage in human eggs, as well as to keep Canadians from engaging in cross-border travel to buy eggs in a bigger, more ethically problematic, global market.⁴¹⁰ The advertisements for egg donors in university newspapers were only one way that Canadians were finding egg donors; going to the United States to openly pay donors, or advertising online also became new alternatives.⁴¹¹

The expansion of the market in eggs, and with it, the understanding that payment for gametes was an “entrenched practice”⁴¹² resulted in a situation where fertility specialists were at once advocating for their patients’ access to services (i.e., being able to acquire eggs in order to undergo IVF) and undermining the possible understanding that egg donors would be patients at risk of harm. The narrative presented was that the “shortage” in eggs impedes intended parents from becoming parents in the way that they desire, and consequently from exercising their capacity to be flourishing reproductive citizens. In this understanding of eggs as part of a free market, and subject to laws of supply and demand, a “shortage” in eggs means that intended parents might not have access to the menu of reproductive options that would otherwise be available to them, unless they circumvent inaccessibility by looking to a different marketplace.

⁴⁰⁹ Harper, “Law of the Seed.”

⁴¹⁰ Eventually Canadian egg donation agencies would exist (as part of the pre-existing surrogacy agencies, including Canadian Surrogacy Options), but this would not occur until approximately 2008.

⁴¹¹ Cheney, “Human Egg Trade Lures Elite Students.”

⁴¹² McIlroy and Fine, “Blind Choice.”

The interests of egg donors themselves, including their future reproductive capacity, were rarely discussed, rather egg donors' interests were reduced to a balance of risk and financial compensation with donors understood as little more than vessels of a reproductive resource to which others were (and are) entitled.

Infertile Canadians/Donor-conceived Families

By 1997, there were two distinct organizations representing infertile Canadians across Canada; IAAC and the Infertility Network. After C-47 died on the Order Paper, IAAC focused on building its organization, supporting its membership, creating a magazine to distribute to its membership (and to place in fertility clinic waiting rooms), and engaging with media as issues arose.⁴¹³ Throughout this period, IAAC continued to operate under the leadership of Dr. Barwin, with a changing executive directorship, first under Marie Morrissey (one of the organization's founders), and then under Justine Espenant. Compared with the significant advocacy work it had done around C-47, the activities of IAAC in this period seem relatively limited, perhaps a function of limited funding,⁴¹⁴ or due to organizational burnout after the extensive work that had gone into fighting against C-47.

However, IAAC's framing of infertility as an explicitly medical issue that was expressed throughout the three-phase approach was gaining some traction, and an important court case proceeded in this period that would reinforce the understanding of infertility as a disability, and the understanding of ARTs not only as a right, but as an entitlements under provincially funded health insurance programs. This case, *Cameron v Nova Scotia*, centered around Alex Cameron (a

⁴¹³See for example "Embryo Mix-up Renews Calls for Tighter Controls," *The Toronto Star*, May 27, 1999, 1.

⁴¹⁴According to Bev Hanck, former executive director of IAAC, funding during this period was not provided by pharmaceutical companies, and corporate support was limited. Interview with Bev Hanck, December 7, 2011.

lawyer) and his wife, Cheryl Smith (an obstetrician and gynaecologist), who had trouble conceiving due to “severe male factor infertility.”⁴¹⁵ Because intracytoplasmic sperm injection⁴¹⁶ (ICSI) was not available in Halifax, they went out of province to seek care, first in Toronto and then in Calgary. Upon their return, they applied to the Nova Scotia Health Care Insurance Plan for reimbursement of the considerable costs of the medical services they had incurred out-of-province, but they were informed that the costs of IVF (and ICSI) were not eligible for reimbursement.⁴¹⁷

Cameron and Smith turned to the courts to seek reimbursement of their medical costs, punitive damages, as well as “a declaration that IVF and ICSI are insured services”⁴¹⁸ in Nova Scotia. They argued that infertility is a disability and the lack of funding under the provincial health insurance plan was a violation of their equality rights under s.15 of the Charter. At trial, Kennedy J., found that the provision of IVF and ICSI are not “medically necessary” in the terms of the Nova Scotia *Health Services and Insurance Act*, although they might be medically indicated and beneficial to some, the risks and still-experimental nature of the procedures did not “come within criteria necessary before a medical procedure is funded.”⁴¹⁹ Recalling the arguments of the Royal Commission about IVF and bilateral fallopian tube blockage, Kennedy J. argued that experimental procedures fall outside of publicly funded health care programs. The

⁴¹⁵ *Cameron v Nova Scotia* (Attorney General) (1999), 172N.S.R. (2d) 227; [1999] N.S.J. No. 33 (N.S. S.C.) (QL) at 2. [*Cameron NSSC*]

⁴¹⁶ Intracytoplasmic sperm injection is a reproductive technology that is used to inject a single sperm directly into ova to facilitate fertilization, often used to overcome male factor fertility problems. It is used in combination with IVF as the ova must be outside of the body in order for the procedure to occur. See for example, R. J. Sherins et al., “Intracytoplasmic Sperm Injection Facilitates Fertilization Even in the Most Severe Forms of Male Infertility: Pregnancy Outcome Correlates with Maternal Age and Number of Eggs Available,” *Fertility and Sterility* 64, no. 2 (1995).

⁴¹⁷ *Cameron NSSC*.

⁴¹⁸ Barbara von Tigerstom, “Equality Rights and the Allocation of Scarce Resources in Health Care: A Comment on *Cameron v. Nova Scotia*,” *Constitutional Forum* 11 (1999): 31.

⁴¹⁹ *Cameron NSSC* at 53. See also von Tigerstom, “Equality Rights and the Allocation of Scarce Resources in Health Care”; Stu Marvel, “Polymorphous Reproductivity and the Critique of Futurity: Toward a Queer Legal Analytic for Fertility Law,” *Jindal Global Law Review* 4, no. 2 (2013): 303–304.

matter of infertility as disability did not therefore need to be addressed, as the denial of funding “is based on the nature of the treatment being sought, rather than the personal characteristics of those persons seeking funding, the infertile.”⁴²⁰ The judgment in favour of the province was upheld on appeal, but with different reasoning. The Nova Scotia Court of Appeal ruled that infertility is indeed a disability under Section 15, but that the denial of funding within the provincial health insurance program is a reasonable limit in a health care system with scarce resources to be carefully allocated. Cameron and Smith sought leave for appeal with the Supreme Court, but it was not granted.⁴²¹

Cameron and Smith did not receive any reimbursement, but nevertheless, their case marks an important juncture in advancing a medical model of infertility. Despite the advancement of a medical model of infertility in the work of the Royal Commission and thereafter, the appeal in *Cameron v Nova Scotia* marks the first time that infertility *qua* infertility was recognized in Canada as a disability and within the purview of the Charter. The medical model was taken for granted in Ontario’s provision of IVF services only to those with bilaterally blocked fallopian tubes, and in the proposed legislation, public debates, and media reports that had been put forth in the previous decade, but *Cameron* marked the first time that an equality rights claim was put forward, recognizing infertility as a disability.

Not only was a medical model of infertility recognized in *Cameron*, but also the characterization of medically understood infertility that it put forth was exceptionally broad. Alex Cameron’s infertility required that his wife, Cheryl Smith undergo IVF, and although the treatment involved the use of his sperm (and the injection of his sperm into her eggs in ICSI), the

⁴²⁰ *Cameron NSSC* at 53.

⁴²¹ Daphne Gilbert and Diana Majury, “Infertility and the Parameters of Discrimination Discourse,” in *Critical Disability Theory: Essays in Philosophy, Politics, Policy and Law*, eds. Dianne Pothier and Richard Devlin (Vancouver: University of British Columbia Press): 285.

interventions would take place largely on Smith's body. She would undertake the risky parts of these procedures and would be the one incurring the costs. As with others who cannot reproduce with their sexual partner, including LGBTQ Canadians, the infertility experienced in this case was not necessarily medical, but could also be understood as social. Alex Cameron certainly experienced infertility, but Cheryl Smith needed infertility care not because she was infertile, but because she was part of a couple that could not effectively reproduce biologically together.⁴²²

The use of a disability rights claims to seek out recognition of infertility as a medical condition, and consequently, funding for reproductive services is especially notable, given its divergence with the history of disability rights claims related to medical care. Following Gilbert and Majury, there is a discord between the disability claims made in *Cameron* and the history of women with disabilities working hard to contest medical understandings of disability in order to promote social acceptance of physiological and psychological diversity. In *Cameron*, and in other cases where reproductive disabilities are claimed, the same discourses of discrimination and equality are used, but instead of contesting medicalization, a medical understanding of disability is actively adopted, "usually in order to gain access to medical technology."⁴²³

In the time that *Cameron* was proceeding, the Infertility Network (which again, had become a standalone organization in the mid-1990s) was engaged in capacity building, and establishing its own framework for advocating for infertile Canadians. Throughout the three-phase approach, Executive Director and spokesperson Diane Allen had continued sending out newsletters, building the membership, facilitating support-groups, and holding the long running seminar series, in addition to a number of new initiatives.⁴²⁴ The focus of the seminars and a

⁴²² Gilbert and Majury, "Infertility and the Parameters of Discrimination Discourse."

⁴²³ *Ibid.*, 71.

⁴²⁴ Interview with Diane Allen, January 20, 2012.

series of conferences that began in 2000 reinforced some of the differences between the positions of the IAAC and the Infertility Network. Both IAAC and the Infertility Network had long been committed to advancing the interests of infertile Canadians, however, the Infertility Network had since started to embrace a nuanced perspective that also considered the self-articulated interests of donor-conceived people. The New Reproductive Alternatives Society, in addition to a number of donor-conceived people, their families, and relevant experts were included in seminars, and subsequent conferences. Donor insemination had been a part of the range of the Infertility Network's seminar topics,⁴²⁵ but between 1996 and 1999, it held five different seminars on donor insemination, anonymity and disclosure,⁴²⁶ in addition to planning the first international conference of donor offspring (*The Offspring Speak*) held in the August of 2000.⁴²⁷

It was through these seminars and conferences that the perspectives of members and organizers of the Infertility Network were heard together with those of donor-conceived families. This marked a turn in the conversation about donor anonymity, as the perspective of IAAC presented to the Standing Committee in testimony on C-47 had been that while donor-conceived people should be entitled to medical and non-identifying information, donor anonymity should continue, suggesting that eliminating donor anonymity would infringe on donors' privacy rights. IAAC, had long argued that an end to anonymity would not only be a matter of privacy, but would reduce the supply of gametes, ultimately pitting the interests of infertile people wanting to have a child against the interests of donor-conceived people who seek to know their genetic

⁴²⁵ Seminars on donor insemination prior to 1996 included "Infertility: Choices (DI, Adoption, Childfree Living) (1992), "Donor Insemination: Issues, Disclosure, Doctors" (1993), and "Donor Insemination: Disclosure" (1994). Personal communication with Diane Allen, April 18, 2014.

⁴²⁶ The five seminars that addressed donor conception and anonymity held between 1996 and 1999 included "Patient Preparation" (1996), "Egg and Sperm Donation" (1997), "Choices and Challenges of Donor Insemination" (1998), "An Identity Release System" (1999) and "Egg, Sperm, and Embryo Donation" (1999). Personal Communication with Diane Allen, April 18, 2014.

⁴²⁷ Infertility Network, *The Offspring Speak* (Conference Recording – DVD) (Toronto: Infertility Network, 2000).

origins. Intended parents and donor-conceived families were seen to have competing interests vis-à-vis donor anonymity.⁴²⁸

In contrast with IAAC, the Infertility Network seemed to resolve the apparent opposition between donor-conceived families and intended parents. The discussion at the August 2000 seminar focused on the interests of donor offspring, and emphasized the position that interests of intended parents who are using donor conception should consider that their child(ren) yet-to-be conceived might one day want access to information about their genetic progenitor. According to Diane Allen, people who may seek out donor gametes in order to have their children may not have thought about what it might mean to the person yet-to-be-conceived until they are a living, breathing person with questions about their genetic origins.⁴²⁹ The conceptualization of the Infertility Network as an organization advocating for the interests of infertile people, not only in having children, but living thereafter with the implications of having used reproductive technologies was almost novel, and the response was strong. The NRAS responded to the invitations of the Infertility Network and the relationship-building that occurred between these organizations included other activists, and worked to create an increasingly unified voice among stakeholders in the “infertility community” (outside of IAAC) that the interests of infertile Canadians in the governance of assisted reproduction reached beyond simply creating a pregnancy and having children. The co-construction of the interests of infertile Canadians and donor-conceived people worked to challenge the idea that unfettered access to ARTs was the best model to meet the needs of infertile Canadians.

A sense of collegiality and like-mindedness thus emerged among the people who organized and participated in these seminars and conferences. Over coffee and conversation, a

⁴²⁸ Ibid. (Presentation by Francine Manseau on the Canadian Regulatory Framework), August 2000

⁴²⁹ Interview with Diane Allen, January 20, 2012.

group of stakeholders interested in ending donor anonymity was loosely established; the Coalition for an Open Model in Assisted Reproduction (COMAR). Many had met through other events—at government consultations and conferences, through research and other organizations⁴³⁰—but by the time of the August 2000 workshop, the loose coalition was beginning to come together. In addition to Diane Allen, and Shirley Pratten, a number of speakers at that conference came to be associated with COMAR. According to Catherine Clute, one of the group’s members, it was really an ad-hoc group that began to mobilize around their shared understanding of the numerous issues that face families trying to conceive using assisted reproduction, as well as the understanding that the range of stakeholders involved would not all be heard by the Standing Committee on Health when the *AHRA* was introduced.⁴³¹ According to Shirley Pratten, COMAR:

[W]as really established more in name only, more than anything else. To just show a united front as a coalition for an open model in assisted reproduction. [...] It was really a political move to push back [against] the incredible lobbying that was going on with the doctors, and we didn’t want to appear fragmented. I mean, we were stronger united as a group.⁴³²

This organizing occurred largely through email, but was effective in bringing together and coordinating testimony to the Standing Committee on Health in 2001.

As to IAAC, the advancement of the medical model of infertility in *Cameron* suggested that access to ARTs are not merely a matter of choice, but also an entitlement. A biomedical understanding of infertility continued to be an important discursive frame used to advance the claims of infertile Canadians, particularly insofar as impediments to access were viewed as infringing on their rights to reproductive choice, and increasingly, to medical care. For IAAC,

⁴³⁰ Ibid.; Interview with Phyllis Creighton, November 30, 2011,

⁴³¹ Interview with Catherine Clute, December 2, 2011.

⁴³² Interview with Shirley Pratten, March 28, 2012.

infertile Canadians required unrestricted access to ARTs, meaning the continuation of compensated, anonymous gamete donation. In conjunction with the infertility industry (of clinicians, pharmaceutical firms, and biotechnology companies) that would stand to benefit from the expansion of access to fertility treatments, IAAC largely advanced a biomedical model of care. At the same time, however, the Infertility Network and the NRAS were coming together to contest the position that infertile Canadians should only be invested in access to medical care. When plans for new legislation were announced, and consultations started to occur, these two perspectives of these groups representing infertile Canadians would become more and more pronounced, with the Infertility Network seeking largely to protect the interests of donor-conceived people and IAAC continuing to promote unfettered access to reproductive technologies.

The divergence between the kind of reproductive citizenship sought by infertile Canadians hinged then on an interest in strong government regulation of commercial practices bound up with concerns about donor privacy. Those interested in the continuation of donor anonymity, or in the provision of compensation or payment to gamete donors and surrogates, were advocating for non-regulation or at the very least, minimal regulation to ensure that access could continue.

Summary

The path between *C-47* and the *AHRA* (that would be introduced in 2001) was indirect and circuitous. Canadians were impatient for clarity about how they could proceed with the use of ARTs, and for either regulation or criminalization (or both) to address technological advancements-to-come. In the meantime, consideration of Bill *C-247* and *A Report from*

Consultations On a Framework for Sexual and Reproductive Health acted as placeholders to demonstrate a federal commitment to eventually moving forward with the recommendations of the Royal Commission. Although Bill C-247 never passed and the sexual and reproductive health framework amounted to little more than the report itself, they were markers of an ongoing legacy of the Royal Commission report.

More than merely inching towards new legislation, other developments following the failure of C-47 promoted the understanding of biotechnology as a site for potential economic growth. The rapid development of the Canadian Biotechnology Strategy and the extent of relevant investment promoted “permissive policies on human biotechnology that were...deemed necessary if Canada wished to maintain its leading position in an increasingly competitive and international industry.”⁴³³ The emphasis on biotechnology as a matter of economic, rather than social, ethical, or health related concern evident in the Canadian Biotechnology Strategy, suggested that the regulation of assisted reproduction, slow as it was to come, would take place in ways that would primarily seek to protect the interests of the biotechnology sector (and ostensibly, the biomedical sector) rather than the interests of Canadians using these new technologies. In this framework, attempting to restrict the ever-expanding marketplace in reproductive technologies would be a Sisyphean task. The semen regulations were an important intervention that did work to regulate ARTs, but did so in a way that was ultimately restricted the capacity of LGBTQ Canadians to provide or access donor semen.

In the meantime, infertile Canadians, surrogates, LGBTQ Canadians, and donor-conceived people were negotiating their interests and taking new steps towards having their concerns about the use and regulation of assisted reproduction recognized. The exclusion of

⁴³³ Scala, “Scientists, Government, and ‘Boundary Work,’” 226.

LGBTQ people from accessing semen as well as from fertility clinics worked to mobilize new stakeholders and to call for the increased recognition of LGBTQ people as potential consumers of reproductive services. Surrogates were increasingly viewed as potential actors in the reproductive marketplace, although concerns about the commercialization of the human body and of reproductive labour would remain. Infertile Canadians were increasingly divided in their positions on access, as the constituency of the Infertility Network was increasingly taking up the concerns of the NRAS to advance the interests of donor-conceived families, while IAAC continued its work calling for fewer restrictions and barriers to accessing treatment. Following the failure of C-47, and in the absence of clear and decisive federal action on ARTs, these groups were able to assert new positions on the governance of ARTs. With the long road to the *AHRA* about to move into the next, and final phase, there was a need to (re)define the reproductive citizenship of these stakeholder groups in order for their recognition to occur in the policy debates, and in the legislation-to-come.

Chapter Six: The Assisted Human Reproduction Act

The debate over Bill C-247 and the move towards a sexual and reproductive health framework served as stopgap measures that suggested some progress towards federal policy on infertility prevention and ARTs. Even so, it was clear that the intention of the federal government was to introduce comprehensive new legislation that would criminalize the practices addressed in the voluntary moratorium and establish a regulatory regime. This model would be an amalgam of both the Royal Commission's recommendations and the three-phase approach.⁴³⁴ For the interest group actors examined in this dissertation—established or emerging—the period between 1997 and 2000, as described in chapter five, was a time to build community, to create inroads for access, and to negotiate their place as stakeholders concerned with ARTs.

By 1999, the federal government had issued a number of preliminary documents and conducted consultations, preparing for the introduction of draft legislation that would be put to Parliament in 2001. The exercise of finding and engaging with stakeholders that had occurred multiple times since the Royal Commission began all over again. This stage of policy development differed from previous iterations, as more than ever before there was a focus on the individual stories of individual actors, and particularly those whose personal lives and bodies would be directly affected by the governance of reproductive technologies. There was at least some consideration given to each of these groups in the debates that immediately preceded the passage of the *AHRA*, and some fared better than others.

This chapter examines the extensive consultative and legislative process that culminated in the passage of the *Assisted Human Reproduction Act* and what has happened since. It suggests that while the process of making the *AHRA* acknowledged a broader range of perspectives than

⁴³⁴ Canada, Health Canada, *Reproductive and Genetic Technologies Overview Paper* (Ottawa: Health Canada, 1999).

had occurred in previous attempts to legislate, those perspectives were only included in the final version of the legislation when they were not seen to interfere with the continuation of the operations of the fertility industry. The neoliberal citizenship regime that privileges the individual patient-consumer was particularly apparent in this period, as concern about protection and equality were eroded even further, replaced by concerns about improving access and enabling a broader range of choices in order to allow individuals to self-govern their interactions with assisted reproductive technologies. For example, this period saw the recognition of some of the interests of LGBTQ people, but only those aspects that would continue to expand access to medicalized fertility services.

Further, while the *AHRA* included prohibitions on payment for surrogacy and gamete donation, the legislation as passed was written in such a way as to enable the continuation of commercial surrogacy and egg donation through loopholes, exceptions, and a lack of enforcement that would encourage the continuation of paid surrogacy and egg donation practices, abroad and underground (and increasingly with new endorsements from Health Canada, out in the open).⁴³⁵ In short, despite provisions that aimed to protect the potential interests of surrogates and donors and of donor-conceived people, what emerged was a framework that was a compromise from the failure of C-47, and enabled the maintenance of the existing market in ARTs. The last section of this chapter provides an overview of the developments since the passage of the *AHRA* outlining challenges to its validity and failures in implementation.

⁴³⁵ Françoise Baylis, Jocelyn Downie, and Dave Snow, “Fake It Till You Make It: Policymaking and Assisted Human Reproduction in Canada,” *Journal of Obstetrics and Gynaecology Canada* 36, no. 6 (2014).

The Assisted Human Reproduction Act

The policy process leading up to the passage of the *AHRA* is relatively well-documented, as far as Canadian legislation goes. One reason is that draft legislation was considered by the Standing Committee on Health prior to its tabling in the House of Commons, which resulted in hundreds of pages of witness testimony and a report from the committee that would not exist in the typical legislative process. Further, ongoing interest in ARTs resulted in nearly constant media reporting on legislative developments. What is particularly notable about this process, and what has also enabled a close tracking of how it took place, is the extent of the public consultations that occurred, and the resulting documentation reveals the lack of influence that these consultations had on the legislation that was eventually passed. This latter has been attributed in part to Health Canada's strategy to "consult on a narrow question"⁴³⁶ in the preliminary consultation processes, and subsequent decisions to simply consult with actors whose positions were already known. Small procedural elements of the draft legislation were altered prior to its passage (as well as the addition of a non-discrimination clause), but despite carefully conceived work by the Standing Committee on Health prior to the tabling of the Bill, little changed from draft to Royal Assent.

Consulting Canadians (Again)

The failure of C-47 left the Liberal government reeling. The planned one-two punch of criminalization followed by regulation advocated in the three-phase approach had failed, and there were concerns that the public and stakeholders would not accept anything similar to C-47 so soon. As noted in chapter four, there had been much criticism of the three-phase approach—for being hastily introduced, for stepping into provincial jurisdiction, and for too-limited periods

⁴³⁶ Montpetit, "Public Consultations in Policy Network Environments," 108.

for policy consultations⁴³⁷—and it was apparent that more consultations were necessary before a new act could be introduced. As the “kicking and screaming”⁴³⁸ of physician experts had been a significant part of the failure of Bill C-47, the new legislation would need them on board to ensure a veneer of legitimacy. At the same time, the federal government’s commitment to governing through criminalization of some practices and regulation of others remained largely unchanged from C-47, and this approach would need to be reimagined. Rather than proposing criminalization *and then* regulation in succession, the new approach would be simultaneous, criminalization *and* a regulatory regime.

The federal government requested that Health Canada conduct a new round of consultations in order to give the new bill the legitimacy with stakeholders that C-47 had lacked.⁴³⁹ These consultations took place in two distinct parts. First, Health Canada consulted both stakeholders and the public to determine whether there were strong objections to the general direction of the proposed policy framework. This process began with consultations on July 5, 1999 when a group of approximately twenty-five stakeholders came together in Ottawa to discuss the regulatory framework.⁴⁴⁰ Although there were no strong objections, there have been claims that the process, at least at this early stage, was unfocused. In his research on stakeholders involved in public consultations on ARTs during this period, Eric Montpetit cites one participant as stating that the July stakeholder meeting was little more than a “cattle call,” in which “[y]ou have forty different groups for four to six hours being told at length what the legislation will be, and then you are asked ‘do you have any thoughts.’”⁴⁴¹ There was a sense that the process of

⁴³⁷ Ibid., 107.

⁴³⁸ Interview with Shirley Pratten, March 28, 2012.

⁴³⁹ Montpetit, “Public Consultations in Policy Network Environments,” 105.

⁴⁴⁰ Canada, Health Canada, *Reproductive and Genetic Technologies Overview Paper*.

⁴⁴¹ Montpetit, “Public Consultations in Policy Network Environments,” 107.

legitimizing the federal intervention in the field would require stakeholder support, and Health Canada sought to acquire validation by asking narrow questions prior to proceeding.

In addition to stakeholder consultations, Health Canada commissioned a public opinion and marketing firm (POLLARA) to conduct research with the general public. Eight focus groups (two each in Vancouver, Toronto, Montreal, and Halifax) were held in September of 1999, followed by a national telephone survey to assess “the awareness and knowledge levels”⁴⁴² that Canadians had of ARTs.⁴⁴³ This commissioned research is rarely mentioned in the existing scholarship on ART policy in Canada, but it is important to note in the trajectory of the *AHRA* insofar as Health Canada’s consultations were not only with the self-identified stakeholders, but rather, with the public writ large. This exercise in citizen engagement, like the consultative exercises and polling that had occurred at the time of the Royal Commission, sought to engage a broader public in the policymaking process, incorporating the perspectives of individuals as well as interest groups. However, the consultation of a broader public prior to introduction of the Bill in this case may have been a means of testing the proposed policy framework. The views of stakeholders can be obscured by the views of a depoliticized public when policy is oriented or reoriented towards the needs of the “ordinary,” individual citizen, who is a consumer-client of the government. Policy that might be controversial, or challenging, but might work to advance the interests of stakeholders, and/or the interests of vulnerable actors may be dismissed in light of something more palatable. These sorts of consultations, as described in chapter one, work to advance a neoliberal model of participation in which the individual is the primary actor.⁴⁴⁴

⁴⁴² Canada, Health Canada, and POLLARA, *Benchmark Survey on Awareness and Knowledge Levels of Assisted Human Reproduction: A National Survey of Canadians* (Ottawa: Health Canada, 2001).

⁴⁴³ Canada, Health Canada, and POLLARA, *Canadians’ Views of Reproductive & Genetic Technologies* (Ottawa: Health Canada, 2001).

⁴⁴⁴ Smith, *A Civil Society?*, 134–135; Susan D. Phillips and Orsini, *Mapping the Links: Citizen Involvement in the Policy Process* (Ottawa: Canadian Policy Research Networks Inc., 2002); Susan D. Phillips, “SUFA and Citizen Engagement: Fake or Genuine Masterpiece?,” *Policy Matters* 2, no. 7 (2001).

The report from POLLARA to Health Canada provided support for the policy framework, stating that overall “Canadians would welcome the upcoming federal legislation.”⁴⁴⁵ With the initial consultations complete and validation for its policy approach affirmed, the intention to go ahead with introducing federal legislation could occur. Health Canada released the *Reproductive and Genetic Technologies Overview Paper* in December 1999, noting the imminent introduction of legislation that “could include”⁴⁴⁶ criminal prohibitions. The *Overview Paper* also noted that while federal leadership on the issue was paramount, consultations would continue, jurisdictional boundaries would be respected, and that there would be potential for equivalency agreements for provinces uninterested in enforcing aspects of the federal legislation.

The second round of consultations occurred with both stakeholders and the provinces and territories. The ongoing resistance of the Health Policy Division to “hearing ideas that would challenge their own,” led the Minister of Health to create “a special project division to conduct additional consultations with the provinces.”⁴⁴⁷ In February 2000, the new special project division within Health Canada circulated a *Workbook* that asked for input about the new direction of the legislation-to-come. Whereas the first round of consultations focused on the intention to legislate and the general policy direction, the *Workbook* asked for specific feedback on the plan to proceed with criminal prohibitions, regulation, and a regulatory body.⁴⁴⁸ Meetings were also held with “provincial colleagues as well as representatives of selected stakeholder organizations”⁴⁴⁹ in February and March 2000. The input on the *Workbook* must have come in

⁴⁴⁵ Canada, Health Canada, and POLLARA, *Canadians’ Views of Reproductive & Genetic Technologies*, 3. See also Leslie Papp, “Ottawa to Target Women in Bid to Sell Cloning Ban: Campaign Seeks Support for Genetic Technology Legislation,” *The Toronto Star*, August 19, 2000, NE10.

⁴⁴⁶ Health Canada, *Reproductive and Genetic Technologies Overview Paper*.

⁴⁴⁷ Montpetit, “Public Consultations in Policy Network Environments,” 106.

⁴⁴⁸ Canada, Health Canada, *Health Canada, Feedback Report: Submissions and Written Comments on Proposed Federal RGTs Legislation* (Ottawa, Health Canada, 2000), 1.

⁴⁴⁹ Interview with anonymous senior public servant, December 16, 2011.

quickly,⁴⁵⁰ as the contributions of respondents were summarized in a *Feedback Report* released in March 2000, which identified a general consensus amongst stakeholders (including provincial and territorial governments), that some level of federal leadership was needed in this area. As noted by one senior public servant, there was feedback, “caution” and “objection in principle” but it was insufficient to convince the federal government not to intercede.⁴⁵¹ According to the *Feedback Report*, however, respondents were clear that they wanted the federal government to make legislation prohibiting the most problematic technologies, although there was less support for a complimentary regulatory framework.⁴⁵²

Taken together, the consultations that took place in 1999 and 2000 appear to be no more than a policy validation exercise, with Health Canada asking for feedback or affirmation of pre-existing policy framework rather than substantive input about how to proceed. This did involve more consultation with the provinces than had occurred previously, but a still-minimal and directed approach to consultation. This is not surprising as there had been hesitancy, on the part of civil servants at Health Canada to consult at all given the numerous public consultations that they had already undertaken on ARTs. Officials from Health Canada had gone across the country in the early 1990s to confirm the findings of the Commission, in addition to considering input provided by the provincial-territorial working group, the Discussion Group on Embryo Research,

⁴⁵⁰ In a letter from the Canadian Bar Association’s National Health Law and Family Law Sections to Rhonda Ferderber (then-Director of Special Projects at Health Canada, working on the ARTs file), the authors note that there was a particularly “short period of time” for a response to the Workbook. Paul M. McDonald and Jennifer A. Cooper (on behalf of the Canadian Bar Association’s National Health Law and Family Law Sections), “Letter to Rhonda Ferderber Re: Reproductive and Genetic Technologies Workbook Issues and Related Questions; Response of the Canadian Bar Association National Health Law and Family Law Sections,” March 10, 2000, <http://www.cba.org/cba/submissions/pdf/00-10-eng.pdf>.

⁴⁵¹ Interview with anonymous public servant, December 16, 2011.

⁴⁵² Health Canada, *Feedback Report: Submissions and Written Comments on Proposed Federal RGTs Legislation*, 2–6. There was also discussion about the need to differentiate between reproductive and genetic technologies, and to address them separately in different legislation. This “splitting” of the scope of the policy field was a narrative that emerged first during debate on C-47 and it was taken up in the debate on C-247.

and the Advisory Committee on Reproductive and Genetic Technologies, prior to the introduction of C-47. The general approach of the policy was nearly fixed from the time of the Royal Commission, and as there was no political will to stray from the criminalization/regulation framework, there was consultation fatigue on the part of both stakeholders and civil servants as both groups sensed that the consultations were a legitimacy exercise, occurring for its own sake.⁴⁵³

This does not necessarily mean that there were no benefits to these consultations, or no room at all for the policy proposals to be altered. While the consultation process was “resistant to network opening” and had limited capacity to “listen or persuade civil society actors,”⁴⁵⁴ at the very least the consultations worked to legitimate the interests of a wide range of actors as relevant to the legislation-to-come. Further, close examination of the *Overview* and *Feedback* reports reveals that there were a few issues regarding which the policy preferences of Health Canada remained unclear and may have differed from the approach taken in C-47 (and from the legislation eventually passed). In the case of commercial surrogacy, for example, the *Overview* paper considered that coercion in surrogacy arrangements could occur not only in commercial arrangements, but in all cases where the “woman [is] in a dependent relationship with the contracting party.”⁴⁵⁵ Further, the *Feedback* paper included more thoughtful and imaginative approaches about how to address surrogacy than in any government document on ARTs issued prior. More specifically, in the *Feedback* paper considerable space was allocated to a proposal for a “public registry of surrogates who would receive modest compensation for their services,

⁴⁵³ Montpetit, “Public Consultations in Policy Network Environments,” 107; Baylis and Herder, “Policy Design for Human Embryo Research in Canada: An Analysis (Part 2 of 2),” 356.

⁴⁵⁴ Montpetit, “Public Consultations in Policy Network Environments,” 108.

⁴⁵⁵ Canada, Health Canada, *Reproductive and Genetic Technologies Overview Paper*.

e.g., Employment Insurance rates,”⁴⁵⁶ as a means to provide equitable access to surrogacy services, and to ensure the fair and equitable treatment of surrogates themselves. The *Overview* and *Feedback* reports together suggested that the federal government was still exploring the extent to which Canadians would accept regulation of “altruistic” surrogacy and whether “modest compensation” for acting as a surrogate would be acceptable to the general public. In short, despite the fixed nature of the general approach and the intent to move forward with comprehensive legislation, some of the finer details were still being sorted.

Considering the Draft Legislation

On May 3, 2001, then-Health Minister Allan Rock released draft legislation to be considered by the Standing Committee on Health before its introduction in Parliament. The unprecedented move to have the draft legislation considered by a Standing Committee prior to being tabled, signaled a *de facto* third round of consultations. The *Feedback Report* had suggested that there was consensus around the need for criminal prohibitions, and for federal regulation of ARTs. However, Health Canada and the federal government anticipated that the legislation would be highly controversial. As it was an issue more “given to greys than black or white,”⁴⁵⁷ more input was needed. There were concerns that if introduced too early and without considerable public consultations, the proposed legislation would fall to the same fate as C-47.⁴⁵⁸ Early consideration of the draft legislation by the Standing Committee on Health was also optimistically seen as a

⁴⁵⁶ Canada, Health Canada, *Feedback Report: Submissions and Written Comments on Proposed Federal RGTs Legislation*, 10.

⁴⁵⁷ Interview with anonymous senior public servant, 16 December 2011.

⁴⁵⁸ Montpetit, “Public Consultations in Policy Network Environments,” 107; Harvison Young, “Let’s Try Again...This Time with Feeling,” 125; Motluk, “Donor Anonymity in the Assisted Human Reproduction Act,” 219.

means to give Members of Parliament a “real opportunity to shape the issue, not just to vote it up or down,” although the draft legislation, as mentioned above, would remain largely unchanged throughout the legislative process.⁴⁵⁹

The draft legislation differed from the three-phase approach in a number of important ways. Most importantly, the draft legislation proposed a model in which criminalization and a regulatory framework would be part of the same Act, addressing the critique of C-47 that the criminal prohibitions would mean little without the simultaneous introduction of a regulatory regime. It also included a preamble that introduced a positive tone about reproductive technologies (addressing the critique of C-47 that it framed ARTs as inherently problematic), that identified the potential benefits of research and clinical uses of the technologies in addition to the need for caution in their use. The interests of the scientific and medical communities were thus acknowledged in the preamble, clearly validating biomedical actors as legitimate and important subjects of the legislation with interests to be protected. Also, for the first time, the reimbursement of expenses for surrogacy and gamete donation were included within the legislative framework. Whereas C-47 and *Setting Boundaries* were unequivocal in the exclusion of payment for surrogacy and for the reimbursement of expenses to donors, the draft legislation walked a finer line, criminalizing commercial gamete donation and surrogacy while providing for the reimbursement of expenditures under the regulations-to-come, and with a license. Furthermore, the draft legislation took a measured approach to donor anonymity, requiring that health reporting information from the donors be obtained, but not, as *Setting Boundaries* had advocated, moving toward “a more open system of information sharing in gamete and embryo

⁴⁵⁹ Interview with anonymous public servant, 16 December 2011.

donation” including identifying information.⁴⁶⁰

The draft legislation thus presented a model of reproductive citizenship that differed only slightly from the three-phase approach. Through the possibility of reimbursing donors and surrogates for expenses, the draft legislation acknowledged that surrogates and donors are active participants in the use of ARTs, and not merely a dichotomous group of either exploited or altruistic women as had occurred during the debates on C-47. At the same time, it moved even further away from the recommendations against egg donation and surrogacy made by the Royal Commission, and the strong commitments to complete non-commercialization made by *Setting Boundaries* in 1997. As to donor conception, the tentative step away from outright anonymity to require the health reporting information of donors was less than the donor conception community had hoped for, providing a more restrained approach to the recognition of the self-articulated interests of donor-conceived people and their families than had occurred during the three-phase approach.

The draft legislation was put to the Standing Committee in May 2001, and over the course of the following months, the Committee saw eighty-five witnesses⁴⁶¹ including former Royal Commissioners, experts from the scientific, medical, and religious communities, disability rights advocates, activists from the infertility community, ethicists, and others, many of whom had been heard by the Standing Committee in relation to C-47 or by the Royal Commission. The usual suspects, including medical associations, IAAC, the Infertility Network, and the NRAS were well-represented, but other groups were also making their position on ARTs known to

⁴⁶⁰ Canada, Health Canada, *New Reproductive and Genetic Technologies: Setting Boundaries, Enhancing Health*, 37.

⁴⁶¹ Not including government witnesses for Health Canada or Justice Canada. The Standing Committee also received seventy-seven briefs on the subject, as well as approximately four hundred and fifty letters on the matter of stem cell research. Canada, House of Commons Standing Committee on Health, *Assisted Human Reproduction: Building Families* (Ottawa: Public Works and Government Services Canada, December 2001).

federal policymakers for the first time.⁴⁶² The Standing Committee listened to groups that were poorly represented in earlier consultations, including witnesses representing surrogates, LGBTQ people, and donor-conceived people (rather than just their families). The range of possible stakeholders on ARTs seemed to be expanding to include users of reproductive technologies that had not previously been included.

In December 2001, the Standing Committee released its report on the draft legislation. The report, *Assisted Human Reproduction: Building Families*, was a carefully drawn reflection on the positions of the Members of the Standing Committee on Health, the witnesses who testified, and written submissions, vis-à-vis the draft legislation. It largely provided support for the legislation, but also suggested four significant changes. First, it challenged the equal prioritization of key stakeholders in the preamble of the legislation. Whereas the draft legislation explicitly identified researchers and clinicians stakeholders with interests equal to those of others, *Building Families* identified three such groups in order of importance; children born of reproductive technologies, followed by adults using these technologies; and then researchers and clinicians.

Secondly, the Standing Committee suggested that given the “many moral, ethical, and social questions surrounding human embryo research and infertility treatment...an arm’s length agency would be more appropriate” than the Minister of Health to ensure the implementation of the Act was occurring and to manage its operations.⁴⁶³ This was not an entirely new consideration; the idea of an arms-length regulatory agency had been addressed in different

⁴⁶² Fortier, Scala, and Montpetit note that there was a decline in the number of women’s organizations that participated in the consideration of the draft legislation by the Standing Committee on Health from the time of the three-phase approach. They note that whereas “seven women’s organizations submitted formal briefs” on C-47, on the draft legislation, “only four women’s organizations presented formal briefs.” Scala, Montpetit, and Fortier, “The NAC’s Organizational Practices and the Politics of Assisted Reproductive Technologies in Canada,” 598.

⁴⁶³ Canada, Parliament. House of Commons Standing Committee on Health, *Assisted Human Reproduction: Building Families*, 25; Rivard and Hunter, *The Law of Assisted Human Reproduction*, 21–23.

iterations in the Royal Commission's *Proceed with Care*, in *Setting Boundaries, Enhancing Health*, and in the *Feedback* report. Its absence in the draft legislation was anomalous, and the Standing Committee suggested its inclusion.

Third, the Standing Committee recommended the elimination of provisions in the draft legislation that permitted reimbursement of expenses incurred by surrogates. Despite the emergence of surrogates as stakeholders articulating an interest in reimbursement or compensation, the Standing Committee took a position more aligned with the Royal Commission and the three-phase approach, suggesting that commercial surrogacy be banned (including compensation or reimbursement of expenses), and non-commercial or "altruistic" surrogacy be discouraged through the prohibition of payment to lawyers, brokers, and others involved in surrogacy arrangements⁴⁶⁴ (with the exception of health care professionals "who provide services necessary for the care of the pregnant woman").⁴⁶⁵ The Standing Committee also recommended that the draft legislation be changed to eliminate provisions allowing for the reimbursement of expenses to gamete donors.

Finally, the Standing Committee made a number of recommendations to extend the protections offered to donor-conceived people through the regulation of gamete donation. This included recommendations to limit the number of children conceived with the gametes of a single donor, the number of eggs that can be "harvested and fertilized,"⁴⁶⁶ and the mandatory provision of counseling to gamete donors. Perhaps the most important recommendation in this regard was the recommendation that gamete donors would have to consent to their identity being

⁴⁶⁴ Canada, Parliament, House of Commons Standing Committee on Health, *Assisted Human Reproduction: Building Families*, 12; Royal Commission on New Reproductive Technologies, *Proceed with Care*, 690.

⁴⁶⁵ Canada, Parliament, House of Commons Standing Committee on Health, *Assisted Human Reproduction: Building Families*, 37.

⁴⁶⁶ *Ibid.*

disclosed to any offspring conceived, which would amount to a prohibition on anonymous gamete donation in Canada. According to *Building Families*, the Standing Committee believed that these matters were too important to leave to the discretion of a regulatory agency yet-to-be-established.⁴⁶⁷

On the whole, *Building Families* accepted the broad vision of the draft legislation; its recognition of the benefits and harms of ARTs, the need to simultaneously introduce criminal and regulatory provisions, and the ongoing need to promote human dignity by prohibiting commercialization. At the same time, the legitimacy accorded to the position of surrogates through the inclusion of the reimbursement of expenditures was erased in *Building Families*, without mention of the concerns articulated by surrogacy advocates about financial output, and compensation for risk.⁴⁶⁸ While the Standing Committee on Health committed to the non-commercialization of surrogacy and egg donation, this position did not take seriously the possibility, articulated by Joanne Wright and others, that some women might be able to engage in receiving some compensation for the physiological, temporal, and psychological costs of engaging without coercion.⁴⁶⁹ The nuanced positions expressed in the *Feedback Report* and in the witness testimony were simply not mentioned at all, and the portrayal of surrogates in *Building Families* simply repeats the tropes of exploitation and payment apparent in the Royal Commission, and the three-phase approach. The failure to address the varied perspectives on surrogacy apparent throughout the legislative consultations, even if only in promoting another

⁴⁶⁷ While embryo research is beyond the scope of this dissertation, the Standing Committee also proposed tightening up the parameters under which research on embryos could be conducted, namely, researchers would have to prove that there were no alternatives to the use of embryos in their research projects. This was a major consideration for the committee, and was a subject of extensive debate.

⁴⁶⁸ Canada, Parliament, House of Commons Standing Committee on Health, *Assisted Human Reproduction: Building Families*, 12–13; Greenaway, “Don’t Outlaw Surrogacy, Lawyer Begs Politicians: Urges Lobby Campaign: MPs Recommend Ban on Payments in Moms-for-Hire Cases,” *Ottawa Citizen*, December 27, 2001, A09.

⁴⁶⁹ For further discussion see Harvison Young, “Let’s Try Again... This Time with Feeling.”

option, is a notable absence that undermines the reproductive citizenship of surrogates, whose role in the policy debates was finally being recognized. Conversely, the prioritization of the interests of people conceived with the use of reproductive technologies, and the strong position taken by the Standing Committee on donor anonymity worked to legitimate the hard-fought position of donor-conceived people and their advocates. For surrogates, this meant largely symbolic representation in the policy process, while for donor-conceived people, *Building Families* was an important landmark, demonstrating that there was substantial support for the elimination of donor-anonymity. The importance of donor-conceived people as key actors in the governance of ARTs was clearer than ever, and their demand for an end to donor anonymity seemed, for the first time, likely to occur.

Passing the Act

Bill C-56 (the *Assisted Human Reproduction Act*) was tabled in the House of Commons on May 9, 2002. Overall, it appeared as if *Building Families* had little effect on the legislation, as Bill C-56 was a near-verbatim replica of the draft legislation with a few exceptions, the most significant of which was the creation of a regulatory agency.⁴⁷⁰ Additionally some clarifications about the creation of embryos were made, and the importance of research was asserted more clearly in the preamble. It passed first and second reading relatively quickly, and was sent back to the Standing Committee on Health by the end of May 2002.

Since the carefully conceived recommendations to change the draft legislation articulated in *Building Families* had, for the most part, not been addressed in the tabled bill, members of the Standing Committee took the government to task. Members asked why the government

⁴⁷⁰ Dennis Bueckert, "Ottawa dépose son projet de loi sur les cellules souches," *L'Acadie Nouvelle*, May 10, 2002, 17.

“ignore[d] the committee recommendation” about donor anonymity, as well the matter of the reimbursement of expenses to surrogates. As to the matter of donor anonymity, officials from Health Canada responded by citing a potential shortage in gamete donors, stating that it was felt that “mandatory donor identification... would unduly affect the capacity or the ability of the infertile couples in Canada to be able to have children.”⁴⁷¹ As to the inclusion of the provisions to permit reimbursement of expenditures to surrogates and gamete donors, the officials vaguely cited “Charter implications,”⁴⁷² explaining only that if women undergoing surrogacy or egg retrieval did not seek medical care (because reimbursement was not possible), it might endanger their security of the person under s.7 of the Charter.

The Standing Committee heard witnesses throughout the spring of 2002, and started again in the fall when Parliament reconvened for a new session and the legislation was reintroduced at committee stage (as C-13). This round of hearings was streamlined, as the Standing Committee had so recently heard the position of many interested stakeholders. The decision was made to only hear witnesses on issues where there had been discord between *Building Families* and the legislation tabled.⁴⁷³ In this round of hearings, for example, there was significantly more representation from infertile Canadians than there had been during the hearings on the draft legislation. Additionally, commercial sperm banks and clinicians were well-represented, and both groups suggested that eliminating donor anonymity or restricting compensation to surrogates and egg donors would collectively cause a problematic shortage in

⁴⁷¹ Canada, Parliament, House of Commons Standing Committee on Health. *Evidence*. Meeting No. 85, May 30, 2002.

⁴⁷² Ibid. This argument was not discussed elsewhere in committee hearings, but is the subject of an article by Dana Hnatiuk, and an article in *Le Devoir*. See Hnatiuk, “Proceeding with Insufficient Care: A Comment on the Susceptibility of the Assisted Human Reproduction Act to Challenge under Section 7 of the Charter,” *University of Toronto Faculty of Law Review* 65 (2007): 49; Hélène Buzzetti, “Procréation Assistée,” *Le Devoir*, May 10, 2002, A3.

⁴⁷³ Canada, Parliament, House of Commons Standing Committee on Health. *Evidence*. Meeting No. 87, June 6, 2002.

gamete donors and surrogates. Donor-conceived people and surrogacy advocates were heard once again, although this time in conjunction with the representatives of commercial sperm banks and fertility clinics, who had their own economic and professional stakes in the governance of ARTs and offered competing perspectives.

Following the witness testimony, the Bill underwent scrutiny by the committee in a clause-by-clause study, followed by the proposal of relevant amendments. There were a number of amendments that attempted to clarify what would constitute expenditures for surrogates and/or gamete donors but these were defeated, and the provisions on reimbursement remained in place. Further, while there seemed to be consensus on the need to require the proposed regulatory agency to disclose the identity of a donor to a person conceived with their gametes, an amendment addressing this matter was also defeated.⁴⁷⁴ Bill C-13 moved forward with clauses protecting donor anonymity and allowing reimbursement to gamete donors and surrogates.

One of the most interesting changes to the Bill throughout the legislative process occurred at this late hour, during the clause-by-clause. Réal Ménard, an MP for the Bloc Québécois proposed an amendment stating that people using ARTs must not be discriminated against on the basis of sexual orientation or marital status. This was an explicit response to the testimony of Mona Greenbaum (co-founder of the Lesbian Mothers' Association) on the draft

⁴⁷⁴ Canada, Parliament, House of Commons Standing Committee on Health, *Evidence*. Meeting No. 13, December 9, 2002.

The failure of an amendment on which there was consensus (and if not consensus, then near consensus) is confusing to be sure. In her "Donor Anonymity in the Assisted Human Reproduction Act: The Back Story," Alison Motluk carefully explores the failure of the *AHRA* to include provisions to eliminate anonymous gamete donation, despite multi-partisan agreement that such a provision was needed. While Motluk is not able to provide a satisfying explanation as to why the amendment failed, she provides a detailed discussion of how the vote took place, noting that two MPs who later brought up the issue abstained from the vote, which resulted in a count of six votes against the amendment and five for it as well as abstentions. She closes this discussion by noting that "in the end, the clause preferred by Minister Anne McLellan was accepted: '...the identity of the donor – or information that can reasonably be expected to be used in the identification of the donor – shall not be disclosed without the donor's written consent.'" Motluk, "Donor Anonymity in the Assisted Human Reproduction Act," 228.

legislation, as well as a follow-up meeting that Greenbaum had with Ménard. As an openly gay man from Quebec, Greenbaum “assumed he would understand...the issues,” or at the very least, have some sympathy for the exclusions that LGBTQ and single people were experiencing.⁴⁷⁵ Ménard was indeed interested in addressing the concerns that Greenbaum raised. He had briefly raised the issue of LGBTQ inclusion in the Bill immediately after it came back to committee, asking Health Canada’s legal officials about the possibility of an amendment to address “sexual orientation and matrimonial status.”⁴⁷⁶ The matter was not discussed again, until he introduced the amendment at clause-by-clause, and his staunch defense that it be included ensured that the provision on sexual orientation and marital status made it into the Act.

Versions of what would become the *AHRA* had been winding their way through Parliament since 2001 when the draft legislation was considered, and in the interim a number of developments in federal politics had occurred which put pressure on the Liberal government to push it through before much longer. The resignation of long-sitting Prime Minister Jean Chrétien in December 2003, and the appointment of successor Paul Martin meant that an election was impending. Further, the Liberal Party was deeply embroiled in the corruption allegations of the sponsorship scandal, and it was unclear that a Martin government would be re-elected. Following more than a decade of consideration of how to govern ARTs following the Royal Commission, there was a lot at stake in the Senate hearings on the *AHRA*. The Bill was put before the Senate in October of 2003. It died on the Order Paper when Parliament was prorogued (beginning a new session with Martin as Prime Minister), but it was reintroduced as C-6 on February 11, 2004 and brought to the Senate at committee stage.⁴⁷⁷

⁴⁷⁵ Interview with Mona Greenbaum, December 7, 2011.

⁴⁷⁶ Canada, Parliament, House of Commons Standing Committee on Health. *Evidence*. Meeting No. 85, May 30, 2002.

⁴⁷⁷ Canada, Parliament, *House of Commons Debates*, February 11, 2004 (Pierre Pettigrew, Lib).

At the Senate Standing Committee on Social Affairs, Science and Technology, senators heard testimony from a range of interests over six meetings. Many of the same people who had been heard by the House Standing Committee on Health either at the time of the draft legislation or at committee stage testified once again. Some of those who testified in one important meeting included a representative from Repromed (a preeminent Canadian sperm bank), Joanne Wright from Canadian Surrogacy Options, Shirley and Olivia Pratten from the New Reproductive Alternatives Society, Diane Allen from the Infertility Network, and a number of other advocates of infertile Canadians and donor-conceived people. Bev Hanck, the representative of the Infertility Awareness Association of Canada appeared in a different meeting altogether.

When the Senate Standing Committee brought the Bill back to the Senate, it proposed passing it without amendment. The looming election and waning public support for the governing Liberals raised concern that the long public policy process might be for naught, if and when the Bill died on the Order Paper once again.⁴⁷⁸ The Senate committee still had reservations about a number of matters, but rather than propose amendments that might delay the passage of the Bill, the Standing Committee on Social Affairs, Health, and Technology “took the opportunity to make the Senate aware of several issues.”⁴⁷⁹ One of these issues was donor anonymity, and the Senate committee noted that testimony from ethicists, donor-conceived people, and their families made compelling arguments about their entitlement to “identifying information regarding their biological origins.” On the other hand, the committee also acknowledged the challenges that eliminating anonymity might result in a dearth of gametes available to Canadians experiencing infertility. The committee recommended that this issue be addressed when the legislation was to come up for review three years after its passage. The

⁴⁷⁸ Canada, Parliament, *Journals of the Senate*, March 9, 2004 (Daniel Hays, Lib.).

⁴⁷⁹ *Ibid.*

committee also acknowledged competing demands in compensation to gamete donors and surrogates, writing that it “supports the non-commercialization of the Bill but is nevertheless concerned about the effect this will have on donations.”⁴⁸⁰ The committee made additional observations about surrogacy, articulating that there was a need for greater study of surrogacy practices. Bill C-6, the *Assisted Human Reproduction Act*, passed third reading with little debate, and received Royal Assent on March 29, 2004.

Individual and Collective Understandings in the Road to the AHRA

The consultative process leading to the *AHRA* included a number of groups and actors that had not been consulted in the three-phase approach. The voices of LGBTQ people, surrogates, and surrogacy advocates were included in the policy debates, and although their presence paled in comparison with those of religious groups, for example, or medical researchers, their inclusion did signal recognition of what was at stake for these communities. These groups emerged as new policy subjects with important interests at stake. What emerged in the case of these groups, as well as that of infertile Canadians and their advocates, was a growing endorsement of unrestricted access to ARTs, and an elimination of all clauses thought to cause a “shortage” in gamete donation or the provision of surrogacy services. Those concerned about the restriction on the reproductive choices of intended parents included (for the first time in the policy debates since the Royal Commission), LGBTQ people. For LGBTQ people, surrogates, and infertile Canadians, the best way to create equitable access to ARTs would be by supporting the status quo, and allowing an unrestricted market in infertility treatments to continue. The right to reproduce using reproductive technologies, without interference from the state, was gaining

⁴⁸⁰ Canada, Parliament, *Journals of the Senate*, 9 March 2004 (Daniel Hays, Lib.).

legitimacy while the right of donor-conceived people to know their origins was losing traction. Considerations of the collective interest in protecting the vulnerable (namely those born of ARTs) fell away, and individual interest in pursuing the use of reproductive technologies prevailed.

Some change was in order as the Government of Canada was committed to limiting commercial practices, however this could be negotiated by altering its rhetorical approach to what constituted commerciality. A loosely defined “reimbursement of expenses” was used in place of “payment,” and concerns about commercialization were shelved, to be reconsidered in a review of the *AHRA* that was scheduled for three years following the passage of the Act (although no such review has ever occurred). The concerns of LGBTQ people and surrogates, as detailed below, were certainly more nuanced than a mere propagation of the existing market in services, but the elements of their positions taken up in the policy debates were those most aligned with the continuation of the provision of fertility treatments with few restrictions in private-for-profit settings. Donor-conceived people and their families who had been advocating for the elimination of donor anonymity saw their positions engaged with and recognized by policymakers, although in the end, the *AHRA* did little for the donor-conceived.

LGBTQ People

In the late 1990s and early 2000s the rights of same-sex couples and adoptive families changed considerably to address the interests of LGBTQ families, both in legislation and in jurisprudence. New developments in case law, employment benefits programs, and provincial and federal legislation resulted in increased relationship recognition for LGBTQ people.⁴⁸¹ For example, in

⁴⁸¹ Smith, “Recognizing Same-Sex Relationships.”

2005 the *Civil Marriage Act* was passed, legally permitting same-sex marriage across Canada. Further, provincial laws were expanding to extend adoption rights to LGBTQ parents, including same-sex couples.⁴⁸² Some of these laws were changing in response to litigation from LGBTQ families, including LGBTQ families with donor-conceived children, making it clear that LGBTQ people had an important stake in the particular governance of ARTs, and in family building more broadly. The recognition of LGBTQ people as parents in adoption law, and the outcomes of debates over same-sex marriage that were taking place as the *AHRA* wove its way through Parliament meant that the hard-fought rights of LGBTQ families were fresh in the minds of parliamentarians as the *AHRA* was being considered.

During the consideration of the *AHRA*, two key LGBTQ organizations participated in consultations on the Act: the Lesbian Mothers' Association of Quebec submitted a policy brief on the draft legislation, with Mona Greenbaum testifying to the Standing Committee, and Egale Canada submitted a brief as well when the *AHRA* returned to the Standing Committee in 2002. The recommendations provided by the LMA and in Greenbaum's testimony was the first provided by an LGBTQ identified group to the federal government in policy discussions on ARTs since the Royal Commission and it focused largely on making clear that lesbians did not have equal access to fertility services in Canada, and raising four key concerns. First, the LMA was most concerned that despite the judgment in *Potter v Korn*, fertility treatment providers were refusing women treatment on the basis of marital status or sexual orientation, and recommended that the proposed Act include provisions that prohibited discrimination on these bases. As Greenbaum noted in her testimony to the Standing Committee on Health in 2001, there were "some provinces, such as Ontario or British Columbia, that do provide access to single women

⁴⁸² See, for example Rayside, *Queer Inclusions, Continental Divisions*.

and lesbians, but in Quebec the policy of every single fertility clinic is to bar access not only to lesbians but to single heterosexual women as well.”⁴⁸³ Second, the submission and testimony suggested that as insemination is not a particularly complicated technique, “both clinics and individual private practitioners” should be allowed to apply for licenses to provide relevant services, although both should have to adhere to certain standards, including access “regardless of sexual orientation, marital status, or fertility status.”⁴⁸⁴ Under the proposed legislation, only licensed service providers would be able to engage in the “acquisition,” “storage,” and “transfer” of gametes “for the purposes of creating an embryo,” effectively criminalizing those attempting to conceive via self-insemination at home or elsewhere. The third recommendation made by the LMA was that any equivalency agreements that should be developed by relevant provinces be contingent on the basis that equal access be provided to all women. Finally, in order to address interest in non-anonymously provided semen, the LMA recommended that “sperm donors be given the choice to consent or not to having their identity revealed to any persons born of their donations.”⁴⁸⁵

Egale Canada also made a submission to the House of Commons Standing Committee on Health on the proposed *AHRA*. Spurred on by its work in the *Susan Doe* case, Egale Canada saw itself, according to its submission, as an important participant in the discussion given its standing in cases related to the governance of the family. The submission notes that as a community, LGBTQ people in Canada “have had our right and our ability to have and raise children, and to adopt the children of our partners, denied by discriminatory laws and regulations.”⁴⁸⁶ The

⁴⁸³ Canada, Parliament, House of Commons Standing Committee on Health. *Evidence*. Meeting No. 44, November 26, 2001.

⁴⁸⁴ Barratt et al., “Access to Fertility Services for Lesbians: A Question of Health (Submission to the Standing Committee on Health on Draft Legislation Governing Assisted Human Reproduction).”

⁴⁸⁵ *Ibid.*

⁴⁸⁶ EGALÉ, *EGALÉ Submission to House of Commons Standing Committee on Health: Re: Bill C-13*.

submission focused on a number of key issues including the proposed prohibitions on payment for sperm and ova, as well as surrogacy services, suggesting that the prohibitions might “lower people’s incentive” to partake, and would limit access to gametes and surrogacy services, which are often vital to the use of reproductive technologies by LGBTQ people. Egale Canada recommended to this end that the federal government consider the impacts of the prohibitions on LGBTQ people, and ensure that relevant regulations be drafted as soon as possible to ensure that reimbursement of expenditures, at the very least, could legally occur. The submission also addressed the semen regulations, “genetic selection and testing,” the criminalization of informal reproductive arrangements, and the need for equal access to ARTs.

The two submissions collectively worked to frame LGBTQ issues related to ARTs to the Standing Committee on Health, particularly as these issues had not been discussed in the three-phase approach or in the preliminary policy consultations on the Act. The range of issues is noteworthy, including the need to address the discrimination inherent to the semen regulations and the legality of self-insemination. However, it was only those issues which did not conflict with an individual, biomedical, and market-based approach to fertility treatments that made it into the legislation. The payment/compensation of gamete donors and surrogates promoted by Egale Canada, the LMA’s endorsement of a gamete donor system in which anonymity is possible, and the need for equal access to ARTs supported by both groups aligned the interests of LGBTQ people with those of other Canadians seeking fertility treatments. Again, the submissions both present a wider range of issues, but the emphasis on access in both Egale Canada and the LMA’s interventions created a space for LGBTQ issues related to ARTs to be reduced to concerns of access alone.

The ways in which the federal government would recognize LGBTQ people's reproductive citizenship in the development of the *AHRA* only occurred where it was easy, not for example in the substantive reconsideration of the discriminatory semen regulations, or the rethinking of licensing regulations to recognize self-insemination. This model of reproductive citizenship that only recognizes the legitimacy of patient-consumers to make choices about their use of ARTs without discrimination on the basis of sexual orientation or marital status, is reminiscent of early scholarship on sexual citizenship. These works argue that the use of equality rights as a means to attain a more robust experience of citizenship for LGBTQ people has been articulated as a strategy of "sameness" that works to invisibilize areas of difference that require addressing discrimination beyond formal equality rights and non-discrimination clauses.⁴⁸⁷ From this view, certain sexual minorities are often able to access certain social and legal rights when able to articulate their experiences as socially productive, non-descript workers, consumers, and taxpayers that contribute to the economic interests of the state without causing too much trouble. This strategy of "sameness" may not be a strategy at all, but rather a means to make the best of public policy which might otherwise be exclusionary. Indeed, recognition need not be revolutionary, sometimes it is a matter of compromise, or of getting access to the resources that might make one's life more livable.

In the context of the legislation, this access came to be understood as access to the range of fertility treatments available within a clinical setting without any undue restrictions on gametes or surrogacy services, rather than access to donor sperm from gay men or assurances that self-insemination would not be restricted under the new law. This is not to diminish the importance of the non-discrimination clause, indeed it was integral to ensuring that all fertility

⁴⁸⁷ Richardson, "Locating Sexualities"; Richardson, "Desiring Sameness?."

clinics opened their doors to LGBTQ people.⁴⁸⁸ However, the emphasis on the non-discrimination clause to the exclusion of other provisions that would have improved the capacity of LGBTQ people to use ARTs suggests that the legislation aimed only to include new provisions that would not alter the proposed legislative and regulatory framework, or impede on the market in infertility services. The ongoing concerns about the semen regulations, and the importance of clarifying the status of low-cost at-home inseminations were not addressed in the Act, and the reproductive citizenship afforded to LGBTQ people in the *AHRA* appeared to be one based on individual, unrestricted access to fertility treatments, within the largely private-for-profit settings of Canadian clinics. The sense of belonging to the state by engaging in reproduction is articulated in the briefs of the LMA and Egale Canada in terms of creating access for all, but as taken up in the legislation, the emphasis is solely on access to those who can afford it in the context of the clinic.

Egg Donors and Surrogates

As described in chapters four and five, following the Royal Commission's report, little had occurred vis-à-vis surrogacy in Canada. In the early 2000s, however, a number of court cases were heard that acknowledged the ongoing nature of surrogacy arrangements, and considered their legitimacy within contemporary models of family building. In 2000, a Manitoba court considered whether a declaration of parentage could be made prior to the birth of a child for purposes of establishing clear surrogacy arrangements, finding that it could not, although

⁴⁸⁸ While the expansion of reproductive citizenship among LGBTQ Canadians through the non-discrimination principles of the *AHRA* contests heteronormative models of the family by promoting equal access to ART services, heteronormative and otherwise discriminatory practices continue in many clinics, including in their intake forms, and testing procedures. See Epstein, "Married, Single, or Gay;" Ross et. al. "Sexual and Gender Minority People's Recommendations for Assisted Human Reproduction Services."

following the recording of the birth as occurring by surrogate, the birth record could be changed.⁴⁸⁹ Further, in Alberta in 2002, a court “declared the genetic mother to be the mother of the child born via surrogate mother.”⁴⁹⁰ In *JR v LH* (2002), an Ontario court was asked to recognize that a child born via surrogate was legally the child of the intended parents (who had provided the gametes for conception). In this case, the intended parents were granted parental rights because they were the gamete providers, and therefore the biological parents of the child.⁴⁹¹ These cases, occurring at the same time as the *AHRA* was being considered, worked to validate the use of surrogacy as a means to build one’s family. The courts were increasingly recognizing the reproductive citizenship of intended parents using surrogates, and surrogacy as a valid practice (although, as noted in *JR v LH*, only when payment was not involved).

Throughout the three-year process from the introduction of the draft legislation to the passage of the *AHRA*, article after article would be published in the popular press challenging the idea that surrogacy in Canada is exploitative, or that payment commercializes human life. These articles suggested that banning surrogacy would limit women’s reproductive choices,⁴⁹² and further, that surrogacy should not be part of legislation seeking to govern “controversial—and frankly bizarre—practices” like cloning and the creation of animal-human hybrids.⁴⁹³ While the Standing Committee would ultimately uphold the ban on payment for surrogacy and leave regulation to the regulatory agency, there was some success in the inclusion of the possibility of reimbursement for expenditures, contrary to the recommendations in *Building Families*.

⁴⁸⁹ *JC v Manitoba* (2000), 12 R.F.L. (5th) 274, 2000 MBQB 173.

⁴⁹⁰ *L. v P.* (No. 0101-22025, *Queen's Bench of Alberta*, February 15, 2002) unreported, cited in Rypkema v *H.M.T.Q. et al.*, 2003 BCSC 1784.

⁴⁹¹ *JR v LH* [2002] OTC 764 (Ont Sup Ct.). See discussion in L’Espérance, “Fertilize-This,” 239; Karen Busby, “Of Surrogate Mother Born: Parentage Determinations in Canada and Elsewhere,” *Canadian Journal of Women and the Law* 25, no. 2 (2013), 299.

⁴⁹² Lisa Priest, “Permit Women to Rent Wombs, MP Says,” *The Globe and Mail*, August 28, 2001, A1.

⁴⁹³ Scott Tracey, “Surrogates Will Continue, with or without Government Endorsement,” *Guelph Mercury*, April 29, 2004, Final edition, A3.

The tempered recognition of surrogates as engaged actors in the policy debates is attributable to the appearances of Joanne Wright (as a surrogate and founder of Canadian Surrogacy Options) before parliamentary committees three times over the course of the consideration of the *AHRA*, each time noting that in her experience surrogates in Canada are not exploited or manipulated, and that surrogacy is a form of largely altruistic reproductive labour that warrants compensation for the time and emotional, physical effort involved. She carefully advocated for the regulation of compensation, rather than an outright ban, in order to ensure that infertile Canadians would continue to have access to surrogacy services. At her first appearance, speaking to the draft legislation, Wright appeared as a member of the Canadian Multi-Disciplinary Assisted Reproduction Coalition. This coalition, drawn together in order to ensure representation of pro-surrogacy voices at the Standing Committee, represented “patients, lawyers, physicians, nurses, infertility clinics, surrogates and mental health professionals” advocating in favour of surrogacy.⁴⁹⁴ The voices of this organization at the Standing Committee included Wright as well as Sherry Levitan, a surrogacy lawyer whose practice was, by that time, well-established. Although she would only appear once before committee, Levitan stated clearly that surrogacy would continue in Canada regardless of the actions of Parliament, and that it was up to parliamentarians to regulate the practice to ensure that “screening, access to legal advice, and counseling”⁴⁹⁵ would continue, ensuring that people would use surrogacy services in non-exploitative and effective ways.

What these surrogacy advocates ultimately wanted was to remove surrogacy from the criminal provisions of the legislation, and if necessary, for regulations to be established in order

⁴⁹⁴ Canada, Parliament, House of Commons Standing Committee on Health. *Evidence*. Meeting No. 23, September 25, 2001.

⁴⁹⁵ *Ibid.*

to legitimize the business of surrogacy in the eyes of the Canadian public. This would include regulations establishing legitimate expenses, including lost wages, costs of pain and suffering, compensation for the health risks undertaken, as well as reimbursement of expenditures. The reliance on Wright and Levitan as the voices of and for Canadian surrogates (in addition to parents whose children were carried by surrogates) meant that the experiences came to represent the experience of surrogacy for the Standing Committee, repeated in subsequent consideration of the Bill.⁴⁹⁶ This is particularly notable given that although Wright and Levitan seemed well-intentioned, and to legitimately view surrogacy with payment or compensation as benign, both also had ongoing financial interests in the proliferation of surrogacy, Wright as a broker of surrogacy arrangements, and Levitan as a lawyer. Wright's testimony (echoed by Levitan) painted the picture of a maternal figure, gestating babies with love and care, in order to help others. The testimony suggested that surrogates would not need the money, but compensation would help, and would ease the difficulty of being pregnant and giving birth for the benefit of another family. Wright and Levitan's testimony was closely aligned with the interests of infertile Canadians advocating for unencumbered access to surrogacy services; potentially limited by removing financial incentives for surrogates. The *AHRA* as passed did ban payment or compensation for surrogacy services, allowing only the reimbursement of expenditures in accordance with regulations yet-to-come.

The inclusion of Wright and Levitan in committee hearings marked a more nuanced understanding of surrogacy presented within the policy debates and discussion leading to the *AHRA*, although what emerged was a very specific understanding of the agency of Canadian surrogates. The dangers of exploitation and commercialization that had pervaded the debate over

⁴⁹⁶ Another woman, Dara Roth Edney, spoke on behalf of people who used surrogacy services to build their families during consideration of the draft legislation.

the three-phase approach were tempered somewhat by an understanding of surrogacy in Canada as relatively innocuous so long as it is conducted by middle-class women acting altruistically. Surrogacy itself was less offensive as a practice, but the line between acceptable and unacceptable practices lay with the ability to assert that surrogates were relatively well-off Canadian women, with their own children and more to give who were not engaging for the money. As such, the reproductive labour of surrogates was presented as pseudo-maternal, invaluable, with surrogates as engaging on their own accord; reproductive angels⁴⁹⁷ to the families that they assist. The potential for surrogacy as state-funded work that had appeared in the *Feedback* report was nowhere to be found in the *AHRA* as surrogates were constructed entirely in the debates on the proposed legislation (and implicitly in the proposed legislation itself) as maternal figures that could use (but did not need) compensation for their services.

In the meantime, egg donors remained absent from the debates. There was, however, a small change in how egg donation was considered, namely a recognition that if egg donation was going to continue in Canada, consideration would have to be given to the tremendous physiological undertaking that it involves. Consideration of the harms of egg retrieval was given not only in regards to reproduction, but also, in regards to embryonic stem cell research, for the first time addressing that perhaps it was not only the moral status of the embryo that was of grave concern, but also the invasive surgical practices required to obtain the eggs from which the embryos could be created.⁴⁹⁸ Concern about the problematic nature of obtaining embryos for

⁴⁹⁷ Despite the payment of surrogates in Canada and in the transnational marketplace, the language around surrogacy is couched nearly always in altruism and kindness, rather than labour. This is reflected in the use of the term “angel” in the marketing materials of surrogacy agencies. Penny Dowdoff, “A Feminist Critical Discourse Analysis of the Representation of the Surrogate, Egg Donors and Reproductive Tourist on Canadian and International Medical Broker and Fertility Clinic Websites” (paper presentation at the Women and Gender Studies/Recherches féministes Annual meeting, Brock University, St. Catharines, ON, May 27, 2014).

⁴⁹⁸ Ann Elizabeth Samson, “Donors Need Defenders; The Debate over Cloning Has Focused on Scientists’ Needs, Not the Rights of Women Who Supply the Eggs, Says Advocate,” *The Globe and Mail*, March 9, 2004, A17.

research or otherwise was raised most prominently by Keith Martin, a physician and then-Alliance Party Member of Parliament who suggested that it might be too much to ask women to undertake the risk of egg donation without some measure of compensation and that more than “bus fare to get down to the clinic” was warranted.⁴⁹⁹ The need to provide egg donors with some payment for undertaking significant risks also appears in the testimony of advocates of infertile people concerned about restrictions that might limit access to gametes. The idea of gamete shortage had appeared little during witness testimony on the draft legislation, but by the time the legislation arrived back at the Standing Committee after second reading, representatives from IAAC asserted that “few women will agree to undergo the painful egg-extraction procedure for free”⁵⁰⁰ and “there isn’t a woman alive who is going to do this for nothing,”⁵⁰¹ arguing that compensation for egg donation (not to mention sperm donation) was needed to ensure an ongoing supply of gametes. The longstanding matter of a “shortage” in gametes would become a refrain amongst clinicians and advocates of infertile people in the last round of standing committee hearings and once the legislation was heard in the Senate Standing Committee on Science, Social Affairs, and Technology prior to its passage. As with surrogacy, the commitment to non-commercialization evident in *Building Families* would slowly fall away, with references to “reimbursement” rather than “compensation” or “payment” assuaging concerns about commodification and economic exploitation.

The model of surrogacy and egg donation that was ultimately included in the *AHRA* allowed both practices to continue, but with criminal sanctions when either of these practices

⁴⁹⁹ Canada, Parliament, *House of Commons Debates* February 27, 2003 (Keith Martin); Alana Cattapan, “Vulnerable Subjects: Agency, Authority, and Assisted Reproduction in Canada,” (paper presentation at Mothers and the Economy: The Economics of Mothering, Ryerson University, Toronto, October 22, 2010).

⁵⁰⁰ Charlie Fidelman, “Critics Assail New Federal Law Banning Sale of Eggs and Sperm,” *The Canadian Press*, June 1, 2004.

⁵⁰¹ Kim Lunman, “Senate Passes ‘Historic’ Bill on Reproductive Technologies,” *The Globe and Mail*, March 12, 2004, A7.

involved payment to the surrogate or donor. There was, in this way, an upholding of the principles of non-commercialization and non-commodification that had appeared in proposed legislation and policy documents since the Royal Commission; Canada would not allow an open market in assisted reproduction. The outright ban on paying surrogates and egg donors for these activities was, however, tempered by a desire to ensure that if these practices were to continue, there was a need to ensure that donors and surrogates would not be saddled with restrictive costs that would hinder them from engaging. What would comprise compensation or “reimbursement of expenditures” would be addressed in regulations-to-come, but until regulations were drafted it was unclear just what would be included. At the time of writing, more than ten years after the passage of the *Act*, regulations are yet to be drafted.

What the criminal provisions of the Act ultimately did, and do, in relation to commercialization is offload the responsibility for the prevention of commercial practices and the commodification of reproduction to clinics, physicians, surrogacy agencies (which themselves are barred from engaging in commercial practices), lawyers, intended parents and others. In the absence of a substantive regulatory framework, as described below, the responsibility for ensuring that egg donation and surrogacy occur altruistically falls out of the purview of the state. While the inclusion of criminal provisions ensured that there was a public commitment on the part of the federal government to non-exploitative and non-commercial practices in the use of ARTs, without oversight and regulations there would be no enforcement, and the day-to-day functioning of surrogacy and egg donation arrangements are now governed only by those engaged in providing or using ARTs. Only the specter of illegality and individual commitments to ethical practices have worked to deter outright and open commodification. The

reproductive citizenship of egg donors and surrogates was affirmed, then, in terms of their role as freelance providers of reproductive services.

Infertile Canadians/Donor-conceived Families

Anonymous gamete donation and the federal government's insistence that it remain possible to donate and use anonymously provided gametes would prove to be one of the most contentious matters debated as the *AHRA* weaved its way through Parliament. During the three-phase approach, the positions of the Infertility Network and the Infertility Awareness Association of Canada were similar, however, as noted in chapters four and five, throughout the late 1990s, the Infertility Network changed its position considerably. Although both IAAC and the Infertility Network continued to run support groups and provide resources to infertile people, politically, the Infertility Network came to advocate for infertile people in ways that reflected the interests of donor-conceived people as well, and thus was more and more aligned with the politics of the NRAS than those of IAAC. Once-patients were later parents, no longer concerned with getting access to gametes or surrogacy services and instead, concerned about the stories that they would tell to their children about their origins. IAAC continued to advocate for people seeking to use reproductive technologies to build their families, and argued against policy proposals that might encumber their access, namely restrictions on payment for gamete donation and surrogacy and the elimination of donor anonymity.⁵⁰²

⁵⁰² Although she appeared in her capacity as a counselor at the London Health Science Centre throughout the hearings leading to the *AHRA*, social worker Jean Haase was a notable presence speaking on behalf of donor-conceived families. Haase had established a support group in 1997 that brought together donor-conceived families in Southern Ontario twice yearly. The group had not been involved in activist pursuits, but Haase testified multiple times in hearings on various iterations of the *AHRA* prior to its passage. The interests of donor-conceived people were not only well-articulated by COMAR, then, but also by Haase, whose support of the elimination of donor anonymity was well-received by Bonnie Brown, herself a social worker, and Chair of the Standing Committee on Health at the time that the draft legislation was being considered. Interview with Jean Haase, December 3, 2011;

When the draft legislation was put to the Standing Committee on Health, donor anonymity was a key issue in which the Committee could intervene in order to protect the best interests of the child. Committee Chair Bonnie Brown was a social worker, and her interventions were notable as she took an approach to the draft legislation that, from the outset, saw safeguarding vulnerable actors as paramount. In contrast to testimony that would emerge after the *AHRA* was tabled, there was almost no mention in witness testimony on the draft legislation of a potential shortage of gametes or a decline that might come with limitations on anonymity. In fact, this perspective was only articulated by Dr. Norman Barwin (of the Infertility Awareness Association of Canada), who vaguely mentioned that there might be reticence on the part of donors to participate in donation programs when they are concerned about being identified to resulting offspring.⁵⁰³ Instead, the elimination of donor anonymity was portrayed positively during this period, with witnesses attesting to the importance of protecting the best interests of the child. Perhaps the most important testimony on the interests of donor-conceived people during the consideration of the draft legislation was that of Olivia Pratten, as she spoke frankly of her experience as a donor-conceived person, calling the legislation “quite disgusting” for permitting donors to have their information destroyed, and “unconscionable” for the proposal of a dual system that would accommodate both open and anonymous donation.⁵⁰⁴ For several members of the committee, it was the first time that they had heard a donor-conceived person describe their experiences in their own words,⁵⁰⁵ and throughout the legislative process, MPs

Interview with Vince Londini, November 15, 2011. See also Canada, Parliament, House of Commons Standing Committee on Health. *Evidence*. Meeting No. 40, November 8, 2001.

⁵⁰³ Canada, Parliament, House of Commons Standing Committee on Health. *Evidence*. Meeting No. 40, November 8, 2001.

⁵⁰⁴ Canada, Parliament, House of Commons Standing Committee on Health. *Evidence*. Meeting No. 35, October 25, 2001.

⁵⁰⁵ Other key actors would also identify the importance of eliminating donor anonymity, including Diane Allen of the Infertility Network and Irene Ryll, the coordinator of the Infertility Connection, a support group based in

would refer to the testimony to speak in favour of banning donor anonymity.⁵⁰⁶

As noted above, the report issued by the Standing Committee on the draft legislation recommended eliminating donor anonymity in Canada, and ensuring that donor-conceived people could have access to identifying information about their donors. *Building Families* emphasized the importance of putting children conceived through ARTs first in any legislation or regulation, noting that "...children conceived through assisted human reproduction warrant even greater consideration than the adults seeking to build families or the physicians or researchers seeking new knowledge."⁵⁰⁷ Concerns about the benefits of these technologies for infertile Canadians were secondary, in the committee's opinion, to those of the donor offspring who would have to live with the consequences of the use of these technologies for their entire lives.

When Bill C-56 was tabled in May 2002 (without the proposed amendments on donor anonymity), then-Health Minister Anne McLellan attempted to pre-empt objections from Standing Committee members by directly addressing the matter of "anonymity." In her carefully worded speech to the House of Commons, McLellan at once asserted that "there will be no anonymous donors" given that donors would be required to provide personal health information under a proposed registry system, but that the practice of anonymous gamete donation (i.e., not providing donor information to donor-conceived people) would continue.⁵⁰⁸ As noted above, when the Bill returned to the Standing Committee on Health following second reading, the

Edmonton. See Canada, Parliament, House of Commons Standing Committee on Health. *Evidence*. Meeting No. 41, November 20, 2001.

⁵⁰⁶ Motluk, "Donor Anonymity in the Assisted Human Reproduction Act," 220.

⁵⁰⁷ Canada, Parliament, Standing Committee on Health, *Assisted Human Reproduction: Building Families*, 4; Motluk, "Donor Anonymity in the Assisted Human Reproduction Act," 222.

⁵⁰⁸ Canada, Parliament, *House of Commons Debates*, May 21, 2002 (Anne McLellan, Lib.). See also Motluk, "Donor Anonymity in the Assisted Human Reproduction Act," 222.

⁵⁰⁸ Canada, Parliament, House of Commons Standing Committee on Health. *Evidence*. Meeting No. 85, May 30, 2002.

longstanding members of the Committee challenged the government for its failure to address key recommendations, and particularly the recommendation to abolish donor anonymity. It was at this time, following the committee report that representatives from Xytex Canada and Repromed (both sperm banks operating in Canada) as well as clinicians who had appeared numerous times before, appeared before the committee suggesting that eliminating anonymity and compensation would have a negative impact on the supply of gametes in Canada. To this end, the representative from Repromed stated clearly that the donors in their program required both anonymity and reimbursement to participate in sperm donation, stating that seventy-one percent “have stated that they will not continue to participate in our program without appropriate reimbursement.”⁵⁰⁹

The eventual passage of the Bill without provisions to eliminate donor anonymity may be attributable, in part, to the changing composition of the Standing Committee on Health. The committee heard witnesses throughout the spring of 2002, and when they reconvened in the fall, the Bill was reintroduced at committee stage (as C-13). The membership of the committee changed slightly at this time, adding two physicians from the then-governing Liberal Party, Carolyn Bennett and Hedy Fry. As general practitioners, Bennett and Fry had experience with infertile patients and were concerned about what Bennett saw as “disdain for the infertile” on the part of committee members.⁵¹⁰ The efforts of these MPs, including Bennett “telephon[ing] physicians to see if they could convince patients to speak,”⁵¹¹ led to more representation from infertile people and their advocates than had occurred in the pre-legislative consultations and in consideration of the draft legislation. Although there had been agreement to hear only witnesses

⁵⁰⁹ Ibid.

⁵¹⁰ Motluk, “Donor Anonymity in the Assisted Human Reproduction Act,” 224.

⁵¹¹ Ibid., 225.

on issues where there was discord between the Bill and *Building Families*, Bennett and Fry's advocacy may have contributed to an overrepresentation of those advocating for the continuation of donor anonymity. Consequently, it was not only the Infertility Network and IAAC that were represented, but so too were a number of individuals speaking on their experience of infertility and the use of donor gametes. These individuals spoke one after another in support of the reimbursement of expenses in gamete donation and surrogacy, and suggested that any prohibition of reimbursement would result in a situation where infertile couples would either be deprived of a chance at building their family, or forced to circumvent the law in ways that would likely put surrogates and donors at risk.⁵¹² Of those representing infertile Canadians in the committee hearings, only the representatives of the Infertility Network argued that the provisions about reimbursement of expenditures were a cause for concern insofar as they might serve as a means to "circumvent the ban on payment to donors and surrogates."⁵¹³

Whereas *Building Families* had identified clear support for the elimination of donor anonymity, the near-consensus of the committee on that issue no longer existed in the later round of hearings. Many committee members remained concerned about the implications of anonymous gamete donation, but if they were indeed attempting to help Canadians create their families using ARTs, restrictions might be counterproductive. In a context of a government dedicated to the expansion of the biotechnology sector, and where the interests of clinics, many infertile Canadians, physicians, and sperm banks were suddenly articulated the same way—concerned about a potential gamete shortage—it would prove difficult to put donor anonymity in the Bill and to keep reimbursements for gamete donation and surrogacy out of it. The expansion of the committee hearings to include sperm banks and more advocates of infertile Canadians

⁵¹² Canada. House of Commons Standing Committee on Health. *Evidence*. Meeting No. 44, November 26, 2001.

⁵¹³ *Ibid.*

effectively tipped the balance away from those most concerned with the interests of the donor-conceived. The interests of clinicians as well as intended parents making use of reproductive technologies were made even clearer than they had been before, and the idea that regulating reimbursement of expenses or anonymous gamete donation was identified again and again as potentially infringing on the capacity of Canadians to use reproductive technologies.

The *AHRA* and the process of its formation, then, put forward a complex view of the reproductive citizenship of donor-conceived families. On the one hand, the inclusion of donor-conceived people and their families at each stage of consultations and throughout the legislative process is notable. The impact of Olivia Pratten's testimony cannot be understated, and *Building Families'* unequivocal commitment to privileging the interests of people born of reproductive technologies, in part by eliminating donor anonymity points to a recognition of the interests of donor-conceived families, and the desire of many to ensure that donor-conceived people can obtain access to information about their genetic origins. Further, the guiding principles of the *AHRA* include that "the health and well-being of children born through the application of assisted reproductive technologies must be given priority in all decisions respecting their use," implying that if eliminating donor anonymity serves the health and well-being of donor-conceived people, then it should be eliminated. At the same time, the *AHRA* does not include provisions to ensure that access to information about gamete donors is available to the donor-conceived. In the words of Shirley Pratten:

in the preamble of the Bill, it said a priority of the Bill was to put the children of the technologies at the forefront. It said that is what mattered the most. It would say that in the Bill, and there was all this evidence and research to show that anonymity was harmful to the child, and yet, the Bill in the end, supported anonymity going through.⁵¹⁴

⁵¹⁴ Interview with Shirley Pratten, March 28, 2012.

If what donor-conceived people and their families really wanted, and what they felt would ensure their well-being, was to have access to information about their donors, then the principles of the Act to protect their well-being were, at best, unrealized.

The failure to include provisions about the elimination of donor anonymity taken together with the ongoing inclusion of provisions to reimburse surrogates and gamete donors for “expenses,” suggests that those whose interests were best heard and incorporated into the *AHRA* were infertile people, their advocates, surrogates, and the clinicians and industry actors whose commitments to unrestricted access to fertility treatments persisted from the time of the Royal Commission through to the *AHRA*. The interests of these actors were presented similarly, in terms of the need for individuals to make choices about their fertility, and to ensure that the range of choices would be as widely drawn as possible regardless of the implications for the donor-conceived. In the federal government’s commitment to criminalization and regulation that had been in place since the time of the Royal Commission, the *AHRA* ultimately privileged the interests of those patient-consumers seeking to access fertility treatments as a means to have biologically related children through biomedical and pharmaceutical interventions in the context of a fertility clinic. The small measures taken to curb commercialization through making it illegal to “pay for” gametes or surrogacy services, were broadly conceived enough “to drive a truck through,”⁵¹⁵ as what would be considered expenses was left to the regulations, although the regulations were never made. By seeking treatment or making payments abroad, or reimbursing a too-broad range of expenses (in the absence of regulation), commercial practices persisted, ultimately doing little to alter the long existing market in reproductive services and materials in Canada. The reproductive citizenship of infertile Canadians, again, often articulated in the same

⁵¹⁵ Canada. House of Commons Standing Committee on Health. *Evidence*. Meeting No. 13, December 9, 2002.

terms as those of for-profit clinics and biomedical and biopharmaceutical firms, was unaltered, largely unrestricted, and reinforced in the *AHRA*.

The road to the *AHRA* involved the recognition of LGBTQ Canadians, surrogates, donor-conceived people, and infertile Canadians all as relevant stakeholders in the governance of assisted human reproduction in Canada. For LGBTQ people, who had not been expressly mentioned in policy debates since the time of the Royal Commission, the inclusion of provisions protecting against discrimination on the basis of sexual orientation or marital status was a means of recognizing that ARTs are a route to family building for people outside of the nuclear, heterosexual family framework. The limited inclusion of surrogates in the policy debates was a meager means of acknowledging their relevance to the policy outcomes, however, the voices of surrogates were not well-heard by policymakers (and the voices of egg donors remained absent). Donor-conceived people were well-heard by the Standing Committee on Health, but ultimately, their concerns about donor anonymity were not taken up in the legislation. Finally, infertile Canadians and others acting in their interest were well-represented in the policy debate, although the balance between criminal provisions and regulations-to-come resulted in potential access to altruistically provided gametes and surrogacy services and the subsequent emergence of a new grey market in surrogacy and gamete provision.

The privileging of the interests of infertile people in the *AHRA* is indicative of a broader understanding of reproductive citizenship in the contemporary period. Donor-conceived families and surrogates experience a mediated and complex relationship with the state vis-à-vis reproduction, with their interests sometimes heard, sometimes recognized, and subsumed by the interests of infertile people and biomedical actors where conflicts exist. The most robust reproductive citizenship is reserved for would-be reproductive entrepreneurs, with the financial

resources to invest in building their families, and the financial and social security to take the risks necessary to do so. LGBTQ people engaged in the use of ARTs may exist in a liminal space between these two groups, sometimes able to invest in the use of ARTs in the context of the clinic, sometimes contesting their medicalization through self-insemination and alternate forms of family building, sometimes unable to engage in their desired practices of family building, priced out of the market.

Governing Reproductive Technologies Since the *AHRA*

In *Governing Molecules*, a history of genetic engineering in Europe, Herbert Gottweis—political scientist and scholar of biotechnology—noted that narratives about biotechnology always “end in the middle of things.”⁵¹⁶ The lengthy legislative process that culminated in the passage of the *AHRA* was indeed, an end of sorts in the middle of the story of the governance of reproductive technologies in Canada, as the governance of ARTs in Canada has continued to evolve since its passage.

A Constitutional Challenge

The *AHRA* received Royal Assent in March 2004, and by December of that year, the Government of Quebec brought forth a constitutional challenge.⁵¹⁷ The challenge was largely concerned with whether the regulatory provisions of the Act infringed on provincial authority over health care, a matter which had been of concern throughout the policy debates leading to the passage of the *AHRA*. Concerns about the federal authority to intervene in an area of health care

⁵¹⁶ Gottweis, *Governing Molecules: The Discursive Politics of Genetic Engineering in Europe and the United States* (Cambridge, MA: MIT Press, 1998), 323.

⁵¹⁷ “Quebec Challenges Constitutionality of Federal Anti-Cloning Law,” *The Canadian Press*, December 16, 2004; Jocelyne Richer, “Querelle constitutionnelle autour des bébés-éprouvettes,” *Le Devoir*, December 17, 2004, A3.

were addressed in the first chapter of the Royal Commission's report, in which federal interventions in the field were validated through references to the "peace, order, and good government power, as well as under the criminal law, trade and commerce, spending and other relevant federal constitutional powers."⁵¹⁸ Further, both at the time of C-47 and later, during the debate over the draft version of the *AHRA*, members of opposition parties (primarily the Bloc Québécois)⁵¹⁹ and legal experts⁵²⁰ advised the federal government that the proposed legislation would be open to constitutional challenge due to what was perceived to be federal encroachment into the governance of health.⁵²¹ Thus, while legal counsel for the federal government continued to advise that the government would be within its jurisdictional authority to regulate if the regulations were relevant to the use of the criminal law power,⁵²² the constitutional challenge to the *AHRA* did not come as a surprise.⁵²³ In June 2008, the Quebec Court of Appeal found in favour of the Government of Quebec, ruling that despite the legitimacy of the criminal provisions of the Act, the medical aspects of reproductive technologies fall within the provincial power to regulate and deliver health care services.⁵²⁴ The Government of Canada appealed the decision, and finally, in a long-awaited and split judgment rendered in December 2010, the Supreme Court agreed with the Quebec Court of Appeal, effectively overturning a number of the

⁵¹⁸ Royal Commission on New Reproductive Technologies, *Proceed with Care*, 18.

⁵¹⁹ See for example, Canada, Parliament, *House of Commons Debates*, October 23, 1996 (Pauline Picard, BQ); Canada, *House of Commons Debates*, October 31 1996 (Monique Guay, BQ; Christiane Gagnon, BQ); Canada, Parliament, House of Commons Standing Committee on Health. *Evidence*. Meeting No. 85, May 30, 2002. Clairandrée Cauchy, "Un consensus se dessine sur le clonage," *Le Devoir*, January 4, 2003, B2.

⁵²⁰ Canada, Parliament, House of Commons Standing Committee on Health (Subcommittee on C-47). *Evidence*. Meeting No. 5, March 20, 1997; Canada, Parliament, House of Commons Standing Committee on Health. *Evidence*. Meeting No. 33, October 24, 2001.

⁵²¹ Hélène Buzzetti, "Le Bloc pourrait se ranger du côté du gouvernement," *Le Devoir*, June 21, 2003, A2.

⁵²² See for example, *RJR-MacDonald Inc v Canada (Attorney General), R v Hydro-Quebec*, and *Reference re Firearms Act*, which address federal capacity to regulate in certain fields under the auspices of the criminal law power. See discussion in I.B. Lee, "The Assisted Human Reproduction Act Reference and the Federal Criminal Law Power," *The Canadian Bar Review* 90 (2011); Graeme G. Mitchell, "Not a General Regulatory Power - A Comment on Reference Re Assisted Human Reproduction Act. (Canada)," *Supreme Court Law Review* 54 (2011).

⁵²³ Louise Leduc, "Québec s'inquiète du vide juridique," *La Presse*, October 8, 2003, A10.

⁵²⁴ *Quebec (AG) v Canada (AG)* 2008 QCCA 1167.

Act's regulatory provisions.⁵²⁵

The Rise and Fall of Assisted Human Reproduction Canada

In 2004, however, the legislation was in force, and as the constitutional challenge would take a number of years to weave its way through the courts there was still work to be done. Amongst the most pressing concerns was the establishment of a regulatory agency, mandated by the Act to “promote and protect the health and safety, and the human dignity and human rights, of Canadians,” and “to foster the application of ethical principles.”⁵²⁶ More specifically, the regulatory agency—Assisted Human Reproduction Canada (AHRC or the Agency)—was to manage the licensing functions of the *AHRA*, advise the Minister of Health on ARTs, “monitor and evaluate” developments related to ARTs, “collect, analyse and manage health reporting information” relevant to the regulatory provisions of the Act, provide public education, and ensure the Act's enforcement.⁵²⁷

From the outset, the Agency was mired in controversy. There were delays in establishing the agency, first due to the calling of the 2004 federal election less than two months after the *AHRA* received Royal Assent. Although steps were subsequently taken following the election to move forward with putting the agency in place (for example, Orders in Council were issued in 2005,⁵²⁸ and the establishment of a process to appoint Board members took place that same

⁵²⁵ Reference re *Assisted Human Reproduction Act* 2010 SCC 61, [2010] 3 S.C.R. 457.

⁵²⁶ Canada, “Assisted Human Reproduction Act,” s. 22.

⁵²⁷ *Ibid.*, s. 24; See also Baylis and Downie, “The Tale of Assisted Human Reproduction Canada: A Tragedy in Five Acts,” *Canadian Journal of Women and the Law* 25, no. 2 (2013): 187.

⁵²⁸ Canada, Privy Council Office. *Order Designating Vancouver, British Columbia, as the Place in Canada Where the Head Office of the Assisted Human Reproduction Agency of Canada Shall Be Located, effective January 12, 2006*, PC 2005-0726 (5 May 2005)/ *Order Fixing January 12, 2006 as the Day on which Sections 21 to 39, 72, 74, and 77 of this Act [Bill C-6], being chapter 2 of the Statutes of Canada, 2004 Come into Force, other than paragraphs 24(1)(a), (e), and (g)*, PC 2005-0725 (5 May 2005).

year),⁵²⁹ all was disrupted when yet another election was called, and the governing party changed in 2006. While the Liberal Party had formed government throughout the long process of the legislative development, following the 2006 election, implementation would be left to the newly elected Conservative Party of Canada with a well-known commitment to decentralization in health, and a lack of political will to openly engage in regulating reproduction. The appointments for the Board of the Agency were nearly complete when the 2006 writ was dropped, as “an independent expert selection committee” had made recommendations of twenty-five applicants to be considered for the Board.⁵³⁰ However, once elected the Conservative Party accepted only two of these recommendations, instead putting forth a new list of candidates criticized widely for social conservatism and a failure to include key stakeholders.

The critiques that the Board was too socially conservative and excluded patients, fertility experts and stem-cell scientists, were soon compounded by criticisms of the agency’s inaction and allegations of mismanagement. Neither Health Canada’s Assisted Human Reproduction Implementation Office (charged with the development of regulations), nor the Agency (with its mandate to implement the *AHRA*) developed a framework for licensing ARTs in the years after the Agency was established, and the regulatory regime promised by the *AHRA* never really emerged.⁵³¹ The Agency cited that it lacked regulations from Health Canada to do the licensing and enforcing of the *AHRA* that it was mandated to do, while Health Canada identified that the regulations were delayed due to the impending decision of the Quebec Court of Appeal, and later, the Supreme Court of Canada. The Agency did do some work during this period, including

⁵²⁹ Gloria Galloway, “Ottawa Rejects Concerns Over Fertility Panel; Board Appointments Reflect ‘Wide Range’ of Viewpoints,” *The Globe and Mail*, December 28, 2006, A4; Caroline Alphonso, “Experts Slam Fertility Board for Ignoring Other Voices: Social Conservatives Dominate Panel That Will Decide Reproduction Policy,” *The Globe and Mail*, December 30, 2006.

⁵³⁰ Baylis and Downie, “The Tale of Assisted Human Reproduction Canada,” 188.

⁵³¹ Sonya Norris, *Legal Status at the Federal Level of Assisted Human Reproduction in Canada* (Ottawa: Library of Parliament, 2011).

organizing an international conference on reproductive tourism, developing educational materials, and holding consultations on potential regulations, however given its broad mandate and substantial funding, it accomplished relatively little.⁵³² This is not to say that the blame for inaction lies with the Agency alone, as Health Canada failed to make the regulations needed to proceed with much of its mandate,⁵³³ however, the Agency could have moved forward with the enforcement of criminal provisions of the *AHRA* without the development of such regulations.⁵³⁴ The problems at the Agency went further, and in 2010, three Board members resigned, citing a lack of transparency in the Agency's operations and spending, and an insular politics that kept certain Board members from fully participating in the Agency's decision-making.⁵³⁵ It was clear that the Agency's dysfunction ran deep.

The decision of the Supreme Court of Canada on the *AHRA* made, in some ways, the functioning of the Agency a moot point. As the primary tasks of the agency included the management of the regulatory functions of the *AHRA*, including its licensing scheme and information collection, following the judgment the Agency's operations were restricted to education, and promoting enforcement of the law that remained (and the one set of regulations that had, in fact, been developed).⁵³⁶ In the 2012 federal budget, the Harper government announced that the *AHRA* would be amended to reflect the Supreme Court decision, including

⁵³² Alana Cattapan and Sara Cohen, "The Devil We Know: The Implications of Bill C-38 for Assisted Human Reproduction in Canada," *Journal of Obstetrics and Gynaecology Canada* 35, no. 7 (2013); Baylis and Downie, "The Tale of Assisted Human Reproduction Canada: A Tragedy in Five Acts"; André Picard, "Fertility Law Needs a Reset: The Assisted Human Reproduction Act and the Agency That Oversees It Are Based on Outmoded and Misguided Thinking," *The Globe and Mail*, April 3, 2012, L5.

⁵³³ Hélène Buzzetti, "L'agence fédérale dépense des millions même si elle a peu à faire," *Le Devoir*, January 20, 2009, A4.

⁵³⁴ Tom Blackwell, "The Impotence of Canada's Fertility Laws: Embryos for Sale, Wombs for Rent," *National Post*, February 14, 2009, A1.

⁵³⁵ Baylis and Downie, "The Tale of Assisted Human Reproduction Canada," 183, 196–197; Hélène Buzzetti, "Départs mystérieux à procréation assistée," *Le Devoir*, April 27, 2010, A2.

⁵³⁶ Canada, "Assisted Human Reproduction (Section 8 Consent) Regulations, SOR/2007-137."

closing the Agency, which ceased operations in March 2013.⁵³⁷

The changes announced in the federal budget were part of a controversial omnibus budget bill that made sweeping changes to *AHRA* reaching far beyond the provisions overturned by the Supreme Court.⁵³⁸ While media reports suggested that the changes to the Act made by the budget bill simply amended the Act to align with the *Reference* decision,⁵³⁹ in fact, the changes included the erasure of a provision requiring a review of the Act after three years, although no such review had ever occurred. The closure came as no surprise following the Supreme Court's decision and the longstanding critiques of the agency's composition and inaction, however proponents of the federal governance of assisted reproduction in Canada are left with little more at the time of writing than the rarely enforced criminal provisions.

Addressing Donor Anonymity

Frustrated with the slow going work of Assisted Human Reproduction Canada, Olivia Pratten wrote to its president to ensure that her donors' records could not be destroyed while waiting for regulations to be made. In an essay about her experience, Pratten noted that "Health Canada promised that the new Assisted Reproduction Agency would protect past files," but that the reply from the agency noted that it had "no jurisdiction to do so."⁵⁴⁰ Without any protections in place, the files containing information about Pratten's donor could be destroyed at any time. In order to

⁵³⁷ Canada, Department of Finance, "Budget 2012 - Budget Plan: Chapter 5 – Responsible Management to Return to Balanced Budgets," March 29, 2010, 5.

⁵³⁸ Andrew Coyne, "Parliament Now Little More than Ceremonial Body," *Windsor Star*, May 1, 2012, Final edition, A9; Jason Fekete, "Omnibus Budget Bill Abusive, Unethical," *Victoria Times-Colonist*, May 4, 2012, A11; Canada, *An Act to Implement Certain Provisions of the Budget Tabled in Parliament on March 29, 2012 and Other Measures*.

⁵³⁹ Anne Kingston, "Assisted Human Reproduction Canada: The Budget Cut Everyone Missed," *Macleans.ca*, April 2, 2012.

⁵⁴⁰ Olivia Pratten, "Attempting to Learn My Biological Father's Identity," in *The Right to Know One's Origins: Assisted Human Reproduction and the Best Interests of Children*, eds. Juliet. R. Guichon, Ian Mitchell, and Michelle Giroux (Brussels: ASP, 2012), 54.

prevent this from happening, and to ensure that others would not have to seek out such protections, she launched a lawsuit to ensure that donor-conceived people could have access to records about the identity, medical, social, and cultural history of their donors. The battle for the inclusion of provisions regarding donor anonymity in the *AHRA* was being waged once again, this time inside a courtroom, rather than the halls of Parliament.

The case was launched in 2008, and despite significant delays, a judgment was rendered in 2011. The details of the case hinged on regulations protecting medical records in British Columbia, namely that at the time of Pratten's conception the regulations required that patient records be kept for "more than six years from the last entry recorded."⁵⁴¹ As too much time had passed between Pratten's conception and the time at which she sought out her donor's records, there was no requirement to keep the records. Pratten argued that the Government of British Columbia failed to enact legislation that would provide donor-conceived people the same protections as adoptees, namely that information about their biological origins was "recorded and preserved" and "could be made available to them."⁵⁴² Pratten won her case at the Supreme Court of British Columbia, and the province was given fifteen months to amend adoption legislation to address the concerns of donor-conceived people. Further, the judgment included the granting of a "permanent injunction prohibiting the destruction, disposal or redaction of any and all Gamete Donor Records in British Columbia."⁵⁴³ The Government of British Columbia won on appeal, however, overturning the earlier decision, arguing that donor-conceived people are more like children whose mothers do not know the identities of their fathers than like adoptees, and therefore there was no obligation for the donor records to be protected and/or available. Pratten's

⁵⁴¹ *Pratten v British Columbia (Attorney General)*, 2011 S087449 656 (BCSC) at para 2.

⁵⁴² *Ibid.*, at para 4.

⁵⁴³ *Ibid.*, at para 355. See also Dave Snow, "The Judicialization of Assisted Reproductive Technology Policy in Canada," 178.

application for leave to appeal to the Supreme Court of Canada was denied in May 2013.

(Non)Enforcement of the AHRA

The failings of Assisted Human Reproduction Canada are not surprising given the simultaneous and egregious non-enforcement of the criminal provisions of the Act. The Act was passed in 2004 and most of the criminal provisions (with the exception of s.8, which required regulations on consent for the use of gametes and embryos) came into effect in April of that year. As the provisions around matters like reimbursement of expenses were never developed, the absence of regulations was widely seen as a loophole to be used to continue to pay gamete donors and surrogates under the auspices of reimbursing expenses. There was at least one instance where it was made clear to Assisted Human Reproduction Canada that payment for eggs had occurred, and without the provision of any receipts or the premise of repayment for expenses. Although “according to records obtained through the Access to Information Act, the RCMP was already investigating the same clinic over similar allegations,”⁵⁴⁴ and the woman in question provided a cheque documenting the payment to the RCMP, no charges were laid.

The only charges ever laid under the *AHRA* occurred in 2013—nearly ten years after the Act was passed. In that case, Leia Picard, the CEO of a surrogacy agency which matches surrogates with intended parents (she is also involved with an affiliate egg donor agency)—was charged with eleven violations of the *AHRA*, “five counts of buying or offering to buy sperm or eggs, three counts of buying or offering to buy the services of a surrogate mother, and three of taking money to arrange such services” in addition to forgery charges and charges laid against

⁵⁴⁴ Alison Motluk, “The Human Egg Trade: How Canada’s Fertility Laws Are Failing Donors, Doctors, and Parents,” *The Walrus* 7, no. 3 (2010).

Picard's agency.⁵⁴⁵ According to the Agreed Statement of Facts for the case,⁵⁴⁶ the investigation began in 2011, after the Agency received information that Picard's agency, Canadian Fertility Consultants was violating the terms of the *AHRA*, although the document focuses primarily on Picard's relationship with Hillary Neiman, a US fertility lawyer who, together with two other lawyers, had been convicted of contracting surrogates under false pretenses without intended parents involved, and then brokering deals to arrange for couples to "adopt" the already-contracted pregnancy, or effectively what amounted to a "baby-selling ring." Picard has not been implicated in those crimes; however, the Agreed Statement of Facts makes note of payments made to Picard by Neiman, and amongst experts in the field, there has been much speculation that pressure was put on the RCMP by the FBI to prosecute Picard.⁵⁴⁷

Picard pled guilty to three counts of violating the *AHRA*, namely the criminal provisions which prohibit paying surrogate mothers,⁵⁴⁸ arranging for the services of a surrogate mother,⁵⁴⁹ and purchasing eggs from a donor.⁵⁵⁰ Although the penalties for violation of these criminal provisions of the *AHRA* are severe—up to \$500,000 and/or a ten year jail sentence for an indictable offence, and up to \$250,000 and/or a four year jail term for a summary conviction—

⁵⁴⁵ Tom Blackwell, "Illegal Surrogacy; Rare Fertility Charges Expose Lax Oversight of Baby Making Industry," *National Post*, February 16, 2013, A1.

⁵⁴⁶ Because Picard pleaded guilty to the charges under the *AHRA*, there was no judgment. Instead, an agreed statement of facts chronicles the facts of the case. *R. v Picard and Canadian Fertility Consulting Ltd. Agreed Statement of Facts*, December 2013.
http://www.dal.ca/content/dam/dalhousie/pdf/sites/noveltechethics/AHRA_Facts.pdf.

⁵⁴⁷ Blackwell, "Fertility Case Tied to 'Baby Selling'; First Conviction Recorded Under Canadian Law," *National Post*, December 16, 2013, A1; Sara Cohen, "Third Party Reproduction and the Law in Canada - Let's Fill in the Blanks" (presentation at the Canadian Fertility and Andrology Society Annual Meeting, Quebec City, QC, September 11, 2014).

⁵⁴⁸ Section 6(1) of the *AHRA* reads, "No person shall pay consideration to a female person to be a surrogate mother, offer to pay such consideration or advertise that it will be paid." Canada, "Assisted Human Reproduction Act," s.6(1).

⁵⁴⁹ Section 6(2) of the *AHRA* reads, "No person shall accept consideration for arranging for the services of a surrogate mother, offer to make such an arrangement for consideration or advertise the arranging of such services. *Ibid.*, s.6(2).

⁵⁵⁰ Section 7(1) of the *AHRA* reads "No person shall purchase, offer to purchase or advertise for the purchase of sperm or ova from a donor or a person acting on behalf of a donor." *Ibid.*, s.7(1).

Picard was fined \$60,000 total for the three counts. Considering the extraordinary amounts of money involved in surrogacy arrangements (Picard received \$31,000 in “referral fees” for three referrals to Neiman),⁵⁵¹ the fines do not represent a significant sum of money and this fine might simply be perceived as a “cost of doing business.”⁵⁵² Suffice it to say that the strange circumstances of this charge, and the relatively small fine that it incurred, Picard’s case does not suggest a new appetite for prosecution in this field, or really that any more charges will be laid.

In short, in the absence of regulations from Health Canada, and with a largely dysfunctional, now-defunct agency, much of the *AHRA*, as it was passed in 2004, was never implemented, or has since been overturned. While the criminal provisions of the Act remain in place, with the exception of the case against Leia Picard and Canadian Fertility Consultants, the long-debated, controversial criminal provisions of the Act have simply never been enforced. Without implementation of the Act, commercial practices related to ARTs in Canada have continued and although reports of the underground trade in human eggs and surrogacy services have been unable to chronicle the extent to which paid egg donors and surrogates are engaged in Canada, message boards, investigative journalism, and first-hand accounts alike suggest that the market is extensive and growing stronger all the time. Buttressed by new developments including the importation of frozen eggs from abroad and overseas travel packages that promise “extraordinary success rates, low prices, and treatment in a tropical paradise,”⁵⁵³ the rising tide of commercialization and commodification that the *AHRA* was intended to stem is little more than empty rhetoric.

⁵⁵¹ *R. v Picard and Canadian Fertility Consulting Ltd. Agreed Statement of Facts.*

⁵⁵² Françoise Baylis and Jocelyn Downie, “Wishing Doesn’t Make It So,” *Impact Ethics* (blog), December 17, 2013, impactethics.ca/2013/12/17/wishing-doesnt-make-it-so.

⁵⁵³ “Barbados Fertility Centre,” *Barbados Fertility Centre* (website), n.d. <http://www.barbadosivf.com>.

Summary

Overall, the *AHRA* is a complicated and multi-faceted piece of legislation that came about through the contestation of the recognition of different groups and different interests in consultation, at committee, and otherwise throughout the policy process. The federal government's approach to the governance of ARTs changed little over this period, and the Act did little to curb commercial practices, or to protect the interests of donor-conceived people. While restrictions on commercial egg donation and surrogacy ostensibly address these concerns, commercial practices continue due to a lack of regulations and limited political will to enforce the Act. The *AHRA* enables individual Canadians seeking infertility services to continue to purchase them with few restrictions on the practice. Ultimately, the compromises that the *AHRA* represented, that is, the continuation of a free market in infertility with some restrictions on reimbursements for gametes and surrogacy services, has resulted in a perpetuation of the status quo. In short, commitments to a biomedical, evidence-based model of decision-making that privilege an individual, market-driven reproductive citizen continue.

Chapter Seven: Conclusion

The *AHRA* marked the long-awaited end to the legislative process initiated by calls for a Royal Commission more than a decade prior. As argued in chapter six, the interests of a range of actors, namely LGBTQ people, donors and surrogates, donor-conceived people, and infertile people, were acknowledged in the legislative process and the Act that passed, although the *AHRA* privileged a biomedical, individually conceived, market-oriented model of assisted reproduction with permeable prohibitions on commercialization. LGBTQ people, egg donors, surrogates, infertile people, and donor-conceived families emerged in different ways, at different times, as subjects of the governance of ARTs, demonstrating the ways in which these groups were at once understood, and understood themselves to be reproductive citizens for a new age.

This final chapter of this dissertation returns to the intersections of neoliberalism and reproductive citizenship to review the central findings of this dissertation and to suggest areas for future research. As to central contributions, this dissertation has provided a theoretical elucidation of “reproductive citizenship” in the context of a neoliberal citizenship regime and its applicability to the example of the governance of assisted reproduction in Canada. Further, it has made a substantive contribution to the scholarship on ARTs by providing a carefully drawn history of the *AHRA* and the first in-depth investigation of the experience of LGBTQ people, donor-conceived people, gamete donors and surrogates, and infertile Canadians in the long policy process leading to its passage. As to areas for further research, this chapter emphasizes two areas for investigation that are particularly relevant to the work done by this dissertation, namely the experiences of egg donors and surrogates, and the potential for future regulation and funding at the provincial level, as well as pointing to a number of other areas where a dearth of research raises challenges for moving forward with policy proscriptions. This chapter and the

dissertation conclude by reaffirming that federal policy has worked in varying ways to construct, contest, and recognize the interests of a range of stakeholders, privileging the reproductive citizenship of those aligned with a personal interest—financial or otherwise—in the ongoing non-regulation of ARTs in Canada.

Neoliberalism, Reproductive Citizenship, and ARTs

Governing ARTs in Canada

From the Royal Commission on New Reproductive Technologies to the passage of the *AHRA*, the history of public policy governing ARTs in Canada reveals much about how neoliberal imperatives have informed the policy process. During the Royal Commission on New Reproductive Technologies, commitments to evidence-based medicine ensured that reproductive technologies were constructed, from the outset, as matters of privately provided medical care, outside of the highly-scrutinized public health care system. Any possibility for publicly funded care was precluded by the understanding that infertility treatments were “experimental,” leaving them to be provided by private clinics. The medicalization of infertility and the validation of its private provision enabled by the Royal Commission’s recommendations worked to remove the sociality of reproduction, reconstructing both reproduction and possibilities for creating a pregnancy as matters of consumer choice available within the free market. The medicalization of infertility evident in the work of the Royal Commission also marked assisted reproduction as a site of medical (and not social) governance, limiting the kinds of actors and the kinds of regulation that were possible. As potential patients, the interests of intended parents were privileged, as were the interests of relevant clinics, clinicians, and other biomedical actors seen to be crucial to the provision of their “medical” care. Furthermore, the Commission’s reliance on

a biomedical understanding of infertility suggested from the first, that certain actors would be excluded from the policy process, including lesbians and others whose experience of infertility was not necessarily medical. At the same time, the extensive consultations of the Royal Commission allowed for an articulation of a range of positions on reproductive technologies, and the act of bringing stakeholders together worked to legitimate their voices.

By the time of the three-phase approach, the expansion of fertility services meant that the market in infertility treatments was well-established, and opposition to government intervention was strong. The language of choice and of a right to reproductive services emerged strongly in this period, and the dominance of biomedical actors, including advocates of infertile Canadians that shared their views, challenged C-47, the proposed legislation which would seemingly curtail commercial egg donation and surrogacy by criminalizing these practices. The policy deliberations and consultations leading to the *AHRA* affirmed these commitments to the continuation of a market in infertility care. Extensive public hearings and a committee report that recommended important restrictions on commercial practices and donor anonymity did little to deter policymakers from proceeding with previous iterations of the policy framework. The consultations themselves, which focused on asking both “ordinary citizens” and stakeholders to respond to narrow questions about an already-established policy framework worked to uphold commitments to criminalization and regulation, and allowed for an easy dismissal of certain stakeholders as special interests. The recommendations to eliminate donor anonymity were ignored, and although some restrictions on egg donation and surrogacy were passed, the failure to make relevant regulations and to implement the law has meant that the provisions related to non-commercialization in the *AHRA* are ineffectual—without teeth. Despite the years of deliberations, policy consultations, and consideration of what to do about ARTs, the *AHRA* does

little to alter the open market in infertility services that had only grown since the time of the Royal Commission.

There were moments when there might have been attempts to substantially intervene in the governance of reproduction in ways that would have protected vulnerable actors, and to address public health concerns. The understanding of egg donation as a matter of public health that emerged at the time of the Royal Commission, for example, offered a means for the federal government to ban the practice for healthy women who were not already undergoing ovarian stimulation or other invasive health interventions. However, the *AHRA* does not address egg donation as a matter of public health, but rather understands it as a private arrangement between a donor and intended parents in which individual egg donors must choose how and when it is appropriate to go forward with donation. Or, the federal government might have taken decisive action in the regulation of surrogacy, reframing surrogacy as a carefully regulated form of labour with rates and terms set by the state, as described in the 2000 *Feedback Report*. However, surrogacy emerges in the *AHRA* in ways similar to egg donation wherein the risks associated with surrogacy are largely left up to the surrogate and intended parents to address. Further, there were opportunities to make law that would ban donor anonymity, giving donor-conceived people the chance to know more about their genetic origins. However, the law as passed focused on the need of intended parents and clinics to have unfettered access to donor sperm, ignoring the positions of donor-conceived people who had clearly articulated that the ongoing practice of donor anonymity was unacceptable and harmful to their well-being. Despite the language of “protection” and of the prioritization of those born of reproductive technologies included in the principles of the *AHRA*, the Act reinforced longstanding commitments to the market-based provision of assisted reproductive services, and the assumption that individual Canadians are

best positioned to make decisions about the risks and benefits of their use. As described throughout this dissertation, the *AHRA* privileges the interests of intended parents and the biomedical actors that help them to access ARTs, leaving surrogates and donors, as well as donor-conceived people in largely the same position that they were prior to the calling of the Royal Commission, but now left to navigate a larger and more complex market in infertility services.

The reflection of a neoliberal citizenship regime in the governance of assisted reproduction then, appears in many ways. The understanding that market participation legitimates citizenship entitlements is reflected in the governance of ARTs, as intended parents (infertile people, LGBTQ people, and single people) came to be understood as market-based actors, and it is as potential consumers of privately-provided ART services that their interests are protected by the *AHRA* and its ongoing non-regulation and non-enforcement. With the ability to actively pursue having genetically related offspring and family building through consumption practices, the use of ARTs serves at once to validate the marketplace of reproductive services, and to do so in self-sufficient ways that replicate existing understandings of private and public life.

There are then, reasons to understand the *AHRA* as a slow march to a neoliberal approach to governing ARTs, but as noted in chapter one, neoliberalism is not consistent, “at times incoherent,” an incremental, pervasive, and at times unintelligible ideology informing governance in the contemporary period. The governance of assisted reproduction in Canada has not simply been a slow march to a totalizing neoliberal reproductive citizenship, but rather, a complex shift that has been diffuse and contested. There is something peculiar about the nature of neoliberal interventions into public policy, and specifically, public policy governing intimate

life, insofar as these interventions are not uniform, and not unified, and are contingent on the “contextual conditions and institutional arrangements,”⁵⁵⁴ that make a clean and direct trajectory from reproductive citizenship in a social citizenship regime to a neoliberal one untenable. For example, while the evidenced-based approach to governing reproduction and the privileging of a biomedical model are clear in the work of the Royal Commission on New Reproductive Technologies, its report did include, as noted in chapter three, recommendations to engage in infertility prevention strategies and to prohibit commercial surrogacy and egg donation. Furthermore, in the late 1990s, the initial steps toward a comprehensive sexual and reproductive health framework (as chronicled by *A Report from Consultations on a Framework for Sexual and Reproductive Health*) suggest that there were, on some level, commitments to engage in preventative approaches to addressing infertility. Indeed, scholarship on the governance of ARTs refers to Canadian legislation as “one of the strictest frameworks in the world”⁵⁵⁵ in its sweeping approach to governing the field and restricting commercial activities. Again, attempts to govern ARTs in Canada have not been uniform or consistent in the embrace of a hands-off approach that requires individual citizens to take individual responsibility for their engagement with ARTs within the context of a free market in infertility services.

The Emergence of New Reproductive Citizens

The *AHRA* and its complex approach to continuing the marketization, privatization, and individualization of assisted reproduction in Canada were not the only outcomes of the long policy process. From the time of the Royal Commission through to the passage of the *AHRA*, new stakeholders emerged as relevant to the policy process that had not been heard previously by

⁵⁵⁴ David Harvey, *A Brief History of Neoliberalism* (Oxford: Oxford University Press, 2007), 116.

⁵⁵⁵ Jones and Salter, *Proceeding Carefully*, 22.

the federal government. The emergence of ARTs and their inclusion in the public policy agenda put intended parents, donor-conceived people, LGBTQ Canadians interested in using ARTs, and surrogates and donors squarely into the purview of the federal government as new interests to be addressed.

The extent to which these actors were heard, and their concerns incorporated into policymaking, varied widely. Intended parents were represented most prominently by IAAC, and were exceptionally visible throughout the policy process, heard at every consultation. Access to services for those deemed medically infertile was critically important to policymakers, and the most contested provisions of proposed legislation were those that were seen to infringe upon the “choices” of intended parents. The positions taken by advocates of infertile Canadians were supported, oftentimes financially, by biomedical actors including clinics, professional associations, pharmaceutical firms and others, making it difficult to discern where the lines between patients, physicians, and those with important financial interests in an expanding market in assisted reproduction might be drawn. Over the course of the long policy process, infertile Canadians went from a relatively small group beginning to establish an advocacy organization to a large, well-funded interest, lobbying and participating in policy debates to ensure ongoing, unrestricted access to ART services.

Donor-conceived people and their families were also well-heard throughout the policy process. The work of Shirley Pratten and the NRAS had already begun at the time of the Royal Commission, and the organization was able to establish itself early on as an important stakeholder in any policymaking process that would occur. The recommendation made by the Standing Committee on Health to ban donor anonymity was particularly important to the validation of the interests of donor-conceived people, it was a victory insofar as the voices of

donor-conceived people and their families were influencing the policy process, even though the recommendation was not incorporated into the *AHRA*. Nevertheless, the validation of donor-conceived people and their families throughout the policy process worked to demonstrate the legitimacy of their claims. With the understanding that donor anonymity is an issue that should be addressed in public policy and law, and that the claims of donor-conceived people and their families should be recognized, Olivia Pratten brought her case before the courts. The reproductive citizenship of donor-conceived families, and the deep-rooted interest in ensuring that donor-conceived people can have access to information about their donors remains a site of struggle.

Those representing LGBTQ interests were incorporated very few times in the many consultations that occurred; only at the time of the Royal Commission and once during the lead-up to the *AHRA*. However some lesbian mothers addressed concerns around access to donor sperm and to ART clinics by seeking change outside of federal lawmaking initiatives. Some brought forward court cases as in *ter Neuzen v Korn*, *Potter v. Korn*, and *Susan Doe v Canada*. Rachel Epstein and the Dykes Planning Tykes program have provided an educational program to address gaps in knowledge about reproductive possibilities and Mona Greenbaum and Nicole Paquette established the Lesbian Mothers' Association of Quebec, developed a small-scale lesbian sperm bank out of their home, and fought for legislative change in Quebec to recognize same-sex adoption. The interventions on the part of Greenbaum and the Lesbian Mothers' Association to incorporate a non-discrimination clause into the *AHRA* are particularly notable because they were not part of any long dialogical process between LGBTQ advocates and the federal government about how to address their interests in the governance of ARTs. Rather certain actors pursued one small change within the context of a policy that was already going

forward, and was relatively fixed. LGBTQ people have emerged as important reproductive citizens within and outside of the federal governance of assisted reproduction, addressing their interests in a wide variety of venues despite limited inclusion in formal policy consultations.

Finally, the interests of surrogates and egg donors were only marginally represented, though oft-talked about throughout the policy process leading to the *AHRA*. Joanne Wright was included in some of the later policy debates prior to the passage of the *AHRA*, and recently, there has been some mobilization by egg donors, but for the most part, egg donors and surrogates were described as potentially exploited subjects best off if they altruistically choose to engage (despite almost no evidence supporting these claims). The non-inclusion of egg donors and surrogates in the policy process, taken together with the well-heard position of infertile Canadians rendered egg donors and surrogates to the status of non-actors in the governance of ARTs. The recognition of infertile Canadians as reproductive citizens, and their ongoing access to fertility services including surrogacy and egg donation has left little space for the articulation of the position of donors and surrogates, themselves involved in the process of reproduction, reproductive citizens in their own right. Their roles in family building, in new conceptions of parenting, and in the governance of reproduction have, at times, been overwhelmed by the call for unrestricted access to reproductive technologies by intended parents, including those technologies that make use of the bodies of donors and surrogates.

The inclusion and exclusion of these groups in the policy debates and the extent to which these groups made their voices heard inside and outside the legislative process is informative about the way in which their reproductive citizenship was experienced. The recognition of infertile Canadians as potentially reproductive, and entitled to accessing ARTs if they had the financial capacity to do so, differs substantially from the understanding of egg donors and

surrogates not as reproductive, but as secondary to the use of ARTs, objects not subjects of reproduction. The recognition of these actors in the policy process marks their recognition as potential subjects of public policy—as potential reproductive citizens—though some experience a more robust reproductive citizenship than others.

Ultimately, as argued in this dissertation, the governance of ARTs in Canada—from the Royal Commission to the *AHRA*—is a testament to the lauding of a new reproductive citizen, one who is self-sufficient, independent, and, where necessary, undertakes the physiological and financial risks necessary to conceive a child. The experiences of stakeholders, namely LGBTQ people, infertile people, surrogates and egg donors, and donor-conceived people, add another important dimension to this history, demonstrating the ways that reproductive citizenship is, and has been negotiated in relation to the governance of ARTs. The diverse experiences of these stakeholders demonstrate how individual and collective concerns, engagement with industry, the “protection” of women and children born of ARTs, and choice were navigated as these groups participated in (or in the case of egg donors, were excluded from) the policy process.

Research Contributions

On Reproductive Citizenship

This dissertation began from the simple premise that recognition matters, and recognition does indeed matter. There is something fundamental about being included in the exchange of rights and entitlements between a state and its people that makes one feel like they are full members of a community, particularly when this exchange works to validate the role of individuals and groups as parents, free to reproduce and pass on their values, their experiences, and share their lives with the next generation of citizens. State provision of services to help people reproduce in

the ways that they want is important, as it allows people to feel secure both in their experience as citizens, and safe in raising their families within that state.

The theorization of “reproductive citizenship” that has occurred throughout this dissertation is rooted in Bryan S. Turner’s use of “reproductive citizenship” to describe how social supports provided to families (e.g., education and health care provision for children, baby bonuses, childcare subsidies, etc.) in the post-war welfare state were granted in exchange for the reproductive labour that parents provide in “reproducing the nation.” Extrapolating from Turner, and with the addition of the contributions of scholarship on gendered, sexual, and biological citizenship, reproductive citizenship comprises the rights and entitlements sought in relation to reproduction, the sense of identity that may accompany those rights, and the way that people have been grouped (e.g., as intended parents, as surrogates) as policy subjects and grouped themselves in order to make their interests known. Further, reproductive citizenship includes the understanding that the governance of reproduction can work to encourage the proliferation of certain kinds of citizens and family forms, resulting in the privileging of the reproductive experiences of some to the exclusion of others.

Despite a long history of scholarship examining the relationships between citizenship, gender, and family life, the study of “reproductive citizenship,” is only now emerging as part of citizenship studies. Scholars of citizenship theory, and particularly since Marshall’s work on the social rights of citizenship, have investigated the ways that the accordance of particular rights and entitlements to certain groups can work to legitimate their place within the state, and to create a robust feeling of citizenship that can contribute to more full, more secure lives.⁵⁵⁶ And as

⁵⁵⁶ Lister, “‘Marshall-Ing’ Social and Political Citizenship: Toward a Unified Conception of Citizenship,” *Government and Opposition* 40, no. 4 (2005); Engin F. Isin and Bryan S. Turner, “Investigating Citizenship: An Agenda for Citizenship Studies,” *Citizenship Studies* 11, no. 1 (2007); Kymlicka and Norman, “Return of the Citizen.”

described in chapter two, these scholars have long been engaged in identifying and critiquing the ways that citizenship has been experienced, especially insofar as the recognition and dismissal of claims to citizenship are tied to evolving understandings of what constitutes a “good” reproductive citizen. Scholarship on gendered and sexual citizenship has challenged the legitimacy of Marshall’s work, based as it was on a particular, relatively exclusionary model of the citizen subject.⁵⁵⁷ More recent contributions of the literature on biological citizenship have challenged the Marshallian approach to citizenship theory in new ways still, interrogating how the relationship between citizens and the state may be read through embodied experiences, corporeal and genetic, by examining both how the state comes to govern its subjects and how citizens come to view and articulate their experiences in their own ways, on their own terms.⁵⁵⁸ It is only since Turner’s work in this field that reproductive citizenship *qua* reproductive citizenship has emerged as a site of study, and while new works continue to build on Turner’s work,⁵⁵⁹ this study is the first to provide an in-depth examination of the concept in the Canadian case.

More clearly, reproductive citizenship offers a dedicated site to identify the ways in which citizenship rights and entitlements related to parenthood and reproduction have changed over time, in relation to changing citizenship regimes. As citizenship rights “remain the object of

⁵⁵⁷ Cossman, “Sexual Citizens”; Phelan, *Sexual Strangers*; Richardson and Turner, “Sexual, Intimate or Reproductive Citizenship”; Evans, *Sexual Citizenship*.

⁵⁵⁸ Fitzgerald, “Biological Citizenship at the Periphery”; Fraser, “Hepatitis C and the Limits of Medicalisation and Biological Citizenship for People Who Inject Drugs”; Orsini, “Hepatitis C and the Dawn of Biological Citizenship”; Petryna, *Life Exposed*; Rose and Novas, “Biological Citizenship”; Stingl, “The Virtualization of Health and Illness in the Age of Biological Citizenship.”

⁵⁵⁹ Lupton, “Precious Cargo”; Salmon, “Aboriginal Mothering, FASD Prevention and the Contestations of Neoliberal Citizenship”; Damien Riggs and Clemence Due, “Representations of Reproductive Citizenship and Vulnerability in Media Reports of Offshore Surrogacy,” *Citizenship Studies* 17, no. 8 (2013); Cattapan, “On Reproductive Citizenship”; Remmenick, “Between Reproductive Citizenship and Consumerism”; Unal and Cindoglu, “Reproductive Citizenship in Turkey”; Ana Amuchástegui and Edith Flores, “Women’s Interpretations of the Right to Legal Abortion in Mexico City: Citizenship, Experience, and Clientelism” *Citizenship Studies* 17, no. 8 (2013); Sasha Roseneil et al., “Reproduction and Citizenship/Reproducing Citizens: Editorial Introduction,” *Citizenship Studies* 17, no. 8.

political struggles to defend, reinterpret, and extend them,”⁵⁶⁰ the study of reproductive citizenship enables scholars to examine more closely the ways that these struggles occur in the governance of reproduction, and to identify the increasing understanding of parenting and parenthood as an individual rather than collective endeavour. As the family wage has fallen away and responsibility for childrearing remains largely within the bounds of the free market, reproductive citizenship allows for conceptual elucidation of how privatization, marketization, and individual choice (for those with the socioeconomic capacity) have emerged as key values in building families, particularly in families in which the children are genetically related to at least one of their parents. Further, with the proliferation of ARTs, entering a fertility clinic in hopes of having a child is one among many options presented to people seeking to parent. What reproductive citizenship offers as a concept, then, is a route to interrogate the changing nature of how reproduction itself is theorized, and the consequences for other aspects of our social lives.

Shifting Citizenship Regimes

This dissertation has demonstrated not only that reproductive citizenship is a fruitful way to study the relationship between parents and the state, but also that studying reproductive citizenship over time can demonstrate whether the exchange of rights and entitlements accorded to individuals and groups in relation to reproduction intersects with, reflects, or challenges broader trends in the governance of citizenship. The erosion of the social citizenship regime of the post-war welfare state has brought with it significant changes to programs like social insurance and unemployment insurance in ways that have rendered them unrecognizable. With time marching on, the weakening of the social safety net has replaced a passive model of social

⁵⁶⁰ Lister, *Citizenship: Feminist Perspectives*, 198.

rights-based citizenship with a new model tied to employment and participation in the market economy.

The examination of reproductive citizenship over time, focusing on the governance of ARTs (in chapters three through six), demonstrates how engagements with assisted reproduction as a site of public policy have replicated the ideological pressures of a neoliberal citizenship regime. The understanding of infertility as a matter of private medical care, the failure of the federal government to restrict egg donation as a matter of public health, and the ongoing lack of implementation which allows the marketplace of infertility services to flourish are all indications of the ways that the governance of assisted reproduction in Canada is embedded in a neoliberal paradigm. With very few exceptions, there have been no substantive attempts to restrict the range of options available to intended parents and their clinicians on the part of the federal government. Far from the collective concerns about the implications of ARTs articulated by the feminist activists who called for a Royal Commission in the early 1980s, the governance of assisted reproduction in Canada has moved towards recognition of reproductive citizenship reliant on the language of choice and embedded in market-based provision of care. Rather than broad, social interventions to reduce infertility in the first place, or enabling flexible work arrangements or childcare programs to help women have children before age-related infertility might occur, the focus of the *AHRA* and the three-phase approach before it has been on creating the means for the ongoing use of highly-profitable ARTs, in order to build their families.

The governance of assisted reproduction is deeply embedded in expanding the range of choices available to women and parents more broadly, without expanding meaningful choices, that is to say, reproductive autonomy. The availability of ARTs within private-for-profit clinics means that certain people will continue to be able to “make choices” about their fertility options,

but those same people might have been able to make decisions about their capacity to reproduce if they had been empowered to have children earlier in their careers, if there was support and widespread acceptance of forms of family building other than having genetically related children, or if prevention programs for sexually transmitted diseases and exposures to environmental toxicants were in place to prevent infertility in the first place. The increased reliance on ARTs as a reproductive choice and a means to “cure” infertility obscure the importance of broader social changes that might enable the exercise of substantive reproductive autonomy, changes that require rethinking that ARTs are a reproductive choice that should be available to all.

Interest Articulation and Emerging Policy Subject

Finally, this dissertation contributes to the literature on political mobilization, particularly in a field of public policy that has received little attention in the Canadian context. Reproduction, the fundamental process of being born, has largely been absent in considerations of political science in Canada, but the very nature of citizenship and belonging is bound to the nature of birth, to whom, how, and where conception and birth occur. With a few exceptions⁵⁶¹ limited attention has been paid to this most fundamental aspect of social and health policy, exploring the very ways that we come into being, and come into being as a citizen of the state. Each time new work on the governance of assisted reproduction is published, it seems as if the story is being told anew, this policy issue rarely recognized as a critical site of analysis.

⁵⁶¹ Lois Harder, “Does Sperm Have a Flag?: On Biological Relationship and National Membership,” *Canadian Journal of Law and Society* 30, no. 1 (2015); L’Espérance, “Fertilize-This”; Montpetit, “Public Consultations in Policy Network Environments”; Scala, Montpetit, and Fortier, “The NAC’s Organizational Practices and the Politics of Assisted Reproductive Technologies in Canada”; Scala, “Scientists, Government, and ‘Boundary Work’”; Scala, “Feminist Ideals Versus Bureaucratic Norms”; Snow and Knopff, “Assisted Reproduction Policy in Federal States.”

Perhaps this is so because, as described in chapter one of this dissertation, the research to date has largely focused on federalism, the judicialization of assisted reproduction, and the squeezing out of the interest groups long fundamental to policymaking, including feminist actors. The lack of research on contemporary interest groups and others with a vested, personal, familial interest in the governance of assisted reproduction and who continue to contribute to the policy debates has meant that much mobilization in this field has gone unstudied. As addressed in this dissertation, the emergence of new interest groups and social actors, and the ways in which they engaged with, and contested the policy framework put forth by the federal government is informative about how interest groups emerge and are recognized in new fields of public policy. In the context of consultative processes that included and excluded different actors at different times, and that often aimed to establish the legitimacy of a preconceived policy framework, there were few opportunities for contestation. However, some of the groups examined in this dissertation mitigated the lack of political opportunities within the formal legislative process by looking to the courts, by engaging in educational campaigns, by engaging with the media, and otherwise articulating their interests in ways that ultimately contributed to the discursive construction of the issues at hand.

Areas for Future Research

Exploitation, Egg Donation, and Surrogacy

This dissertation reveals a number of gaps in existing knowledge about current practices in egg donation and surrogacy. First, despite a range of literature identifying that there may be exploitation and commercialization occurring in Canada, there is little information about the actual experiences of egg donors and surrogates. Like the policy process leading to the *AHRA*,

contemporary scholarship on the governance of egg donation and surrogacy is largely based on limited data about who egg donors and surrogates are, as well as the nature of their experiences. Claims of exploitation and commercialization persist, as do journalistic accounts of surrogacy arrangements gone awry and catastrophic illnesses following egg donation, but in terms of empirical study, the Canadian situation is little changed since the time of the Royal Commission.

Regarding egg donation, freelance journalist Alison Motluk conducted a study of egg donors across Canada between 2010 and 2012. In the resulting articles she revealed not only that egg donors travel long distances and are paid varying amounts, but also that they report a higher incidence of severe side effects than identified in the medico-scientific literature. Eight of the eighteen women Motluk interviewed reported experiencing severe ovarian hyperstimulation⁵⁶² to the point that they required “either hospitalization or abdominal draining,”⁵⁶³ although the risks of experiencing these effects are widely reported as being less than one percent. Motluk included a note about the possibility of selection bias in her study, that, “it could be that women who suffered injury are more likely to talk to a journalist, and are so over-represented. It could be a coincidence that I spoke to a disproportionate number of people who suffered ill effects.”⁵⁶⁴ But Motluk’s work provides initial empirical support for a phenomenon long suspected by scholars

⁵⁶² Ovarian hyperstimulation syndrome is a result of the overstimulation of the ovaries which may occur in women undergoing ovarian stimulation for IVF or egg donation. In its mild and moderate forms may involve symptoms like cramping, nausea, bloating, vomiting, diarrhea, and abdominal distention. In more severe cases, ovarian hyperstimulation may have life-threatening implications including kidney failure, respiratory distress, blood clots, hemorrhaging from the rupture of the ovaries. See K. Jayaprakasan et al., “Estimating the Risks of Ovarian Hyperstimulation Syndrome (OHSS): Implications for Egg Donation for Research,” *Human Fertility* 10, no. 3 (2007).

⁵⁶³ Alison Motluk, “Is Egg Donation Dangerous?,” *Masonneuve* 46 (2012). See also, Motluk, “The Human Egg Trade,” Alison Motluk, “Egg Donor Sues Doctor after Suffering Stroke; Accuses Clinic and Doctor of Negligence,” *National Post*, March 28, 2013, A5; Alison Motluk, “Wanted: Egg Donor in Good Health,” *The Sunday Edition, CBC Radio One*, February 19, 2012, <http://www.cbc.ca/player/Radio/The+Sunday+Edition/Full+Episodes/2012/ID/2198382210>; Alison Motluk, “Insurer Denies Coverage for Fertility Doctor Facing Lawsuit,” *Canadian Medical Association Journal* 186, no. 2 (February 4, 2014), E75-76.

⁵⁶⁴ Motluk, “Is Egg Donation Dangerous?”

of women's reproductive health and ARTs, namely that there may be a propensity among clinicians to push the limits of ovarian stimulation when women are seen as *donors* and not as patients.⁵⁶⁵ The one percent risk of severe ovarian hyperstimulation syndrome is the rate of incidence for women undergoing ovarian stimulation for IVF (which is the same as egg donation in its early stages), and Motluk's work points to the ways that the risks of egg donation might be drastically different from those of IVF despite the similarity in medical protocol. Some advances have been occurring, most importantly a new advocacy group, We Are Egg Donors, was established in 2013 to create an international network of egg donors, and to make experiential information about egg donation widely available. However, scholarship in this field is still extraordinarily limited and there is no empirical evidence of how egg donation in Canada takes place beyond Motluk's study. As to surrogacy in Canada, since Eichler and Poole's 1985 study of surrogacy in Canada there have been two relevant empirical studies, both Master's theses which have included interviews with eight or fewer surrogates in each case.⁵⁶⁶ In order to move forward with analyses and (perhaps) policy that addresses the potential for exploitation, commercialization, and altruism, more research is needed, engaging with the real life experiences of surrogates and egg donors in Canada (including their mobilization through groups like We Are Egg Donors), both to support and recognize the articulation of the position of egg donors and surrogates on their own terms.⁵⁶⁷

Outside of empirical research, what scholarship does exist on egg donation and surrogacy

⁵⁶⁵ Vanessa Gruben, "Women as Patients, Not Spare Parts: Examining the Relationship Between the Physician and Women Egg Providers," *Canadian Journal of Women and the Law* 25, no. 2 (2013).

⁵⁶⁶ Ann Muriel Fisher, "A Narrative Inquiry: How Surrogate Mothers Make Meaning of the Gestational Surrogacy Experience" (MA Thesis, University of Victoria, 2012); Shireen Kashmeri, "Unraveling Surrogacy in Ontario, Canada. An Ethnographic Inquiry on the Influence of Canada's Assisted Human Reproduction Act (2004), Surrogacy Contracts, Parentage Laws, and Gay Fatherhood" (MA Thesis, Concordia University, 2008). See also Busby and Vun, "Revisiting the Handmaid's Tale."

⁵⁶⁷ See discussion in Angela Campbell, "Law's Suppositions about Surrogacy against the Backdrop of Social Science," *Ottawa Law Review* 43, no. 29 (2012); Cattapan, "Risky Business."

in Canada has evolved out of a dichotomous trajectory of scholarship on ARTs that describes the technologies as either beneficial or problematic. Here, the threat of exploitation and concerns about the commercialization of human life are contrasted with demands for women's reproductive autonomy to participate in fertility services within a free market. The shift in rhetorical strategy that took place during the debate on C-47 to allow only altruistic surrogacy and egg donation in Canada is an important example of this either/or model of theorizing exploitation in the governance of assisted reproduction, wherein concerns about exploitation and commercialization have been seen as significant enough to prohibit women from engaging in egg donation or surrogacy for pay. This remains the case under the criminal provisions of the *AHRA*, although the lack of regulations and enforcement mean that payment is likely occurring under the guise of the reimbursement of expenses.

These two options, altruism (freely chosen) versus commercialization (with related exploitation), are extremes too-often viewed as the only options available to govern egg donation and surrogacy. There are other potential strategies that might allow a theorization of third party reproduction as aligned with other practices that can be viewed as both exploitative and empowering, or autonomously chosen with parameters coerced. As suggested in Health Canada's 2000 *Feedback Report* on consultations prior to the tabling of the draft *AHRA*, there might be support for alternative models of governing surrogacy and egg donation. This report included, as described in chapter six, suggestions about the provision of public funding to surrogates through a program like Employment Insurance, to ensure that there would not be barriers to access to surrogacy, or undue inducement.⁵⁶⁸ Even if public funding is not possible, the suggestion raised in the *Feedback Report* points to the thinking about egg donation and

⁵⁶⁸ Canada, Health Canada, *Feedback Report: Submissions and Written Comments on Proposed Federal RGTs Legislation*.

surrogacy as labour might both enable surrogacy to take place and to enable regulation of problematic practices.⁵⁶⁹ Models of theorizing egg donation and surrogacy beyond the altruism/commercialization dichotomy may provide innovative policy strategies that could move this policy field forward. Regardless of how this field proceeds, the recognition of surrogates and donors as legitimate actors in the policy process—through newly formed interest groups or otherwise—is integral to recognizing their critical role in the use of ARTs.

Provincial Interventions

Following the overturning of the regulatory provisions of the *AHRA*, the demise of Assisted Human Reproduction Canada, and relevant litigation, “Canadians are worse off now than they were before the Royal Commission on New Reproductive Technologies recommended national oversight of assisted human reproduction.”⁵⁷⁰ What remains in the wreckage of the largely unimplemented criminal provisions of the *AHRA* and a federal government uninterested in enacting the regulatory provisions that remain, is a void in the governance of ARTs that falls to the provinces. Some jurisdictions, Quebec most prominently, have engaged in regulation of the technologies independent of the federal government, and a new framework for legislating in the field is emerging. We are embarking on a new phase of the governance of ARTs, bound up in calls for provincial funding and related regulation.

⁵⁶⁹ Amarita Pande, “Not an ‘Angel’, Not a ‘Whore’ Surrogates as ‘Dirty’ Workers in India,” *Indian Journal of Gender Studies* 16, no. 2 (2009); Melinda Cooper and Catherine Waldby, *Clinical Labor: Tissue Donors and Research Subjects in the Global Bioeconomy* (Durham, NC: Duke University Press, 2014); Waldby and Cooper, “The Biopolitics of Reproduction”; G.K.D. Crozier, “Care Workers in the Global Market: Appraising Applications of Feminist Care Ethics,” *International Journal of Feminist Approaches to Bioethics* 3, no.1 (2013); G.K.D. Crozier, Jennifer Johnson, and Christopher Hajzler, “At the Intersections of Emotional and Biological Labor: Understanding Transnational Commercial Surrogacy as Social Reproduction,” *International Journal of Feminist Approaches to Bioethics* 7, no. 2 (2014).

⁵⁷⁰ Baylis and Downie, “The Tale of Assisted Human Reproduction Canada,” 184.

In Ontario, a program had once existed to broadly fund three cycles of IVF, but since 1993 (following the Royal Commission on New Reproductive Technologies' emphasis on evidence-based medicine), the funding has been restricted to only those women with bilateral fallopian tube blockages. Between 1993 and 2000, the provinces engaged little in the governance of ARTs, except in consultation with the federal government in its attempts to legislate and regulate. In 2000, however, the Government of Quebec announced a tax credit for up to 25% (or up to \$15 000) for eligible fertility treatments. This was raised to 30% (or up to \$20 000) in 2001 and again in 2007 to 50%. In 2009, Quebec implemented a comprehensive program of regulations under Bill 89 and an increase in funding provisions,⁵⁷¹ through its public health insurance program, effectively covering most fertility services in the province.⁵⁷² The provision of public funding in Quebec was attached to a public health campaign to reduce the number of high-risk multiple births in the province (i.e., twins, triplets, etc.) through the use of single embryo transfer in IVF.⁵⁷³ Recent data has suggested that although the program has been much more costly than anticipated, the number of multiple births in the province has decreased substantially since the program's implementation.⁵⁷⁴ In 2015, legislation was introduced to cut back the program and to limit access to ARTs through Quebec's provincial health insurance

⁵⁷¹ Sara Champagne, "La fécondation in vitro sera gratuite au Québec," *Le Droit*, July 13, 2010, 14.

⁵⁷² Although private fertility clinics had advocated for an increase of the tax credit to 100% , which would have ensured the continuation of their monopoly on service provision, the introduction of funding through the provincial health insurance program gave the province greater regulatory control, as well as facilitated the development of public clinics. See L'Espérance, "Fertilize-This," 112.

⁵⁷³ Multiple births are associated with low birth rates and prematurity that may result in stays in high-cost neonatal care units, and negative health outcomes over the course of the child's life, amongst other risks. There are also risks to women bearing multiples, including "premature labour, premature delivery, pregnancy-induced hypertension, toxemia, gestational diabetes, and vaginal-uterine hemorrhage." Nanette Elster, "Less Is More: The Risks of Multiple Births," *Fertility and Sterility* 74, no. 4 (2000). Despite these risks, patients may want to implant multiple embryos to increase their chances of success, to have their children 'all at once,' often influenced by the expense of each cycle.

⁵⁷⁴ Bissonette et al., "Working To Eliminate Multiple Pregnancies: A Success Story in Québec," *Reproductive Biomedicine Online* 23, no. 4 (2011).

program. As of June 2015, the proposed legislation (Bill 20) is in committee hearings in Quebec's *Assemblée nationale*.

Other provinces have since established their own programs. In 2009, Manitoba implemented a 40% infertility tax credit (up to \$8000), although this was not tied to any regulatory provisions. In March 2014, the Government of Ontario announced that it would help couples and reduce multiple births by providing funding for one round of IVF, although it is unclear that this program will result in the reduction of multiple births.⁵⁷⁵ Furthermore, in July 2014, the Government of New Brunswick announced one-time grants to fund 50% of certain fertility treatments (up to \$5000) without relevant regulatory provisions. Announcements in Alberta and Newfoundland and Labrador suggest that similar funding is forthcoming in these provinces.⁵⁷⁶

While the establishment of the public funding program in Quebec has been attributed to the advocacy of high-profile individuals (and the interest groups that they supported), policy framing that made infertility an important medical issue, and the failure of the federal government to provide substantive regulation of ARTs,⁵⁷⁷ the rapid expansion of public funding initiatives suggests that something broader is occurring. One explanation lies with the number of interest groups lobbying provincial governments for IVF funding. The work of these interest groups has, for the most part, been received uncritically,⁵⁷⁸ however there are potential conflicts

⁵⁷⁵ There has been significant critique about this approach to funding IVF and its potential to address multiple births. In short, the funding of one cycle of IVF might work effectively to facilitate the entrance of patients in to the clinics, but given that success rates hover around 30%, more than two thirds of patients will likely either return for future embryo transfers, or alternately be unable to do so. This approach may cause more problems than it solves. See Martin Regg Cohn, "It's an ill-conceived idea to fund in vitro fertilization," *The Toronto Star*, April 16, 2014; Alana Cattapan, "Limited Funding of IVF Doesn't Go Far Enough," *The Toronto Star*, April 15, 2014, A15.

⁵⁷⁶ Keith Gerein, "Alberta Considers Funding in Vitro Fertilization," *Edmonton Journal*, July 26, 2014, B4; "In Vitro Fertilization Services Being Considered by Eastern Health," CBC.ca, September 13, 2014.

⁵⁷⁷ L'Espérance, "Fertilize-This."

⁵⁷⁸ Julia Belluz, "Should the State Pay for in Vitro Fertilization?," *Macleans.ca*, n.d., <http://www.macleans.ca/authors/julia-belluz/in-vitro-fertilization-pregnancy-politics-an-evidence-free-zone>.

of interest manifest in the strong financial relationships between these groups and the pharmaceutical companies poised to benefit from the increased accessibility of IVF. In Ontario, for example, inquiries to the provincial lobbyist registry reveal that the lobbying efforts of one such patient group were paid for directly by EMD (the parent company of Serono), the market firm that controls most of the Canadian market share for infertility medications, and a long time supporter of IAAC.

Pharmaceutical industry funding of patient groups is nothing new. Within medical sociology, scholars including Sharon Batt and Barbara Mintzes have examined the extent to which such financial relationships may compromise and undermine the capacity of patient groups to act in the best interests of those they represent.⁵⁷⁹ There may also be good reason to take private funds, as patient groups may be able to maintain arms-length relationships and may want to “get something back” from the pharmaceutical companies that profit from their treatment(s). Despite the importance of these relationships, however, scholarship on reproductive technologies in Canada has largely ignored the implications of industry funding, with scholarship limited to a few studies on commercial interests in the work of the Royal Commission on New Reproductive Technologies in the early 1990s. Without an understanding of the ongoing relationships between private interests and patient groups advocating for the public funding of IVF, it is unclear to what extent the policy initiatives are reflecting the interests of the public, patients, and/or industry and further, the possibility for alternatives to address infertility beyond the public funding programs favoured by industry and industry-funded patient groups.

Given what this dissertation has demonstrated about the ongoing advancement of the interests of consumer-patients and industry in the governance of ARTs, there is reason to believe

⁵⁷⁹ Sharon Batt, “Marching to Different Drummers”; Barbara Mintzes, *Blurring the Boundaries: New Trends in Drug Promotion* (Amsterdam: HAI-Europe, Health Action International, 1998).

that the public funding of IVF may work to advance the reproductive citizenship of the already-privileged infertile, private-for-profit clinics, and the infertility industry more broadly, overlooking the implications for the reproductive citizenship of others who draw on provincial health insurance programs for care. In a context where services like IVF are funded under provincial health insurance programs, rural women remain far from birthing centres, and access to abortion is far from universal, the limits of reproductive citizenship become clear. This reality was particularly stark when the announcement for public funding of infertility treatments in New Brunswick came the same week that the only abortion clinic in the province closed.⁵⁸⁰ An important area for future research in this field, then, are the ongoing intersections of patient advocacy, industry engagement, and provincial initiatives to fund infertility treatments in the provinces. Following the Supreme Court judgment and the continued decentralization of ART policy, scholars will do well to remain vigilant to the ways in which the interactions between market actors, provincial governments, and others shape this policy field.

Other Initiatives

The governance of infertility and assisted reproduction in Canada reaches far beyond the scope of the areas for future research identified above. The emergence of research on the potential reproductive effects of exposures to household chemicals on reproductive health, for example, raises issues about the ongoing emphasis on reproductive technologies as a solution to infertility, and the near-absence of preventative care.⁵⁸¹ Further, the unenforced provisions of the *AHRA*

⁵⁸⁰ “Morgentaler Clinic in Fredericton Performs Last Abortions before Closure,” *CBC News New Brunswick*, July 18, 2014., <http://www.cbc.ca/1.2710909>; Rachael Johnstone, “Privileging Infertility over Abortion in New Brunswick,” *Impact Ethics* (blog), August 6, 2014, impactethics.ca/2014/08/06/privileging-infertility-over-abortion-in-new-brunswick; Johnstone, “The Politics of Abortion in Canada After Morgentaler Women’s Rights as Citizenship Rights.”

⁵⁸¹ Dayna Scott, “‘Gender-Benders’: Sex and Law in the Constitution of Polluted Bodies,” *Feminist Legal Studies* 17, no. 3 (2009); Alana Cattapan, Roxanne Mykitiuk, and Mark Piore, “Notions of Harm in Canadian Law:

vis-à-vis commercial surrogacy and egg donation have resulted in an influx in transnational reproductive travel, an area currently receiving some attention, but that requires more systematic and in-depth research.⁵⁸² This field is particularly important given that it is amongst certain economically privileged groups (including a disproportionate number of gay men) who have been seeking out transnational surrogacy,⁵⁸³ and there are concerns about legal citizenship that emerge as reproductive tissues move across borders.⁵⁸⁴ Additionally, there are a number of changes to regulation and family law that would improve the capacity of LGBTQ people to use ARTs. These include, for example, changes to the semen regulations, as well as family law provisions to better protect lesbian-led families and donor-conceived families where only one parent is genetically related to their child(ren).⁵⁸⁵ Finally, new technologies continue to emerge each year, such as egg vitrification,⁵⁸⁶ mitochondrial replacement,⁵⁸⁷ and uterine transplantation,⁵⁸⁸ each raising new concerns about the ethical and legal limits of controlling conception through biomedicine.

Addressing Exposures to Household Chemicals as Reproductive Torts,” *Canadian Journal of Comparative and Contemporary Law* 1, no. 1 (2015).

⁵⁸² Jocelyn Downie and Françoise Baylis, “Transnational Trade in Human Eggs: Law, Policy, and (In)Action in Canada,” *The Journal of Law, Medicine & Ethics* 41 no. 1 (2013); Crozier, Johnson, and Hajzler, “At the Intersections of Emotional and Biological Labor”; Amarita Pande, “Transnational Commercial Surrogacy in India: Gifts for Global Sisters?,” *Reproductive Biomedicine Online* 23, no. 5 (2011); Amarita Pande, *Wombs in Labour: Transnational Commercial Surrogacy in India* (New York: Columbia University Press, 2014); Vida Panitch, “Surrogate Tourism and Reproductive Rights,” *Hypatia* 28, no. 2 (2013).

⁵⁸³ Damien W. Riggs and Clemence Due, “Gay Men, Race Privilege and Surrogacy in India,” *Outskirts Online Journal* 22 (2010); Susan Markens, “The Global Reproductive Health Market: U.S. Media Framings and Public Discourses About Transnational Surrogacy,” *Social Science & Medicine* 74, no. 11 (2012).

⁵⁸⁴ Harder, “Does Sperm Have a Flag?”

⁵⁸⁵ Rachel Epstein, “The Assisted Human Reproduction Act and LGBTQ Communities”; Cattapan and Cohen, “The Devil We Know”; Renée Joyal, “Évolution des normes juridiques et nouvelles formes de régulation de la famille: regards croisés sur le couple et l’enfant,” *Enfances, Familles, Générations* 5 (2006).

⁵⁸⁶ Cattapan et al., “Breaking the Ice: Young Feminist Scholars of Reproductive Technologies Reflect on Egg Freezing,” *International Journal of Feminist Approaches to Bioethics* 7, no. 2 (2014).

⁵⁸⁷ Françoise Baylis, “The Ethics of Creating Children with Three Genetic Parents,” *Reproductive Biomedicine Online* 26, no. 6 (2013).

⁵⁸⁸ Liza Johannesson and Anders Enskog, “Experimental Uterus Transplantation:,” *Best Practice and Research Clinical Obstetrics and Gynaecology* 28 (2014); Angel Petropanagos, “The Ethics of Uterine Transplantation” (Grand Round Presentation, IWK Health Centre, Halifax, January 29, 2015).

Summary

This dissertation, then, has demonstrated that there is a compelling story in the experiences of those who are personally invested in the use of these technologies as surrogates, donors, intended parents, or as people conceived through their use. This story points to the ways that the experiences of those with a familial and/or corporeal interest in the governance of ARTs have intersected with government action and inaction, shaping the terms in which people can access reproductive technologies. More compelling still are the ways that the interests and experiences of these actors correspond to broader trends in governance, namely the ascendancy of a neoliberal governing ideology. By exploring the simultaneous practices of a federal government attempting to make law and public policy on ARTs, and the experiences of those invested in the uses of these technologies in their personal lives, this dissertation has worked to reconcile the space between historical concerns about the impacts of ARTs with more recent work on interest group participation in the governance of ARTs in Canada. It has demonstrated how interest articulation and the governance of ARTs in Canada have long been bound up in a neoliberal logic that affirms and contests the legitimacy of certain policy subjects in relation to their position as citizen-consumers in the market in reproductive services. Both the policy process itself and the experiences of interest group actors point to the ways that the processes of medicalization, individualization, and commercialization have defined how certain interests were articulated, recognized, and prioritized in the resulting policy.

If the state has no place in the bedrooms of the nation and maintains a stronghold in its nurseries, what it means to reproduce and to be a desirable reproductive subject is tied to the governing ideology of the day, and in the case of the period examined in this dissertation, a neoliberal citizenship regime. Reproductive citizenship in 21st century Canada is rife with

manifestations of citizenship as duty; contemporary pronatalism subtly appears in the discursive practices of provincial governments and political laments about our declining population. As explored throughout this dissertation, assisted reproduction policy in Canada has worked to reify longstanding notions of who is a desirable citizen, enabling a free market in reproductive services that understands infertile, middle-to-upper class individuals as its ideal subject.

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Appendix A: List of Interviews

Public Servants

Anonymous senior public servant, Telephone Interview, December 16, 2011
Manseau, Francine, Personal Interview, December 8, 2011
Hatcher Roberts, Jan, December 15, 2011

Interest Group Leaders/Staff/Volunteers

Allen, Diane, Personal Interview, January 20, 2012
Boodram, Chris, Telephone Interview, December 10, 2011
Boscoe, Madeline, Telephone Interview, December 13 and 20, 2011
Clute, Catherine, Telephone Interview, December 2, 2011
Creighton, Phyllis, Personal Interview, November 30, 2011
Dale, Sherry, Personal Interview, December 20, 2011
Epstein, Rachel, Personal Interview, December 14, 2011
Greenbaum, Mona, Personal Interview, December 7, 2011
Hanck, Beverly, Personal Interview, December 7, 2011
Haase, Jean, Skype Interview, December 3, 2011
Londini, Vince, Telephone Interview, November 15, 2011
Pratten, Shirley, Telephone Interview, March 13, 21, 28, 2012

Experts/Academics

Achilles, Rona, Personal Interview, February 9, 2012
Baylis, Françoise, Personal Interview, February 15, 2012
Lippman, Abby, Personal Interview, December 7, 2011

Appendix B: Consent Forms/Script

Informed Consent Form

Study Name: Controlling Conception: Reproductive Citizenship in Canada, 1988-2009

Researcher: Alana Cattapan
 Department of Political Science, York University
 XXXXXXXXX@XXXXX.XX

This document is intended to inform you as to what this research project is about, and to ensure that as a potential participant, you understand enough about any potential risks or benefits related to this study to make an informed decision about your participation. The form also describes your right to withdraw from the study at any time, as well as your right to decline to answer any questions that you may be uncomfortable answering. If, at any time in this process, you require further information, please feel free to ask. You will receive a copy of this form for your own records and reference.

Purpose of the Research:

The main goal of this research is to study public policy on assisted reproductive technologies (ARTs). This research will culminate in a book-length dissertation and may also result in a number of shorter article-length papers and relevant research presentations. The works resulting from this research may be published as a dissertation, as a scholarly book, in academic journals, or presented at academic conferences.

What You Will Be Asked to Do in the Research:

The interview process to which you may consent by signing this form involves one interview that should last no longer than ninety minutes. This interview can take place over the phone, or in person. In either case, the interview will consist of a series of open-ended questions pertaining to your work or volunteer experiences related to assisted human reproduction (through advocacy, research, self-help counseling, organizing, etc.).

Risks and Benefits of the Research:

As someone with a great understanding of assisted reproductive technologies as they have used in Canada, your participation is an asset to this research. Hopefully, you will benefit from this research as well, as the information provided may be useful to you in analyzing the effects of the Assisted Human Reproduction Act, the non-regulation that has followed, and how this relates to the lives of those using ARTs. I do not foresee any risks or discomfort from your participation in the research.

Voluntary Participation/Withdrawal from the Study:

You can stop participating in the study at any time, for any reason. Your decision to stop participating, or not to answer particular questions, will not affect your relationship with me, York University, or any other group associated with this project. In the event you withdraw from the study, all associated data collected will be immediately destroyed wherever possible. Please

know that your participation in the study is completely voluntary, and that your decision not to engage with any part of the research process will remain confidential.

Confidentiality:

All information you supply during the research will be held in confidence and unless you specifically indicate your consent, your name and the name of your organization will not appear in any report or publication of the research. Your data will be safely stored in a locked facility and only research staff will have access to this information. Confidentiality will be provided to the fullest extent possible by law. After five years, your data will be destroyed.

Please indicate if you wish to be interviewed anonymously (Circle one):

Yes No

Please indicate if you wish **part of the interview** to be conducted anonymously (Circle one). [In this case, please indicate when you wish to go “off the record” in the interview and this will be noted when the recording is transcribed for use in research].

Yes No

Please indicate if I may use your name, the name of your organization, and the information you provide in publications stemming from this project (Circle one):

Yes No

Please note that you may change your mind regarding these options at any point during the interview by amending your choices on this form.

Questions?

If you have questions about the research in general or about your role in the study, please feel free to contact me at XXXXX@XXXXX.XX, or XXX-XXX-XXXX. You may also contact XXXXX. If you have any questions about this process, or about your rights as a participant in the study, please contact XXXXX. Please note that this research has been reviewed and approved by the Human Participants Review Sub-Committee, York University’s Ethics Review Board and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines.

Legal Rights and Signatures:***For Participant***

I, _____, consent to participate in *Controlling Conception: Reproductive Citizenship in Canada, 1988-2009* conducted by Alana Cattapan. I understand that I will participate in an interview, from which I may withdraw at any time without explanation. I have had the opportunity to discuss my participation in this study and my questions have been answered to my satisfaction. I understand the nature of this project and wish to participate. I understand that I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

Signature: _____
Date: _____

I _____, consent to having my interview audio recorded and transcribed. I understand that any recordings will remain confidential and will be used for research purposes only.

Participant Signature: _____
Date: _____

For Researcher

I confirm that I have explained the nature and purpose of the study to the subject named above. I have answered all questions. I have provided a copy of this document for the participant's own records.

Researcher: _____
Signature: _____
Date: _____

Informed Consent Script (For Telephone Interviews)

Before we begin, I need to inform you what this research project is about, and to ensure that as a potential participant, you understand enough about any potential risks or benefits related to this study to make an informed decision about your participation. I also want to review your right to withdraw from the study at any time, as well as your right to decline to answer any questions that you may be uncomfortable answering. If, at any time in this process, you require further information, please feel free to ask. You will receive a copy of this form for your own records and reference.

This research is intended to study public policy on assisted reproductive technologies (ARTs). The works resulting from this research may be published as a dissertation, as a scholarly book, in academic journals, or presented at academic conferences.

The interview process involves just this one interview that should last no longer than ninety minutes. It will consist of a series of open-ended questions pertaining to your work or volunteer experiences related to assisted human reproduction (through advocacy, research, self-help counseling, organizing, etc.).

As someone with a great understanding of assisted reproductive technologies as they have used in Canada, your participation is an asset to this research. Hopefully, you will benefit from this research as well, as the information provided may be useful to you in analyzing the effects of the Assisted Human Reproduction Act, and how this relates to the lives of those using ARTs. I do not foresee any risks or discomfort from your participation in the research.

You can stop participating in the study at any time, for any reason. Your decision to stop participating, or not to answer particular questions, will not affect your relationship with me, York University, or any other group associated with this project. In the event you withdraw from the study, all associated data collected will be immediately destroyed wherever possible. Please know that your participation in the study is completely voluntary, and that your decision not to engage with any part of the research process will remain confidential.

All information you supply during the research will be held in confidence and unless you specifically indicate your consent, your name and the name of your organization will not appear in any report or publication of the research. The interview will be recorded and the data will be safely stored in a locked facility and only research staff will have access to this information. Confidentiality will be provided to the fullest extent possible by law. After five years, your data will be destroyed.

I now need to ask a few questions about how you want to participate. Do you want to participate anonymously? Or, would you prefer that part of this interview be conducted anonymously? Note that you can indicate at any time when you would like to go “off the record” and this will be noted when the recording is transcribed for use in research.

May I use the name, the name of your organization, and the information you provide in publications stemming from this project?

Please note that you may change your mind regarding these options at any point during the interview by stating that you wish to change your options.

If you have questions about the research in general or about your role in the study, please feel free to contact me at any time at XXXXX@XXXXX.XX, or XXX-XXX-XXXX. You may also contact XXXXX. If you have any questions about this process, or about your rights as a participant in the study, please contact XXXXX. Please note that this research has been reviewed and approved by the Human Participants Review Sub-Committee, York University's Ethics Review Board and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines.

Do you have any questions about this research before I confirm your consent?

By consenting, you are stating that you understand that you will participate in an interview, from which you may withdraw at any time without explanation. You are also stating that you have had the opportunity to discuss my participation in this study and that any questions that you may have, have been answered to your satisfaction. Further, you are stating that you understand the nature of this project and wish to participate. Note that you are not waiving any of your legal rights by consenting to this research.

Do you consent to participating in this interview?

Appendix C: Timeline of Key Events

- 1983** Infertility Self-Help Support Group is founded in Ottawa
- 1987** The New Reproductive Alternatives Society is established
- 1989** (April) Throne Speech announcing the Royal Commission on New Reproductive Technologies
- (October) Order-in-Council establishing the Royal Commission on New Reproductive Technologies
- 1990** Infertility Self-Help Support Group becomes the Infertility Awareness Association of Canada, and receives \$450,000 in federal funding from Health Canada's Health Promotion Directorate
- (June) Royal Commission "Search Conference" on New Reproductive Technologies
- (September-November) Public Hearings of the Royal Commission
- 1993** (December) The report of the Royal Commission on New Reproductive Technologies, *Proceed with Care*, is published
- Health Canada establishes a federal/provincial/territorial working group on reproductive and genetic technologies (1993-1996)
- 1994** (April) Following December announcement of the re-evaluation of the program, the Government of Ontario ceases funding for IVF (except in cases of complete bilateral fallopian tube blockage)
- Health Canada engages in consultations with approximately fifty key stakeholders to confirm the findings of the Royal Commission
- 1995** (February) Budget announcement that provincial health and social transfer programs would be changing considerably
- (April) Health Canada establishes a Discussion Group on embryo research with a one-year mandate to provide a report on the status of the embryo

(July) Health Minister Diane Marleau announces a voluntary moratorium on nine of the technologies deemed most reprehensible by the Royal Commission

1996

(January) Health Canada establishes an advisory committee on the voluntary (interim) moratorium (1996-2002)

(April) Supreme Court of Canada rules in *Potter v. Korn*

(May) Health Canada introduces first iteration of the regulations for the processing and distribution of semen for assisted conception

(June) Health Minister David Dingwall announces the three-phase approach (i.e., the already-announced voluntary moratorium, C-47, and a subsequent regulatory regime). At this time, *Setting Boundaries, Enhancing Health* is published and C-47 is tabled

(September) IAAC releases *Response to Bill C-47 and "New Reproductive and Genetic Technologies: Setting Boundaries, Enhancing Health"*

1997

(March-April) Witness testimony on C-47 is heard by the Standing Committee on Health subcommittee on C-47

(April) C-47 dies on the Order Paper

Rachel Epstein and Kathie Duncan run Dykes Planning Tykes for the first time in Toronto

(November) Bill C-247 is introduced

1998

(August) Canadian Biotechnology Strategy is announced (1998-2007)

(October) Lesbian Mothers' Association of Quebec holds its first meeting

1999

(July) Health Canada holds consultations with stakeholders (one-day workshop)

(September) Bill C-247 dies on the Order Paper

(September) Health Canada commissioned research (focus groups and telephone surveys) is conducted

(September) Judgment is rendered in *Cameron v. Nova Scotia*. At appeal it is determined that infertility is a “disability,” but that the Government of Nova Scotia does not have to fund infertility services.

(September) Federal-Provincial-Territorial Health Ministers’ meeting includes ARTs policy on the agenda

(December) Health Canada releases its *Overview Paper* articulating intent to legislate and the general direction of the legislation-to-come

(December) Health Canada updates semen regulations to extend donor exclusion criteria (i.e., men who have sex with men) through the *Technical Requirements for Therapeutic Donor Insemination*

2000

(February) Health Canada circulates a *Workbook* to facilitate stakeholder and federal/provincial consultations

(February and March) Health Canada holds consultations with stakeholders and provincial and territorial officials.

(March) *Feedback Report* is published.

Government of Quebec introduces its first infertility tax credit

2001

(May) Draft legislation governing assisted human reproduction put before the Standing Committee on Health for consideration

(May; October-December) The Standing Committee on Health hears a wide range of witnesses on the draft legislation

(December) The Standing Committee on Health tables *Assisted Human Reproduction: Building Families*

2002

(May) Bill C-56, *The Assisted Human Reproduction Act* is tabled in the House of Commons, passes first and second reading; sent to committee.

(June) Witness testimony on C-56 heard by the Standing Committee on Health

(October) Bill C-56 reintroduced in new session of Parliament as C-13

(November-December) Witness testimony on C-13 heard by the Standing Committee on Health

(December) Amendment to eliminate anonymous gamete donation fails in committee; amendment to include provisions on sexual orientation and marital status incorporated into the Bill

2003 (October) Bill C-13 passes third reading, sent to Senate

2004 (February) Bill C-13 reintroduced as C-6 in the Senate

(February-March) Witness testimony heard in the Senate Committee on Social Affairs, Science, and Technology

(March) *AHRA* receives Royal Assent

(April) Most of the provisions of the *AHRA* come into force

(December) Government of Quebec files a constitutional challenge to the *AHRA*

2005 (May) Orders-in-Council issued to establish Assisted Human Reproduction Canada

2006 (January) Judgment in the *Susan Doe* case rendered (initial case heard in 2003, appeal heard in 2007), upholding the semen regulations

(December) Board of Assisted Human Reproduction Canada appointed

2007 (April) Deadline for three-year parliamentary review of the *AHRA* passes without review occurring

(June) *AHRA* guidelines on consent-to-use (s.8) come into force

2008 (June) Quebec Court of Appeal finds certain provisions of the *AHRA* to be unconstitutional

2009 Manitoba introduces an infertility tax credit

Government of Quebec implements comprehensive public funding for IVF and other ARTs under Bill 89

- 2010** (Spring) Three board members of Assisted Human Reproduction Canada resign due to a lack of transparency in operations
- (November) Parliamentary Hearings (Standing Committee on Health) on the resignation of the AHRC Board members
- (December) Supreme Court of Canada upholds much of the judgment of the Quebec Court of Appeal, overturning the regulatory provisions of the *AHRA*
- 2011** (May) Superior Court of British Columbia finds (in *Pratten v British Columbia*) that the Government of British Columbia should (as in adoption), protect the records of donor-conceived people
- 2012** (June) Omnibus budget bill significantly amends the *AHRA* including (and beyond) the changes germane to the Supreme Court judgment in Reference Re: *AHRA*
- (November) British Columbia Court of Appeal overturns the lower court decision decision in *Pratten* and finds that there is no obligation for government to provide or protect information about the genetic origins of donor-conceived people
- 2013** (February) First charges laid under the *AHRA* (following a raid on the offices of Canadian Fertility Consultants in February 2012) (fined in December 2013)
- (March) Assisted Human Reproduction Canada closes
- (May) Pratten case refused leave to appeal at the Supreme Court
- 2014** (April) Government of Ontario announces IVF funding
- (July) Government of New Brunswick announced new IVF funding
- (November) Government of Quebec introduces Bill 20 to limit existing IVF funding program