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## Reproducing Oppression: A Discourse Analysis of OFP Funding for IVF Through the Lens of Reproductive Justice

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# **Reproducing Oppression: A Discourse Analysis of OFP Funding for IVF Through the Lens of Reproductive Justice**

Major Research Paper

By Kirandeep Randhawa

Completed in partial fulfillment for the Master of Arts in Social Justice and Community

Engagement at Wilfrid Laurier University

Dr. Rebecca Godderis, Dr. Vanessa Oliver

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## **Abstract**

Canada has long been viewed as a beacon of progressive universal healthcare. However, a closer look into reproductive healthcare services at the provincial level reveals some services are not as accessible as they are portrayed to be. The existing literature demonstrates the ways in which the bodily autonomy of marginalized groups has been restricted through reproductive oppression, as well as how the discourses surrounding infertility have influenced health policy. Using Reproductive Justice (RJ) theory, this research contributes to this literature by examining what discourses are employed in relation to the Ontario Fertility Program (OFP) funding model for IVF in the province, and the implications of these discourses for the accessibility of reproductive health care services in Ontario. The OFP is a government-run program that funds IVF treatment in the province.

The primary question this research sought to address is as follows: Through the lens of reproductive justice, who does the state support in becoming parents via in vitro fertilization? To answer this question, a critical discourse analysis informed by Foucauldian and feminist methodological approaches was conducted on a foundational report on infertility and IVF in Ontario and current OFP policy documents. The themes that emerged from this analysis were: (1) the use of gendered language and (2) IVF policy shifting accountability for services away from the Ontario government. In terms of the first theme, this discourse analysis finds that the foundational report used to inform Ontario's IVF policy viewed fertility services as a means to achieve the goal of building a family through conceiving children with government assistance. The lack of gender-inclusive language and conflation of sex and gender in the report resulted in the erasure of those outside the gender binary as well as reinforced gendered assumptions that bodies assigned female are passive towards their fertility. This culminated in the report emphasizing the

need for women to “protect” their fertility from the dangers of infertility, and the need for the state to fund IVF for the betterment of Ontarians.

The second theme focuses on shifting accountability. Within various documents that communicated how OFP funding and IVF delivery operate, this study finds that the Ontario government presented the OFP as a progressive government-run, state sponsored program that is similar to other forms of healthcare in the province. However, documents about the IVF program were often unclear regarding how IVF funding actually operates, which includes a significant reliance on private fertility clinics, creating the impression that the funding for fertility treatment was being increased through OHIP rather than a separate program known as the OFP. The use of language within these documents also emphasized the government’s contributions to the OFP and allowed it to present itself as progressive for increasing support for fertility services while obfuscating how and how much support is provided. The lack of clarity within these documents is significant because it plays into assumptions that IVF is covered under universal healthcare. In actuality, fertility clinics must deliver IVF services while not having to meet the standards set by the Canada Health Act (CHA).

This paper concludes with a discussion on IVF and the right to have a child, and employs the principles of RJ to further interrogate how OFP funding actually restricts the right to have a child for those seeking to get pregnant through assisted reproduction rather than fully supporting it. The report used to inform IVF policy in Ontario also used a singular view of identity that did not take into account the barriers to IVF for those with intersecting identities. As a result, the OFP was not designed with these considerations in mind, and therefore, primarily supports white, cisgender, heterosexual couples with financial privilege in becoming parents through IVF.

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self love cannot flourish in isolation - bell hooks

## **Introduction**

Canada's healthcare system and the rhetoric surrounding it create an image of a utopian nation where all citizens have their healthcare needs met, without cost, prejudice, or hardship. A closer look into Canadian healthcare policy and its discourse demonstrates that not all health services are adequately funded by the public healthcare system funding leading to inequities. Thus, health inequity is inherently a systemic social justice issue because it results from the uneven distribution of resources at the hands of the state.

Explaining how inequities are produced first requires a brief overview of Canada's healthcare system. The passing of the Canada Health Act (1984) (CHA) established the conditions that provinces and territories must meet in order to receive federal funding to support the running of the healthcare system and called for all medically necessary services to be funded without direct charge to recipients (Government of Canada, 2019). The five criteria for health services under the CHA are: universality, which means provincial/territorial health insurance plans must be provided to all Canadians; comprehensiveness, which means all medically necessary services must be covered under provincial/territorial health insurance plans; accessibility, which states barriers to publicly funded health services should be eliminated when possible; portability, which means public health services must be available to all Canadians in and out of their home province; And lastly, public administration requires provincial/territorial health care to be run by a public agency for no profit (Government of Canada, 2019).

Provinces are expected to administer medically necessary services through provincial/territorial health insurance plans, even though what is considered medically necessary was never defined in the legislation (Government of Canada, 2019). Thus, what healthcare costs are covered because they are deemed “medically necessary,” and to what extent those services are

covered, are defined by provincial governments. The consequence of this legislative framework is that healthcare coverage can vary across the country and cause discrepancies in accessibility.

Canada is considered to have a universal healthcare system. It is notably different from the healthcare systems of its two most similar Western nations: The United Kingdom and the United States. For instance, in the US, individuals fund their own health care insurance through their employers or out of pocket (Starfield, 2010). According to Starfield (2010), while there are some government health insurance programs available for those who qualify, Medicare (for older adults) and Medicaid (for those with low income), the US does not have public health insurance available for all citizens (Starfield, 2010). Conversely, the UK has a universal healthcare system that provides healthcare for all that is free at the point of delivery (Grosios, Gahan, and Burbidge, 2010). This approach is similar to the payment setup of the Canadian healthcare system. However, a key difference is that in the UK, the government owns hospitals and employs healthcare workers directly whereas in Canada, those in the health sector are privately employed and doctors practice independently and then meet insurance requirements for reimbursement from the government (Grosios et al, 2010).

As shown, there is variety between healthcare systems even across comparable nations. and this creates its own unique inequities between and among countries. These differences in healthcare systems are important to analyze as the institutional design of a system can provide insight into the inequity seen in healthcare access. For instance, because universal healthcare systems rely on government funding for healthcare, politicians establish funding priorities. A lack of investment in certain healthcare services warrants a closer look as to why governments have chosen to put their funding elsewhere, and which populations are the most impacted.

To further explore inequities in the healthcare system, this research focuses on the program that funds IVF, the Ontario Fertility Program (OFP), as well as its relationship to the Ontario government-run health insurance plan, the Ontario Health Insurance Plan (OHIP). According to Ontario's Ministry of Health (2022), and required by the Canada Health Act, OHIP is the government-funded health insurance plan that pays for basic medical and emergency services deemed necessary for medical reasons for the residents of Ontario. Although fertility services are related to healthcare, financial support for fertility services in Ontario are outside of OHIP and instead this assistance is provided through the OFP, which is funded by the Ontario government but remains separate from OHIP funding which means that this program is not subject to the principles outlined in the CHA (Izenberg, Buchanan, and Iroanyah, 2019).

To qualify for OHIP, you must reside in Ontario and those new to the province must wait 3 months before OHIP will cover their medical costs (Ontario Ministry of Health, 2022). If residents want to utilize fertility support under the OFP, they must possess a valid Ontario health card, which means that by default the 3-month waiting period for people new to Ontario also applies to the OFP (Ontario Ministry of Health, 2022).

The reality of receiving health services often does not align with approved policies, especially in the case of specialized health services (such as fertility services) not widely utilized by the general population. In the case of specialized health services, vulnerable people run the risk of being made invisible if governments do not consider their care a priority. Meaning, vulnerable populations looking to receive specialized health services can face additional barriers to receiving the care they are entitled to under federal and provincial health policies. For instance, a study on Indigenous mothers' experiences with acute care for their infants in Ontario found this group encounters barriers to accessing specialized inpatient hospital care due to intersecting causes such

as high uninsured costs for children's care, long wait times, as well as racism and discrimination from healthcare providers (Wright, Jack, Ballantyne, Gabel, Bomberry, & Wahoush, 2019). This has resulted in Indigenous infants experiencing higher rates of mortality and hospital admissions than their non-Indigenous counterparts (Wright et al, 2019).

Newcomers, young adults and women in small rural, Northern and Indigenous communities have also been identified as facing barriers to specialized reproductive health services in Canada (Hulme, Dunn, Guilbert, Soon, & Norman, 2015). Reproductive healthcare refers to matters relating to the reproductive system and its functions, including birth control, pregnancy, and family making (Action Canada SHR, 2022). It can involve a broad array of services such as maternal and newborn care, access to contraception, and fertility treatments, such as IVF (Action Canada SHR, 2022). In 2015, interviews with samples from the above-mentioned populations across Quebec, Prairies, and Maritimes provinces revealed that not having access to a primary care provider acted as a significant barrier to contraception (Hulme et al, 2015). Thus, these groups faced inadequate family planning counselling from physicians who lacked the time and resources to consult on matters related to birth control (Hulme et al, 2015). In addition, it was found that geographical barriers and the lack of service providers in rural, northern and Indigenous communities also meant these communities have limited choices in healthcare providers for reproductive health services (Hulme et al, 2015). Therefore, gaps in specialized healthcare access are prevalent especially among marginalized populations across Canada.

This study focuses on a specific type of specialized reproductive healthcare service: in-vitro fertilization (IVF). IVF is an assisted reproductive technology (ART). ART is defined as medical procedures or treatments used to address infertility (Luna and Luker, 2013) and IVF specifically is the process of manually fertilizing eggs with sperm and transferring the embryo into

a uterus (Ministry of Health, 2021). The process consists of the surgical retrieval of eggs or the use of donor eggs, which are then combined with sperm (which can also be from a donor), and then lastly, are implanted into the person carrying the baby (Cranston-Reimer, 2019).

Some reproductive healthcare services are covered under OHIP, including obstetrician services, medical or surgical abortions, and any other similar procedures deemed to be medically necessary (Ontario Ministry of Health, 2017). However, not all reproductive services are covered under the provincial health insurance plan. Contraception, such as oral birth control, and intrauterine devices (IUD) are not covered by OHIP and so they must be paid for out of pocket or through private insurance (CBC News, 2022). According to CBC News (2022), a single IUD can cost upwards of \$350. This points to the inequities that can arise in the Canadian model of “universal” healthcare when not every aspect of healthcare services is covered under provincial health insurance. This example also highlights how decisions about what is not deemed “medically necessary” can disproportionately impact specific populations—in this instance the lack of coverage for contraception would disproportionately impact people who can become pregnant.

With respect to IVF funding, currently, only four provinces in Canada offer financial assistance for the procedure (Government of Canada, 2013a). According to the Canadian government, Ontario is the only province to cover some expenses for IVF procedures upfront rather than offering a tax credit. This occurs through the Ontario Fertility Program (OFP). In 2015, Ontario delisted IVF from OHIP and created the OFP in its place (Izenberg, Buchanan, and Iroanyah, 2019). The OFP provides public funding for one IVF treatment cycle per patient per their lifetime (Ontario Ministry of Health, 2021). While paying for a complete cycle may appear to reduce barriers to accessing IVF, authors Lanes, Meng, and Johnson (2019) of the Canadian Fertility & Andrology Society report the average pregnancy rate for the first attempt at IVF for

those under 35 is less than half (44%). This number further decreases as a person gets older until finally depleting to a 12 percent success rate for first attempt at IVF past the age of 42 (Lanes, Meng, and Johnson, 2019). Thus, to be successful, IVF often requires multiple treatment cycles, and any subsequent IVF cycles must be paid for out of pocket by the patient. In addition, The Ontario Ministry of Health (2021) states that neither OFP nor OHIP covers any fertility drugs needed to help produce viable eggs for IVF, which can amount to \$5,000 per IVF cycle. Moreover, the provincial funding does not cover any additional expenses that are often required, such as genetic testing, which is needed to test for genetic conditions before embryos are transferred to the uterus. If any condition is found, the embryo is usually not transferred (Government of Canada, 2013b). Finally, the storage of sperm, eggs, and/or embryos is also not covered under either program (Ontario Ministry of Health, 2021). Proper storage is needed to preserve the viability of sperm, eggs, and/or embryos in order to be used during the implementation process, as well as preserved for later use (Elder and Dale, 2020).

The consequences of low public funding for IVF are that individuals who want to access these services will not be able to obtain them if they cannot afford the cost of the fertility drugs, any additional services that are required such as genetic testing, and any additional treatment cycles after the initial cycle that may be required for the procedure to be successful. This research aims to examine further what discourses are employed in relation to this OFP funding model for IVF and the implications of these discourses for the accessibility of reproductive health care services in Ontario. This discursive exploration of government funding is informed by the principles of Reproductive Justice (RJ) theory to interrogate how the OFP funding restricts the bodily autonomy of those with experiences of infertility and/or seeking to get pregnant through assisted reproduction. The key tenets of RJ and discourse analysis will be discussed in more detail below.

## Language Use

This paper is mindful of the importance of linguistic inclusion within written texts about reproduction. Linguistic inclusion is crucial within this work because when a range of identities are not reflected within our language, the experiences of those communities are invalidated. Scholarly literature discussing gender as it relates to health commonly employs a gender binary, where people are classified as only being either male or female/men or women. For instance, the idea of cisnormativity (the assumption that one's sex assigned at birth will always align with their gender identity) has been put forward to describe how cisgender bodies have historically been privileged and naturalized in healthcare settings, and as a result, non-cisgender bodies have been systematically erased from healthcare research (Frohard-Dourlent, Dobson, Clark, Doull, and Saewyc, 2017). The consequences of such exclusion is the harm of further stigmatization of non-cisgender bodies (Frohard-Dourlent et al, 2017). In order to improve the material conditions for those outside the gender binary, their experiences must be incorporated into research and validated through inclusion (Frohard-Dourlent et al, 2017). Therefore, this paper ensures that “marginalized, non-binary individuals are represented in research so that their unique challenges can be better understood and addressed” (Frohard-Dourlent et al, 2017, p.5).

This research will not continue the erasure of transgender people, non-binary folks, and anyone who falls outside the gender binary within discussions about infertility and RJ. Therefore, my voice and analysis will use the language of “childbearing bodies” and “bodies that reproduce” and similar gender neutral terminology to discuss all people who are impacted by reproductive healthcare policy, infertility, and RJ. This is done so that my language reflects “a range of gender identities and the diversity of people's lived experiences” (Ross and Solinger, 2017, p.6).

Gendered language such as “woman” will be used when it is the specific terminology employed by previous authors of academic literature, legislation, and other texts included in my discourse analysis. The purpose of using a combination of gendered and non-gendered language is to highlight and confront the unquestioned use of gendered language that relies on a binary which is deeply embedded within healthcare policy and society as a whole. As a result, I aim to use my discourse analysis to interrogate the use of gendered language as it relates to academic literature, reproductive health services, and health policy.

Similar to the approach taken in relation to gender identity, I will be using gender-neutral terms such as “parent” and “parenthood” to describe caring for children in my own voice and analysis. However, I will be using gendered terms like “mother” and “women” when referencing academic literature and past legislation to mirror the language used by lawmakers and researchers.

## **Literature Review**

### *Reproductive Oppression*

The literature on bodily autonomy has focused heavily on how state actors place restrictions on bodies that reproduce. Specifically, reproductive oppression—defined as the regulation and exploitation of bodies, sexuality, labor, and procreation as a means to control individuals and communities—is a prevalent theme within the academic literature about reproductive health services (Hayes, Sufrin, and Perritt, 2020). Academic literature shows that reproductive oppression has manifested both within reproductive health services and in their absence.

Michelle W. Tam (2021) argues that reproductive oppression occurs as the result of violence at the hands of the state towards Black, Indigenous and people of color (BIPOC) communities in Canada. For instance, reproductive control through ART has resulted in purposeful

attempts to lower the birth rates in BIPOC communities as they were seen as a threat to the majority white population (Tam, 2021). In one such example given by the author, in 2017, an Indigenous woman in Saskatchewan launched a lawsuit after experiencing coerced and forced sterilization in Canada. As Tam (2021) states, this lawsuit allowed others to come forward, and as a result, from 2015 to 2019, over 100 Indigenous women from six provinces and two territories reported experiences of forced sterilization. Additionally, these violations expanded beyond Indigenous women. In 2019, Canada's Standing Senate Committee on Human Rights found evidence that coerced and forced sterilization was committed on other vulnerable populations such as trans people, women and girls with disabilities, and Black women (Tam, 2021). Thereby, as the author argues, these attacks on bodies by the state are rooted in racism, transphobia, and ableism (Tam, 2021).

Discourses about bodies that reproduce have also been used to uphold white nationalist ideas that advocate for more restrictive immigration and reproductive policies. For example, Franklin and Ginsburg showcase European discourse that uses white reproduction as a "solution" to immigrants entering local white European communities (Franklin and Ginsburg, 2019). In one instance the authors state that an advertisement in Germany from the populist-nationalist party *Alternative für Deutschland* used images of a smiling white pregnant woman along with anti-immigrant sentiments. The advertisement read "New Germans? We can make them ourselves," (Franklin and Ginsberg, 2019, p.5), and the image is juxtaposed with a statement that those immigrating to Germany are lesser than those born from those like the white woman shown in the advertisement. Franklin and Ginsburg (2019) go on to say this was done to advocate against racialized migrants entering the country, in addition to reinforcing gender roles around female domesticity.

These authors also argue that the material consequences of anti-immigrant discourse coupled with reproduction can also be seen in former U.S president Trump's support for the anti-abortion movement that resulted in a policy to exclude Planned Parenthood facilities from Medicaid programs. As Franklin and Ginsburg (2019) showcase, the result is that abortions are less accessible to racialized and low-income communities. Thus, similar to what Tam (2021) observed, reproductive oppression from the state has greatly impacted BIPOC communities in particular. Thereby, once again linking marginalized communities and reproductive oppression.

Reproductive oppression is also seen in the policies created to "treat" infertility and, thus, who is supported in becoming a parent. The gatekeeping of reproductive technology as a means to control communities can be seen in who is "allowed" to use IVF services. In one such study, Luna and Luker (2013) use an RJ lens to analyze how, in America, marginalized populations are blocked from using fertility services in contrast to more privileged communities. Through examining the histories of the reproductive health, reproductive rights, and reproductive justice movements in America, the authors found that infertility treatment is more often advertised to white and affluent couples as a way to reproduce. Thus, reproductive racism is seen through white, wealthy, heterosexual couples being constructed as the ideal people to use fertility treatments by the healthcare system because they did not face scrutiny from the state about whether reproducing would place a burden on society (Luna and Luker, 2013). This construction is seen in the lack of institutional barriers for white, wealthy, heterosexual couples in using fertility services.

However, this privileging does not extend to low-income and people of color who are often denied the right to have a child through an RJ lens because they face additional barriers to receiving a diagnosis and treatment for infertility (Luna and Luker, 2013). Even if they are successful, low-income and BIPOC patients face doubts by government institutions if it is their right to access

fertility treatment for the child's wellbeing (Luna and Luker. 2013). For instance, Luna and Luker (2013) found women who use government insurance to access ART face scrutiny from society and the state. As a result, Luna and Luker (2013) conclude that they faced questions "about their right to do so and represented as bad mothers whose actions require legal sanction" (p.340). In one example of a woman using ART being labeled as a bad mother, the authors detail how a mother who became pregnant with octuplets through IVF that she obtained while unemployed led to calls for regulation for ART because she was viewed by the public as "unfit" to reproduce (Luna and Luker, 2013). Thus, this literature showcases there is an "ideal" body and social circumstance to be infertile, require IVF, and be a parent.

The consequence of this discourse is a lack of bodily autonomy at the hands of the medical system for some bodies that reproduce at the hands of the medical system, but not for others. The influence of discourse on bodily autonomy and parenthood is similarly seen in a non-North American context through the construction of children conceived via IVF as "monsters" in Poland (Radkowska-Walkowicz, 2012). Radkowska-Walkowicz (2012) explains that right-wing politicians and the Catholic church have utilized negative discourse as a means to criminalize and prohibit IVF in Poland. Specifically, children are portrayed as having the characteristics of "monsters" due to claims by opponents that IVF increases the risk of being born with "deformities" as it is seen as posing a risk to the social order (p.33). By extension, those who seek IVF are contributing to the destruction of society. As Radkowska-Walkowicz (2012) argues, this creates justification for restricting IVF out of concern for children's wellbeing and emphasizes the lives of the fetus over the person who is carrying the fetus. Thus, childbearing bodies are surrounded by discourse regarding the "risks" they can pose to offspring and this acts as a means to justify the state restricting choice.

Reproductive control and regulation over bodies are not just found in the state's actions but also in the state's inaction to provide services for all, leading to privatized ART services. As explained by Tam (2021), private fertility clinics in Canada have catered to heterosexual married couples that face "infertile/low fertility" while excluding marginalized groups, such as 2SLGBTQIA+ people (Tam, 2021, p.3). This is especially significant in the case of IVF and state funding because most fertility clinics in Ontario are privatized (Tam, 2021). Meaning, those who can afford to pay out of pocket for IVF services are able to stay on the waitlists to use publicly funded services, while also being able to skip the line through using private fertility services. Therefore, there is an inequitable distribution of public funding for IVF when more privileged groups are able to reap the benefits of both public and private healthcare services, while less privileged groups do not have access to either due to long waitlists for public services and inability to afford services out of pocket (Tam, 2021). The structure of the OFP is a direct factor to this inequity because The Ministry of Health and Long-Term care did not create "guidelines or principles of prioritization for fertility clinics to distribute resources" (Tam, 2021, p.3). Thus, Tam (2021) states this creates a hierarchy where the reproductive needs of privileged heterosexual married couples are centred over those of marginalized groups.

Additionally, the lack of state-collected information on the accessibility and use of public fertility services for racialized, low-income, 2SLGBTQIA+ people in Canada further indicates that bodies of dominant white wealthy, heterosexual couples are privileged (Tam, 2021). This is because the research on fertility clinics is primarily conducted on the experiences of "white, cisgender, heterosexual couples with socioeconomic privilege" (Tam, 2021, p.4). Meaning, the experiences of marginalized populations' access to such services are rarely explored, and thus, issues they encounter are not addressed (Tam, 2021). The intersections of race and income also

highly impact whose experiences are researched as the author states the rare research study conducted on 2SLGBTQIA+ people's reproductive services access is focused on white, cisgender queer women with high incomes (Tam, 2021). Thereby further ignoring the experiences of other marginalized groups' access to IVF and allowing the inequalities they face to go unnoticed. Thus, as Tam argues, the state's lack of research and action ultimately upholds wealthy, white, cisgender couples' access to ART while limiting the access of other bodies that reproduce (Tam, 2021).

Themes of centering whiteness in IVF continue within Cranston-Reimer's (2019) article on Ontario's IVF program feigning progressiveness for its inclusion of 2SLGBTQIA+ people while facilitating homonationalist white reproduction over marginalized communities. According to the author, the exclusion is seen in how the program does not support the additional cost, time, and pain caused by IVF that less privileged groups cannot afford to shoulder. For instance, additional costs include the ability to take time off work in order to attend multiple doctors appointments for fertility treatment, as well as the ability to travel to fertility clinics that are predominately in large urban areas and cities (Cranston-Reimer, 2019). Because the program does not cover such expenses, access to fertility treatment remains limited to those with high incomes. The author goes on to explain the state's narrow inclusion of queer people when saying "Though the program does not target queer people exclusively, explicitly including LGBTQ+ people certainly signals an openness to (some) queer people that is new in reproductive medicine (Cranston-Reimer, 2019, p.77). Thus, while the program presents itself as being progressive through its promotion of 2SLGBTQIA+ people using IVF, this inclusion is mostly limited to those who are white, queer, and with high incomes. The program is thereby homonationalist because it facilitates the procreation of queer white people who can afford to take on the additional costs associated with IVF treatment, while denying many racialized and other historically marginalized

groups the same opportunity by not removing the specific barriers they face to receiving IVF (Cranston-Reimer, 2019). Both Cranston-Reimer's (2019) and Tam's (2021) articles dovetail to showcase how the construction of infertility and who can access IVF privileges white couples over other marginalized communities.

In sum, the literature about reproductive oppression tends to center American and European contexts as sites where reproductive oppression occurs. For instance, Franklin and Ginsburg (2019) explored reproductive oppression and the material consequence of discourse as it pertains to politicians in the United States and Germany. Furthermore, Luna and Luker (2013) illustrate the medicalization and state surveillance of childbearing bodies and the construction of what a mother “should” be. With the exception of Tam (2021) and Cranston-Reimer (2019), access to IVF in Canada was rarely analyzed in relation to the specific language of policy itself impacting access to health services. Thus, my exploration of IVF policy and how the state constructs parenthood through access to IVF will begin to fill the knowledge gap of IVF and discourse created by the language of policy in the Ontario context.

### *Reproductive Justice*

Reproductive Justice (RJ) is a theoretical framework rooted in the belief that systemic oppression and inequality shape marginalized bodies' decision-making and autonomy over childbearing and parenting (Ross, 2017). The guiding claim of this framework is that “all fertile persons and persons who reproduce and become parents require a safe and dignified context for these most fundamental human experiences” (Ross and Solinger, 2017, p.9). As Ross and Solinger (2017) detail, the three core principles of RJ include: the right to have a child by choice, the right not to have a child, and the right to parent children in environments free from state or individual violence. Additionally, RJ also believes in making these principles a reality through successful

fertility management, childbirth, and parenting through community-based resources such as accessible health care, affordable housing, education, economical equity, as well as social safety nets (Ross and Solinger, 2017).

Aligned with using an RJ frame to examine infertility, Ross and Solinger (2017) detail the right to have children, RJ in the American context, and how its goals differentiate from those associated with second wave, pro-choice feminism. For instance, an RJ framework prioritizes the social contexts that impact individuals' lives and reproductive health care rather than advocating broadly for legal rights through the judicial system. In the text, the authors point to the example of the legalization of contraception for married couples in 1965 (Ross and Solinger, 2017). The authors go on to state that those who could afford to have family doctors could now legally access birth control without government interference. However, this decision had little to no impact on BIPOC and low-income communities that have faced racist population-control measures preventing them from obtaining any reproductive health services in the first place (Ross and Solinger, 2017). In other words, white feminists advocating for choice did little for those who were given no choice in the first place in terms of how to dictate their fertility (Ross and Solinger, 2017).

In contrast, RJ calls for “the network of opportunities, support, and services that would allow all women to meaningfully exercise the abortion right in a context that supports reproductive health, economic justice, motherhood, and the well-being and safety of individuals and their communities (Ross and Solinger, 2017, p.122). Furthermore, the authors state that white feminists’ commitment to choice does not guarantee true access to reproductive rights and the right to have children and keep them safe amidst sexism, racism, economic injustice, and xenophobia in society (Ross and Solinger, 2017). Thus the fight for access to abortion does not address all of the different injustices people face in relation to reproduction.

There is diverse literature that incorporates RJ principles, including works that understand the principles of RJ as a lens to understand reproductive oppression and provide solutions. As with RJ theory itself, the literature aims to go beyond an individualist framework that focuses on an individual's right to choose with respect to abortion and contraception and moves towards highlighting structural causes of oppression faced by bodies that reproduce.

For instance, Perritt and Eugene (2021) discuss IVF and infertility as an underrepresented reproductive justice issue. In this article, the authors begin by detailing how popular discourse regarding reproductive health and rights in the United States has been dominated by narratives about the rights of contraception and abortion care, over the right to infertility treatment access. This is especially damaging given the socioeconomic and racial disparities present within IVF access as they go on to explain that BIPOC women have seen higher rates of infertility but lower rates of access. Perhaps unsurprisingly given the cost of IVF treatment, individuals of middle to lower socioeconomic status are underrepresented in seeking infertility services, but as the authors explain, BIPOC women also experience higher rates of infertility.

It is noted that Black women are only half as likely to be evaluated and treated for infertility as their white counterparts. Perritt and Eugene (2021) also look at issues beyond the barriers to receiving an infertility diagnosis and explore the hindrances to evaluation and treatment as the result of high costs, along with inadequate insurance coverage. Furthermore, this aspect of infertility is also intertwined with race and income as BIPOC and low-income people who rely on US government insurance face additional barriers to treatments such as IVF. These factors create a disparity between those who can and cannot receive the reproductive services they desire.

An RJ lens has been applied to reproductive healthcare in a Canadian context as seen through a study conducted by LaMarre, Rice, Cook, and Friedman (2020) on the experiences of

people in larger bodies seeking fertility and/or pregnancy care. LaMarre et al (2020) state sizeism and fatphobia are relevant to IVF policies due to growing calls to deny services to those with larger bodies in Canada on the grounds of protecting the well-being of the fetus, as well as skepticism about their suitability to be parents. The RJ framework is explicitly utilized to explore how weight stigma and bias has impacted the “physical, mental, spiritual, political, social, and economic well-being of fat women and trans people in (and beyond) reproductive care settings” (LaMarre et al, 2020, p.3). Thereby using RJ to illustrate how individuals within a healthcare setting facilitate such harm and how this stigma intersects with other systems of oppression.

More specifically, the authors found that fatphobic rhetoric regarding IVF within policy discussions had materialized in access to fertility care and debates about who is “fit” to receive such services, and by extension, be a parent (LaMarre et al, 2020, p.6). Through interviews with 17 participants who had been labelled obese while seeking reproductive healthcare related to fertility and/or pregnancy, they spoke about their experiences being controlled and treated poorly by healthcare providers because of their body size. One participant (Pamela) recounts seeking fertility treatment, but because of her weight, she was made to undergo unnecessary testing and procedures by doctors based on medical assumptions about her body size and if she was “healthy” enough for fertility treatment (LaMarre et al, 2020). This experience was shared by other participants and led them to encounter feelings of blame for trying to reproduce while having larger bodies, even when they had no medical issues (LaMarre et al, 2020). LaMarre et al (2020) concluded that because of assumptions about fertility and body size, participants commonly felt the need to “prove” they were healthy to service providers via unnecessary medical testing. Therefore the authors provide an RJ lens toward reproductive health services that showcase how

attitudes surrounding those with larger bodies have been entrenched within the medical system and impeded their access to fertility treatment.

Paynter's (2022) book *Abortion to Abolition: Reproductive Health and Justice in Canada* documents the history of reproductive health in Canada and puts the principles of RJ in conversation with cases about the intersections of reproductive health and systems of oppression that threaten bodily autonomy. The section pertaining to IVF within the chapter "Having Children" begins by detailing how the fertility industry began to expand across Canada with no regulation until 1989 when the Federal government appointed the Royal Commission on New Reproductive Technologies to investigate the implications of these new reproductive technologies (Paynter, 2022). The chapter goes on to explain how in modern day, the use and demand for IVF has increased, as well as its costs. Fertility services have been regarded as a luxury rather than a medical service because almost all the costs of it are paid out of pocket and thus, it is viewed as the privatized solution to the "problem" of decreased fertility (Paynter, 2022). This high cost has meant IVF has yielded a white, wealthy, and heterosexual demographic who are privileged enough to afford such services (Paynter, 2022).

Furthermore, Paynter (2022) details how the barriers to IVF vary across Canada but are largely based on cost and proximity to a clinic. Through an RJ lens, while IVF is legal across the country, issues of access remain unaddressed. The lack of public funding for IVF has resulted in those from higher incomes being able to use the service for fertility issues while those unable to afford the \$10,000 to \$20,000 cost for a single round of IVF treatment have no access (Paynter, 2022). This has meant the advocacy around IVF in Canada has centered the "right to affordable treatment" (Paynter, 2022, p.92). Thus, IVF intersects with issues of economic inequality, as well as ageism, ableism, and LGBTQ discrimination (Paynter, 2022). Therefore, the author calls for the

growing demand for IVF to coincide with further conversations about nationwide cohesive coverage to make the service more accessible and “reduce unequal access to the right to have a family” (Paynter, 2022, p.92).

Overall, RJ theory and literature emphasize the historical and modern-day shortcomings of individually focused reproductive health care and advocacy. As Ross and Solinger (2017) emphasize, a litigious approach to reproductive rights often upholds the same harm it claims to relieve because it does not address the underlying material conditions that cause reproductive oppression in the first place. While Perritt and Eugene (2021) present IVF through an RJ framework, their work is focused on IVF within the American context, as is Ross and Solinger’s (2017) work on abortion and birth control. For instance, Perritt and Eugene (2021) highlight the cost of IVF across various states in the United States and limited access to services through government insurance as a barrier to receiving fertility care. Thus while the literature provides important case studies related to fertility and within an RJ framework, the authors were focused on the American context of IVF. Although the US and Canada share many similarities in terms of political culture, the differing histories and healthcare systems do not allow for one-to-one comparisons. LaMarre et al (2020) use an RJ lens in a Canadian context to explore access to reproductive health services, but their study consisted of a wide variety of services from infertility treatment to pregnancy care, as well as how those services are impacted by weight stigma. Their focus was on how this stigma was perpetrated by healthcare providers and not specifically how health policy can create this stigma. Additionally, Paynter (2022) deploys an RJ lens to IVF to put it in context with the right to have children. However, their approach views IVF from a nationwide standpoint and documents how these infertility services have developed since the Royal

Commission. Therefore, while they make mention of IVF in Ontario, their focus is primarily towards advocating for IVF access on a national level.

In contrast, my research aims to examine how the language of policy can contribute to the inaccessibility of IVF in the Ontario context. Thus, the focus of my analysis is on the language found in Ontario health policy rather than the experiences of a certain population.

### *Construction of Infertility & Assisted Reproductive Technology*

Social constructions of infertility and ART produce discourses that can have material consequences on those seeking fertility treatment. The definitions of words such as “infertility” provide insight into the discourse surrounding this medical procedure. In an international example, The World Health Organization defined clinical infertility as “a disease of the reproductive system defined by the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse” (Hall and Hanekom, 2019, p.168). This definition is significant because it frames infertility as “a disease,” which infers it must be treated or cured. Similarly, this definition also uses negative language by describing infertility as a “failure” to achieve a pregnancy within a finite amount of time thus contributing to a discourse where those unable to achieve pregnancy have “failed” to fulfill an expected outcome. In terms of discourse about parenthood and infertility, both examples demonstrate how this choice of language in the definition can contribute to discourse about those who are infertile failing to achieve what is expected of them due to a deficiency in their bodies. Additionally, the WHO also refers to infertility as a disability that requires healthcare under the Convention on the Rights of Persons with Disability (Hall and Hanekom, 2019). This indicates less of a sign of moral failing as seen in the social framing of infertility and leans more towards medicalizing infertility as a condition that requires treatment.

In the Canadian context, infertility has not been characterized as a disability but it is still heavily medicalized because it is seen as a medical condition that requires treatment. As seen in the WHO's definition, the medicalization of infertility frames it as an issue to be monitored and solved. Additionally, this monitoring is also seen in how infertility is defined when tracked and monitored by researchers. In one such paper researching the prevalence of infertility in Canada, women were categorized as infertile if they had unsuccessfully attempted to get pregnant while being exposed to "the risk of conception" (Bushnik, Cook, Yuzpe, Tough, and Collins 2012, p.738). The authors used three different definitions of "the risk of conception" when collecting data on infertile cisgender heterosexual couples attempting to conceive (Bushnik et al, 2012). Per this study, people were at the risk of conception if the couple: (i) "did not use any form of birth control within the past 12 months (ii) did not use any form of birth control within the past 12 months and reported having sexual intercourse in the past 12 months (iii) did not use any form of birth control within the past 12 months, reported having sexual intercourse in the past 12 months, and reported ever having tried to become pregnant with their current partner" (Bushnik et al, 2012, p.739). These definitions were arranged from the first one being the oldest used in previous studies to the last one being newer ones developed within recent years at the time of this study. What differentiates these definitions is they become more specific in their criteria, with the last definition including a couple's desire and efforts to get pregnant (Bushnik et al, 2012).

Thus, this demonstrates how definitions of infertility are malleable, even within medicine. Acknowledging this malleability is significant because it showcases that infertility is constructed by medicine and how it is "treated" as a health condition is subjective and can change depending on how it is informed by and informs the discourses surrounding it. This, in turn, impacts how it is researched and viewed by health institutions. Across the three differing definitions, infertility

rates were seen to have increased since the last time it was studied. Thereby the authors urge more research on the topic needs to be conducted (Bushnik et al, 2012).

Franklin (2013) similarly focuses on shifting definitions of infertility but explicitly explores the impact of IVF and how it has changed the ways reproduction and family are viewed. Due to the broader availability of ART, sexual reproduction can be perceived as occurring in at least two different ways: through nature or by technology that determines the course of biological action.

Along with new social norms, ART has brought new reproductive choices for individuals wanting to start families. The definitions of parenthood and family have shifted due to ART, as IVF has increased the prominence of what Franklin (2013) refers to as alternative family structures. The author classified various family structures, such as donor, step, transnational, multi-parental, same-sex, and cross-racial, as “alternatives” (Franklin, 2013, p. 7). Thus, IVF indicates a shift from biological-based discourse to loosening social conventions on what is accepted as a family (Franklin, 2013).

Different constructions of infertility have also manifested in policy discussions about whether IVF funding is medically necessary and therefore should receive government support. Cattapan (2020) details how IVF has become understood as a medically essential service in Ontario and thus became highly medicalized. Medicalization occurs when a problem is recognized as a medical issue and in this case, now requires state involvement through public funding (Cattapan, 2020).

Drawing on an analysis of policy documents from 1989 to 2015 and interviews with government actors, the Expert Panel on Infertility and Adoption, and lobbyists, Cattapan (2020) found that public funding for IVF was recognized as medically necessary by emphasizing

infertility as a medical condition, IVF's efficiency in treating infertility without putting financial strain on the province, and the immediate need for this service. Part of this occurred because the Expert Panel on Infertility and Adoption assembled to research public funding for IVF in 2009 reframed infertility as a pressing issue due to the assertion that infertility is on the rise and thus, needs to be treated (Cattapan, 2020). This discourse was supported by data used in the report provided by the Infertility Awareness Association of Canada (IAAC). The IAAC is a patient advocacy group that was also "deeply invested in the proliferation of funded infertility services" (p.71).

In addition to efficiency, Cattapan (2020) states that discourse around immediacy was also used to advocate for public funding through the claim that infertility was rapidly increasing in Ontario due to an outdated statistic that stated that 1 in 6 couples experience infertility. Despite, according to Cattapan (2020), this figure is based on outdated American data, the Expert Panel wrote both that "right now in Ontario, one in eight couples is struggling with infertility" and "one in six couples" experienced the same (p.72). Despite being different figures, both statistics aided in creating a sense of urgency and the immediate need for publicly funded IVF when they were repeated in press releases and media reports (Cattapan, 2020). As the author states on this framing of infertility as an increasing issue, "The rising incidence of infertility and its assumed prevalence have been articulated as important reasons why IVF should be funded in Ontario, insofar as the pressing demand necessitates supply: more and more people need care" (Cattapan, 2020, p.72). Advocates and the media repeated this figure of "1 in 6" to create more public support for IVF funding because this framing made infertility appear as a pressing issue that needed to be addressed through medical intervention (Cattapan, 2020). Additionally, this report also stated that funding

one cycle would reduce multiple births and save taxpayers \$400–550 million over time (Cattapan, 2020). Thereby further supporting advocacy and lobby efforts for publicly funded IVF.

The advocacy described above resulted in the Ontario government utilizing the framing of infertility as a disease to be treated through treatments in their new fertility program that funded one cycle of IVF in 2009. Additionally, they committed to expanding services to single and LGBTQ+ adults that may not experience medically indicated infertility, therefore, incorporating both medical and non-medical justifications for IVF as a publicly funded health service (Cattapan, 2020). These discourses contrasted previous definitions of infertility as solely a medical issue. Thus demonstrating, as Cattapan (2020) argues, the malleability of constructions of infertility. Especially when these constructions are strategically utilized for lobbying efforts, as was the case of justifying infertility treatment as a public health expense.

In direct contrast to this advocacy, McLeod (2017) makes the case for IVF as a medical non-necessity by stating the implications of public funding for it would portray the government as valuing assisted reproduction over adoption and childlessness. For instance, McLeod (2017) states that if the Ontario government claims that they believe all family structures are treated equally, then they should not subsidize IVF if they are also not going to fund private adoptions. As the author argues, the public funding of the former but not the latter indicates who is valued in society. While Cattapan (2020) demonstrated how discourse can influence government policy in support of public funding, McLeod (2017) argues public IVF funding will impact the discourse on parenthood and families, thus showcasing the various ways discourse is thought to be utilized within discussions of public funding for IVF in Ontario.

Izenberg, Buchanan, and Iroanyah (2019) provide more insight into funding for fertility services in the Ontario context. The article begins by providing context for the prevalence of

fertility services as starting from 2014 to 2019, there was a more than 30 percent increase in the number of IVF cycles in Canada, with 36 clinics initiating 33,092 cycles in 2017 alone (Izenberg et al, 2019). However, the demand for IVF does not meet what is allocated by the OFP, whose \$70 million annual budget only funds 5,000 cycles a year (Izenberg et al, 2019). Meaning, not all who seek a funded cycle of IVF through this program will receive it within that year.

The authors argue the OFP is inclusive to those with limited income in some aspects as it allows for all those eligible to receive a funded cycle of IVF. This is shown through the example of a couple who had spent more than \$35,000 on fertility services before the program and were able to successfully try once more through their funded cycle (Izenberg et al, 2019). However, for those with limited incomes and insurance, fertility services are still unattainable due to the cost of paying out of pocket ranging from \$10,000 and \$20,000 per cycle for additional IVF cycles, not including the cost of needed fertility drugs (Izenberg et al, 2019). Thus, IVF under the OFP has created issues for patients and providers alike who both have to deal with long waitlists due to the program's lack of funding to meet the demand.

The funding structure of the OFP reflects societal views of infertility and ART. Discussions about the construction of infertility impacting the funding structure of IVF in Ontario are seen within an article by Lapinsky (2022) that details how the OFP has allowed for a two-tiered healthcare system in the province. The article goes on to explain how before the OFP, OHIP provided funding for IVF for only those who had bilateral fallopian tube blockages. However, this resulted in a “human rights complaint against the government for discriminating against other medical conditions” (Lapinsky, 2022, para 3). Meaning, advocacy for expanding IVF funding was presented through a medical lens. However, the author argues that the view of infertility as a social issue rather than a medical condition resulted in IVF being delisted from OHIP. Infertility as a

social issue consists of it being related to issues regarding creating a family, parenting, and social safety nets for families (Lapinsky, 2022). Thus, infertility is tied to one's preference to have children rather than a medical issue that requires a medically necessary procedure (Lapinsky, 2022).

As the author states “These prevailing views of infertility as a social issue likely helped create a situation where ART was removed from provincial health insurance, and an alternative public funding source was created” (Lapinsky, 2022, para 3). This alternative funding source became the OFP and while in comparison to the limited funding from OHIP, the OFP offered more funding (one funded cycle per lifetime to all eligible), but it also created a two-tier system where IVF services are public and private (Lapinsky, 2022). The OFP creates a two-tier system because some aspects of IVF are covered by the government and simultaneously available to those who can pay for them through private providers. In other words, privatization is seen in privately funded IVF services that can be accessed whenever, while those using the publicly funded services through the OFP have to endure a waitlist that is on average, 12 months long to receive the same services (Lapinsky, 2022). Such extensive waitlists mean IVF is not always accessible within a timely manner. Additional private services are also seen in how clinics delivering fertility services can charge out of pocket expenses that are not OFP or OHIP-covered (Lapinsky, 2022).

Although public and private IVF services provide the same services, the accessibility of said services has been directly impacted by societal ideas of infertility as an individual problem rather than medically necessary. Thus, similar to Izenberg et al (2019), the author concludes the OFP has created a dual funding structure where IVF is both a public and private service because infertility is not viewed as a medical condition that should be included within OHIP.

In sum, authors such as Bushnik et al. (2012), Cattapan (2020), Franklin (2013), and Lapinsky (2022) demonstrate how IVF is seen from a medical and social lens. Lapinsky (2022), in particular, showcases how these lenses have material consequences through their impact on public funding for IVF within the Ontario context. Cattapan (2020) follows a similar line of inquiry on the discourses impacting the OFP, but does not narrow in on its specific funding structure as Lapinsky does. My research aims to contribute to this knowledge by further exploring the language used in Ontario health policy and how this language informs discourse about infertile bodies.

### *Conclusions and Ways Forward*

In sum, this literature review showcases the various ways the construction of infertility and the treatment of infertility through IVF impacts bodies that reproduce. The impacts of these constructions are seen in how they influence health policy. For instance, Cattapan (2020) and Lapinsky (2022) demonstrated how such constructs of infertility impact health policy through the case of discourses around medically necessary services that lobbied the Ontario government to enact policy that publicly funded one round of IVF. In both cases, how the state viewed infertility had a direct impact on the extent to which fertility services were accessible to all seeking these services.

Additionally, this literature review has also shown constructions of infertility have material consequences that produce harm towards marginalized bodies. As a result, the theme of reproductive oppression is present within the state itself both directly and indirectly. Directly, the state has enacted violence against BIPOC communities as seen in the example of the forced sterilization of Indigenous women (Tam, 2021). Indirectly, fertility treatment has been denied to low-income, queer, and BIPOC communities in favor of serving white, wealthy populations. For instance, Cranston-Reimer (2019) showcases this reality in Ontario. Failing to provide additional

funding for cycles of IVF has resulted in BIPOC populations being excluded from Ontario's IVF program, while the government also positions itself as including marginalized populations through its inclusion of 2SLGBTQIA+ people.

As both constructions of infertility and reproductive oppression have shown, the state can be the perpetrator of harm towards marginalized bodies that reproduce, and thus, this perspective is important to incorporate into an analysis regarding the accessibility of IVF and how the state can facilitate its inaccessibility. While reproductive rights provide a framework to evaluate the state's actions and discourse, this literature is limited to managing fertility through abortion and birth control (Ross and Solinger, 2017). RJ can provide a more nuanced exploration of the discourses that inform reproductive health services by illuminating the various causes and effects that have historically impacted marginalized communities from having full autonomy over their fertility.

While some authors featured in this literature review have studied how the discourse surrounding IVF has affected its accessibility, as well as literature that has used an RJ lens to examine reproductive health services, in general, an RJ lens has not been widely adopted to examine how the language of policy has impacted IVF access.

For example, although Cranston-Reimer (2019) references RJ scholars, such as Dorothy Roberts, when discussing the historical marginalization of BIPOC communities, an explicit RJ lens is not incorporated into the author's analysis of the discourse surrounding IVF. Similarly, LaMarre et al (2020) utilize an RJ lens to examine the experiences of those with larger bodies seeking reproductive healthcare and how their access to care is impeded due to weight stigma. While this study provides an overview of how an RJ lens explains the causes and consequences of inaccessible health services, the authors examine a wide range of fertility and pregnancy services

and do not focus explicitly on funding for IVF in Ontario. Lastly, Paynter (2022) also provides a historical view of IVF in Canada from its beginnings to modern day under the banner of an RJ lens of the right to have a child. While the book provides insight into the barriers associated for those with low income accessing IVF, as well as advocates for the removal of said barriers, it does not put forward an analysis as to how the language of policy creates and upholds these barriers.

My research aims to build on this existing work to explicitly examine the language used to regulate and fund IVF in Ontario with the goal to fill in the knowledge gaps on the impact of discourse and Ontario's fertility policy through an RJ lens.

## **Research Design**

The primary question this research sought to address is as follows: Through the lens of reproductive justice, who does the state support in becoming parents via in vitro fertilization? To answer this question, I examined the specific case of IVF funding provided by the provincial government of Ontario.

### *Methodological Framework*

My chosen methodology was a qualitative study using discourse analysis. I chose to do a qualitative analysis because it was best suited for analyzing text-based data sources that can also incorporate the context in which they were written (Mertens, 2009). According to Khan and MacEachen (2021), the purpose of qualitative research is to analyze how people are impacted by the constructs of the social world. In the case of my research, I looked at the discourses constructed and informed by the contents of policy documents about IVF funding in Ontario, which in turn, provided insight into the possible implications these discourses have on those seeking IVF. The qualitative data I collected derived from the contents of documents I analyzed as a part of my

discourse analysis that aimed to identify relationships and themes from the content of these documents (Mertens, 2009).

I incorporated an intersectional feminist lens when analyzing reproductive health inequities and evaluating the uneven distribution of resources across vulnerable communities at the hands of the state through the OFP. This intersectional lens for this study meant acknowledging how multifaceted identities impact various populations' interactions with the state and policy (Oluo, 2019). Meaning, I aimed to analyze the ways in which various identities such as race, class, and sexuality intersect to influence vulnerable populations' lives.

Additionally, I incorporated Foucauldian methodological approach because it allows texts to be examined for how they produce and reproduce social actions that are intertwined with historical and political contexts, which in turn reveals how power relations are produced and reproduced (Khan and MacEachen, 2021). In other words, this lens allowed for qualitative data to be read for how it is active in producing meaning and actions within the social world (Khan and MacEachen, 2021). This was especially useful when analyzing policy as a Foucauldian-informed discourse analysis views policy formation as “the production of discourses,” which questions how policy is “shaped and reshaped” and is linked to the power maintained within institutions (Khan and MacEachen, 2021, p.6). Therefore, this Foucauldian lens allows me to analyze how power within institutions manifests both in the formation of health policies regarding IVF and in the discourses present in the language of policies.

### *Methods*

Discourse analysis consists of reading texts closely to interrogate their contents and subtexts (Mertens, 2009). Discourse for the purposes of this study is defined as “talk, to text, and also to the large-scale cultural rhetorics” (Miller, 2000, p.317).

Specifically, I utilized a feminist critical discourse analysis that forefronts intersectionality (Crenshaw, 1991). This entailed analyzing the gendered nature of texts regarding healthcare services, and how they worked to reinforce ideas of control over bodies that reproduce through reinscribing gendered norms. Feminist critical discourse analysis calls for an understanding of the entrenched asymmetrical gendered power relations within medical and policy discourse and how these discourses are linked to power (Lazar, 2007). When informed by Foucauldian theory, this approach also highlights the ways in which power internalizes gender norms and then acts these out routinely through texts and everyday life (Lazar, 2007). However, unlike Foucault, this approach acknowledges how gendered subjects are affected by power in different ways (Lazar, 2007). Therefore, a feminist critical discourse analysis emphasizes the interconnectedness of gender and power relations, complimenting a Foucauldian-informed discourse analysis, which does not have a specific focus on gender (Lazar, 2007).

This approach to analysis also aligns well with RJ theory as both frameworks call for praxis-oriented research that not only identifies systemic issues but also calls for direct actions to work to resolve these issues (Lazar, 2007). Overall, this methodological approach examined how dominance and gendered social practices are produced and reproduced through the language utilized when communicating policy about IVF.

### *Sample*

The sample for my discourse analysis consisted of OFP policy documents and texts produced in relation to the actions and non-actions taken by the Ontario government to address the “issue” and construction of infertility within Ontario. Policy, for this study, is defined as “a course of action (or non-action) taken by a government or legislature with regard to a particular issue” (Knill and Tosun, 2020, p.4). The reasoning for following this definition of policy is that it includes

both the actions and inactions of the government as elements of public policy. This allowed my analysis to incorporate what is included within the texts of written policy, as well as what is not mentioned or excluded from such texts. Additionally, policy within this definition is not limited to direct actions taken by the government, but also includes any texts used by the government to address the “issue” of infertility. Thus, I expanded the sample size of the documents beyond the Ontario Ministry of Health policy documents, to policy texts related to infertility and treatment commissioned by the Ontario government. For instance, although *Raising Expectations* predates the creation of the OFP, it was commissioned to inform the government’s IVF policy. Thus, it is a course of action taken by the Ontario government to address infertility.

More specifically, the sample includes relevant Ontario government legislation, such as *The Building Opportunity and Securing Our Future Act (2014)* which details “the government’s commitment to providing additional support for people in the province who want to become parents by expanding coverage of fertility services for one cycle of IVF per patient per lifetime for all causes of eligible infertility” (p.4). Documents will also include non-government committee reports commissioned by the Ontario government to inform the province’s IVF policy, like *Raising Expectations (2009)*, a report conducted by a panel of adoptive parents, infertile people, clinicians and academics, and a more recent report titled the *Advisory Process for Infertility Services Key Recommendations Report (2015)*, which details recommendations for expanding IVF services in Ontario. Lastly, the sample also consists of online bulletins about the OFP for health care professionals published by the Ontario Ministry of Health and Long-Term Care. As well as the “Get fertility treatments” (2021) webpage published by the Ontario government and meant to inform people who live in Ontario about fertility services that are provided for in the province. For a full listing of the documents included in the sample see Appendix A.

## *Analysis*

As a part of my discourse analysis, I looked at numerous documents and put them in conversation with each other by analyzing them for various themes and then coding them to see how the state views infertility and parenthood through its choice of policy language (Mertens, 2009). My analysis of these documents consisted of interrogating the language found within written policies related to publicly funded IVF treatment. Thus, the written language of the documents was analyzed to identify recurring words or phrases used when discussing the treatment of infertility and public funding for IVF.

The purpose of analyzing the language of these documents through a Foucauldian and intersectional feminist lens was to identify and deconstruct discourses around public funding and access to IVF services. The reasoning behind examining the language of the documents is that “the discursive perspective treats language as making moral/political claims about reality rather than neutrally reporting on it” (Miller, 2000, p. 343). This means that the language of the documents is not merely descriptive; rather, it reveals dominant discourses regarding how the institutions perceive infertility (Miller, 2000). As a result, this informed my analysis of the government's decisions regarding public funding for IVF.

Each document included in the sample was read multiple times and coded in order to analyze its contents as they pertained to IVF and funding for fertility services. The online health bulletins and webpage were coded in their entirety, while pages 5-10, 16-21, 23-30, and 85-148 out of 148 of *Raising Expectations* (2009) and page 31 out of 72 of *The Building Opportunity and Securing Our Future Act* (2014) were read and coded. Select pages from these texts were chosen to be read and coded because they were most relevant to IVF. For instance, sections of *Raising*

Expectations were excluded because the report also pertains to adoption, and thus, not relevant to the scope of this study.

The purpose of repeated readings was to discover overarching themes present across multiple documents. After such themes began to emerge, subsequent readings were conducted to produce a coding framework in order to highlight words and phrases found within IVF policies that were relevant to two central themes: gendered language and shifting accountability. Keywords and phrases were highlighted such as the use of a male/female gender binary when discussing fertility services, the use of gender-neutral language or lack thereof, and words with negative or gendered connotations in reference to infertility. Equity language and words with positive connotations were also used to present the OFP as progressive.

Several sub themes also emerged that consisted of gendered risk factors for infertility and family building discourse within the former, as well as the absence of clarity about IVF funding within the latter. For example, risk factors were divided between males and females, with more scrutiny placed on the female bodies and the ways in which they can become infertile.

Overall, it was discovered that the discourses surrounding infertility and IVF do not fully align with the principles of reproductive justice, the consequences of which are reflected within IVF policy.

### *Ethical Considerations & Positionality*

Because this research utilizes publicly available documents and there are no direct research participants, approval from the Research Ethics Board was not required (The Panel on Research Ethics, 2022). While I did not require formal ethics approval, I upheld concern for the welfare of those seeking IVF by balancing the risks and benefits of my research by ensuring that any

outcomes do not harm individuals and groups by advocating for their mistreatment (Community Research Ethics Office, 2015).

As a queer racialized woman who has experienced chronic reproductive health issues, I understand the harm the medical system can cause when informed by dehumanizing discourse and lacking sufficient support, and I come to this work with this perspective. However, I also recognize my positionality as a cisgender non-Black/non-Indigenous Canadian citizen with financial privileges means I will not understand the full extent of reproductive violence at the hands of the state. I want to work to better understand these experiences through the research I complete while not invalidating others' lived experiences and not conflating or comparing them to my own.

## **Results**

This critical feminist discourse analysis identified two primary themes in the documents that were reviewed. The first theme is “The Use of Gendered Language & Constructions of Infertility.” This theme is derived from the foundational report *Raising Expectations* (2009), which was commissioned by the Government of Ontario to inform the province’s publicly funded IVF policy. The subthemes that emerged as part of this central theme included: “Family Building” Discourse, Family Building & the State, Infertility as Gendered Risk, Medicalization, and Morality & Protecting fertility. The second central theme is “Shifting Accountability.” This theme was found within the documents detailing the funding and delivery of the OFP. Specifically, this is derived from the “Get fertility treatment” (2021) webpage, The Building Opportunity and Securing Our Future Act (2014), the Advisory Process for Infertility Services Key Recommendations Report (2015), and the “Changes to publicly funded fertility services” (2015) health bulletin. The subthemes for this theme are: Absence of Clarity about IVF funding, Faux-Progressivism, and Shifting Responsibility.

## **The Use of Gendered Language & Constructions of Infertility**

The first major theme is the use of gendered language in constructions of infertility. The gendered nature of IVF treatment in Ontario is a pervasive theme within the reports used to inform publicly funded IVF and what would become the OFP in the coming years. Gendered in this context refers to documents assigning IVF and/or infertility aspects to one particular gender within a gender binary of male/female and man/woman. Specifically, the report entitled *Raising Expectations* (2009) by Ontario's Expert Panel on Infertility and Adoption (Expert Panel) uses highly gendered language that conforms to a gender binary to create discourses about bodies utilizing IVF (Cattapan, 2020). The Expert Panel consisted of representatives of infertile people, clinicians, and academics (Cattapan, 2020).

*Raising Expectations* is a significant document within the Ontario IVF policy because it is a foundational report used to inform fertility services in the province. Commissioned by the Ontario government to advise on matters related to public funding for IVF, the report recommended funding three cycles of IVF (Cattapan, 2020). In 2014, the Ontario government announced it would act on the Expert Panel's recommendations. A year later, the OFP began covering one cycle of IVF for eligible citizens (Cattapan, 2020). While the government ultimately did not enact all the recommendations of the Expert Panel, this report was nevertheless influential in the shaping of Ontario's current infertility program (Cattapan, 2020). Thus, its contents and language also influence current discourses surrounding IVF and infertility.

### *“Family Building” Discourse*

Throughout *Raising Expectations*, recurring references to “building families” are intertwined within the goals and recommendations of IVF treatment in Ontario. Throughout the 148-page report, references to family building within the context of IVF appear 137 times. In

comparison, any reference to same-sex, gay, and LGBT people only appears a combined total of 13 times and race is not mentioned at all in regards to IVF. The frequency of language related to family building indicates its high importance within the report. While these mentions include variations of the phrase “family building” (for example: building a family, build a family, build their family) it is continuously used within the context of it being a goal to be achieved, with barriers to pregnancy directly interfering with said goal of family building.

The discourse surrounding the goal of family building is present within the report's contents from the very beginning of the document. For example, the report's executive summary states: “Everyone in Ontario knows someone who has struggled to build their family. Ontario's adoption and assisted reproduction services are not working as well as they could – and should – for children and families” (Johnston, 2009, p.5). Within this context, a “family” is then presented as consisting of children and thus, the inability to have children in one's life is thereby the failure to have a family. More specifically, in the report the discourse of “family building” or being part of a family is tied directly to inadequate adoption and fertility services. This is seen in the use of the verb “struggled” to describe unsuccessful attempts at either adopting children or assisted reproduction. The negative connotations of the word “struggled” within this quote indicates that to “build a family” is synonymous with having children. Thus, the consequences of struggling to have children are presented as not being able to build a family, and therefore the unstated assumption is there is only one type of family (i.e., one that includes children) and that this type of family is universally desired. This implicitly presents the idea to the reader that the absence of children within the life of a couple or single person is also the absence of a family as those who cannot have children are also those who cannot “build a family.” In sum, the discourse of family building in the report supports the idea that if one wants to create a family, they must do so by having children.

Additionally, the word “Everyone” in the above quote also plays into the assumption that the desire to build a family through having children is also a common or even universal goal and that many face barriers to fulfilling. This language evokes a sense of universality with the idea of having children to build a family. Meaning, the goals of building a family that includes children - either by birth or adoption - are presented as being widely shared by Ontarians. Furthermore, by stating “everyone” knows someone who has faced such problems, the report implies having children is a norm and that the inability to have children is a direct obstacle to fulfilling the goal of having a family. This language frames the desire to have children as universal. As a result of the above framing, it is also implied that the inability to have offspring is a common issue that needs to be addressed through assistance within the context of IVF and adoption. Thus, as will be shown in more detail below, assisted reproduction is presented as not only an aid for those seeking to have children but also as an essential service that allows couples to build their families.

However, this presentation of universality is actually exclusive as it only represents the experiences of some. This exclusion is enacted through the report’s lack of gender-neutral inclusive language and reinforcement of cisnormativity. Specifically, this family building discourse centers cisgender men and women within its discussion of barriers impacting family building and assumes sex and gender are interchangeable with one another. The distinction between sex and gender is as follows: Sex refers to the binary of male/female assigned by biological attributes such as reproductive/sexual anatomy, while gender refers to socially constructed roles placed on girls/women and boys/men that influence gender expression and behaviours (Frohard-Dourlent et al, 2017). However, classifying sex as a binary can also be problematic because biological sex also exists on a spectrum. For example, those who are intersex

and/or identify as outside the male/female sex binary do not always have reproductive/sexual anatomy that aligns with the male/female binary (Intersex Society of North America, 2008).

Cisgender refers to those whose gender identity does match their sex assigned at birth but these binaries also carry the assumption that gender always “naturally” aligns with the sex assigned at birth (Frohard-Dourlent et al, 2017, p.2). Transgender refers to those whose gender identity does not match the sex they were assigned at birth (Frohard-Dourlent et al, 2017). Under the umbrella of trans also include non-binary identities, which refer to gender identities outside the man/woman gender binary (Frohard-Dourlent et al, 2017).

Throughout the report, infertility and fertility services are only presented as being for those within a cisgender binary of man and woman. The first section of the assisted reproduction portion of the report titled “Care to Proceed: Infertility and Assisted Reproduction in Ontario,” proceeds to describe the ways infertility impacts Ontarians' ability to build families while using highly gendered language (Johnston, 2009, p.85). For example, gendered language is seen in the first paragraph where the report notes that “Both male and female infertility are on the rise” (Johnston, 2009, p.85). Within this statement, infertility is presented only within a gender binary because it is only spoken about as an issue only impacting males and females. Such binary language plays into the assumption that infertility can only impact those who are cisgender and identify within this binary.

The report also uses language that refers to sex and gender interchangeably working to continue to reinforce gender binaries and cisnormativity. For instance, throughout the section titled “All Ontarians Should Know How to Protect Their Fertility,” male/female and men/women are used to refer to all people who experience infertility even though the former refers to sex and the latter, to gender. For example, the beginning paragraph states “Both male and female fertility

decrease with age,” indicating the report is referring to sex (Johnston, 2009, p. 87, emphasis added). However, the same page goes on to recommend “. . . specialists should give special consideration to age when diagnosing fertility problems in *women* beginning at age 28. . . and include their *male* partners in assessments” (Johnston, 2009, p. 87, emphasis added). This quote not only switches between sex and gender by using “women” and “male” but also assumes couples undergoing fertility are heterosexual by suggesting “women” and their “male partners” receive assessments. This conflation of sex, gender, and sexuality is significant because the report reinforces that everyone seeking IVF is cisgender and heterosexual through assuming sex assigned at birth and gender identity always align. Thus, this discourse works to assume everyone who seeks IVF is cisgender and heterosexual. Through these assumptions, those who are not cisgender or heterosexual are implicitly excluded from IVF as the services are not designed with their experiences in mind.

For instance, some bodies are missed in the report’s conceptualization of sex and gender because not all bodies with a uterus are women. Presenting this binary erases the experiences of, for example, trans people. In this example, a trans man can have a uterus and be able to receive IVF to get pregnant, but is still not a woman, despite the report presenting as such. However, such experiences that are inclusive of the gender identification of those seeking IVF are not presented within the report due to only using biological sex categories of male and female. The lack of gender-inclusive language also means the experiences of those within the gender binary are valued more than those outside the gender binary due to being directly mentioned within a report commissioned by the province. The same attention is not provided to trans, non-binary or intersex people that also experience infertility, as indicated by their lack of mention within the report. Thus, this language erases the experiences of those outside a gender binary that face infertility. This is

significant because the lack of inclusion within a report meant to inform Ontario assisted reproduction policy means those outside the gender binary are not included within government policy regarding fertility services.

In contrast, the report could have employed inclusive language by using gender-neutral terms when discussing IVF. For example, phrases such as “people seeking IVF” or “people with a uterus” could have been used instead of conforming to the male/female binary when discussing IVF. By using gender-neutral terms, they are no assumptions made about the sex or gender identification of those seeking IVF, and thus, can be more inclusive of a wide range of experiences.

Furthermore, by placing this sentence under the goal of “To help more Ontarians build families through high quality and safe fertility education, monitoring and assisted reproduction service,” it also associates gendered assumptions about infertility with family building. The use of a gendered language under the goal of “family building” assumes those who want to build families fall within this gender binary. While the report also references same-sex and single people using fertility services, assumptions about infertility center IVF as being utilized by cisgender couples to fulfil the goal of building a “family.”

Because the report notes issues surrounding infertility in males and females and assumes these individuals are cisgender, said issues are framed as impeding family building for such cisgender groups. The focus on male and female infertility within the report coincides with the absence of any mention of groups outside the gender binary and their needs regarding family building. This lack of mention in itself reinforces the discourse that family building is meant to be done by cisgender couples. Meaning, that the issues that impact the family building of those who identify as male or female are emphasized while others are erased. Thus, this discourse of family building being impacted by male and female infertility is presented as dominant within the report

as other framings that are inclusive of other experiences are never shown. Therefore, how the report views family building and assisted reproduction is limited to a lens that upholds the cisnormative gender binary.

### *Family Building & The State*

The discourse centering family building as the goal of IVF is also evident within the goals and vision detailed in the report. The Expert Panel states the following as their vision for the report under the heading “Our Vision”: “Ontario should aim to be the best jurisdiction in the world to build a family” (Johnston, 2009, p. 6). This quote from the report puts focus on not only the goal of building a family for individuals but that the province should also take this up as important to the state. For instance, the use of the word “jurisdiction,” evokes sentiments of control and the power to administer decisions, as per its definition (Oxford University Press, n.d.). Furthermore, the placement of “Ontario” at the beginning of this quote also places the province as active in family building. Ontario in this sense refers to the Ontario government that controls state institutions and all that falls under provincial jurisdiction, such as health services. Meaning, the provincial government is responsible for creating a jurisdiction to facilitate family building. Thus, this vision statement brings attention to the role the Ontario government has in supporting family building.

Support for family building in this context refers to making fertility services accessible as indicated by the goals of the report listed under the heading “Our Goals” following the vision. The first goal that pertains to fertility services states: [Our goal is] “To help more Ontarians build families through high quality and safe fertility education, monitoring and assisted reproduction services” (Johnston, 2009, p.6). Within this goal, the Expert Panel once again mentions family building and specifies it can be achieved through assisted reproduction services (such as IVF).

This goal not only correlates family building and assisted reproduction, but also associates it with the government of Ontario providing the latter. This is because the goal follows the report's vision of state involvement in building families. By outlining a goal that specifies the need for further support through state involvement within family building and assisted reproduction, the reader can assume that state involvement is needed to facilitate greater support for both building families and fertility services. Thus, the report emphasizes the need for the Ontario government to take on the responsibility of ensuring all those who seek to "build their family" can do so. Therefore, family building is not only a goal for individuals but rather, a goal for the Ontario government to support through fertility services.

### *Infertility as Gendered Risk*

The discourse is also tied to the report's framing of fertility as needing to be protected from the threat of infertility. For example, the previously mentioned section on risk factors is under the subheading "Many Ontarians are Unaware of How to Protect Their Fertility" (Johnston, 2009, p.88). Within this subheading, Ontarians are presented as needing to be informed about how to "protect" their fertility. The quote emphasizes that not only does fertility require protection, but it is also constantly weakening, and that Ontarians are unaware that it is even happening to them. The use of "protect" in this subheading is significant because it projects, per its definition, that fertility needs to be guarded against some impending danger (Oxford University Press, n.d.). Through its language and content, the report reinforces discourse about bodies assigned female needing to monitor and preserve their fertility in a way that removes agency over their bodies in order to "protect" them from infertility and thus achieve pregnancy.

For example, the first section within the recommendations for helping "more Ontarians build families through high quality and safe fertility education, monitoring and assisted

reproduction services” contains a gendered list of risk factors divided by “men” and “women” that impact fertility (Johnston, 2009, p.85). Risks for fertility problems within “women” are presented first and foremost with a focus on how they are under continuous “risk” of their bodies becoming infertile and how they are powerless to stop the decline of their fertility. This is seen in the report when stating “For most women, fertility begins declining around age 30 – even for women with healthy lifestyles” (Johnston, 2009, p.88, emphasis in original). Within this quote, the decline of fertility is presented as inevitable by its emphasis on “most” women when discussing the decline of fertility. This indicates that a decline in fertility will occur to the majority of women once they reach age 30. This inescapable fact of infertility is also further supported by the quote going on to state that this decline will occur “even for women with healthy lifestyles.” Meaning, a decline in fertility is not just an outcome for “unhealthy women” who have harmed their bodies through “unhealthy lifestyle” choices, but rather, this is also an inevitable outcome for “healthy women” who have not made lifestyle choices that would result in infertility. In other words, regardless of the choices “women” make, the report dictates they will eventually face a decline in their fertility due to their body's natural aging process. Therefore, this focus on a decline in fertility occurring regardless if they make “unhealthy” or “healthy” lifestyle choices showcase how the report presents low fertility as inevitable once bodies assigned female hit a certain age, and thus, their bodies face this constant threat of infertility that cannot be stopped.

Additionally, discourse about infertility as a danger to be protected from is seen within the subsequent section on risk factors. This is seen in the textbox that reads, “Many women are not aware of how they can be proactive in protecting their reproductive health” (Johnston, 2009, p.88). Within this quote, the need to protect fertility is gendered and singled out as an important aspect of women’s health. The passivity assigned to “women” against their fertility is also seen through

the language about needing to protect their fertility because women are “not aware” of how to protect their fertility. This further reinforces the discourse that bodies that reproduce lack agency over their bodies as the text continuously states that fertility is under constant threat yet they do not know to defend themselves from infertility. Thus, the language of this quote and previously discussed risk factors indicate that not only are “women” unaware of their declining fertility, but they are also unaware as to how to protect it.

The point that women’s fertility decreases with age is repeated throughout the section. Not only is it placed first on the list of risk factors, but this point is also expanded upon in a text box on the right-hand side of the page. Within this textbox, it states “Every woman is born with all of the eggs she is ever going to have. Each month, for every egg that is released and available for fertilization, many eggs mature and most are absorbed into the body. Most women will ovulate about 400 times in their lifetime.” (Johnston, 2009, p.88). Within this quote, bodies assigned female are presented as passive against the loss of eggs as it is noted they have a finite number of eggs to use for fertilization within their lifetime. By stating a numerical value and that many eggs are lost monthly, it is emphasized that female fertility is rapidly decreasing as time goes on. Meaning, this focus on how eggs will inevitably be lost presents their fertility at constant risk of decline. The text box states, “Eggs get older as women age, making conception more difficult and increasing the chance for chromosomal abnormalities, which often causes miscarriage” (Johnston, 2009, p.88). Similarly, this quote also mentions how fertility is in constant decline and how this creates risks to conception in the form of “abnormalities ” and miscarriages. By making explicit mention of eggs aging as women age and how conception becomes more “difficult” as time goes on, the report creates the discourse that bodies have a uterus being constantly under threat of losing their fertility due to natural causes such as age.

The text is primarily focused on bodies that are assigned female and cisgender women rather than bodies assigned male and cisgender men. A lack of agency is assigned to specifically bodies that are assigned female. These gendered distinctions are seen through the text implying the risk factors that impact fertility for bodies assigned female are not just present from the beginning of their lives, but they are persistent to the point where these bodies face a continuing decline in their fertility without even knowing it. Because aging is constant throughout one's life, bodies assigned female are assigned little to no agency over their loss of fertility. This focus on age as a risk factor further upholds the discourse that bodies assigned female are helpless against the threats of declining fertility. The lack of focus on bodies assigned male's aging impacting fertility, as well as the lack of mention of those outside the gender binary place high importance on cisgender women and the risks they face because of their age. Thus, this discourse simultaneously excludes those outside the binary, and does not assign the same helplessness to bodies assigned male.

Rather, for cisgender men, age is just listed as a risk factor and is not emphasized as it is for the female list. Other factors listed for men include external risks such as cigarettes, alcohol, use of prescription medications, and occupational hazards (Johnston, 2009). Listing primarily external risks indicates "men" as having more agency over their fertility because they could conceivably control some of these factors. Moreover, the absence of detail about the internal risk factors that impact men's fertility signals that their bodies are not under the same constant threat of infertility as other bodies. This is because while the risk factors for bodies assigned women go into detail on how infertility is constantly declining throughout one's life, that same passivity is not projected onto men's risk factors as their risks are primarily situational. Therefore, these risk

factors are not only gendered but also assume “women” are passive towards their fertility, unlike “men”.

### *Medicalization, Morality and Protecting Fertility*

The medicalization of infertility is a recurring element of the report, with the treatment of the problem of infertility coinciding with the idea of protecting the body from danger. Infertility is medicalized in the sense that it is recognized as a medical issue and requires state involvement through public funding (Cattapan, 2020). From the beginning of the report, infertility is described as requiring treatment. Specifically, the report states at the beginning of the section on assisted reproduction, “We believe that all Ontarians should have the opportunity to build a family. Infertility is a medical condition that prevents some Ontarians from doing so. These medical problems often require medical treatment(s) to overcome infertility” (Johnston, 2009, p.85). Within this quote, not only is infertility explicitly described as a “medical condition,” but family building is framed as being hindered by it, and thus, requiring medical treatment in order to overcome it. This point is even repeated through an additional text box on the right-hand side stating a similar sentiment: “Infertility is a medical condition that often requires medical treatment. Infertility has wide-reaching consequences for individuals, families and society” (Johnston, 2009, p.85). In this quote, the framing of infertility as a medical condition is emphasized by this repetition of the quote, thus indicating to the reader that it is of high importance. The quote also puts forward that infertility not only impacts the body but also produces harm beyond the body by hurting even those in close proximity to someone impacted by it, and society more generally. This construction of the potentially wide-ranging impacts of infertility further reinforces the discourse that infertility is a danger that requires protection.

The findings of the report supported publicly funded IVF cycles for Ontarians based on IVF being medically necessary (Cattapan, 2020). Meaning, IVF was viewed as a healthcare service needed in order to treat infertility. The phrasing of “medically necessary” is found explicitly within the report on various occasions. For instance, in reference to IVF treatment affecting work, the report states, “As assisted reproduction services are necessary medical treatments, we believe that they should be eligible for personal emergency leave in the Employment Standards Act” (Johnston, 2009, p.124). It is also found more implicitly in reference to OHIP, which is expected to provide medically necessary services (Government of Canada, 2019). Regarding the cost of IVF as a barrier, the report says “Despite the fact that infertility is a medical condition, most assisted reproduction services . . .are NOT covered by our universal health insurance plan” (Johnston, 2009, p.109, emphasis in original). Within this quote, the report expresses that infertility is a medical condition that should be deemed medically necessary in order to be covered under OHIP. Thus, infertility is not only medically necessary but also requires treatment that should be the government's responsibility.

The report goes on to present the ways in which the Ontario government should fund assisted reproduction services to treat infertility. The Expert Panel preface these recommendations with why funding these services is necessary by stating, “We believe that Ontario should fund safe assisted reproduction. Not only is this the right thing to do, but it will also protect the health and well-being of the children, women and men who use the services . . .” (Johnston, 2009, p.118). Assisted reproduction is framed as aiding in protecting fertility to allow for family building. This is seen in the explicit mention of protecting children as well as adults who would utilize these services. Specifically, the use of phrasing such as “protect the health and well-being of the children, women and men who use the services . . .” presents the idea that in order for family building to

occur, the government must aid in funding reproduction services. The quote also mentions that funding these services is the “right” thing to do, indicating that to not do it, would be “wrong” in a way that would be unjust towards the mentioned groups. This binary of classifying government funding of assisted reproduction services as either right or wrong is seen in the explicit mention of children, men and women within this statement as to imply not following the panel’s recommendations would be putting them in harm's way.

Furthermore, preceding the panel's recommendations with such straightforward language on the morality of funding assisted reproduction creates greater justification for their claim that these services are not only medically necessary, but that the province has a duty to do so in order to protect the welfare of men, women, and children. This is seen in the quote being presented under the subheading of “A Proposed Approach to Funding Assisted Reproduction.” By placing the above quote before the report’s proposed funding approach, the panel once again frames their recommendations through a morality lens as it connects protecting men, women, and children with their proposal for the state to fund IVF. Because a subheading is meant to signal to the reader what the following passage is meant to be about, placing the previously mentioned subheading over this quote clearly informs how the recommendations are meant to be received. In other words, through placing the two so close to one another, the reader also sees these recommendations as appeals to the state to do the “right” thing and fund IVF. Thus, the placement of this quotation adds to its significance because it heightens the moral weight of the recommendations that follow it and further creates a dichotomy of right and wrong regarding whether the state chooses to publicly fund IVF. In essence, in order to protect Ontarians, the report urges the state to make the “right” decision and follow their recommendations to fund IVF.

This theme of assisted reproduction and morality is further seen in the conclusion of the report that makes mention of reducing multiple births to protect children. In the conclusion, it states, “Ontario’s multiple birth rates resulting from assisted reproduction services are too high. We know that – to provide the best opportunity for Ontario’s children to reach their full potential – we must reduce these rates and ensure that the health of each and every child born through assisted reproduction is protected” (Johnston, 2009, p.137). Within this quote, children’s ability to thrive (“to reach their full potential”) is directly connected to protecting their health through reducing multiple births (“reduce these rates and ensure that the health of each and every child born through assisted reproduction is protected”). Similar to the previous example, the need to protect children is emphasized and thus moralized to justify support for assisted reproduction promoting single births. Furthermore, this quote also notes children must be safeguarded after they are born when stating Ontario must ensure the health of “every child born through assisted reproduction is protected.” Meaning, the role of the state protecting children extends beyond their conception that uses assisted reproduction. Thus, assisted reproduction is not only a means to protect those seeking to get pregnant, but should also protect children themselves after they are born.

In sum, the gendered language within Raising Expectations has reinforced several discourses about infertility and centered family building. Firstly, the subtheme “‘Family Building’ Discourse” showed the report upholds gendered assumptions about families due to emphasizing the need for “family building” through having children. This view of families presented a “family” as requiring children in order to be complete and that having children was a universal goal. Additionally, the lack of gender-neutral language also meant family building and IVF was conceived through a heteronormative and cisgender lens. The experiences of those outside the

gender binary utilizing IVF and experiencing infertility were entirely invisible in the report. Thus, infertility was framed as only impacting the family building of cisgender people. The subtheme “Family Building & The State” showcased the discourse surrounding fertility services in Ontario views fertility services as a means to achieve the goal of building a family through conceiving children with government assistance. This resulted in the report framing funding for assisted reproduction as the responsibility of the state in order to facilitate family building. Thereby further reinforcing family building as a crucial duty for cisgender couples in order to create families and for government to support this goal by providing financial assistance for IVF for this group. Therefore upholding cisnormative views of a “family” only consisting of cisgender heterosexual couples and children birthed by a cisgender female.

The Expert Panel also reinforced gendered risk about infertility and the idea that infertility must be treated by the healthcare system for the betterment of society through assisted reproduction, which was discussed within the sub theme “Infertility as Gendered Risk.” Through discourses about infertility as gendered risks, the report presents “women’s” bodies as under the constant threat of becoming infertile, while “men’s” bodies were not under the same threat or scrutiny. The report goes on to emphasize the need for cisgender women to protect their fertility from the risk of infertility in the face of these many attacks<sup>[10]</sup>. This framing of infertility presents it as a medical condition that requires treatment. Furthermore, family building is framed as being hindered by infertility. Thereby leading the Expert Panel to also dovetail these ideas of family building and infertility, as seen in the subtheme “Medicalization, Morality and Protecting Fertility,” with the idea that the state should fund assisted reproduction. The report goes on to present the ways in which the Ontario government should fund assisted reproduction services to

combat infertility. Thus, within discourses surrounding public funding for IVF, infertility is seen as a problem whereas IVF is viewed as its solution.

However, this level of intervention was not actually taken by the state, as will be shown in the next primary theme below. While *Raising Expectations* was meant to inform Ontario's IVF policies, the theme of "Shifting Accountability" showcases the ways in which the OFP lessens state involvement with fertility services.

### **Shifting Accountability**

The second main theme that was identified during the analysis was "shifting accountability." Within various documents that communicate how IVF funding and delivery operate, there is a theme of the Ontario government presenting the OFP as a progressive government health program. Progressive in this context refers to providing more substantive government-funded support towards fertility services than is typically associated with the Ontario provincial health plan. This framing of the government's actions as progressive co-exists with the Ontario government distancing itself from accountability for ensuring these services are delivered sufficiently or equitably. Thus, a discursive contradiction develops where, on the one hand, the government takes credit for offering a progressive health service to those seeking fertility treatment while in practice it is shifting the responsibility of providing IVF services from the government (under OHIP) to individual clinics (under the OFP), as well as to patients through out of pocket payments for healthcare costs not covered by either OHIP or the OFP (such as prescription medication taken during IVF).

This mix of how fertility services are funded has occurred because fertility services were removed from OHIP when the Ontario government created the OFP. This means that the government finds a loophole in follow the guidelines set out by the Canada Health Act (CHA)

(1984) in how they fund and provide IVF services. As previously noted, the CHA is federal legislation that dictates key criteria that must be followed by provincial governments regarding publicly funded health care insurance (Government of Canada, 2019). These criteria include: public administration, comprehensiveness, universality, portability, and accessibility (Government of Canada, 2019). Because the OFP is separate from OHIP it actually circumvents hallmarks of progressive health care, such as the CHA condition of accessibility that facilitates access to health services without additional barriers. The theme of shifting responsibility will be discussed in more depth by examining the following sub themes: Absence of Clarity about IVF funding, Faux-Progressivism, and Shifting Responsibility.

#### *Absence of Clarity about IVF funding*

As previously noted, IVF services were delisted from OHIP in 2015 and are now provided through the OFP, which covers the cost of one cycle of IVF treatment for eligible citizens through participating fertility clinics (Izenberg, Buchanan, and Iroanyah, 2019; Ontario Ministry of Health, 2021). However, the language used to communicate these changes (i.e., the move from OHIP to OFP) to the public and to fertility clinics on government websites and online health bulletins do not highlight or fully explain this separation of IVF services from the provincial health insurance plan. This leads to a lack of clarity regarding how IVF funding in Ontario operates, creating the impression for those seeking information about IVF that the funding for fertility treatment is being increased through OHIP rather than funded by a separate program called the OFP.

For example, on the Ontario Ministry of Health's (2021) fertility treatment webpage, titled "Get fertility treatments," the change of IVF being funded under the OFP rather than OHIP is not stated but fertility services are first and foremost described as being "government-funded" (para.1). This is notable because while the government funds the OFP, this funding is not from OHIP as

other healthcare services are, and thus this funding is not connected to the federal transfer payments for healthcare. Rather, the funds for the OFP come from a separate provincial budget line. As a result, OFP funding is not subject to the principles of the CHA such as accessibility. Because most of the healthcare services provided by the government are connected to OHIP (and therefore *are* subject to the CHA), the use of phrases like “government-funded” without additional clarification means that readers will likely assume the support for fertility services are the same as other government-funded health services typically associated with OHIP.

These assumptions matter because services covered by provincial health insurance plans are expected to be accessible to eligible citizens without financial hardship or other barriers (Government of Canada, 2019). This is the principle of accessibility in the CHA which states citizens should have “reasonable access” to insured health services (Government of Canada, 2019, para 22). Thus, because of these principles being enshrined in the CHA, “government-funded” healthcare is assumed/expected to be geographically available and at next to no cost at the point of delivery. However, as discussed in more detail below, the decision of the Ontario government to fund IVF through the OFP means that the Ontario government does not actually have to adhere to what most would consider as the progressive principles of universal healthcare as enshrined in the CHA.

In addition to assumptions related to healthcare services that are “government-funded”, the “get fertility treatment” webpage by the Ministry of Health (2021) highlights the need for those seeking these services to possess a valid Ontario health card both under the subheading of “Eligibility” and as a category of a chart listing coverage limits titled “Additional eligibility” which directs those seeking fertility treatment to a webpage about how to apply for an Ontario health card. This further plays into assumptions that fertility treatment is connected to OHIP as access to

both the OFP and OHIP insured services requires a valid Ontario health card in order to receive health services. While this fertility treatment webpage does not outwardly claim that fertility services are a part of the provincial health insurance plan, these subtle omissions about the differences between OHIP and the OFP give the impression to those seeking information about IVF treatment that it is a health care service covered under OHIP. Thus, the lack of explicit acknowledgement of the OFP within the “Get fertility treatment” webpage, as well as OHIP requirements of having a healthcare card to receive funded services discursively creates the sense to those seeking information about IVF that these services are also a part of the provincial health insurance plan.

### *Faux-Progressivism*

The framing of the OFP as progressive has allowed the state to create a discourse about itself as providing substantive social assistance to Ontarians seeking fertility services. This discourse can be viewed as “faux-progressive” because it presents the actions of the government as expanding access and support to those seeking fertility services. The discursive emphasis on the progressive elements of the OFP obscures how IVF services remain limited. For the OFP to be progressive, the program would have to provide more equitable and substantive support to those seeking IVF. For example, the OFP could also go further in its support of people seeking to get pregnant by funding additional cycles and also covering the cost of fertility drugs, as well as other expenses related to IVF that are currently paid for out of pocket. However, the lack of more substantial government funding means the OFP fails to provide these elements that would aid in making it a truly progressive fertility program. Currently, by emphasizing the expansion of some support by the OFP, IVF services can be viewed as progressive for these efforts even though these additional supports can be, in actuality, very minimal. Thus, the government positioning itself as

creating progressive IVF policies is present in how IVF services are written about for both healthcare providers and those seeking services.

This progressive framing of the OFP is seen in the discourses created by highlighting how the program provides new additional support to those seeking it, while not making clear the ways in which this support has limits. Across various samples, positive language positions the government as having increased its efforts to provide IVF services. This language includes the consistent use of phrases such as: “providing additional support” and “expanding coverage” for infertility services while underplaying the limitations of this support. For example, an information bulletin for healthcare professionals posted by the Ontario Health Services Branch (2015) begins by stating, under the subheading “Changes to publicly funded fertility services,” that the Ministry of Health and Long-Term Care is “implementing a new Fertility Program that expands access to In Vitro Fertilization (IVF). . . for more patients with all eligible forms of infertility” (p.1). In this statement, the government of Ontario chooses to first highlight how their fertility program *expands access*, thereby implying more support for those who are infertile. However, the statement also includes “eligible forms of infertility” which means that there will additionally be ineligible forms of infertility. Yet the bulletin does not expand on this distinction until later on in the document. Thus, the discourse highlights how the program is expanding its efforts and thereby playing into the assumption this will be able to help more people seeking IVF. By presenting the program this way, the OFP is discursively positioned as progressive by committing to aid all those seeking IVF. Thus, acting as a robust social safety net, just as OHIP is meant to be, through its apparent aim to increase the accessibility of fertility services in Ontario regardless of being separate from provincial health services.

However, while this progressive framing of the program is brought to the foreground through the language of the text, the fact that eligibility for the OFP is limited is not as clearly explained. The eligibility criteria is eventually described later on within a chart that showcases the patient eligibility for various fertility services included within the OFP. For IVF, a patient is only eligible if they possess a valid Ontario Health Card, are under age 43, and have not previously received a funded cycle of IVF under the OFP (Ministry of Health, 2015).

These criteria limit the pool of those who would be able to receive government-funded IVF. For instance, the Ontario Health Card requirement eliminates anyone who has just moved to Ontario and non-citizens from receiving IVF. This group includes international students, migrant workers, undocumented migrants, and any other persons who do not hold citizenship or permanent residence in Canada (Ontario Ministry of Health and Long-Term Care, 2022). These non-citizen groups are excluded because they are ineligible for OHIP, which is required under the OFP even though the two programs are separate (Ontario Ministry of Health and Long-Term Care, 2022).

Similarly, the age limit of 43 also creates a cut-off of who can receive services. This age limit creates a binary of who is “able” to conceive with fertility treatment. This cut-off range is even arbitrary as those above the age of 43 are able to get pregnant. For example, a 2017 study on age and conception in North America found that couples aged 40 to 45 still had a 55.5% chance of getting pregnant within the first 12 months of trying to conceive without the assistance of fertility treatments (Wesselink, Rothman, Hatch, Mikkelsen, Sørensen, & Wise, 2017). While chances of pregnancy do decrease after the age of 35, there is nevertheless still the possibility of conceiving naturally beyond the age of 40 (Wesselink et al., 2017). Thus OFP’s age limit reduces the number of people who can receive IVF to aid their fertility even though such treatment would greatly assist those whose ability to get pregnant is lower than it once was. Thus, these

requirements heavily restrict the number of people able to use the OFP. The consequence of the way the OFP is portrayed versus the realities of the program is that the language of these documents mean that government financial assistance often seems more equitable than it is. While the government may appear as if it is providing a great deal of support through a progressive fertility program, this is not an accurate characterization of the program once the ways in which access is limited are brought from the background of the text and highlighted.

Therefore, the framing of the OFP as “expanding access” to IVF does not reflect the fact that many people are actually ineligible to receive such services based on the program’s own criteria. Those who do not fit into the eligibility criteria have no other publicly funded options to receive IVF despite needing fertility treatment just as much as those who are citizens and those under the age of 43. Thus, while access to IVF has been expanded for some, it has narrowed for others based on such rigid criteria. Furthermore, the location of OFP funded fertility clinics in primarily large urban areas means people in rural regions must invest additional time and resources in order to access them (Cranston-Reimer, 2019). Those who do not have the resources to commute to these clinics, in addition to having to pay out of pocket for fertility drugs and/or subsequent unfunded cycles, means the OFP has not truly expanded access for all those seeking IVF. Thus, where funded clinics are located acts as another less explicit way access to the program is restricted. The emphasis on the program expanding access while downplaying its various restrictions has the discursive impact of presenting the program as progressive when, in reality, there are many limits on the amount of support provided by the government. Therefore, the statement that the OFP “expands access” evokes a sense of faux-progressivism because the document highlights the ways in which this program is “new” and a progressive improvement to

what was previously available while secondarily including the caveat that it is limited to those whose infertility is deemed “eligible” to receive such services.

Similar discursive constructions of the OFP are seen in the documents within the budget measures (summary of expected income and expenditure of the province) published by the Ontario Ministry of Finance, where it is stated that the government will provide “additional support for people in this province who want to become parents by expanding coverage of infertility services for one cycle of in vitro fertilization per patient per lifetime for all causes of eligible infertility” (Sousa, 2014, p.31). Just as with the previously discussed sample, the use of words such as “additional” and “expanding” suggests the government is putting forward a *greater* amount of support for infertility treatment. However, also just like the previous example, this statement includes the limitations of this expansion, such as only providing one round of IVF for those who are eligible.

This single round of IVF itself is also not as progressive as the province portrays it to be. While providing one funded cycle may appear to reduce barriers to accessing IVF, the Canadian Fertility & Andrology Society reports the average pregnancy rate for the first cycle of IVF for those under 35 has a success rate of only 44% (Lanes, Meng, and Johnson, 2019). This success rate also decreases to 12% for those aged 42 and over (Lanes, Meng, and Johnson, 2019). Meaning, that while government communications portray the OFP as new and progressive support for those fertility services, the funded support provided is often not sufficient enough to yield 50% success on the first attempt of IVF. In other words, providing one cycle of funded IVF is not as significant of a contribution as the government claims because it is likely more unfunded cycles will be needed. This contradiction of what is presented in the documents versus what is actually provided is what I have termed “faux progressive” because it allows the government to seem as if they are

providing more support than they are because a single cycle of IVF only achieves pregnancy less than half the time. Thus, despite the language of these documents highlighting the ways in which IVF support is “expanding,” the reality of the program is it is not sufficiently funding the IVF process and requires people to fund their own subsequent cycles to make up the difference. Therefore, this use of language that emphasizes the government’s contributions allows it to present itself as progressive for increasing support for fertility services while obfuscating how much support is actually provided.

The government placing additional IVF costs on patients while also claiming to provide sufficient support is similarly seen in the report titled “Advisory Process for Infertility Services Key Recommendations” commissioned to inform Ontario’s IVF program in 2015 by the Advisory Process for Infertility Services (Advisory Process). The Advisory Process was asked by the government to provide recommendations for infertility services but was also instructed not to include those related to fertility drugs (Advisory Process, 2015). In their report, the Advisory Process stated the Ontario Ministry of Health and Long-Term Care deemed recommendations about fertility drug costs out of scope for the Advisory Process because “the government will not contribute to the cost of drugs to support the IVF procedure. Families or health plans will continue to pay the cost of the associated drug treatments” (2015, p.1). This means that even in the early stages of establishing the parameters of the OFP, the government has put the responsibility of providing other elements of fertility care on individual patients rather than on the province itself. Thus, despite the province's rhetoric about improving fertility services, the government was only willing to accept recommendations limited to what they had pre-determined their role should be before the report could even be written. This shows that despite the progressive framing, fertility

services are constructed to be limited, and thereby not actually progressive, even though this contradicts the messaging given to the public about said services.

Even though the costs of fertility drugs needed to help produce viable eggs for IVF can amount to \$5,000 per IVF cycle, this vital aspect of the IVF process was purposely omitted from the purview of the Advisory Panel and was still later not included in the funding of the program (Ontario Ministry of Health, 2021). While the government claims they are increasing the availability of IVF, not funding a crucial aspect of the process means the service remains limited to those who have the financial privilege to take on these additional costs. This demonstrates the faux progressiveness of the OFP as the realities of the program do very little to expand IVF services even though communications state the very opposite.

### *Shifting Responsibility*

In conjunction with an absence of clarity about IVF funding within communications about IVF, the language within documents detailing the OFP functions to place responsibility for providing fertility services on individuals and healthcare providers rather than the government. This means the responsibility of managing these services and providing oversight is placed on individual fertility clinics. Moreover, it also means that these services are not held to the standards dictated by the CHA. Specifically, the design of the OFP creates a dual funding setup where a patient can utilize both public funding in the form of one funded cycle of IVF (for those who are eligible) and private payment for subsequent cycles (Lapinsky, 2022). As stated by Lapinsky (2022), the OFP essentially allows the Ontario government to violate the CHA because its public funding derives from outside of OHIP, thereby allowing the program to include private health services and avoid the expectations laid out by the CHA.

Not only does the design of the OFP allow it to circumvent the CHA, but the discourse in government communications about fertility treatments also plays into assumptions related to accessibility held by those seeking health services. These assumptions are that the Government of Ontario has a responsibility to ensure fertility services are accessible for those who seek them as is required under the CHA. For instance, while the first half of the Ontario Ministry of Health's (2021) "Get fertility treatments" webpage highlights the government's financial contributions to IVF, the latter half places the responsibility of actually delivering those services on fertility clinics. Meaning that clinics then have to decide how to prioritize access. This is seen under the subheading of "Wait times" which states, "Clinics are responsible for managing their own wait lists and prioritizing patients using the physician's best clinical judgment" (para. 5). This is significant because as previously noted, while IVF is portrayed as a government-funded health service, it is not a part of the provincial insurance plan. Instead, the OFP is funded from another part of the provincial budget. Thus, the OFP does not need to meet the standards of the CHA, which dictates there must be timely access to health services as a part of the principle of accessibility (Government of Canada, 2019). While the "Get fertility treatment" webpage also states clinics must report wait times to the Ministry of Health and Long-Term Care, the language used by government communications portrays the government as providing progressive health services. However, they also remove themselves from any obligations that come from determining who gets prioritized for IVF since clinics handle the management of services and waitlists.

In sum, the theme of "shifting accountability" brings to light the ways in which the OFP does not live up to its progressive promises and claims. The "Absence of Clarity about IVF funding" sub-theme demonstrates how the language of the OFP plays into assumptions about universal healthcare due to its failure to mention how the OFP and OHIP differ from one another.

“Faux-Progressivism” also plays into assumptions about the amount of support provided by the government and allows the program to appear progressive by emphasizing the “additional support” added to the program, while downplaying the extensive eligibility criteria and waitlists that limit who can receive a funded cycle of IVF. Thus, the program is faux-progressive because what is actually provided in the program does not sufficiently support all those seeking IVF.

Additionally, the sub-theme of “Shifting responsibility” demonstrates how language within documents detailing the OFP places the responsibility of providing fertility services on providers and the onus to fund some elements of the IVF process on individuals. This shift is seen in how the funding structure of the OFP allows the Ontario government to circumvent the criteria of the CHA, which would normally dictate the standard of care that health services provided by the province must meet. However, because the OFP does not derive its funding from OHIP, the program is able to place the responsibility for managing fertility services on fertility clinics. The realities of the OFP and the ways it fails to meet the needs of diverse populations are explored below within the discussion section. This discussion showcases how the OFP, through an RJ lens, does not support the right to have a child in Ontario.

## **Discussion**

### *IVF funding & The Right to Have a Child in Ontario*

As previously stated, a key tenet of Reproductive Justice (RJ) is the right to have a child (Ross and Solinger, 2017). This right entails that all those wanting to have a child should have the opportunity to do so freely without hindrance such as financial or structural barriers preventing them from doing so (Ross and Solinger, 2017).

*Raising Expectations* and the documents pertaining to the OFP showcase the ways the Ontario government has failed to ensure all Ontarians are able to adequately access IVF services

through an RJ lens. While the report's use of gendered language does not present infertility and IVF through an intersectional lens, its focus on eliminating the financial barriers to assisted reproduction through state-funded services aligns with some aspects of the right to have a child according to RJ lens. However, this lack of an intersectional lens means the report does not take into account how various identities (race, class, gender, as well as others) interact with one another to impact access to IVF.

In terms of financial impediments to having children, *Raising Expectations* aims to remove the financial barriers to IVF services by advocating for the expansion of public funding for IVF. This includes funding three cycles of IVF, as well as the additional costs associated with fertility services (Johnston, 2009). The latter consisted of several recommendations to help control the cost of fertility drugs, such as a 50% refundable tax credit to help offset fertility medication costs, as well as funding one counselling session for all Ontarians using assisted reproduction services (Johnston, 2009). In this case, the Expert Panel's suggestions generally align with RJ principles because they emphasize the government going beyond issues of choice regarding IVF and provide recommendations to expand access to such services through additional public funding. Enabling access is a key aspect of the right to have a child because it promotes all people not just having the individual choice or right to use fertility services in theory, but also actually being able to utilize them in practice without additional financial barriers or otherwise preventing them from having the choice to use these services. By advocating for the government to remove more of the financial barriers associated with IVF, the Expert Panel aids in ensuring Ontarians have all the options to choose assisted reproduction without such choices causing significant difficulty or cost at their expense.

The report recommended funding three cycles of IVF to eliminate cost as a barrier to assisted reproduction, yet the OFP now only offers one funded cycle to eligible citizens but purports such changes are progressive (Johnston, 2009; Ontario Ministry of Health, 2015). Despite *Raising Expectations* being commissioned to inform Ontario's IVF policy, the recommendations taken up by the government from the report have been diluted to allow for choice but not access. In other words, while the choice to use IVF remains because the OFP provides one funded cycle for those that qualify, the lack of support for other aspects required for IVF to be successful is not provided. Meaning, Ontarians are provided funding for one cycle of IVF under the OFP if they choose to use the program, as well as if they fit both the age and citizenship requirements. However, even if they are eligible, they can still face additional costs in the form of needing non-funded IVF cycles and fertility drugs that the OFP and OHIP do not cover. Such additional costs mean that those with limited income cannot have full access to all that is needed to have success getting pregnant through IVF. This directly impacts the right to have a child because financial barriers to utilizing IVF still remain, and thus, while there is some choice in terms of having the choice to use the OFP, IVF in its entirety remains inaccessible to many who seek it.

Additionally, while the language used in *Raising Expectations* directly calls for additional funding to be put towards fertility services, communications about the OFP uphold the image of the government providing sufficient support for those seeking IVF while minimizing the additional costs and lack of government involvement within the prioritization and delivery of IVF. For instance, as discussed, the fertility treatment webpage of the Ontario Ministry of Health (2021) omits mentions or information about the OFP's role in funding IVF, and thus, gives the impression to those seeking information about IVF that it is covered under OHIP.

Furthermore, the right to have a child is also violated through the funding structure of the OFP and how it allows for the Ontario government to distance itself from the requirements of the CHA that call for health services to be accessible under OHIP. As discussed, because IVF is not part of the provincial health insurance, the material consequences of the government removing itself from the responsibility to provide fertility services are that it removes the government's duty to create accessible and universally available services. For instance, under the CHA, the government is required to ensure services are accessible through eliminating barriers (Government of Canada, 2019). However, long wait times for public IVF services have increasingly become a barrier, and yet, the responsibility of managing waits is put on fertility clinics rather than the government (Izenberg et al, 2019). As previously mentioned, this waitlist can last up to 12 months or longer (Lapinsky, 2022). Such extensive waitlists mean IVF is not always accessible in a timely manner, meaning, IVF is not accessible to those who cannot wait for these long lines or afford to pay for private services to skip the line (Lapinsky, 2022). If the government was responsible for providing services as per the CHA, they would need to take a role in addressing wait times that are reducing accessibility. However, this is not the case under the OFP as the CHA does not apply, leaving fertility clinics with limited funding to address accessibility concerns. This can further interfere with an individual's right to have a child as it is another way for fertility services to remain unattainable. Thus, separating CHA from fertility services is another avenue where the government lessens its support for IVF, allows financial and accessibility barriers to remain, and ultimately prevents people from making use of fertility services in Ontario.

### *The OFP, Raising Expectations, & RJ*

The report and the OFP do not fully utilize an RJ lens due to their lack of intersectional analysis of the barriers to IVF. Advanced by Black feminists, RJ centers the marginalization and

intersecting oppressions of BIPOC women, trans, and non-binary people (Ross and Solinger, 2017). Issues of race, gender, sexuality, or any other aspects of identity intersecting with one another to produce additional barriers to IVF are not featured within the report. While the report begins by stating “To become the best jurisdiction in the world to build a family, Ontario must ensure that all Ontarians – regardless of income, race, culture, sexual orientation, marital status or geography – have access to adoption and assisted reproduction services,” these topics are seldomly mentioned or presented with nuance as to how they affect access to fertility services (Johnston, 2009, p.133). For example, issues pertaining to LGBTQ people and fertility services are referenced when saying “We recognize that there are specific barriers to assisted reproduction services experienced by the LGBTQ communities and encourage the government to continue to work with LGBTQ communities and advocacy groups to develop policies that will reduce discriminatory practices and social barriers to assisted reproduction services” (Johnston, 2009, p.133). But then the report continues to uphold a heteronormative and cisgender view of IVF and its users.

While *Raising Expectations* provides some recommendations for expanding access to IVF services, the report does not incorporate gender-inclusive language in its discussion of fertility. This is especially interesting because the report itself notes the importance of gender-inclusive language when stating: “Clinics and providers should strive to be aware of and sensitive to the reproductive needs of all Ontarians. This includes using gender-neutral language, providing cues that the clinic is a positive space and allowing women to make choices about procedures that reflect the fact that they’re not infertile”; however, this is not seen in practice within the report itself (Johnston, 2009, p.133). The report uses primarily gendered language and refers to gender and sex interchangeably, with no mention of the experience of non-binary and trans people accessing assisted reproduction. Rather than supporting gender neutrality in relation to IVF, the report

further the erasure of trans and non-binary people by assuming gender identity always aligns with sex and all those who seek to use assisted reproduction are cisgender men or women.

Similarly, race is also absent from the report and the OFP as it is not discussed, nor are the unique barriers to fertility services faced by BIPOC groups. Instead of discussing the experience of BIPOC communities with assisted reproduction, the report generalizes the users of IVF as either male/female and/or men/women and assumes all users within these categories face the same barriers. In other words, by not explicitly naming race as a factor that influences interactions with fertility services, the report makes race invisible and puts forward the assumption that racialized people and white people's experiences with IVF are one to one with each other. This is mirrored in the OFP as the documents about the program do not make any mention of how barriers created by racism have been accounted for and are addressed within the design of the program.

Such assumptions and generalizations are problematic as the literature has showcased how BIPOC communities have faced more restricted access to IVF than their white counterparts. For instance, Cranston-Reimer (2019) showcases how the state's inclusion of 2SLGBTQIA+ people in the OFP is limited to white queer people with financial privilege, while the barriers for racialized queer people still remain. The program presents itself as being progressive through its promotion of 2SLGBTQIA+ people using IVF, but this inclusion is only limited to those who are white, queer, and with high incomes due to the program not supporting the additional costs and time commitments that come with IVF (Cranston-Reimer, 2019). Within the racialized medical context, this exclusion continues the long history of fertility services not being open to racialized populations as:

Researchers and scholars have advanced several theories, including lower income levels and access to insurance in minority populations, social factors that make women of color

less likely to seek treatment for infertility, historic factors that give rise to a continuing aura of mistrust in the doctor-patient relationship, and express an implied discrimination by doctors who view minority populations as less deserving of parenthood than white patients. . . (Daar, 2017, as cited in Cranston-Reimer, 2019, p.75)

This quote provides an overall summary about the ways in which BIPOC communities have been historically disadvantaged in receiving fertility care. From being priced out of the service, to having their bodily autonomy restricted by doctors, IVF is not always an accessible or safe option for BIPOC communities seeking fertility care. Therefore, the lack of explicit inclusion of racialized marginalized groups from fertility services upholds white couples dominating fertility clinics. As a result, the author posits the OFP is homonationalist because it facilitates the procreation of only queer white people who can afford the additional costs of IVF while denying racialized groups the same opportunity by not removing the specific barriers they face to receiving IVF (Cranston-Reimer, 2019). Tam (2021) reaches a similar conclusion about the OFP centering white couples as they found that because the government does not take into account the historical marginalization of racialized groups, white people remain more privileged in obtaining IVF services. Specifically, these equity-deserving groups do not have access to IVF because of the long waitlist for public services and/or lack of income to afford services out of pocket (Tam, 2021). Thus, because of the lack of consideration of race, the OFP is a contributor to inequity because the Ministry of Health and Long-Term care did not create “guidelines or principles of prioritization for fertility clinics to distribute resources” (Tam, 2021, p.3).

Therefore, because race is made invisible, and the material consequences are that racialized people have not benefited from the OFP as their white counterparts have.

This is why assuming the experiences of white people will align with those of racialized people, as the report does by not mentioning race, does more harm than help to BIPOC seeking IVF. Because the report predates the creation of the OFP and was meant to inform it, the lack of inclusion of race within the report and the current racial disparities within the OFP that Cranston-Reimer (2019) and Tam (2021) speak about, showcase how such erasure upholds barriers to IVF for marginalized groups. In other words, the lack of consideration about race contributed to the overrepresentation of white people using IVF seen in the OFP today.

Moreover, absolutely no attention is placed in the report or OFP documents on how race, gender, *and* other intersecting identities create unique barriers to using fertility services. While issues pertaining to sexuality and income are touched upon as individual contributing factors in the report, the lack of acknowledgement of how these identities influence and are influenced by each other means the unique barriers they create for marginalized groups are erased. Thus, this one-dimensional view of identity does not align with RJ as it does not take into account the needs of women of color and other marginalized women and trans people (Ross and Solinger, 2017). While the report is correct in advocating for greater state support, this support also needs to consider how not all people using fertility services face the same barriers. Therefore, *Raising Expectations* and the OFP do not align with RJ as they fail to consider and uplift the most marginalized within its exploration of assisted reproduction in Ontario.

#### *IVF, Intersectionality, and Parenthood*

The consequences of both *Raising Expectations* and documents about the OFP failing to demonstrate an RJ lens within their discourse is it creates a narrow view of who uses IVF in Ontario to become parents and the barriers they face, and thus who is supported by the state in becoming a parent. For instance, because the report utilizes a singular view of identity when assessing the

barriers to IVF, the imagined user of these services that want to become a parent is also highly limited to this construction. As previously stated, because barriers related to race, gender, sexuality, and any other aspects of identity intersecting with one another are not mentioned within the report, the barriers named, for the most part, only impact white and cisgender (cisgender and heterosexual) groups and do not account for the experiences of more historically marginalized groups. Furthermore, beyond the barriers explicitly named in the report, the assumptions that are embedded in the discursive constructions of IVF reveal that the imagined IVF users are also white, cisgender heterosexual couples with sufficient incomes to afford additional IVF costs.

While the report explicitly uses gendered and cisgender language, the imagined IVF user is white specifically because *Raising Expectations* does not address race. The state has actively not included BIPOC communities within IVF services as a means to uphold white people's dominance within fertility services. For instance, Tam (2021) argues that ignoring the experiences, through the lack of data collected on BIPOC's experience with ART, ultimately upholds wealthy, white, cisgender couples' access to ART at the expense of other marginalized groups. Meaning, the inaction to include BIPOC within research pertaining to IVF serves as an action on its own to exclude them. Additionally, as the literature above has shown, the experiences of white and BIPOC communities are not comparable to one another as the latter faces historical and systemic reproductive oppression that impacts their interactions with state fertility services. Thus, the overrepresentation of white people within IVF users makes it so the default IVF user is white. While the report makes generalizations about "men" and "women," these imagined users are white precisely because they are not stated to be otherwise and IVF research has historically centered the experiences of white people. Therefore, the lack of mention of BIPOC users has made it so the imagined user for IVF is white.

Additionally, the lack of intersectionality in the report results in IVF services being designed for this imagined user/parent, who is white, cisgender, and a high income earner, while all those outside this construction are erased. This reflects that certain groups' lack of inclusion means they are also not the parent who IVF is imagined to support through publicly funded IVF services. Instead, the imagined parent for IVF is white. Furthermore, as shown in the results section, a lack of inclusion within the text is seen in the report only using language that reflects cisgender and heteronormative assumptions about IVF users, and thereby, assumes people becoming parents via IVF are also cisgender and heterosexual. For example, because the report only makes generalizations about the barriers “women” and some LGBTQ people face, the specific barriers faced by Black queer women are not addressed and continue to persist as their specific experiences are not applicable to all women or queer people. Thus, whose barriers are acknowledged and addressed are also who is imagined to become a parent through IVF.

The OFP was informed by the assumptions *Raising Expectations* made about those trying to become parents through IVF being primarily white, cisgender and heterosexual and ensured the state supports these groups, as well as those with financial privileges. The lack of mention of how the OFP accounts for any specific barriers faced by marginalized groups other than brief mentions of LGBTQ people means the program is constructed to aid those who are white, cisgender and heterosexual. This is seen in the documents pertaining to the OFP also not acknowledging the various ways intersecting identities impact IVF access. In terms of who the state supports in becoming a parent through IVF, this narrow construction of who a potential IVF user may be means the state supports white, cisgender and heterosexual couples with financial privilege through the OFP. This is because, in conjunction with not examining and addressing the specific barriers faced by marginalized groups, the OFP’s funding structure assumes users will be able to

take on the additional costs of fertility drugs, as well as subsequent cycles in order to achieve pregnancy. This is seen in the program going against the recommendations of the Expert Panel and choosing to only fund one cycle of IVF, without covering the cost of fertility drugs. This means the funding structure of the program has been designed to allow those who can take on the additional costs associated with IVF, as well as those who are not impacted by other barriers related to race, gender identity, and/or sexuality. In other words, those who meet these criteria are those who the state views as ideal candidates in becoming parents through IVF, and thereby, who are set up for success in using the OFP to achieve pregnancy.

## **Conclusion**

Discourses surrounding IVF and infertility have a significant impact on the policies that regulate them. Several case studies demonstrate the ways the state has tried to control the bodily autonomy and reproduction of marginalized groups (Tam, 2021; Franklin and Ginsberg, 2019; Perritt and Eugene; Luna and Luker, 2013). For instance, reproductive control through assisted reproduction has resulted in purposeful attempts to lower the birth rates in BIPOC communities as they were seen as a threat to the majority white population (Tam, 2021). Discrimination also been seen in private fertility clinics in Canada that have catered to heterosexual married couples that face “infertile/low fertility” while excluding LGBTQ2SIA+ people (Tam, 2021, p.3).

In regards to infertility, the literature found that infertility is heavily medicalized as it is viewed as a medical condition that requires treatment. Within the Canadian context, IVF policy has been highly influenced by the medicalization of infertility. For instance, Cattapan (2020) demonstrated how discourse about infertility as a medically necessary service influenced government policy in support of public funding in what would later become the OFP.

However, despite these cases, the literature about reproductive oppression tends to center America and Europe as sites where reproductive oppression occurs. Similarly, literature on infertility and the field of reproductive justice has also primarily focused on the American context. Thus, this study aimed to expand the literature on IVF and RJ by analyzing the discourse surrounding IVF within Ontario's IVF policy.

In Ontario, OHIP funds health services while the OFP funds IVF. Specifically, the OFP provides public funding for one IVF treatment cycle per patient per their lifetime (Ontario Ministry of Health, 2021). To qualify for OHIP, one must reside in Ontario and those new to the province must wait 3 months before OHIP will cover their medical costs (Ontario Ministry of Health, 2022). Similarly, to utilize OFP, residents must possess a valid Ontario health card (Ontario Ministry of Health, 2022).

This discursive exploration of OFP funding was informed by the principles of RJ theory to interrogate how the OFP funding restricts the right to have a child of those who experience infertility and/or are seeking to get pregnant through assisted reproduction. The primary question this research sought to address is as follows: Through the lens of reproductive justice, who does the state support in becoming parents via in vitro fertilization? A Foucauldian and feminist critical discourse analysis were conducted on various OFP policy documents and other communications related to the construction of infertility and IVF support within Ontario. The major themes that emerged were the use of gendered language and shifting accountability.

Within *Raising Expectations* (2009), this analysis found the discourse surrounding fertility services in Ontario viewed fertility services as a means to achieve the goal of building a family through conceiving children with government assistance. Furthermore, the use of cisnormative and gendered language to discuss infertility and risk factors not only resulted in not the erasure of those

outside the gender binary, but also advanced gendered assumptions about women as passive towards their fertility and bodily functions. Lastly, the discourse within this report emphasized the need for “women” to “protect” their fertility from the dangers of infertility. Infertility itself was viewed as a medical condition that required treatment through assisted reproduction. Such discourses informed the recommendations that IVF is a medically necessary service and that public funding for IVF is connected to the betterment of society.

Within various documents that communicate how OFP funding and IVF delivery operate, this study found that the Ontario government presented the OFP as a progressive government program. However, the OFP circumvents hallmarks of progressive health care, such as the CHA conditions that facilitate access to health services without additional barriers. These documents that communicated information for those seeking IVF contained a lack of clarity regarding how IVF funding operates, creating the impression that the funding for fertility treatment is being increased through OHIP rather than the OFP. The use of language within these documents emphasized the government’s contributions to the OFP and allowed it to present itself as progressive for increasing support for fertility services while obfuscating limitations around how much support is provided. Thus, the framing of the OFP expanding access to IVF does not reflect the fact that many people are actually ineligible to receive such services based on the program’s own criteria. What is covered under this program is very limited and carries additional costs that will need to be paid for by patients. Therefore, the consequence of this lack of clarity is that it plays into assumptions that these services will be accessible for all who seek them, as would be expected under insured health care services and the CHA. Thus, even though the language used in these documents positions the government as increasing coverage, in practice the organization of

the OFP places the responsibility for providing and fully funding fertility services on patients and those outside the government rather than on the government itself.

The discussion of this analysis showcases how the Ontario government has failed to ensure all Ontarians are able to adequately access IVF services through an RJ lens. Firstly, The OFP's funding structure assumes users will be able to take on the additional costs of fertility drugs and subsequent cycles in order to achieve pregnancy. Further, the principles of RJ are also not found within the OFP as circumventing the CHA and shifting the accountability of delivering services from the government to individuals impacts the right to have a child by producing additional accessibility barriers, such as long wait times and geographical barriers.

While the report's focus on eliminating the financial barriers to assisted reproduction through state-funded services aligns with some aspects of the right to have a child, its use of gendered language and erasure of race does not present infertility and IVF through an intersectional lens and fails to address the needs of the most marginalized as is required within RJ. The lack of intersectionality in the report results in IVF services being designed for an imagined user/parent, who is white, cisgender, and with high income, while all those outside this construction are erased. In other words, this discourse analysis of IVF documents has found that the state supports white, cisgender and heterosexual couples with financial privilege in becoming parents through the OFP.

The lack of intersectional consideration of the barriers within *Raising Expectations* has greatly influenced the singular view of identity that is seen in the construction of the OFP. Thus, to begin to rectify this, further research is needed on the barriers to IVF faced by marginalized groups. For example, race-based data needs to be collected and analyzed in order to better understand IVF beyond how white people experience it. By doing so, the experiences of white people are not viewed as universal and thus, barriers to IVF can begin to be dismantled rather than

reinforced by upholding the status quo. Therefore, a more nuanced view of identities and the right to have a child needs to be considered when analyzing IVF and who is able to become a parent in Ontario.

Bringing more consideration to the impact that intersecting identities have on IVF access allows more barriers to come down permanently as it truly expands who can become a parent. The right to have a child should not be limited to those who fit into the narrow definition of parenthood. Instead, once the most marginalized groups are able to use IVF without the worry of discrimination, inaccessibility, or financial ruin, IVF can actually become an accessible fertility option for those who want to use it to become parents. Therefore, IVF and the discourse around fertility services need to stop viewing the service as a luxury for a few to obtain, but rather, one of many ways the state supports *all people* wanting to become parents.

## Appendix A – Research Sample Documents

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