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Blyth, Eric

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Die »Notwendigkeit eines Vaters für das Kind« und der Zugang lesbischer Frauen zur Reproduktionsmedizin (The child's need for a father and access to assisted reproductive technologies by lesbians). In Funcke, D. and Thorn, P. (eds) (2010) *Die gleichgeschlechtliche Familie mit Kindern*. Transcript Verlag: Bielefeld, Germany: pp. 195-223

Eric Blyth

Abstract

This chapter provides an overview of two broad areas relating to lesbians' use of reproductive services for family building. First, it identifies strategies used in the building of 'planned' lesbian families – where a lesbian couple, the genetic mother and the social or 'co' mother, plan their family together - and in which children are raised from birth without the presence of a father. Second, it reviews policy and legislation regulating and restricting lesbians' use of reproductive services in a number of countries both globally and specifically in Europe, before considering in more detail the 'need for a father' debate in the United Kingdom that resulted in legislative provisions effective from October 2009, formally ending discrimination against lesbians seeking to access fertility services in the United Kingdom.

“The 'lesbian baby boom' and the growing visibility of lesbians who became mothers through donor insemination constitute the most dramatic and provocative challenge to traditional notions of both family and of the non-procreative nature of homosexuality” (Lewin, 1993: 19).

Introduction

Although semen is required to fertilise an egg in order to conceive a child, conception is not dependent on penetrative heterosexual sexual intercourse, and may be achieved by means of non-coital insemination, either by using donor insemination (DI) services provided by fertility clinics, sperm banks or individual health care professionals, or through self insemination – the latter, self-evidently, requiring no professional intervention or supervision. Consequently, women who so choose may conceive a child and achieve parenthood without the presence of a male partner - whether for the sole purpose of conceiving a child or for the longer-term care and upbringing of their child. While every child 'needs a father' in the exclusively generative sense of 'fathering', a child may be reared by a woman (heterosexual or lesbian) either as a 'solo' mother or in a same-sex partnership.

Academic and policy interest in ‘planned’ lesbian families, in which a lesbian couple - the genetic mother and the social or ‘co’ mother - plan their family together, and in which children are raised from birth without the presence of a father - has fuelled speculation of a lesbian ‘baby boom’ - or ‘gayby’ boom (e.g. Weston, 1991; Lewin, 1993; Patterson, 1995; Gartrell, Hamilton, Banks, Mosbacher, Reed, Sparks and Bishop, 1996; Morningstar, 1999; Amato and Jacob, 2004; Azpiri, 2007). While evidence of the number of children born into planned lesbian families – and therefore of the reality of such a ‘boom’ - is elusive, increasing use of fertility clinics and sperm banks by lesbians is evident, leading to what Morrisette (2008) has described as “transforming the donor insemination industry”. Alvarez (2004) claims that lesbians and single women provide “the fastest-growing markets for sperm banks”. Lesbians and single women together currently comprise half of the clientele of California Cryobank, one of the world’s largest sperm banks (Morrisette, 2008), and Stryker (2007) suggests that this group comprises around two thirds of the clientele of all American sperm banks. A survey undertaken by Gumankin, Caplan and Braverman (2005) revealed that 82% of directors of American fertility clinics were ‘not at all’ or merely ‘slightly’ likely to refuse to provide a service to a lesbian couple requesting DI, while 17% were ‘very’ or ‘extremely’ likely to turn them away. Stern, Cramer, Garrod and Green (2001) reported that in 2001, 74% of fertility clinics in the United States provided services for lesbian couples. While statistics for lesbians *per se* are not recorded in official US data, the Centers for Disease Control report that in 2007 (the most recent year for which data are available) 91% of reporting fertility clinics stated that they offered services to single women (Centers for Disease Control and Prevention, 2009).

In the UK, official data for the period 1991-2006 provided by the regulatory body, the Human Fertilisation and Embryology Authority (HFEA), show that while the absolute number of treatment cycles for lesbians provided by licensed clinics increased over the seven year period, these still remain a very small proportion of total treatment cycles (Table 1).

TABLE 1 ABOUT HERE

While both the number of DI cycles undertaken by lesbians and lesbians’ share of all DI cycles increased significantly over this period, changing practices regarding DI need also to be taken into account to adequately contextualise lesbians’ current usage of fertility services. Before the advent of ICSI¹, DI was the principal clinical

¹ Intracytoplasmic injection of sperm (ICSI) involves the injection of a single sperm into an oocyte (egg). ICSI was initially indicated for use with male factor fertility difficulties and has therefore become the ‘treatment of choice’ for heterosexual couples. For reasons that are not currently entirely

fertility service available to heterosexual couples experiencing male factor fertility difficulties; however, since its introduction in the early 1990s ICSI has increasingly replaced DI as the treatment of choice for heterosexual couples with male factor fertility difficulties who are desirous of conceiving a child who is genetically related to each partner, contributing to a decline in recourse to DI by heterosexual couples (Godman, Sanders, Rosenberg and Burton, 2006).

At the same time, it should be acknowledged that such figures are inevitably an underestimate since they do not take into account the (unknown) number of lesbians who make use of self-insemination.

Building planned lesbian families

Conventionally, planned lesbian families have been built following self-insemination using semen acquired informally, directly from a male acquaintance or through friendship networks, rather than using DI (Dunne, 2000). Such practices have been influenced by two major considerations. First, the practical consequences of legal prohibitions against lesbians accessing services or – where no such legal barriers exist - discrimination by clinics, which have restricted lesbian access to fertility services and resulted in limited real choice (Steinberg, 1986; Douglas, 1992, 1993; Haines and Weiner, 2000; McNair, Dempsey, Wise and Perlesz, 2002). Second, where clinic services are available and accessible, but where donor anonymity is practiced, a woman may desire to know her donor's identity both for her own interests and in order to provide her child with information about his or her genetic and biographical history (McNair, Dempsey, Wise and Perlesz, 2002; Almack, 2006).

Historically, lesbians appear to have preferred a gay, as opposed to a heterosexual, donor for three principal reasons. First, a gay donor may be regarded as posing less of a threat to the stability of the lesbian parent family than a heterosexual donor, since the former is assumed to be less likely to wish to parent children or, if he does have such a desire, to succeed in establishing paternal legal rights in respect of a donor-conceived child (Haines and Weiner, 2000; Almack, 2006). Second, a gay donor may be assumed to be more likely than a heterosexual donor to be ideologically committed to helping lesbians build their family and less likely to repudiate a previously-made agreement (Saffron, 1994). Third, compared to a heterosexual man, a gay donor may be perceived as representing a more acceptable form of masculinity for lesbians (Dunne, 2000).

clear, in many countries ICSI has become a preferred form of treatment by physicians in the absence of male factor fertility problems (Centers for Disease Control and Prevention, 2008; Andersen, Goossens, Bhattacharya, Ferraretti, Kupka, de Mouzon and Nygren, 2009).

Over time, lesbian family building has demonstrated more diversified practices, in particular including use of anonymous donors, heterosexual donors, and clinic services and/or sperm banks. An *unidentifiable* donor may be preferred to a known donor by some lesbians since it is assumed he will be less likely to seek any involvement in the child's life or 'interfere' in the lesbian family. A heterosexual donor who is already a father has both demonstrated proof of his fertility and may be perceived as less likely to seek a parenting role in relation to the donor-conceived child. In circumstances where a personally-recruited donor may be held financially liable for any child born, a wish to avoid such responsibility may deter a heterosexual donor from asserting any paternal interest in the child. Furthermore, since gay parenting is receiving increasing validation, there is a risk that a gay donor may regard donating to a lesbian couple (or to a single woman) as his best (or sole) chance of becoming a father, and he may therefore wish to play more of a parenting role than the mother wishes or had been agreed at the outset (Almack, 2006). Finally, uncertainties surrounding the potential legal and health implications (especially relating to HIV/AIDS) of informal arrangements, both for the woman and for any child, have encouraged a perception of self-insemination as a "doubtful and dangerous clandestine practice" (Englert, 1994: 1977) to be contemplated less as a method of choice but more as a risky 'last resort', and women to seek out sources of 'safe(r)' semen offered by fertility clinics and sperm banks.

It is self-evident that lesbians' choice of family-building options and the extent to which these are facilitated or constrained are to a large extent dependent on the moral and regulatory context in the jurisdiction in which they reside – or jurisdictions to which they have access (Pennings, Autin, Decler, Delbaere, Delbeke, Delvigne, Neubourg, Devroey, Dhont, D'Hooghe, Gordts, Lejeune, Nijs, Pauwels, Perrad, Pirard and Vandekerckhove, 2009²). The next section of this chapter considers in more detail the political and regulatory context of assisted reproduction as it impacts lesbians' access to family-building options.

The political context of lesbians' use of assisted reproductive services

The context in which any discussion of planned lesbian families takes place must necessarily take account of dominant heteronormative assumptions surrounding child-rearing in which the heterosexual two-parent household is perceived as the unquestioned "gold standard for raising children" (Peterson, 2004: D.01).

² In this context, Pennings et al. note that approximately 80% of sperm donation procedures undertaken by foreign patients in Belgian fertility clinics are French lesbian couples, who are ineligible to access fertility services in France.

Derived from deontological considerations (see Pennings, this volume), dominant faith-based discourses, notably those derived from Christian and Islamic theology, consider that *only* the heterosexual male-female headed family - and preferably in which the parents are legally married - is the acceptable model for conceiving and raising children. So, for example, the Roman Catholic Church considers that allowing single women and lesbians access to DI “doubly wrongs” children since they are “deprived of both a genetic and a social father” (Catholic Bishops' Conference of England and Wales and the Linacre Centre for Healthcare Ethics, 2004). Islam forbids all sexual relationships outside heterosexual marriage and a woman undergoing any form of assisted reproductive services may use only her husband’s semen in order to conceive a child (Iqbal and Noble, 2009).

Secular groups also adhere to similar heteronormative values, as indicated by the results of a public opinion poll conducted in the UK in 2008 in which 60% of respondents *who expressed an opinion* (the proportion of participants expressing an opinion was not disclosed) agreed on the importance that children have “both a male and female parent” (YouGov Polling, cited in Centre for Social Justice, 2008: 9).

According to such discourses, notions of the child’s ‘need for a father’ arise, and child-rearing in same sex relationships is perceived as self-evidently deficient (even though available empirical evidence suggests the contrary – see Scheib & Hastings, this volume). This is demonstrated by the early experiences of lesbians who, having conceived a child within the context of a heterosexual relationship, found their suitability to parent under scrutiny in child custody disputes once they had come out as lesbian. These mothers risked losing custody of their child(ren) because of concerns about: the absence of a father and consequent lack of an adult male role model for their child, the presence of one or two mothers whose sexual orientation could result in children showing atypical gender or psychosexual development, including an increased likelihood of their becoming lesbian or gay also, and the children being teased and/or stigmatised by peers (Rand, Graham and Rawlings, 1982; Golombok, Spencer and Rutter, 1983; Golombok, 1999; Patterson, 1992, 2002; Falk, 1994; Brewaeys, Devroey, Helmerhorst, Van Hall and Ponjaert, 1995; Walker, 2000; American Academy of Pediatrics, 2002).

However, while judicial dispositions in child custody cases – in some jurisdictions at least – are now likely to be less prejudicial against lesbian mothers, accompanying a developing interest in and acceptance of parenting within gay and lesbian communities (Saffron, 1994; Weeks, Donovan and Heaphy, 1997), such decisions favouring mothers’ interests are made in the context of preserving *existing* mother-child relationships and based on the child’s need to maintain the relationship with her or his mother - essentially making the best of what is still considered an

unsatisfactory situation. This is clearly quite different to permitting an avowed lesbian to embark on parenthood in the first place.

This leads to the second key assumption impacting contemporary debates regarding planned lesbian families, that use of assisted reproductive technologies should be restricted to “repairing nature when it fails” (Somerville, 2007), rather than being seen as increasing the repertoire of family building options to promote reproductive autonomy and facilitate child bearing and child raising opportunities among those who do not conform to heterosexist conventions.

International legislative context

Such would appear to be borne out by the results of recent reviews of legislative requirements regarding assisted reproductive technologies undertaken by the International Federation of Fertility Societies and the Council of Europe respectively.

The International Federation of Fertility Societies’ survey of 57 jurisdictions worldwide showed that “the majority of societies, either as expressed through legislation or as influenced by religious or cultural issues, appear to prefer a traditional heterosexual family (marriage or stable relationship) and hesitate to provide full access to alternative groups” (Jones, Cohen, Cooke and Kempers, 2007: S17).

Thirty-six of the reviewed jurisdictions specifically prohibited lesbians from accessing reproductive services, either by means of ‘formal restrictions’ or ‘customary practice’ (Argentina, Austria, Chile, China, Colombia, Croatia, the Czech Republic, Denmark, Ecuador, Egypt, France, Germany, Greece, Hong Kong, Hungary, India, Ireland, Italy, Japan, Jordan, Lithuania, Malaysia, Morocco, Norway, the Philippines, Portugal, Russia, Singapore, Slovenia, Sweden, Switzerland, Taiwan, Tunisia, Turkey, Uruguay and Vietnam). On the other hand, ten jurisdictions were identified that specifically permitted lesbians to access reproductive services (Australia, Belgium, Brazil, Canada, Israel, the Netherlands, New Zealand, South Africa, the United Kingdom and the United States of America). Of the remaining 14 jurisdictions surveyed, Bulgaria, Korea, Latvia, Mexico, Spain and Thailand were reported as having ‘no requirements’ as regards ‘couple requirements’ for eligibility, while this was reported as ‘not an issue’ in Finland³, Romania or Venezuela; presumably, therefore, lesbians are not specifically ineligible for reproductive services in these jurisdictions. In the remaining two jurisdictions, Saudi Arabia provided no information, while the situation in Peru -

³ The Finnish parliament has since implemented legislation confirming lesbians’ eligibility for assisted conception services.

reported as having no regulations, but permitting services to single women - seemed unclear as regards lesbians.

Two earlier studies undertaken by the Council of Europe (1998; 2005) of policies and practices in member countries also revealed variable practices, although the questions asked in these surveys did not specifically relate to lesbians. Instead, the surveys enquired whether 'medically assisted procreation' services were available to women who were not married or not in a heterosexual relationship. In 1998 35 member states took part in the survey and 41 did so in 2005. Where relevant information was available (for 29 member states in 1998 and for 34 in 2005), this showed an increase both in the number of states specifically prohibiting access to medically assisted procreation services by an unmarried couple (from 7 states in 1998 to 22 in 2005) and in the number of states prohibiting access to medically assisted procreation by women who were not living in a heterosexual couple relationship (from 15 states in 1998 to 19 in 2005) (Table 2).

The chapter now considers in more detail the specific "need for a father" debate held in the UK, the removal of which, according to lawmaker, Dr Evan Harris, ended 16 years of "licensed discrimination against solo mothers and lesbian couples" (Harris, 2006).

"Need for a father" debate in the United Kingdom

As in other societies, providers of assisted conception services in the UK initially demonstrated comparatively high levels of social conservatism when deciding to whom to offer their services and rarely considered as eligible candidates those who were not married, or at the very least cohabiting in a heterosexual couple relationship (Steinberg, 1986; Douglas, 1992, 1993; Haines and Weiner, 2000). Thus, when UK lawmakers began to frame legislation to regulate fertility services their decision to require a licensed clinic to take account of the child's 'need for a father' before offering services to a woman (Human Fertilisation and Embryology Act 1990 Section 13[5]) impacted hardly at all on clinics' practices. Elsewhere I have provided a detailed account and critique of the origins of the child welfare requirement in the 1990 Act (Blyth, 2007); suffice here to note that the 'need for a father' requirement was inspired by some lawmakers' desires to prohibit individual women and lesbian couples from accessing reproductive services (the possibility that single men or men in a same-sex relationship might also wish to avail themselves of such services having yet to impact legislators' consciousness). Although the government stopped short of an outright ban on single women and lesbian couples, it nevertheless expressed hope that counselling would provide the means by which they would be "dissuaded from having children" (Mackay, 1990: col. 1098). It is not a little ironic

therefore that, by virtue of Section 28 of the 1990 Act, a man who donates sperm to a licensed clinic in accordance with the Act's informed consent provisions is exempt from legal and financial responsibility for any child conceived as a result of his donation⁴, and that where the child is born to a woman who has used donor sperm, but who does not have a male partner, the child will be legally fatherless. At the same time, although this is not an area that has been explicitly subjected to empirical study, intuitively it seems highly improbable that UK fertility clinic counsellors would see themselves as responsible for "counselling out" women seeking fertility services simply on the basis of their marital status or sexual orientation – and especially within a dominant model of "non-directive" counselling (Blyth and Hunt, 1994).

In practice, as indicated by the data from the Human Fertilisation and Embryology shown above, rather than making it impossible for single women or lesbian couples to find a clinic willing to offer them a service, the 'need for a father' requirement has made it more inconvenient and costly for them to do so, since the nearest clinic willing to offer them a service may be far from home and accessing its services may require women to take more time off work and incur additional travel and accommodation costs (Haimes and Weiner, 2000; Saffron, 2002, 2004; House of Lords / House of Commons, 2007).

From its inception, Section 13(5) was controversial for many reasons and service providers found it difficult to operationalise coherently (Blyth, 2007). However, it was to be nearly 13 years following implementation of the 1990 Act, amidst increasing concerns about its continuing fitness for purpose to ensure effective regulation in the 21st century, before concrete proposals for reform were initiated. The first step was taken by the House of Commons Science and Technology Committee, which launched a systematic review of the Act in 2004 and published its findings in 2005 (House of Commons Science and Technology Committee, 2005a, b). In the event, the Committee's conclusions were highly contested; half of the Committee members formally dissociated themselves from the final report, which was approved only by the casting vote of the Committee chair (House of Commons Science and Technology Committee, 2005c).

One of the key highlights of both evidence presented to the Committee and its own conclusions was extensive disagreement concerning Section 13(5) – disagreement that continued to surface over the next three years of debate concerning the future

⁴ However, where a man donates sperm 'informally' to a recipient, he could be held legally and financially liable for any child born as a result of his donation – as has occurred in at least one highly publicised instance in the UK (Truscott and Williams, 2007).

direction of UK legislation in this area. Some of those giving evidence to the Committee, including the then responsible government Minister, Melanie Johnson MP, argued for retention of the 'need for the father' requirement (Johnson, 2005), while others called for its removal. The Committee itself advocated the abolition of the child welfare provision from the Act in its entirety, while specifically criticising articulation of the 'need for a father' both for being "out of tune" with contemporary family life in the UK and recent legislative measures, such as the Adoption and Children Act 2002 and the Civil Partnership Act 2004, designed to enhance the civil rights (including parental aspirations) of same sex partners, and for implicitly endorsing unjustified discrimination against "unconventional families" (House of Commons, 2005a: 48).

In response to the Science and Technology Committee report, the government promised its own review of the Act, in which it proposed to seek "wider public views on how the welfare of children born as a result of assisted reproduction may best be secured" (Department of Health, 2007: 40).

In the meantime, in 2005 the Human Fertilisation and Embryology Authority initiated a public consultation on the operation of Section 13(5) (Human Fertilisation and Embryology Authority, 2005a). Although the HFEA was not authorised either to invite proposals for reformulation of the existing legislation or to advocate itself for legislative change, it noted that the consultation provided further evidence of the controversial nature of Section 13(5) (Human Fertilisation and Embryology Authority, 2005b). Following the consultation, the HFEA revised its guidance to clinics with regard to taking account of the welfare of the child in the 7th edition of its *Code of Practice* (Human Fertilisation and Embryology Authority, 2007). Where a woman with no male partner sought services – and where provision of such services could result in the conception and birth of child who would, therefore, have no father - the revised guidance advised clinics to "assess the prospective mother's ability to meet the child's/children's needs and the ability of other persons within the family or social circle willing to share responsibility for those needs" (Human Fertilisation and Embryology Authority, 2007: G.3.3.3). The guidance further warned against unfair discrimination on the grounds of sexual orientation (Human Fertilisation and Embryology Authority, 2007: G.3.2.2). It could be argued, therefore, as indeed it has been, that Section 13(5) combined with the revised HFEA guidance, specifically *did not* discriminate against lesbians (Centre for Social Justice, 2008).

In the first stage of its promised review of the 1990 Act, the government initiated a public consultation that specifically asked whether: "... the requirement to take account of 'the need of the child for a father', as part of considering the welfare of the child, should be removed from the Act? Alternatively, do you think that it should

be replaced with ‘the need of the child for a father and a mother’? (Department of Health, 2005: 3.32). Submissions to the consultation variously advocated maintenance of the current provision, the entire removal of all reference to the child’s ‘need for a father’, and replacement of the reference to the ‘need for a father’ with alternatives, including use of less gender-specific terminology referring to ‘adequate’, ‘good enough’ or ‘high quality’ parenting rather than focussing on specific family structures or forms, and the addition of the need for a mother, as suggested by the government (People Science & Policy 2006: pp. 18-19). However, a number of responses considered that adding ‘...and for a mother’ was “superfluous” since “a child cannot be born without a mother...” (People Science & Policy 2006: pp. 18-19). Of the 505 responses to the consultation submitted, 103 only endorsed removal of the ‘need for a father’ requirement, and 208 supported its replacement with ‘the need for a father and a mother’.

As a follow-up to the consultation, the government published a White Paper in 2006 (Department of Health, 2006). Despite acknowledging that, on the basis of submissions to the consultation, “individual members of the public generally favoured retention of a reference to the child’s need for a father” (para 2.25), the government announced its intention to remove the requirement, taking account of recent legislation relating to civil partnerships, and its failure to be “convinced that the retention of this provision could be justified in terms of evidence of harm, particularly when weighed against the potential harms arising from the consequences of encouraging some women who wish to conceive to make private arrangements for insemination rather than use licensed treatment services” (para 2.26).

In 2007 the government produced draft legislation, the Human Tissue and Embryos (Draft) Bill 2007 that explicitly removed the requirement to take account of the child’s ‘need for a father’ (Department of Health, 2007, Clauses 21 and 59), and, in revising parenthood provisions, specifically allowed for two women to be regarded as the child’s parents (Clauses 48 and 49), although otherwise retaining the need to take account of the child’s welfare.

In line with recently introduced provisions for preliminary parliamentary scrutiny of legislation, the draft Bill was reviewed by a joint committee comprising members of the House of Lords and the House of Commons. Under examination, officials and the Minister articulated the government’s further thinking about removal of the need for a father requirement. According to a Department of Health official, the existing requirement was not seen as “achiev[ing] anything”; while it did not prevent single women or same-sex couples accessing services, neither did it “fit too comfortably” with the government’s wider policy on civil partnerships (House of Lords/House of

Commons, 2007, para 225). In endorsing these views, the then Minister, Caroline Flint MP, described the existing law as “illogical”, adding: “To be honest, we have a piece of legislation which says one thing in terms of legal entitlement and then has a caveat which is difficult to enforce in any coherent way. I am not sure if that is good law.” (House of Lords/House of Commons, 2007, para 226). As had occurred with evidence to the House of Commons Science and Technology Committee and responses to the HFEA and Department of Health consultations, those providing evidence were divided as regards their views on the need for a father provision (House of Lords/House of Commons, 2007, para 229). The Committee itself concluded that:

“a loving, supportive family network is more important for a child’s development than the gender of the second parent and we note the provisions on parenthood in the draft Bill in which a reference to a ‘father’ would no longer simply refer to a child’s male parent, but would also refer to a woman who is a child’s parent.... In an area such as this, the law has symbolic value. Ultimately, however, the issue is one of what is in the best interests of the child” (House of Lords/House of Commons, 2007, para 242),

recommending that:

“the current provision ... including the need of that child for a father” should be retained but in an amended form in a way that makes clear it is capable of being interpreted as the ‘need for a second parent’” (House of Lords/House of Commons, 2007, para 243).

In responding to the comments of the committee, the government redrafted its proposals for legislative reform. Its new child welfare requirement, that:

“a woman shall not be provided with treatment services unless account has been taken of the welfare of any child who may be born as a result of treatment (including the need of that child for supportive parenting), and of any other child who may be affected by the birth”,

thus side-stepping further controversy as to whether one or two parents are necessary to ensure the child’s welfare, withstood further challenges from lawmakers during its parliamentary passage and now stands as the revised Section 13(5) of the Human Fertilisation and Embryology Act 1990 (as amended by the Human Fertilisation and Embryology Act 2008).

In 2009, the Human Fertilisation and Embryology Authority revised its *Code of Practice* to take account of the legislative changes. In the revised *Code*, the HFEA reiterated its existing guidance that:

“Those seeking treatment are entitled to a fair assessment.... and the assessment must be done in a non-discriminatory way. In particular, patients should not be discriminated against on grounds of gender, race, disability, sexual orientation, religious belief or age” (Human Fertilisation and Embryology Authority, 2009: para 8.7),

and proposed a definition of “supportive parenting” as:

“a commitment to the health, well being and development of the child. It is presumed that all prospective parents will be supportive parents, in the absence of any reasonable cause for concern that any child who may be born, or any other child, may be at risk of significant harm or neglect. Where centres have concern as to whether this commitment exists, they may wish to take account of wider family and social networks within which the child will be raised” (Human Fertilisation and Embryology Authority, 2009: para 8.11).

Summary and Conclusions

Legislative review in the UK exposed key arguments in support both of abandoning and retaining the requirement to take account of a child’s ‘need for a father’.

Rationale for its removal included assertions that:

1. The provision is pointless since it does not prevent either single women or women in a same sex partnership from accessing services;
2. It is potentially discriminatory and inconsistent with recent anti-discrimination measures, such as arrangements for Civil Partnerships and changes in adoption legislation permitting homosexuals to adopt children;
3. It is anachronistic, since it does not reflect the reality of contemporary family life in the UK;
4. It is irrelevant, since what evidence indicates to be important for successful child rearing are security, and unconditional love – not the gender of a parent or particular family structures;
5. The fear – or reality – of being refused a service by clinics may encourage some lesbians to seek a donor through personal contacts or to travel to another country and thus fail to ensure for themselves and their child necessary health and legal protections;
6. The State should not interfere or legislate on what shall constitute a family.

On the other hand, proponents of retention of the 'need for a father' requirement argued that:

1. The provision exercises a symbolic role emphasising the importance of fathers in the life of children, and its removal "ignore[s] the contribution made by half of the human race towards the upbringing of the next generation" (Deech, 2007a);
2. There is little evidence that existing provisions have caused harm or have prevented single women or lesbian couples from receiving fertility services;
3. Removal is inconsistent with research and other Government policies emphasising the importance of fathers (e.g. recent proposals regarding the role of the Child Support Agency⁵);
4. Removal is inconsistent with the removal of sperm donor anonymity to allow donor-conceived persons to trace and identify their donor (House of Lords/House of Commons, 2007, para 229);
5. Removal simply defers to 'political correctness' (Deech, 2007b).

Lesbians' family-building aspirations well exemplify how a range of moral assumptions, beliefs, convictions and empirical evidence interact to fashion policies regarding access to fertility services. Revision of legislation in the UK appears to have endorsed contemporary prioritisation of evidence-based policy formulation. It will be of interest to see in which direction policies in other jurisdictions will follow.

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Table 1: Estimated number and percentage of lesbians receiving licensed fertility treatment in the UK

Year	IVF treatment cycles (and % of total IVF cycles) for lesbians registered after 1 April 1999	DI treatment cycles (and % of total DI cycles) for lesbians registered after 1 April 1999
1999	14 (0.1%)	284 (6.6%)
2000	36 (0.1%)	413 (6.7%)
2001	51 (0.2%)	541 (8.5%)
2002	90 (0.3%)	645 (9.7%)
2003	83 (0.2%)	712 (10.2%)
2004	98 (0.2%)	921 (13.7%)
2005	156 (0.4%)	788 (14.3%)
2006	197 (0.5%)	761 (20.1%)

(Source: HFEA, 2007: Table 29)

Table 2: Access to Medically Assisted Procreation services by women who are not married or who are not in a heterosexual relationship – Council of Europe member states (1998 and 2005)

Country	Is M-A.P available to an unmarried couple? (1998 ¹)	Is M-A.P available to an unmarried couple? (2005 ²)	Is M-A.P available to a woman who is not in a heterosexual relationship? (1998 ³)	Is M-A.P available to a woman who is not in a heterosexual relationship? (2005 ⁴)
Albania	Not included in survey	No information	Not included in survey	No information
Armenia	Not included in survey	No information	Not included in survey	No information
Austria	Y	N	Y	N
Azerbaijan	Not included in survey	N	Not included in survey	Y
Belgium	Not regulated	Y	Y	Y
Bosnia and Herzegovina	Not included in survey	No information	Not regulated	No information
Bulgaria	No information	No information	Not included in survey	No information
Croatia	Not included in survey	N	No information	No information
Cyprus	N	N	Not included in survey	N
Czech Rep	N	N	N	N
Denmark	Y	N	N	N
Estonia	Y	N	Y	Y
Finland	Y	Y	N	Y
France	Y	N	N	N
Georgia	Not included in survey	DI to single women; IVF to heterosexual couples only. Proposed law extends eligibility to all MAPs to single women	Not included in survey	DI to single women; IVF to heterosexual couples only. Proposed law extends eligibility to all MAPs to single women
Germany	Y	N	No information	N
Greece	Y	Y	No information	Y
Hungary	Y	No information	No information	No information
Iceland	Y	N	N	N
Ireland	N	No information	N	No information
Italy	N	N	N	N
Latvia	Y	Y	Y	Y
Lichtenstein	Not regulated	Not included in survey	Not regulated	Not included in survey
Lithuania	Not regulated	N	Not regulated	N

Luxembourg	Not regulated	Y	Not regulated	Y
Malta	N	Not regulated	N	Not regulated
Netherlands	Y	Y	Y	Y
Norway	Y	N	N	N
Poland	N	N	N	N
Portugal	Not regulated	N	Not regulated	N
Romania	Not regulated	No information	Not regulated	No information
Russian Federation	No information	Y	Y	Y
San Marino	Not regulated	Not included in survey	Not regulated	Not included in survey
Serbia and Montenegro	Not included in survey	Y	Not included in survey	N
Slovakia	Y	N	N	N
Slovenia	Y	N	N	N
Spain	Y	N	Y	Y
Sweden	Y	N	N	N
Switzerland	Y	N	N	N
FYROM*	Not included in survey	N	Not included in survey	N
Turkey	N	N	N	N
Ukraine	Not regulated	Y	Not regulated	Y
United Kingdom	Y	Y	Y	Y
Total Y	18	9	8	12
Total N	7	22	15	19

* Former Yugoslavian Republic of Macedonia

1 Question asked in 1998: "Is M-A.P available to an unmarried couple?"

2 Question asked in 2005: "Is access to M-A.P restricted to heterosexual couples?"

3 Question asked in 1998: "Is M-A.P available to a woman who is not in a heterosexual relationship?"

4 Question asked in 2005: "Is access to M-A.P possible for women not living in a heterosexual couple?"

(Sources: Council of Europe, 1998; 2005)