

# Rhetoric and Reality: “Protecting” Women in Canadian Public Policy on Assisted Human Reproduction

Alana Cattapan

*Lors du discours du trône de 1989, le gouvernement du Canada annonçait la création de la Commission royale sur les nouvelles techniques de reproduction. La Commission royale avait pour mission d'étudier et de signaler les conséquences des nouvelles techniques de reproduction, et son énoncé de mandat indiquait explicitement que “la santé génésique et le bien-être des femmes” seraient une préoccupation principale. Lorsque la Loi sur la procréation assistée a été adoptée quinze ans plus tard, ses principes directeurs affichaient le même engagement envers la santé des femmes. Après 2012, cependant, la majeure partie de la Loi a été renversée, l'organisme qu'elle établissait est en voie d'abolition et les dispositions criminelles qui restent ne sont plus appliquées. Bref, malgré des engagements continus pour que les femmes soient protégées par une politique publique concernant les techniques de procréation assistée, ce domaine n'est toujours pas réglementé.*

*Le présent article examine le discours de “protection” dans la politique publique canadienne sur la procréation assistée, en donnant pour exemples la position précaire des donneuses d'ovules, les coûts élevés des services de procréation assistée ainsi que les ratés dans la mise en œuvre de la Loi sur la procréation assistée. En s'appuyant sur la presse écrite, les débats parlementaires, la recherche universitaire et les documents gouvernementaux, l'auteure affirme qu'il existe un écart énorme entre l'engagement rhétorique envers le bien-être des femmes et les réalités incertaines de la vie reproductive des femmes.*

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the Assisted Human Reproduction Act was passed fifteen years later, its governing principles included the same commitment to women's health. As of 2012, however, much of the Act has been overturned, the agency it established is being abolished, and the criminal provisions that remain are not enforced. In short, despite ongoing commitments to protect women through public policy on assisted reproductive technologies, the field remains unregulated.

This article explores the discourse of "protection" in public policy on assisted human reproduction in Canada, using the examples of the precarious position of egg donors, the high-cost of assisted reproductive services, and failures in implementing the Assisted Human Reproduction Act. Drawing on print media, parliamentary debates, academic research, and policy documents, it argues there is a significant gap between the rhetorical commitment to women's welfare articulated in policy and the tenuous realities of women's reproductive lives.

In the 1989 Speech from the Throne, the Government of Canada announced its decision to establish a Royal Commission on New Reproductive Technologies (Royal Commission or the Commission). Mandated to study and report on the broad "social, ethical, health, research, legal and economic implications"<sup>1</sup> of reproductive technologies, the Royal Commission's mandate also included a focus on the protection of women's health. The Order in Council stated that the effects of assisted reproductive technologies (ARTs) on "women's reproductive health and well-being" would be a primary area of concern.<sup>2</sup>

After more than a decade of false starts and failed legislation, the *Assisted Human Reproduction Act* (AHRA) was passed in 2004, prohibiting some technologies and regulating others.<sup>3</sup> The AHRA's broad framework mirrors many of the major recommendations made by the Royal Commission and included in its statement of principles is a declaration about the protection of women that uses language similar to that of the Commission's mandate. The AHRA states that although ARTs affect everyone in society, "women . . . are directly and significantly affected by their application and the health and well-being of women must be protected in the application of these technologies."<sup>4</sup> The need to regulate ARTs to ensure women's continued "health and well-being" is a trope repeated throughout the long history of public policy on assisted reproduction in Canada.<sup>5</sup> As of 2012,

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

2. *Ibid.*

3. *Assisted Human Reproduction Act*, SC 2004, c 2 [AHRA].

4. *Ibid.* at s 2(c).

5. The protection of women's health and well-being was one of seven guiding principles of the Act. These guiding principles also addressed the "health and well-being of children born through the application of assisted human reproductive technologies," the need to protect and promote

however, following the judgment rendered in *Reference re Assisted Human Reproduction Act*,<sup>6</sup> many of the regulatory provisions of the *AHRA* have been overturned, and, though its criminal provisions remain in effect, they are rarely enforced.<sup>7</sup> Furthermore, as of March 2013, the agency intended to promote compliance with, and enforcement of, the *AHRA* has been shut down. In short, despite the federal government's enduring commitment to protect women from the negative implications of ARTs, reproductive technologies remain largely unregulated today.

This article argues that, though policy interventions in the field of ARTs in Canada have historically been justified in terms of a need to protect Canadians, women using ARTs have not been well served by this rhetoric. The problem is not the policy goal—indeed, protecting women's "health and well-being" is a laudable one as women's interests are central to the regulation of ARTs (not to mention other matters of reproductive health) and women's bodies are most often the sites on which ARTs are used and developed. Though men and women may experience infertility and may undergo invasive and intimate procedures as part of infertility treatment, women's bodies are generally at a greater risk than men's in the use of reproductive technologies, and, consequently, women are disproportionately vulnerable to their misuse.<sup>8</sup> Women using ARTs are subject to a variety of physiological risks not endured by men, including exposure to pathogens for women using "donated sperm, ova, or embryos,"<sup>9</sup> the wide-ranging side effects associated with taking high levels of fertility drugs, and the challenges posed by the implantation of

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"human health, safety, dignity, and rights in the use" of ARTs, the importance of "free and informed consent," non-discrimination on the basis of "sexual orientation and marital status," the prevention of "trade in the reproductive capabilities of women and men and the exploitation of children," and the preservation of "human individuality and diversity, and the integrity of the human genome." *AHRA*, *supra* note 3 at s 2. The inclusion of some of these principles, particularly the statement of non-discrimination of people based on sexual orientation and marital status has been important for lesbian, gay, and transgender claims to equal access to assisted reproductive technologies. See, for example, Angela Cameron, "Regulating the Queer Family: *The Assisted Human Reproduction Act*" (2008) 24 *Canadian Journal of Family Law* 101.

6. *Reference re Assisted Human Reproduction Act*, 2010 SCC 61 [*Reference re AHRA*].

7. In February 2013, the first charges under the *AHRA*, *supra* note 3, were laid against Leia Picard, and her business, Canadian Fertility Consultants, a fertility agency that brokers agreements between surrogates, egg donors, and intending parents. Picard and Canadian Fertility Consultants were charged with nineteen offences under the *AHRA*. Royal Canadian Mounted Police, *RCMP Charge Owner of Human Fertility Consulting Business* (15 February 2013), online: Government of Canada <<http://www.rcmp-grc.gc.ca/on/news-nouvelles/2013/13-02-15-newmarket-eng.htm>>; Tom Blackwell, "Business Has Boomed: Canadian Surrogacy Agent Facing 27 Charges Continues Her Controversial Work," *National Post* (17 March 2013), online: National Post <<http://news.nationalpost.com/2013/03/17/business-has-boomed-canadian-surrogacy-agent-facing-27-charges-continues-her-controversial-work/>>.

8. Angela Cameron and Vanessa Gruben, "Quebec's Constitutional Challenge to the Assisted Human Reproduction Act: Overlooking Women's Reproductive Autonomy" in Stephanie Pateron, Francesca Scala, and Marlene Sokolon, eds, *Fertile Ground: Reproduction in Canada* (Montreal and Kingston: McGill-Queens' University Press) [forthcoming].

9. *Ibid.*

multiple embryos.<sup>10</sup> Protecting women's health and well-being in the governance of ARTs means developing policies that lead to positive physiological and psychological outcomes for women and that simultaneously enable women to exercise their reproductive autonomy.

The problem then is not the policy goal but, rather, that in Canada it seems that women's health and well-being has not been prioritized in the governance of assisted reproduction, as the language of protection has been used to justify public policy and law that have been detrimental to women's health and welfare in a number of ways. First, attempts to protect egg donors from exploitation have not adequately considered the impact of banning commercial egg donation on the lives and interests of egg donors themselves. The relevant provisions of the *AHRA* that ban donation for pay (but not when altruistic) assume that providing eggs for pay is inherently exploitative and were made without due consideration of the possibility of exploitation when pay is not involved.<sup>11</sup> Additionally, banning payment often forces those engaging in for-profit egg donation to do so covertly and, at times, without adequate medical care.<sup>12</sup> Second, the Royal Commission's identification of certain technologies as "experimental" worked to legitimate the exclusion of many ARTs from coverage under provincial health insurance programs, particularly in Ontario.<sup>13</sup> As part of a mixed-market for-profit health

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10. The risks of implanting multiple embryos are largely the risks that come with multiple births both to mother and child, which include for the mother pre-eclampsia, pregnancy-induced hypertension, gestational diabetes, miscarriages, post-partum bleeding, and a greater chance that a caesarian section will be needed in delivery, among other risks. For the children, there are a variety of potential negative implications including (but not limited to) an increased likelihood of low birth weight, developmental delays, and congenital malformations. Ontario, Ministry of Children and Youth Services Expert Panel on Infertility and Adoption, *Raising Expectations: Recommendations of the Expert Panel on Infertility and Adoption* (Toronto: Government of Ontario, 2009) at 111-13; Cameron and Gruben, *supra* note 8.
  11. This article uses the expression "egg donation" to describe both egg donation for pay and egg donation where no money is exchanged. "Egg donation for pay" or profit and "commercial egg donation" are used interchangeably to describe arrangements where monetary compensation is involved. These terms are used to reflect the common and contemporary usage of "donation" for gametes (eggs and sperm) even where money is involved. "Altruistic egg donation" is used to identify arrangements where no money is exchanged. Questions about the validity of "donors" and "donation" in this field have long been raised. For a recent discussion of the problems associated with the language of donation, see Jocelyn Downie and Françoise Baylis, "Transnational Trade in Human Eggs: Law, Policy, and (In)Action in Canada" (2013) 41:1 *Journal of Law, Medicine and Ethics* 224 at 225; and Samantha Yee, Jason A Hitkari, and Ellen M Greenblatt, "A Follow-up Study of Women Who Donated Oocytes to Known Recipient Couples for Altruistic Reasons" (2007) 22:7 *Human Reproduction* 2040 at 2047.
  12. Alison Motluk, "The Human Egg Trade: How Canada's Fertility Laws Are Failing Donors, Doctors, and Parents," *The Walrus* (April 2010) 30; Alison Motluk, "Is Egg Donation Dangerous?" *Maisonneuve* (21 January 2012), online: Maisonneuve <<http://maisonneuve.org/article/2013/01/21/egg-donation-dangerous/>>.
  13. Éric Montpetit, "Policy Networks, Federalism and Managerial Ideas: How ART Non-Decision in Canada Safeguards the Autonomy of the Medical Profession" in Ivar Bleiklie, Malcolm L Goggin, and Christine Rothmayr, eds, *Comparative Biomedical Policy: Governing Assisted Reproductive Technologies* (London and New York: Routledge, 2004) 64.

industry, the high costs of infertility treatments have led some users of ARTs to make riskier, but more cost effective, choices about how they try to conceive.<sup>14</sup>

Third, the failure to develop regulations and enforce the criminal provisions of the *AHRA* have meant that in reality the Act has done little more than create a legal situation that too often pushes paid gamete donors and surrogates abroad and underground. Health Canada has failed to develop substantive regulations to govern ARTs in the years after the *AHRA*'s passage, and the regulatory agency established by the Act—Assisted Human Reproduction Canada (AHRC)—did not engage in the licensing and enforcement work it was created to do.<sup>15</sup> Although the Act was vested deeply in the language of protecting Canadians, and particularly women, from the misuse of ARTs, the lack of an effective and coherent strategy of enforcement suggests that, despite the rhetorical commitment in the *AHRA*'s guiding principles, there was no political will to ensure the protection of women's "health and well-being."<sup>16</sup> Collectively, these examples identify the contradiction between public policy seemingly made in the name of protecting women and the realities faced by women using these technologies.<sup>17</sup>

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14. Motluk, "The Human Egg Trade," *supra* note 12, and Motluk, "Is Egg Donation Dangerous?" *supra* note 12; and Jeff Nisker, "Distributive Justice and Infertility Treatment in Canada" (2008) 30:5 *Journal of Obstetrics and Gynaecology Canada* 425 at 427.
  15. The failure of Health Canada to develop relevant regulations to be implemented by Assisted Reproduction Canada would become a moot point when the regulatory provisions of the *AHRA* were overturned by *Reference re AHRA*, *supra* note 6. Bill C-38 (2012) would go further to eliminate the potential for regulation by eliminating the mandate of Assisted Human Reproduction Canada. See *An Act to Implement Certain Provisions of the Budget Tabled in Parliament on March 29, 2012 and Other Measures (Jobs, Growth and Long-term Prosperity Act)*, RSC 2012, c 19 at s 713 [*Act to Implement Certain Provisions*]. See discussion in text at note 67 in this article.
  16. This article examines the medical and procreative uses of reproductive technologies, but the language of protection was also used as justification for federal intervention *vis-à-vis* the need to protect the dignity of human life and the integrity of the human genome. For analyses of the language of protection as used in these debates, and especially around the protection of the embryo, please see Françoise Baylis, "Brickbats and Bouquets for the Draft Legislation on Assisted Human Reproduction" (2001) 10:1 *Health Law Review* 3 at 4; Diana Backhouse and Maneesha Deckha, "Shifting Rationales: The Waning Influence of Feminism on Canada's Embryo Research Restrictions" (2009) 21:2 *Canadian Journal of Women and the Law* 229; and Angela Campbell, "A Place for Criminal Law in the Regulation of Reproductive Technologies" (2002) 10 *Health Law Journal* 77.
  17. Though the focus of this article is the failings of public policy governing assisted reproduction *vis-à-vis* women, other scholars have documented the ways that the current system fails donor conceived people, LGBTQ people, and Canadians more broadly. Vanessa Gruben, "Assisted Reproduction without Assisting Over-Collection: Fair Information Practices and the Assisted Human Reproduction Agency of Canada" (2009) 17 *Health Law Journal* 229; Lori E Ross, Leah S Steele, and Rachel Epstein, "Lesbian and Bisexual Women's Recommendations for Improving the Provision of Assisted Reproductive Technology Services" (2006) 86:3 *Fertility and Sterility* 735; Angela Cameron, Vanessa Gruben, and Fiona Kelly, "De-Anonymising Sperm Donors in Canada: Some Doubts and Directions" (2010) 26 *Canadian Journal of Family Law* 95; Fiona Kelly, "Alternative Conception: The Legality of Home Insemination under Canada's Assisted Human Reproduction Act" (2010) 26 *Canadian Journal of Family Law* 149.

## **Background**

The birth of the first so-called test tube baby occurred in 1978 in the United Kingdom, capturing public imagination and spurring debate over the ethical, social, and political implications of new reproductive technologies. Though the United Kingdom would call its Warnock Commission to study “human fertilisation and embryology” in 1982, in Canada state intervention did not come for another seven years.<sup>18</sup> Procedures such as *in vitro* fertilization (IVF) and prenatal genetic diagnosis proliferated in the interim and, by the mid-1980s, Canadian feminist activists<sup>19</sup> mobilized to express concern about the potential effects of these technologies. These activists also raised concern about the ways that older reproductive technologies such as artificial insemination might be used in new ways to commodify women’s bodies or engage in new forms of eugenics—the stuff of science fiction.<sup>20</sup>

After announcing its intention in its Throne Speech, the federal government formally appointed the Royal Commission in October 1989. As noted earlier, the Commission was in part called to address reproductive technologies to protect women’s “reproductive health and well-being” and to recommend relevant “policies and safeguards.”<sup>21</sup> In November 1993, the Royal Commission released its report, *Proceed with Care*, which addressed a range of issues related to ARTs, from the prevention of sexually transmitted diseases to xenotransplantation. The report included 293 recommendations aimed at a variety of actors (including provincial governments, health care professionals, employers, and school boards), in addition to providing a framework for federal intervention, namely through the criminalization of certain practices and the establishment of a national commission to develop regulations.

The language of protection is rife throughout *Proceed with Care*, from discussion about protecting “the public interest, the well-being and interests of women, the creation of children, and the formation of families”<sup>22</sup> to the idea that the

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18. Andrew Grubb, “Regulating Reprogenetics in the United Kingdom” in Lori P Knowles and Gregory E Kaebnick, eds, *Reprogenetics: Law, Policy and Ethical Issues* (Baltimore: Johns Hopkins University Press, 2007) 144 at 145.

19. For discussion of the feminist views that shaped and contested early government interventions on assisted reproductive technologies (ARTs) in Canada, see Francesca Scala, Éric Montpetit, and Isabelle Fortier, “The NAC’s Organizational Practices and the Politics of Assisted Reproductive Technologies in Canada” (2005) 38:3 *Canadian Journal of Political Science* 581 at 589; Gwynne Basen, Margrit Eichler, and Abby Lippman, eds, *Misconceptions: The Social Construction of Choice and the New Reproductive and Genetic Technologies* (Hull, QC: Voyageur Publishing, 1993).

20. National Action Committee on the Status of Women, *The New Reproductive Technologies: A Technological Handmaid’s Tale: A Brief Presented to the Royal Commission on New Reproductive Technologies* (Ottawa: National Action Committee on the Status of Women, 1991); Basen, Eichler, and Lippman, *supra* note 19.

21. RCNRT, *supra* note 1 at 3.

22. *Ibid* at 17.

regulation of commercial interests in assisted reproduction is necessary as “there are vulnerable interests to be protected.”<sup>23</sup> Government regulation was seen by the Commission to be critical to ensuring the well-being of Canadians and especially women (as well as the children borne of ARTs).

The protection of women’s health was also important to the justification of federal intervention into the field of reproductive technologies. Though health care is a matter of provincial jurisdiction, the federal government has long interceded in matters of health, through the use of the peace, order, and good government clause of the *Constitution Act*, the criminal law power, and the allocation of conditional funding (through the *Canada Health Act*).<sup>24</sup> The Royal Commission used a number of these strategies to legitimate federal intervention in the field, including discussion of the peace, order, and good government clause in its first chapter<sup>25</sup> and the recommendation that the federal government make law using criminal prohibitions.<sup>26</sup> The Commission buttressed its arguments with the mention of the broad and long-standing role of the federal government in public health and health protection, particularly in relation to the criminal law power.<sup>27</sup> The Commission’s report also stated that leaving the issue to the provinces would result in an unsatisfactory patchwork approach and, since ARTs so challenge the moral and ethical fabric of Canadian society, that federal intervention to protect women, children conceived using reproductive technologies, and society writ large is not just warranted but required.<sup>28</sup>

A year and a half after the Royal Commission released its report, the federal government issued a tentative response. Then federal Health Minister Diane Marleau called for a voluntary moratorium on nine practices that the Commission deemed most reprehensible, including an outright ban on commercial surrogacy, sperm, and egg donation. This moratorium was necessary, according to Marleau, to address the “social, ethical, and health risks” raised by reproductive technologies

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23. *Ibid* at 695.

24. Martha Jackman, “Constitutional Jurisdiction over Health in Canada” (2000) 8 *Health Law Journal* 95. *Constitution Act, 1982* (UK), 1982, c. 11, s 59, *Canada Health Act*, RSC 1985, c C-6.

25. RCNRT, *supra* note 1 at 19.

26. Though the commissioners could not have predicted this at the time, the use of peace, order, and good government as support for controversial legislation would fall out of favour with the courts after 1993, with judges increasingly using the criminal law power as justification for federal legislation in areas of provincial jurisdiction. Dave Snow and Rainer Knopff, “Assisted Reproduction Policy in Federal States: What Canada Should Learn from Australia” (2012) 5:12 *University of Calgary School of Public Policy Research Papers* 1 at 11. As the federal government moved forward with legislation, it would increasingly rely on the need to protect public health and safety through the criminal law power as justification for its intervention in a field that might otherwise be understood as health care. The perceived inability of the federal government to provide legitimate policy rationales for intervening in ARTs was a point of contention throughout the history of public policy in this field and served as the basis for the Government of Québec’s challenge to the *AHRA*. For more discussion of the questions at issue in *Reference Re Assisted Human Reproduction Act*, see Cameron and Gruben, *supra* note 8.

27. RCNRT, *supra* note 1 at 108; Jackman, *supra* note 24; Cameron and Gruben, *supra* note 8.

28. RCNRT, *supra* note 1 at 18.

and to prevent the treatment of “reproduction, women, and children” as commodities.<sup>29</sup> There was concern about adherence to the voluntary interim moratorium on the part of “researchers and clinicians,”<sup>30</sup> and, by June 1996, the federal government had developed a more substantive approach, introducing Bill C-47 (the *Human Reproductive and Genetic Technologies Act*) as part of a two-part legislative process that would definitively ban the practices and technologies covered by the interim moratorium.<sup>31</sup> Health Canada issued a press release that stated that the legislation and related discussion paper would work to “protect the health and safety of Canadians who use or are affected by these technologies, would ensure the appropriate use of reproductive material and protect the dignity and security of Canadians, especially women and children.”<sup>32</sup> Bill C-47 failed to pass into law before an election was called, and though there were attempts to establish a strategy to govern ARTs in the years that followed, little progress was made.<sup>33</sup>

In 2001, then Health Minister Allan Rock, tried to legislate again. He presented draft legislation of what would eventually become the *AHRA* to the Standing Committee on Health, seeking input from stakeholders and parliamentarians. The Standing Committee consulted widely and issued a report urging the Government of Canada to introduce legislation. The proposed bill included, much like the failed Bill C-47, criminal prohibitions on certain practices and established a regulatory regime vested in the creation of a federal agency. The Government of Canada

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29. Health Canada, *Health Minister Calls for Moratorium on Applying Nine Reproductive Technologies and Practices in Humans* (Ottawa: Health Canada, 1995).

30. Françoise Baylis and Matthew Herder, “Policy Design for Human Embryo Research in Canada: A History (Part 1 of 2)” (2009) 6:1 *Journal of Bioethical Inquiry* 109 at 114.

31. The interim moratorium prohibited sex selection for non-medical reasons; commercial pre-conception or “surrogacy” arrangements; buying and selling of eggs, sperm, and embryos; egg donation in exchange for in-vitro fertilization services; germ-line genetic alteration; ectogenesis (the creation of a fetus in an artificial womb); cloning human embryos; formation of animal-human hybrids; and the retrieval of eggs from cadavers and fetuses for purposes of donation, fertilization, and research. Health Canada, *supra* note 29; Baylis and Herder, *supra* note 30; Montpetit, *supra* note 13 at 66. Bill C-47 proposed all of the prohibitions included in the moratorium and added, “the transfer of embryos between human and other species; the use of human sperm, eggs or embryos for assisted human reproduction procedures or for medical research with the informed consent of the donor(s); research on human embryos later than fourteen days after conception; creation of embryos for research purposes only” and “offer[ing] to provide or offer[ing] to pay for prohibited services.” Health Canada, “Health Canada News Release: Human Reproductive and Genetic Technologies Act—Prohibited Practices (June 1996)” in Lorna Weir, ed, *Governing Medically Assisted Human Reproduction: Report of an International Symposium* (Toronto: Centre of Criminology, University of Toronto, 1997) 121.

32. Health Canada, “Comprehensive National Policy on Management of New Reproductive and Genetic Technologies Proposed,” News Release (14 June 1996).

33. Discussion about how to develop a comprehensive pan-Canadian strategy on ARTs continued through Health Canada’s *Reproductive and Genetic Technologies Overview Paper* (1999), its consultations on sexual and reproductive health (1999), and the release of a workbook designed to promote dialogue between the federal government and stakeholder groups (2000), though no substantive progress was made. A private member’s bill attempting to ban human cloning was also introduced in Parliament in the late 1990s, though it failed to pass into law.



first tabled the Act in Parliament in May 2002, and, though the bill failed to pass twice, it was twice reintroduced and received royal assent in April 2004. The Government of Québec challenged the constitutionality of the *AHRA* soon after, resulting in the overturning of the provisions of the Act that had allowed for federal regulation of ARTs and eventually resulted in the closure of the agency.<sup>34</sup> Today, despite this decades-long history of public policy in this field at the federal level, little remains other than the guiding principles of the *AHRA* and its rarely enforced criminal prohibitions.<sup>35</sup>

### *Protection/Exploitation*

The failure of protection as a policy goal is perhaps most clear in the example of egg donation. Banning payment for egg donation was a key element of *Proceed with Care*, included in every incarnation of the legislation to come. Commissioners, and later, parliamentarians and committee witnesses opposed to egg donation generally articulated the need to ban egg donation on two grounds.<sup>36</sup> First, the “commercialization of human reproductive material” was deemed to be unethical in and of itself.<sup>37</sup> Second, egg donation was seen to be particularly problematic as it puts young, healthy women in the position of accepting money in exchange for taking “powerful drugs with unknown long term effects to stimulate multiple egg production and to undergo invasive and often painful medical procedures to retrieve those eggs.”<sup>38</sup>

The Royal Commission was critical of egg donation as the associated physiological risks were deemed too significant to undergo unless absolutely necessary. The Royal Commission recommended that egg donation be prohibited except for women who were already undergoing egg retrieval and had surplus eggs or for women who were already undergoing medical interventions that might harm their reproductive systems.<sup>39</sup> As for paid egg donation, *Proceed with Care* stated that the practice was unacceptable not only because it violated the commissioners’

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34. See discussion in text at note 67 in this article.

35. Other than the principles and the criminal prohibitions, there are a number of regulatory aspects of the *AHRA* still in force, notably the consent provisions under s 8. For more discussion of the implications of *Reference Re Assisted Human Reproduction Act*, see Ubaka Ogbogu, “*Reference Re Assisted Human Reproduction Act* and the Future of Technology-Assisted Reproduction and Embryo Research in Canada” (2011) 19 *Health Law Journal* 153.

36. Critics of commercial egg donation and surrogacy often opposed commercial sperm donation on the grounds that it would commodify human reproductive materials. However, as sperm donation does not typically cause physiological harm to donors, opposition was not expressed on the grounds of health risks.

37. RCNRT, *supra* note 1 at 593-4.

38. *House of Commons Debates*, 35th Parl, 2nd Sess, Vol 134, No 89 (23 October 1996) at 5614 (Hon Joe Volpe).

39. RCNRT, *supra* note 1 at 583.

fundamental commitment to the non-commercialization of reproduction but also because “the potential for exploitation is simply too great to justify this practice.”<sup>40</sup> The report also reiterated that egg donation for pay should not occur as the health risks associated with donation are so significant that only women already undergoing invasive procedures are able to consent. In the Royal Commission’s report, then, egg donation—altruistic or otherwise—was seen to be inherently problematic due to associated health risks. Commercial egg donation was particularly objectionable both because it violates the principle of non-commercialization/commodification of reproduction and because of the potential for exploitation implicit in an exchange of high-risk reproductive services for money.

When the Government of Canada responded to the Royal Commission’s report with the voluntary moratorium, with Bill C-47 and eventually with the *AHRA*, altruistic egg donation was permitted, and only commercial donation was banned. In parliamentary debates and committee testimony, the risks to women’s health were again raised but this time as part of the danger of exploitation, rather than on the dual grounds of physiological damage and exploitative potential. *Proceed with Care* reasoned that egg donation was too risky to be permitted in all but exceptional cases because of health concerns and that paid egg donation was objectionable as it commercialized reproductive material and enabled exploitation. Bill C-47, however, was justified on the grounds that prohibiting paid donation would mitigate exploitation and health risks by ensuring that all egg donation would take place in above-board medical environments. When Bill C-47 was introduced by Joe Volpe, then the parliamentary secretary to the minister of health, Volpe noted that 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.”<sup>41</sup> The assumption here, which was also repeated throughout the ensuing debate on Bill C-47 and, later, in the debates around the *AHRA*, is that the potential for exploitation is vested in offers of financial compensation, and women would only donate if they did not fully understand the risks involved and were being paid handsomely to engage.

The prohibition of commercial egg donation when altruistic egg donation is completely legal (as occurred under Bill C-47 and the *AHRA*) is inconsistent with the commitment to protect Canadian women in a number of ways. First, banning commercial donation without banning altruistic donation fails to address the possibility that coercion and exploitation are possible without financial recompense, as might occur within family relationships.<sup>42</sup> As a number of scholars

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40. *Ibid* at 594.

41. *House of Commons Debates*, *supra* note 38 at 5617.

42. Alison Harvison Young, “New Reproductive Technologies in Canada and the United States: Same Problems, Different Discourses” (1998) 12 *Temple International and Comparative Law Journal* 43 at 80.

have noted, though intra-familial egg donations are often positive experiences, the potential for coercion and residual feelings of being “used” are high.<sup>43</sup> Furthermore, pressure to donate a second or third time to provide “full siblings” to a donor-conceived child may occur with or without financial compensation.<sup>44</sup> Mary Lyndon Shanley, writing on surrogacy asks to this end: “Why am I exploited if I am paid, but not if I am not paid?”<sup>45</sup> Opportunities for the coercion or exploitation of donors through emotional or social pressure are clearly available outside of monetary transactions.

Second, banning donation for pay when these same activities are legal if altruistic suggests that women cannot genuinely consent to participate in egg donation when financial incentives are involved. In this framework, a woman cannot make an autonomous, well-informed choice about donating her eggs if she is being paid, though she can do so if she is not being paid and donating for seemingly altruistic reasons.<sup>46</sup> If it is unethical to allow women to donate eggs for payment because it puts donors at unnecessary physiological risk for which they are compensated, it is unclear how not compensating these same donors, and limiting their capacity to issue consent, is a more ethical practice.<sup>47</sup>

Finally, the elimination of payment for egg donation has pushed the practice away from public scrutiny. With the passage of the *AHRA*, paying someone for their eggs outright became a criminal offense, though the possibility of paying for “reimbursement of expenditures” has been used to justify circumvention of

43. Roberta Lessor, “All in the Family: Social Processes in Ovarian Egg Donation between Sisters” (1993) 15 *Sociology of Health and Illness* 393 at 400; Yee, Hitkari, and Greenblatt, *supra* note 11; and Douglas M Saunders and Felicity Garner, “Oocyte Donation Using ‘Known’ Donors: It May Seem the Convenient Answer but Who Pays?” (1996) 11:11 *Human Reproduction* 2356-7.

44. Motluk, “The Human Egg Trade,” *supra* note 12.

45. Mary Lyndon Shanley, cited in Young, *supra* note 42 at 80.

46. The inability of donors to consent, or to speak on their own behalf, was implicit in the long history of public consultations that took place throughout the development of public policy on ARTs. Though the Royal Commission engaged in extensive public consultations—and in every attempt to make legislation or regulations since there have been meetings with stakeholders—egg donors have never been part of this process. This non-participation of egg donors in policy consultations may be attributable to the relatively rapid period that one is an active egg donor as well as to the illegality of participating in egg donation for pay, which hinders the formation of advocacy and support groups as well as other forms of mobilization. However, it is still striking that though the Royal Commission report dedicated a section of its chapter on “The Handling of Eggs and Embryos” to the views of Canadians, and particularly to “practitioners and individuals who are infertile,” the perspectives of egg donors themselves are not discussed. The voices of egg donors as well as sperm donors and surrogates are rarely, if ever, included in stakeholder consultations in this policy field, and, as such, it is not surprising that donors are not seen in the policy as actors capable of informed consent. RCNRT, *supra* note 1 at 582.

47. The risks that egg donors from outside of Canada face, either in coming to Canada to donate or remaining in their own country, is a relatively new area of research. See Alison Motluk, “Wanted: Egg Donor in Good Health” *Sunday Edition* (19 February 2012), online: Canadian Broadcasting Corporation <<http://www.cbc.ca/thesundayedition/documentaries/2012/02/19/wanted-egg-donor-in-good-health/>>; Motluk, “The Human Egg Trade,” *supra* note 12; Motluk, “Is Egg Donation Dangerous?” *supra* note 12.

the ban on payment.<sup>48</sup> Rather than have open and forthright relationships between egg donors, parents-to-be, doctors, and clinic staff, donors and intended parents have had to establish the terms of their agreements in an aura of illegality likely to discourage women from returning to the clinics where they donated when complications arise or unwilling to speak out if and when any mistreatment occurs.<sup>49</sup> Experts in this field have suggested that left to the unregulated grey market, donors are more likely to experience harm by going without the support services they need.<sup>50</sup>

In short, women's health and well-being have largely not been protected by the banning of commercial egg donation in Canada. Rather, women are seen to be in need of protection only when pay is involved and, relatedly, only capable of consent when it is not. Further, women who want to donate their eggs are left to do so in the context of a grey market that forces them to act outside of the legitimacy of legal, compensated donation and beyond the realm of legislation.

### *Protection/Experimentation*

From the time of the Royal Commission, reproductive technologies in Canada have been governed with deference to a biomedical model in which evidence-based medicine plays a significant role.<sup>51</sup> The Royal Commission's report used this framework to identify which reproductive technologies were experimental for certain medical indications and which had been proven to be safely used for treatment. Recommendations 106 and 107 of the Royal Commission's report suggested, to this effect, that IVF be removed from Canada's provincial health insurance programs, namely Ontario's, except in cases of double-blocked fallopian tubes for which IVF was seen to be a proven treatment.<sup>52</sup> The Royal Commission stated that Canadians were concerned that the use of IVF for non-proven indications (which the Ontario Health Insurance Plan had been paying for in Ontario) "amount[ed] to experimentation on women's bodies without their informed

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48. Downie and Baylis, *supra* note 11 at n 45; Françoise Baylis, "Letter to the Editor: Enforcing the *Assisted Human Reproduction Act*" (2012) 34:5 *Journal of Obstetrics and Gynaecology Canada* 415.

49. Motluk, "The Human Egg Trade," *supra* note 12; Motluk, "Is Egg Donation Dangerous?" *supra* note 12. See also Alison Harvison Young and Angela Wasunna, "Wrestling with the Limits of Law: Regulating New Reproductive Technologies" (1998) 6 *Health Law Journal* 239 at 269.

50. Ubaka Ogbogu and Erin Nelson, "Trade in Human Eggs Not Unethical: Clear Rules Needed to Prevent Exploitation of Participants," *Edmonton Journal* (16 May 2012) A23; Motluk, "The Human Egg Trade," *supra* note 12; Motluk, "Is Egg Donation Dangerous?" *supra* note 12.

51. Lorna Weir and Jasmin Habib, "Comment: A Critical Feminist Analysis of the Final Report of the Royal Commission on New Reproductive Technologies" (1997) 52 *Studies in Political Economy* 137 at 143. Francesca Scala, "Scientists, Government, and 'Boundary Work': The Case of Reproductive Technologies and Genetic Engineering in Canada" in Michael Orsini and Miriam Smith, eds, *Critical Policy Studies* (Vancouver, BC: UBC Press, 2007) 211.

52. RCNRT, *supra* note 1 at 520.

consent.”<sup>53</sup> Citing a need for protection and the difficulty of consenting to risky, though widely used medical procedures, the Royal Commission asserted that Canadian health insurance plans could not condone the continued use of IVF for all but one very specific condition and, instead, that all other services should be made available outside of the provincially funded health care system, as part of a mixed-market system that requires payment for service.

After the report was released, this recommendation was taken up by the Government of Ontario, which proposed delisting IVF from the Ontario Health Insurance Plan (OHIP). At the time, it was the only province providing funded IVF, and, within several months, IVF was only funded by OHIP for women with bilateral fallopian tube blockage. The recommendation and eventual delisting of IVF by OHIP elicited concern from advocates of infertile people, who stated that the cuts infringed on women’s reproductive autonomy by eliminating options for infertile people to conceive.<sup>54</sup> By the time the Royal Commission issued its report, IVF had become a relatively common medical practice used to treat a wide variety of infertility issues.<sup>55</sup> Infertile people in Ontario had long received IVF to correct for male-factor infertility, endometriosis, single-blocked fallopian tubes, and other conditions, and the delisting of IVF was seen as an unnecessary impediment to access.<sup>56</sup> In the years that followed, as it became evident that IVF was effective in treating various conditions, the listing under OHIP, as in most other provinces, was not reconsidered.<sup>57</sup>

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53. *Ibid* at 502.

54. Tony Wong, “Infertile Couple Fear Cutbacks in Care,” *Toronto Star* (2 December 1993) A30; “Plan to Ask Public about OHIP Cuts Called ‘a Sham,’” *Toronto Star* (2 December 1993) A14.

55. Francesca Scala, “Experts, Non-Experts, and Policy Discourse: A Case Study of the Royal Commission on New Reproductive Technologies” (2002) at 82 [unpublished, archived at Department of Political Science, Carleton University, Ottawa]. See also Jean Haase, “The Long Road to Regulation” in Eric Blyth and Ruth Landau, eds, *Third Party Assisted Conception across Cultures: Social, Legal and Ethical Perspectives* (London: Jessica Kingsley Publishers, 2004) 55 at 56.

56. Nisker, *supra* note 14 at 429; Jeff Nisker, “Socially based Discrimination against Clinically Appropriate Care” (2009) 181:10 *Canadian Medical Association Journal* 764. See also *Cameron v Nova Scotia (Attorney General)* (1999), 204 NSR (2d) 1 [Cameron].

57. Though this example focuses largely on the Ontario case, there have been struggles over access and public funding for ARTs in other provinces. Since the elimination of funding for in vitro fertilization (IVF) in Ontario (except for women with bilateral fallopian tube blockages), Manitoba and Québec have changed their approach to funding ARTs. The Government of Québec instituted a tax credit to offset 30 percent of the cost of ARTs in 2002, which was replaced with a 50 percent tax credit in 2008. In 2010, Québec started funding ARTs under its provincial health insurance program, including three cycles of IVF. As of 2010, the Government of Manitoba has offered a 40 percent tax credit to offset the cost of certain ARTs. Francois Bissonette et al, “Funding Is the Most Powerful Tool against Multiple Pregnancies in ART” 26 *Human Reproduction (Issue Supplement 1)* i113 at i114; and Samantha Yee et al, “‘Just What the Doctor Ordered’: Factors Associated with Oncology Patients’ Decision to Bank Sperm” (2012) 6:5 *Canadian Urological Association Journal* 1 at 5. In Nova Scotia, the struggle for funding has largely occurred through the case of *Cameron, supra* note 56. In this case, a heterosexual couple underwent infertility treatments for male-factor infertility and challenged that the failure to include infertility treatments under the provincial health care program constituted discrimination on the basis of disability

While infertile couples critiqued the Royal Commission's recommendation for validating decreased access to assisted reproductive services, women's groups, including the National Action Committee on the Status of Women,<sup>58</sup> praised the Royal Commission and OHIP for protecting women from the ethical and physiological challenges posed by IVF and encouraged even more regulation. The Ontario Medical Association also supported limiting the funding of IVF on the grounds that it was both expensive and, in most cases, not "medically necessary."<sup>59</sup> Broadly including IVF as a listed service was seen to put unneeded strain on an already over-extended health care system, which was simultaneously reducing pharmaceutical subsidies to seniors and people on social assistance. IVF was simply not seen by critics as a health care priority, particularly when described by the Royal Commission as an experimental procedure with low success rates.

The result is that now, though IVF has long been used to treat a variety of infertility-related issues in clinics where the patients must foot the bill, OHIP only pays for treatment for one indication, based on the criteria that it is "medically necessary," in keeping with the *Canada Health Act*. Infertility is seen as an illness requiring "medically necessary" IVF when caused by double-blocked fallopian tubes. However, for other indications, the treatment is not deemed necessary. This attitude contributes to a system of stratified reproduction<sup>60</sup> in which infertility (other than the case of bilaterally blocked fallopian tubes) is a medically treated procedure for those who can afford it.

Effectively, certain indications are seen to merit funded treatment to the exclusion of others, which has often resulted in a two-tier market in IVF, wherein those who fall outside of provincial health care funding must pay for treatments

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under s 15 of the *Canadian Charter of Rights and Freedoms*. They were unsuccessful in court (both at trial and appeal), though the judgment at appeal stated that infertility is a disability and that the treatments for which the appellants were seeking funding "could qualify as being medically necessary." However, the discrimination was saved under s 1. See *Cameron, supra* note 56 at para 85; and Daphne Gilbert and Diana Majury, "Infertility and the Parameters of Discrimination Discourse" in Dianne Pothier and Richard Devlin, eds, *Critical Disability Theory: Essays in Philosophy, Politics, Policy and Law* (Vancouver: UBC Press, 2006) 285 at 285.

58. Frank Jones, "Solid Logic in OHIP Bid to Drop in-vitro Fertilization: [AM Edition]," *Toronto Star* (26 July 1993) E1; "Plan to Ask," *supra* note 54 at A14. See also Heather Menzies, "What Women Need to Control in-vitro Fertilization" (1994) 8:1 *Horizons* 21.
59. M Giacomini, J Hurley, and G Stoddart, "The Many Meanings of Deinsuring a Health Service: The Case of In Vitro Fertilization in Ontario" (2000) 50 *Social Science and Medicine* 1487.
60. Rayna Rapp, *Testing Women, Testing the Fetus: The Social Impact of Amniocentesis in America*, 1st ed (New York: Routledge, 2000) at 31; Faye Ginsburg and Rayna Rapp, eds, *Conceiving the New World Order: The Global Politics of Reproduction* (Berkeley, CA: University of California Press, 1995); Francesca Scala, "IVF Policy and the Stratification of Reproduction in Canada" in Stephanie Paterson, Francesca Scala, and Marlene Sokolon, eds, *Fertile Ground: Reproduction in Canada* (Montreal and Kingston: McGill-Queens' University Press, 2014) [forthcoming]. See also Dorothy Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty* (New York: Pantheon Books, 1997).

themselves or do without.<sup>61</sup> Further, as noted by Ontario's Expert Panel on Infertility and Adoption, the high cost of IVF leads patients to make unhealthy and riskier choices to get pregnant using ARTs, such as using treatments less effective for their circumstances "because they cannot afford more appropriate procedures" or request the implantation of several embryos in IVF (which increases the chance of high-risk multiple births).<sup>62</sup> Women may be more likely to engage in experimental uses or misuses of ARTs including IVF when cost becomes a factor.<sup>63</sup>

It is important to note that the recommendation to delist IVF is not part of the *AHRA*, nor is it part of the legislative and regulatory approach taken by the federal government to intervene in the field of ARTs following the Royal Commission. It is, rather, an outcome of the recommendations of the Royal Commission and the approach to governing ARTs in Canada that it espoused, combining evidence-based medicine with claims to protecting the interests of vulnerable groups, including women.<sup>64</sup> The consequence of this delisting is that in the name of "protecting" women from untested technologies that had, by that point, been used for more than a decade, the Royal Commission effectively recommended that poorer Canadians be rendered unable to access IVF, requiring some to settle for cheaper alternatives that might be riskier or less effective.<sup>65</sup>

This is not to say that provinces should fund IVF. Indeed, as Abby Lippman has argued, although assisted reproductive services are important for many people's quality of life, they are not "medically necessary" in conventional terms, and it is difficult to justify public funding in the context of provincial health care systems under fiscal constraint.<sup>66</sup> Nevertheless, the Royal Commission's recommendation to largely delist IVF was made in the name of protecting women from being subjects of experimentation for new ways that IVF might be used. Instead, women trying to conceive, with the means to do so, could pay to engage in the so-called experimental usages of IVF within for-profit clinics and undergo procedures

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61. In provinces other than Manitoba, Québec, and Ontario, there is no funding at all for IVF, and the two-tier market for IVF is even more clear, as access is only available to those with the means to pay. See all references in note 57 of this article.

62. Ministry of Children and Youth Services Expert Panel on Infertility and Adoption, *supra* note 10 at 111–13.

63. Nisker, *supra* note 14 at 427.

64. Scala, *supra* note 55; Weir and Habib, *supra* note 51.

65. Nisker, *supra* note 14 at 427.

66. Abby Lippman, "Comment: Saying 'No' to the Funding of Assisted Reproduction Services in Québec," *BioNews* (25 May 2010), online: Bionews <[http://www.bionews.org.uk/page\\_61600.asp](http://www.bionews.org.uk/page_61600.asp)>. See also Warren Gerard, "Ontario Pays Out \$4 Million a Year for In-Vitro Fertilization," *Toronto Star* (27 May 1993) F5. Others have argued that the costs of multiple births associated with lower cost fertility options (such as using gonadotropin fertility drugs) rather than IVF, is higher than the cost of the public provision of funding for ARTs. The argument often made is that by attaching conditions to IVF (for example, requiring single-embryo transfer), provincial governments can reduce the negative outcomes associated with multiple births and also reduce the associated costs on health care systems. See Ministry of Children and Youth Services Expert Panel on Infertility and Adoption, *supra* note 10 at 110; Bissonette et al, *supra* note 57 at 114.

deemed too risky for OHIP to fund. Women without the financial means, or otherwise excluded, had to make do with their circumstances, unable to undertake the same risks. The Royal Commission's recommendation enabled the Government of Ontario to validate a reduction of their ART costs in the name of evidence-based medicine and to legitimate a system of access largely based on socio-economic status in the name of protecting women from being the subjects of medical experimentation.

### *Protection/Enforcement*

The failure of public policy governing assisted human reproduction in Canada to adequately address “women’s health and well-being” remains most apparent in the ongoing non-implementation and enforcement of the *AHRA*. Though the passage of the *AHRA* occurred a long fifteen years after the Royal Commission was first called, there was still much work to be done, as the Act mandated the creation of a regulatory agency (AHRC) to enforce the *AHRA* as well as the development of regulations by Health Canada for the agency to implement. Penalties for certain prohibited practices—issuing payment or brokering the sale of eggs, sperm, or embryos or paying or brokering surrogacy arrangements—were set as a \$500,000 fine or ten years in jail (or both). However, despite the inclusion of these harsh penalties, little has been done to enforce the Act.<sup>67</sup> Only one set of regulations was ever issued by Health Canada, and, once established, the agency did little beyond generating controversy and consulting with stakeholders, resulting in a situation where a law was on the books that explicitly articulated its dedication to protecting women though nothing was being done. Attributed both to delays in the work of Health Canada as well as to the institutional shortcomings of AHRC, the outcome of almost three decades of work towards robust legislation has been little more than words.

Charged with promoting compliance with, and enforcement of, the *AHRA*, the agency was mired with controversy from the first.<sup>68</sup> The initial appointments of its Board of Directors drew criticism both for the social conservatism of many of the appointees<sup>69</sup> and for the lack of representation of key stakeholders, including users

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67. See discussion at note 7 in this article.

68. Françoise Baylis, “The Demise of Assisted Human Reproduction Canada” (2012) 34 *Journal of Obstetrics and Gynaecology Canada* 511 at 512.

69. The Board of Directors was appointed on 21 December 2006 and included former Conservative Nova Scotia Premier John Hamm as chair; Elinor Wilson, the newly named president of Assisted Human Reproduction Canada, and former chief executive officer of the Canadian Public Health Association. Other members included Suzanne Rozell Scorsone, former member of the Royal Commission on New Reproductive Technologies and director of research for the Archdiocese of Toronto; David Novak, a professor of Jewish studies at the University of Toronto; Joseph Ayoub, an oncologist at the University of Montreal, all known to be social conservatives. The rest of the Board consisted of Françoise Baylis, Canada Research Chair in Bioethics and Philosophy at Dalhousie University; Roger Bilodeau, an Ottawa-based lawyer; Albert Chudley,



of reproductive technologies, research scientists, and physician experts. Furthermore, the agency was widely critiqued for its high cost to taxpayers with little return on investment. Though AHRC was founded in 2006 and began operations in 2007, by 2010 when the Supreme Court of Canada effectively overturned the agency's mandate, little had been achieved. It is unfair to lay blame with AHRC alone, as there was an "excessive delay" in the development of regulations on the part of Health Canada. This delay was explained by Health Canada first in relation to the challenges posed by the ironically named "Cabinet Directive on Streamlining Regulations" and later when the *Reference Re Assisted Human Reproduction Act* was heard. Health Canada's Assisted Human Reproduction website displayed a message that the regulations would be further delayed "until an opinion is provided by the Supreme Court of Canada on the constitutionality of parts of the *Assisted Human Reproduction Act*."<sup>70</sup> However, while these delays occurred in part because Health Canada was slow to develop the licensing, inspection, reimbursement, and other regulations that AHRC would need to implement the regulatory aspects of the *AHRA*, critics have suggested that the criminal provisions of the Act could have been enforced without the development of such regulations.<sup>71</sup> Commercial surrogacy and egg donation—illegal under the Act—proliferated while AHRC was in operation, and, though there have been a few investigations of egg donation for pay<sup>72</sup> and surrogacy brokering, few charges have ever been laid.<sup>73</sup>

The agency came under fire again in 2010 when three members of the Board of Directors stepped down from their posts, citing a lack of transparency, poor communication amongst board members, and concerns about mismanagement of public funds.<sup>74</sup> The resignations occurred within months of each other and in the wake of the departure of "four senior staff members,"<sup>75</sup> raising fears that the agency was

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director of the genetics and metabolism program at the Winnipeg Regional Health Authority; Barbara Slater, a health policy consultant; and Theresa Kennedy, a director at ResVerlogix, a biotechnology firm. Laura Eggertson, "New Reproductive Technologies Board Belies Expert Selection Process" (2007) 176:5 *Canadian Medical Association Journal* 611 at 612.

70. Health Canada, *Publication of Proposed Assisted Human Reproduction Regulations Delayed until Supreme Court Appeal Is Decided* (28 March 2007), online: Wayback Machine <<http://web.archive.org/web/20130110202031/http://www.hc-sc.gc.ca/hl-vs/reprod/hc-sc/legislation/delay-interruption-eng.php>>; Maneesha Deckha, "Legislating Respect: A Pro-Choice Feminist Analysis of Embryo Research Restrictions in Canada" (2012) 58 *McGill Law Journal* 199; Baylis, *supra* note 68.
71. Deckha, *supra* note 70.
72. Motluk "The Human Egg Trade," *supra* note 12 at 35.
73. Tom Blackwell, "Fertility Consultant at Centre of RCMP Investigation in the Dark about Reason for Investigation: Lawyer," *National Post* (1 March 2012), online: *National Post* <<http://news.nationalpost.com/2012/03/01/fertility-consultant-at-centre-of-rcmp-raid-in-the-dark-about-reason-for-investigation-lawyer/>>. See also Baylis, *supra* note 48. See also discussion of charges laid at note 7 in this article.
74. *Evidence from the Standing Committee on Health*, 37th Parl, 3rd Sess, No 37 (16 November 2010) at 1.
75. Tom Blackwell, "Red Flag Raised at Fertility Agency," *National Post* (20 April 2010).

falling apart from within. A parliamentary hearing was held in November 2010, and the two-part hearing demonstrated that “the integrity of the Board ha[d] been compromised.”<sup>76</sup> Some parliamentarians called for an independent inquiry into the board’s actions, but before any inquiry could get underway, the Supreme Court of Canada released its judgment in *Reference Re Assisted Human Reproduction Act* overturning provisions of the *AHRA* that enabled the operations of the agency. In June 2012, the Harper government enacted the changes included in the judgment of the Supreme Court of Canada, by including amendments to the *AHRA* in its omnibus budget bill that effectively ended the operations of AHRC.<sup>77</sup> The agency closed in March 2013.

The failure to implement the *AHRA* on the part of Health Canada, AHRC, and the Royal Canadian Mounted Police has meant that women’s “reproductive health and well-being” under the Act has been sidelined. First, the non-implementation of the law has meant that donors and surrogates have continued to engage in clandestine relationships with intended parents to avoid the relatively empty threat of prosecution. Second, the idea that in some way the *AHRA* would work to protect women—from exploitation, from health risks, or otherwise—has been abandoned. Though the *AHRA* recognizes that women are disproportionately impacted by ARTs and therefore in need of some measure of protection, little is being done to uphold this principle. AHRC, the agency established to ensure that the *AHRA* was implemented and to ensure that the principles of the Act were being upheld, including the protection of women’s reproductive health and welfare, is no more. If the criminal provisions of the *AHRA* could protect women in some way, the failure to enforce the Act’s criminal provisions have largely left this possibility unrealized.

### *Protecting Women, Protecting the Status Quo*

Almost twenty-five years after the Royal Commission was called with the intention to protect women’s health and well-being from the negative implications of ARTs, much has occurred, but little has changed. Despite the language of protection deeply entrenched in the text of the report of the Royal Commission,

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76. *Evidence from the Standing Committee on Health, supra* note 74.

77. Bill C-38 (2012), *An Act to Implement Certain Provisions of the Budget Tabled in Parliament on March 29, 2012 and Other Measures*, included more than four hundred pages, simultaneously altering more than seventy different pieces of legislation. The Act was the subject of significant public outcry as it was seen to be a political tactic to get many amendments to many pieces of legislation passed through parliament without scrutiny. Bill C-38 contained thirty-two different sections amending the *AHRA*, some related to the Supreme Court of Canada’s judgment in *Reference Re Assisted Human Reproduction Act* (such as the closure of AHRC) and others (such as the elimination of the use of the *Food and Drugs Act* to regulate sperm and ova usage) that have no clear relation to the Supreme Court of Canada’s case. Bill C-38 received royal assent on 29 June 2012. See *Act to Implement Certain Provisions, supra* note 15.

Bill C-47, and eventually the *AHRA*, Canadian women, in reality, remain without the safeguards that they need to effectively access and safely use ARTs. Although the Government of Canada has worked to protect egg donors from exploitation by banning commercial egg donation, the outright ban on compensation or payment has led women to participate in an unregulated market and to be deemed unable to consent to donation for pay.

Further, the elimination of funding for IVF in Ontario in the name of protecting women from experimentation (building on the recommendations of the Royal Commission) has led to a two-tiered model for infertility services in the province that steers women towards riskier choices to make the most of their limited ART budgets. Unlike other provinces where IVF has never been available within the publicly funded health care system, the experience in Ontario demonstrates the challenge of a government actively choosing to delist IVF and to do so in part because of claims that it was an experimental procedure and that delisting the service would work to protect women's welfare. However, keeping women from engaging in experimental procedures by forcing them to seek these same services in private-for-profit clinics fails to protect potential patients from purportedly unsafe uses of reproductive technologies. Furthermore, despite the inclusion of women's health and well-being as a guiding principle of the *AHRA*, Health Canada's failure to develop regulations that would enable the Act to be implemented and the inaction of AHRC have meant that the elements of the Act that were intended to protect women have not been enacted.

The goal of protection in this field remains an important one. Women continue to disproportionately experience the negative implications of reproductive technologies, and as surrogacy, gamete donation, IVF, and other interactions with reproductive technologies become fixtures of contemporary family life, women are increasingly prone to their potential misuse. In Canada, we remain without substantive regulations, without avenues to safe access, and without clear direction about what is to come. Despite a long history of promises for protection, the need to safeguard "women's reproductive health and well-being" *vis-à-vis* the challenges posed by ARTs remains as urgent as ever.<sup>78</sup>

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78. *AHRA*, *supra* note 3.